MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Health and Human Services

Bulletin Number: MSA 16-42

Distribution: All Providers

Issued: November 30, 2016

Subject: Updates to the Medicaid Provider Manual; Blood Lead Nursing Assessment Visits

Effective: January 1, 2017

Programs Affected: Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, Children's Waiver, Maternity Outpatient Medical Services, MIChoice Waiver

Updates to the Medicaid Provider Manual

The Michigan Department of Health and Human Services (MDHHS) has completed the January 2017 quarterly update of the Michigan Medicaid Provider Manual. The Manual is maintained on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy and Forms >> Medicaid Provider Manual. A compact disc (CD) version of the Manual is available to enrolled providers upon request.

The January 2017 version of the Manual does not highlight changes made in 2016. Refer to the online version of this bulletin at www.michigan.gov/medicaidproviders >> Policy and Forms to view the attachments that describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change. Subsequent changes made for the April, July, and October 2017 versions of the manual will be highlighted within the text of the on-line manual.

Blood Lead Nursing Assessment Visits

Blood lead nursing assessment visits for children with blood lead levels of 5 mcg/dL or greater will be covered under the Children's Special Health Care Services case management benefit. Providers should refer to the Children's Special Health Care Services Chapter, Section 9.4 Case Management Benefit for more information. Procedure code T 1028 will be end dated as of December 31, 2016.

Manual Maintenance

If utilizing the online version of the manual at www.michigan.gov/medicaidproviders >> Policy and Forms, this bulletin and those referenced in this bulletin may be discarded. If using a CD version of the Medicaid Provider Manual, providers should retain all bulletins issued since the version date of the CD. Providers are encouraged to use the Michigan Medicaid Provider Manual on the MDHHS website; the online version of the manual is updated on a quarterly basis.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Chris Priest, Director
Medical Services Administration

Michigan Department of Health and Human Services

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	12.1.A. Hospitals and Nursing Facilities	The following text was added: A nursing facility must notify the local MDHHS office if there is a change in the facility's NPI/Medicaid Provider ID number. Notification to the local MDHHS office must be made via a revised Facility Admission Notice (form MSA-2565-C) for all current Medicaid beneficiaries and newly admitted Medicaid beneficiaries. Notification applies to a facility enrolling in the Medicaid program or an enrolled facility that has a change of ownership where the NPI/Medicaid Provider ID number changes, including an enrolled ventilator dependent unit. When completing the MSA-2565-C, the NPI field must also contain the effective date of the NPI. An MSA-2565-C is not submitted for beneficiaries receiving hospice services in a nursing facility.	Process information from Letters L 16-13 and L 16-16.
Coordination of Benefits	2.6.A. Medicare Eligibility	In the 2nd paragraph, the 1st sentence was revised to read: If a Medicaid beneficiary is eligible for Medicare but has not applied for Medicare coverage, Medicaid does not make any reimbursement for services until Medicare coverage is obtained.	Clarification.
Coordination of Benefits	2.6.B. Medicare Part A	In the 5th paragraph, the 1st sentence was revised to read: To expedite the buy-in process, providers may notify MDHHS, in writing, when a beneficiary covered by Medicare Part B only is admitted to an inpatient hospital.	Clarification.
Coordination of Benefits	2.6.J. Psychiatric Services	The 2nd and 3rd paragraphs were deleted.	Removed language as Medicare reimburses mental health treatment services at parity with other Part B services.
Billing & Reimbursement for Dental Providers	Section 9 – Julian Calendar	In the first paragraph following the table, text was revised to read: For leap year, one day must be added to the number of days after February 28. The next three leap years are 2020, 2024, and 2028.	Update.

* Technical Updates/Clarifications are always highlighted in yellow in the online manual.

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	9.3 Blood Lead Poisoning Nursing Assessment/ Investigation Visits	Subsection was deleted. Following subsections were re-numbered.	Changed to align with existing processes.
Billing & Reimbursement for Institutional Providers	Section 13 – Julian Calendar	In the first paragraph following the table, text was revised to read: For leap year, one day must be added to the number of days after February 28. The next three leap years are 2020, 2024, and 2028.	Update.
Billing & Reimbursement for Professionals	Section 9 – Julian Calendar	In the first paragraph following the table, text was revised to read: For leap year, one day must be added to the number of days after February 28. The next three leap years are 2020, 2024, and 2028.	Update.
Ambulance	1.1 General Information	The 2nd paragraph was revised to read: The Michigan Department of Health and Human Services (MDHHS), which administers the Medicaid Program, reimburses for ambulance services as medically necessary and appropriate, regardless of whether there is a corresponding medical claim on the date of service, when: ...	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Ambulance	2.1 Air Ambulance	In the 1st paragraph, the second-to-last sentence was revised to read: Providers must indicate on the enrollment application that they are requesting either fixed-wing air ambulance or rotary wing air ambulance status. In the 3rd paragraph, the 1st sentence was revised to read: Hospital-to-hospital emergent transfers performed by either a rotary wing or fixed-wing air ambulance require … The following textbox was added at the end of the subsection: The ambulance company must bill any ground ambulance transportation ordered to and from the airport in the normal manner.	Consistency in terminology. Relocated from 2.1.B. Helicopter Air Ambulance
Ambulance	2.1.B. Rotary Wing Air Ambulance	The subsection title was revised to read: Rotary Wing Air Ambulance Text was revised to read: The Medicaid Provider Enrollment file reflects enrollment as a rotary wing air ambulance provider.	Consistency in terminology.
Ambulance	2.2 Base Rate	In the 1st paragraph, the 7th bullet point was revised to read: • Rotary Wing Air Ambulance; or	Consistency in terminology.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.26 Telemedicine	In the 1st paragraph, the last sentence was removed.	MDHHS allows for reimbursement of the facility fee to be consistent with FFS and others. The code is available in the array of services code chart.

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	15.1 Waiver Supports and Services	At the end of "Private Duty Nursing", the textbox was revised to read: Private Duty Nursing is a Medicaid coverage for beneficiaries under age 21 who meet the medical criteria for eligibility. Refer to the Private Duty Nursing Chapter of this manual for additional information.	Clarification.
Dental	6.1.A. Clinical Oral Evaluation (Examinations)	Text after the 2nd sentence was revised to read: Typically, it should include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, periodontal conditions, occlusal relationships, hard and soft tissue anomalies, oral cancer screening, and prosthesis condition and usage. All clinical oral evaluations must include a diagnosis and treatment plan. Examinations without this documentation are not a covered benefit.	Added for clarification
Dental	6.6.A. General Instructions	In the 2nd paragraph, the 3rd bullet point was removed. The 6th paragraph was revised to read: Complete or partial dentures are not authorized when: • A previous prosthesis has been provided within five years, whether or not the existing denture was obtained through Medicaid. • An adjustment, reline, repair, or rebasing will make a prosthesis serviceable. • A complete or partial denture has been lost or broken beyond repair within five years, whether or not the existing denture was obtained through Medicaid.	Removed due to conflicting language. Clarification.
Early and Periodic Screening, Diagnosis and Treatment	12.4.B. Blood Lead Nursing Assessment Visits	Text was revised to read: Blood lead nursing assessment visits for children with blood lead levels of 5 mcg/dL or greater are covered under the Children's Special Health Care Services (CSHCS) case management benefit. Beneficiaries are eligible for a maximum of six billing units per year. (Refer to the Children's Special Health Care Services Chapter, Case Management Benefit for more information.)	Changed to align with existing processes.

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CHAPTER	SECTION	CHANGE	COMMENT
Plan First! Family Planning Waiver	Table of Contents page	The burst box was revised to read: The *Plan First!* waiver expired on June 30, 2016. *Plan First!* coverage for all enrollees ended effective July 1, 2016.	Update.
Home Health	6.1.B. Blood Lead Poisoning Nursing Assessments/ Investigation Visits	Subsection was deleted. Following subsections were re-numbered.	Changed to align with existing processes.
Hospice	6.7.E. Private Duty Nursing	The last paragraph was revised to read: This does not apply to beneficiaries receiving PDN services under the Habilitation Supports Waiver (HSW) and over 21, or the MI Choice Waiver. For beneficiaries under the HSW, providers should contact the beneficiary's case manager to inform them of hospice eligibility. If the beneficiary is under the MI Choice Waiver, providers should contact the MI Choice Waiver Supports Coordinator.	Clarification.
Hospital	5.7 Private Duty Nursing	The 2nd paragraph was revised to read: If the beneficiary is enrolled in or receiving case management services from one of the following programs, the applicable program authorizes the PDN: • Habilitation Supports Waiver (the Community Mental Health Services Program), and over age 21 • Home and Community-Based Services Waiver for the Elderly and Disabled (the MI Choice Waiver)	Clarification.
Hospital Reimbursement Appendix	2.6 Episode File	In the 15th bullet point, 2nd sub-bullet point, the 2nd sentence was revised to read: Wage data is collected using the Medicare-audited wage data, as published on the Centers for Medicare & Medicaid Services (CMS) website.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	2.7.B. Updated Cost Adjustor	The 1st bullet point was revised to read: Wage data is collected using the Medicare-audited wage data, as published on the Centers for Medicare & Medicaid Services (CMS) website.	Clarification.
Hospital Reimbursement Appendix	3.3 Michigan State-Owned Hospitals	Text was revised to read: Michigan state-owned hospitals are reimbursed for their services using a prospective per diem rate. Each facility, in aggregate, will not receive payments in excess of the costs it incurs providing services to its Medicaid patients. Reimbursement for Michigan state-owned hospitals is subject to Federal upper payment limits. The upper payment limit for state-owned hospitals utilizes allowable inpatient charges as described in the Initial Settlement(s) subsection of the Hospital Reimbursement Appendix.	Clarification.
Local Health Departments	2.2.B. Blood Lead Poisoning Follow-Up Services	Text was revised to read: LHDs may provide blood lead poisoning follow-up services which consist of environmental investigations and nursing assessment visits. LHDs may provide blood lead poisoning follow-up services provided to any Medicaid-covered child, regardless if the child is enrolled with an MHP or is in the FFS program. Authorization for these services is not required by the MHP; however, LHDs must notify the plan of the service(s) provided and provide the plan with a summary of each. Documentation of the child's blood lead poisoning level that initiated service must be maintained, as well as documentation of all environmental investigations and nursing assessment visits.	Changes made to align with subsection headings.
Local Health Departments	2.2.B.1. Blood Lead Nursing Assessment Visits (new subsection)	New subsection text reads: Blood lead nursing assessment visits for children with blood lead levels of 5 mcg/dL or greater are covered under the Children's Special Health Care Services (CSHCS) case management benefit. Beneficiaries are eligible for a maximum of six billing units per year. (Refer to the Children's Special Health Care Services Chapter, Case Management Benefit for more information.)	Changed to align with existing processes.

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CHAPTER	SECTION	CHANGE	COMMENT
Local Health Departments	2.2.C. Environmental Investigations	Removal of: 2.2.C. Environmental Investigations o 2.2.C.1. Initial Investigations o 2.2.C.2. Follow-Up Investigations o 2.2.C.3. Resource Documents	Text was relocated within Section 2.
Medical Supplier	1.7.C. Emergency Prior Authorization	The 2nd paragraph was revised to read: To obtain a verbal PA, the provider may call the Program Review Division or fax a request. (Refer to the Directory Appendix for contact information. Refer to the Forms Appendix for copies of forms MSA-1653-B and MSA-1653-D and completion instructions.) In the 4th paragraph, the 1st bullet point was revised to read: • Submission of the PA request to MDHHS within 30 days of the verbal authorization. (Refer to the Forms Appendix for copies of forms MSA-1653-B and MSA-1653-D and completion instructions.)	
Nursing Facility Coverages	5.2.B. Provider Appeals	In the 1st paragraph, text after the 1st sentence was revised to read: If the facility disagrees with the MDHHS Adverse Action Notice, the facility may appeal if their written request is date-stamped as 'RECEIVED' by the MDHHS Michigan Administrative Hearing System office or the MDHHS Appeals Section office within 30 calendar days from the date of the MDHHS Adverse Action Notice.	Clarification.
Nursing Facility Cost Reporting & Reimbursement Appendix	4.2 Nursing Facility Cost Report	In the 1st paragraph, the 3rd sentence was revised to read: These records must be maintained in a manner consistent with the Medicare Principles of Reimbursement, except where modified by Medicaid policy. In the 2nd paragraph, the 1st sentence was revised to read: Related organizations and costs to related organizations, as defined in federal policies and regulations, must be disclosed on the nursing facility cost report.	Updated for grammatical changes and rewording.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	4.3 Cost Report Requirements	In the 2nd paragraph, the 3rd bullet point was revised to read: ▪ A copy of the nursing facility's detailed general ledger and complete (no grouping or summary) trial balance of revenues and expenses.	Technical change and clarification to the existing requirements.
Nursing Facility Cost Reporting & Reimbursement Appendix	Section 6 – Audit	The 5th bullet point was revised to read: • To confirm that, in all material aspects, the nursing facility provider is in compliance with the reimbursement policies and regulations.	Updated for grammatical changes and rewording.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	8.14 Medical Supplies, Durable Medical Equipment (DME), Orthotics, and Prosthetics (new subsection; following subsections were re-numbered)	New subsection text reads: The cost of medical supplies or DME are generally considered an allowable cost. However, the following items are not allowable and must be billed by the medical supplier: ▪ Air-fluidized beds ▪ Bariatric beds ▪ Bilevel positive airway pressure (BiPAP) device ▪ Continuous positive airway pressure (CPAP) device ▪ Custom-fabricated seating systems may be covered outside of the nursing facility per diem rate when a standard item will not meet the medical and functional needs of the user and standards of coverage are met. ▪ Negative pressure wound therapy pump and accessories (wound VAC) ▪ Orthotics and Prosthetics ▪ Parenteral nutrition, including all supplies, equipment, and solutions ▪ Powered air flotation bed (low air loss therapy) ▪ Selected surgical dressings ▪ Shoes and additional components The Nursing Facility Coverages chapter further describes the services included in the Medicaid per diem rate.	This new subsection consistent with current policy found in the Medical Supplier and Nursing Facility Coverages chapters.
Nursing Facility Cost Reporting & Reimbursement Appendix	9.6.A.3. Ancillary/Therapy Services Administrative Overhead	In the 2nd paragraph, the 3rd sentence was revised to read: The provider must demonstrate considerable inequity of the overhead cost allocation to these service activities that have been identified as excluded groups under the Medicare Principles of Reimbursement and that it is not incurring additional costs beyond the activity for arranging for the services.	Updated for grammatical changes and rewording.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	9.8 Day Care Services Provided in the Nursing Facility	The 1st sentence was revised to read: According to federal principles, day care services provided to an employee's dependent are not a fringe benefit when furnished for the convenience of the provider.	Updated for grammatical changes and rewording.
Nursing Facility Cost Reporting & Reimbursement Appendix	9.8.A. Employee Dependents	The 1st paragraph was revised to read: According to federal principles, the costs of operating a day care center for the children of a facility's or related facility's employees must not be reported as an employee fringe benefit. The costs are allowable to the extent that the amount is reasonable. "Reasonableness" means that the services are provided in accordance with the policies and regulations established for the provision of such services, and must take into account both direct and indirect costs. The provision of ...	Updated for grammatical changes and rewording.
Nursing Facility Cost Reporting & Reimbursement Appendix	Section 13 - Appraisal Guidelines	In the 2nd paragraph, under "Appraisal Expert", the last sentence was revised to read: The appraisal expert must employ a specially trained and well supervised staff with a complete range of appraisal and cost construction techniques; be experienced in appraisals of plant assets used by providers; and demonstrate a knowledge and understanding of the reimbursement principles, particularly those pertinent to depreciation.	Updated for grammatical changes and rewording.

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CHAPTER	SECTION	CHANGE	COMMENT
Private Duty Nursing	Section 1 - General Information	The 2nd and 3rd paragraphs were revised to read: PDN is covered for beneficiaries under age 21 who meet the medical criteria in this section. If the beneficiary is enrolled in or receiving case management services from the Habilitation Supports Waiver (the Community Mental Health Services Program) and over 21 years of age, that program authorizes the PDN services. For a Medicaid beneficiary who is not receiving services from the Habilitation Supports Waiver (the Community Mental Health Services Program), the MDHHS Program Review Division (PRD) reviews the request for authorization and authorizes the services if the medical criteria and general eligibility requirements are met. The last paragraph was revised to read: Beneficiaries who are receiving PDN services through one Medicaid program cannot seek supplemental PDN hours from another Medicaid Program (i.e., Habilitation Supports Waiver, MI Choice Waiver).	Clarification.
Private Duty Nursing	1.4 Prior Authorization	In the 1st paragraph, the 1st sentence was revised to read: PDN services must be authorized by the PRD before services are provided. In the 2nd paragraph, text after the 3rd sentence was revised to read: This form is **not** to be used for beneficiaries enrolled in the MI Choice Waiver. Private Duty Nursing is not a benefit under CSHCS. Individuals with CSHCS coverage may be eligible for PDN under Medicaid.	Clarification.
Private Duty Nursing	2.7 Hospice Services	The last paragraph was revised to read: This does not apply to beneficiaries receiving PDN services under the Habilitation Supports Waiver (HSW) and over 21 years old, or the MI Choice Waiver. For beneficiaries under the HSW (over 21 years old), providers should contact the beneficiary's case manager to inform them of hospice eligibility. If the beneficiary is under the MI Choice Waiver, providers should contact the MI Choice Waiver Supports Coordinator.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Vision	1.5 Contractor Guarantee	In the 1st paragraph, the 1st sentence was revised to read: Frames and lenses furnished by the contractor are guaranteed for 90 days.	Updated per current contract.
Directory Appendix	Provider Assistance	Under 'CSHCS Customer Support', information for 'Phone # Fax #' was revised to read: 517-335-8986 Fax 517-335-9491 (submission of medical reports, applications, and all other information) The e-mail address was removed.	Updates. Email address decommissioned.
Directory Appendix	Billing Resources	Under 'MDHHS Procedure Code Databases/Fee Screens, …', the phone number was revised to read: 517-284-1245	Update.
Directory Appendix	Policy/Forms/ Publications	Under 'Draft Medicaid Policy', the phone number was revised to read: 517-284-1245 Under 'Medicaid Policy Manuals and Bulletins', the phone number was revised to read: 517-284-1245	Update.
Directory Appendix	Health Plan Information	Under 'Medicaid Health Plans', the phone number was revised to read: 517-284-1162	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Provider Resources	Under "MDHHS Bureau of Epidemiology; Division of Communicable Disease": 'Contact/Topic' was revised to read: Bureau of Epidemiology and Population Health; Division of Communicable Disease The mailing address was revised to read: MDHHS Bureau of Epidemiology and Population Health Division of Communicable Disease 333 S. Grand Ave., 3rd Floor Lansing, MI 48909	Update.
Directory Appendix	Provider Resources	Under "MDHHS Bureau of Epidemiology; Division of Immunization": 'Contact/Topic' was revised to read: Bureau of Family Health Services; Division of Immunization The mailing address was revised to read: MDHHS Bureau of Family Health Services Division of Immunization 333 S. Grand Ave., 3rd Floor Lansing, MI 48909	Update.
Directory Appendix	MI Choice Waiver Resources	The fax number of 517-241-7186 was revised to read: 517-241-7816 The mailing address was revised to read: Home and Community-Based Services Section 400 S. Pine St. Lansing, MI 48909	Correction. Update – reflects relocation of office within building.

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CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Nursing Facility Resources	Under 'Certificate of Need Commission', the address was revised to read: MDHHS Certificate of Need Evaluation Section South Grand Building, 4th Floor 333 S. Grand Ave. Lansing, MI 48933	Update.
Directory Appendix	School Based Resources	The phone number of 517-241-8398 was revised to read: 517-284-1197	Update.
Directory Appendix	Other Health Care Resources/Programs	Under 'Program of All-Inclusive Care for the Elderly (PACE)', the phone number was revised to read: 517-373-7493	Update.
Forms Appendix		The following forms were revised to meet Department standards. • DCH-0893 • DCH-1074 • DCH-1185 • DCH-1401 • DCH-3877 • DCH-3878 • DCH-3890 • MSA-2218	Forms were revised to meet Department formatting standards. Although revisions will be noted in the appearance of the form only -- no changes were made to the function of or information on the forms. Providers/users should use the updated version of the form(s) as all previous versions are considered obsolete.

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CHAPTER	SECTION	CHANGE	COMMENT
Forms Appendix	MSA-1653-D	Field previously identified as 'Description of Service, Brand, Model, Catalog, and Parts' was reformatted into two fields: Field 20) Brand Name, Model, Catalog or Part Number, and Field 21) Description of Service. • Instructions were revised accordingly • Field numbers were revised accordingly	Form was revised to assist with Department operational needs.
Forms Appendix	MSA-1680-B	Revisions to fields and instructions.	Form was revised to assist with Department operational needs.
Forms Appendix	MSA-2565-C	Under 'General Instructions/Distribution', the following text was added to the 3rd bullet point: A nursing facility must notify the local MDHHS office if there is a change in the facility's NPI/Medicaid Provider ID number. Notification to the local office must be made via a revised Facility Admission Notice (MSA-2565-C) for all current and newly admitted Medicaid beneficiaries. Notification applies to a facility enrolling in the Medicaid program or an enrolled facility that has a change of ownership when the NPI/Medicaid Provider ID number changes, including an enrolled ventilator dependent unit. Note: When completing the MSA-2565-C, the NPI field must also contain the effective date of the new NPI. MSA-2565-C is not submitted for beneficiaries receiving hospice services in a nursing facility.	Form was revised to assist with Department operational needs.
Forms Appendix	MSA-1653-B	Field previously identified as 'Description of Service' was reformatted into two fields: Field 19) Brand Name, Model, Catalog or Part Number, and Field 20) Description of Service. • Instructions were revised accordingly • Field numbers were revised accordingly	Form was revised to assist with Department operational needs.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 15-49 and MSA 15-38	12/1/2015 and 9/1/2015	General Information for Providers	11.2.C Cost-Sharing Limits (new subsection)	New subsection text reads: Medicaid cost-sharing, which includes premiums, contributions, copays and co-insurance incurred by individuals in a Medicaid household, may not exceed an aggregate limit of 5% of family income. MDHHS implements these limits on a calendar quarter basis through the tracking of applicable incurred cost-sharing, including paid claims for services as they are processed through the MDHHS Community Health Automated Medicaid Processing System (CHAMPS). Providers are expected to utilize the cost-sharing information in CHAMPS to determine whether cost-sharing may be assessed at the time of the visit and inform the beneficiary of their cost-sharing obligations. The eligibility response within CHAMPS includes the following cost-sharing information for the current calendar quarter: • Cost-Share Met (Y or N); • Cap Amount Remaining; and • Copayment (for various services). If the "Cost-Share Met" is listed as "Y" in CHAMPS, a beneficiary may not be charged any cost-sharing for the remainder of that quarter. In addition, regardless of the approved copayment amount for a particular service, beneficiaries may not be charged any cost-sharing that exceeds the "Cap Amount Remaining" amount listed. Finally, beneficiaries and services that are exempt from cost-sharing as set forth in this Section will remain exempt from cost-sharing. For pharmacy providers, any remaining copay responsibility will be communicated in the National Council for Prescription Drug Programs (NCPDP) transaction response field 505-F5 (Patient Pay Amount). The Point of Sale (POS) system will determine whether the aggregate limit has been met. Because CHAMPS tracks beneficiary costs-incurred as claims are adjudicated, providers are directed to bill all claims in a timely fashion. Providers are also directed to review the remittance advice to ensure that any copay charged at the time of service was appropriate and to provide refunds if necessary. Medicaid Health Plans that charge copays to Medicaid beneficiaries may also have administrative responsibilities to work with their providers to provide refunds when necessary or as directed by MDHHS.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 16-23	8/1/2016	Behavioral Health and Intellectual and Developmental Disability Supports and Services	18.3 Comprehensive Diagnostic Evaluations	In the 2nd paragraph, the 2nd sentence was revised to read: In addition, a qualified licensed practitioner will rate symptom severity with the Developmental Disabilities Children's Global Assessment Scale (DD-CGAS).
			18.5 Determination of Eligibility for BHT	In the 1st paragraph, the 2nd sentence was revised to read: Eligibility determination and recommendation for BHT must be performed by a qualified licensed practitioner through direct observation utilizing the ADOS-2 and symptom rating using the DD-CGAS.
			18.7 Re-evaluation	Text was revised to read: An annual re-evaluation by a qualified licensed practitioner to assess eligibility criteria must be conducted through direct observation utilizing the ADOS-2 and symptoms rated using the DD-CGAS. Additional tools should be used if the clinician feels it is necessary to determine medical necessity and recommended services. Other tools …
			18.12.A. BHT Supervisors	Under 'Qualified Behavioral Health Professional (QBHP)', 4th bullet point, 2nd sub-bullet point, the 1st sentence was revised to read: ➢ Minimum of a master's degree in a mental health-related field or BACB approved degree category from an accredited institution with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD.
MSA 16-24	8/1/2016	Early and Periodic Screening, Diagnosis and Treatment	12.4.A. Environmental Investigations	Text was revised to read: An environmental investigation of a beneficiary's home or primary residence is covered for the LHD. If more than one child in the home has blood lead poisoning, the LHD must select one child's Medicaid ID number and report a single environmental investigation visit. (Refer to the Local Health Departments Chapter for additional information on blood lead testing and follow-up services.)

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Local Health Departments	2.2.B.2. Environmental Investigations (new subsection)	Text was revised to read: An environmental investigation of a beneficiary's home or primary residence is covered for the LHD. A beneficiary's home is defined as their legal address. The beneficiary's primary residence is a place other than their legal address where the beneficiary spends a significant amount of time. To be eligible for the service, the beneficiary must be under 21 years of age and have a confirmed elevated blood lead level of 5 mcg/dL or greater. If more than one child in the home has blood lead poisoning, the LHD must select one child's Medicaid ID number and report a single environmental investigation visit. An environmental investigation visit can be billed directly to Medicaid FFS regardless if the beneficiary is enrolled in a MHP. Reimbursement is limited to the time and activities provided by certified assessors during the on-site investigation. Environmental investigations must be performed by assessors certified by the Michigan Department of Health and Human Services (MDHHS) Healthy Homes Program. The home or primary residence to be investigated must meet one of the following criteria: • The home or primary residence was built before 1978. • A home or primary residence built after 1978 when identification of other possible sources of lead exposure such as a job, hobby, environmental, home remedies, or cultural practices that use lead are associated with the property in question. The investigation must follow the Protocol for Environmental Investigations for Children with Elevated Blood Lead Levels and risk assessment activities per the Lead Abatement Act of 1998. The investigation must include testing of appropriate potential sources of paint, house dust, soil, water, and other household risk factors such as pottery and home remedies. Education must be provided regarding known and potential sources of lead poisoning, reduction of future exposures, and suggestions for specialized cleaning techniques. Risk assessors must prepare a risk assessment report per rule R325.9916 promulgated pursuant to the Lead Abatement Act that includes lead hazard control recommendations and the potential relocation of the child depending upon the severity of the lead hazards found.

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				Discussion with the family must include agencies that may be able to provide assistance with lead hazard control recommendations provided in the risk assessment report. An episode includes a venous blood sample indicating the child is at risk according to recommendations by the Centers for Disease Control and Prevention (CDC), and also includes resulting treatment and follow-up services. When an environmental investigation of the home finds no sources of lead or insufficient evidence to justify the beneficiary's elevated blood lead level, a second site may be investigated (e.g., home of a family member, relative, or other informal child care where a child often visits). When billing for the second site, local health departments must report the TS modifier with the procedure code on the claim. A maximum of two sites may be investigated.
			2.2.C. Blood Lead Resource Documents (new subsection)	Subsection text reads: Providers may obtain the Protocol for Environmental Investigations for Children with Elevated Blood Lead Levels, a list of certified risk assessors, applications for training and certification, and education materials from the MDHHS Lead Hazard Remediation Program. (Refer to the Directory Appendix for contact information.) Refer to the Early and Periodic Screening, Diagnosis and Treatment Chapter for additional information on blood lead.
			2.2.C. Environmental Investigations	Text was relocated within Section 2, resulting in the removal of: 2.2.C. Environmental Investigations o 2.2.C.1. Initial Investigations o 2.2.C.2. Follow-Up Investigations o 2.2.C.3. Resource Documents

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MSA 16-25	9/1/2016	Maternal Infant Health Program	2.10 Transportation	The following text was added after the 3rd paragraph: Reimbursement for transportation services provided to Medicaid FFS beneficiaries is made according to the allowable amount established by MDHHS and aligns with rates established for Non-Emergency Medical Transportation (NEMT) services. Refer to the MDHHS Non-Emergency Transportation Database located on the MDHHS website. (Refer to the Directory Appendix for website information.) MDHHS reimburses the MIHP provider an administrative fee equal to six percent of the cost of transportation provided to MIHP FFS beneficiaries. The 4th paragraph was revised to read: When billing, the six percent fee should be calculated and included in the amount charged, not to exceed the maximum amount allowed. The MIHP provider must determine the most appropriate and cost effective method of transportation. MDHHS reimburses transportation costs at the lesser of actual cost or the maximum/upper limit for: ▪ Bus ▪ Mileage (personal, including beneficiary, relative or friend) ▪ Taxi: If other methods of transportation are not available or appropriate, the MIHP provider may make arrangements with local cab companies to provide taxi service for MIHP beneficiaries. Since this is a more expensive service, MDHHS reimburses a maximum of 20 trips per beneficiary through the MIHP. The 8th paragraph was revised to read: MDHHS contracts with a transportation brokerage company to arrange and provide NEMT for beneficiaries residing in Wayne, Oakland and Macomb counties. Transportation may be provided when the beneficiary qualifies for service and has no other means of transportation. (Refer to the Directory Appendix for contractor contact information.)

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MSA 16-27	9/1/2016	Dental	9.1 Coverage and Service Area Information	The 1st paragraph was revised to read: MDHHS contracts for the administration of the Medicaid dental benefit called ***Healthy Kids Dental*** to all Medicaid beneficiaries under age 21. The dental services provided through the contractor are the same services provided through the Medicaid FFS program. (Refer to the Directory Appendix for contact information.)
			9.3 Loss of Enrollment	The 1st paragraph was revised to read: Beneficiaries are enrolled in ***Healthy Kids Dental*** until the last day of the month in which they turn age 21. If the beneficiary loses enrollment and is in active treatment that requires multiple appointments, the provider may bill the contractor for the treatment as long as it is completed within 60 days of the loss of eligibility.
MSA 16-31	9/28/2016	Vision	3.4.D. Replacement or Repair	The subsection title was revised to read: Replacement or Repair Under 'Eyeglasses', text was revised to read: Eyeglass repairs are a separately reimbursed service when the repair is considered major (e.g., reinsertion of a lens, repair of a sheared screw, shortening or replacing temples, etc.) and when the glasses are deemed repairable. Minor repairs (e.g., insertion of screw, adjustments of nose pads or temples, etc.) that occur as a result of the beneficiary's typical wear patterns are not separately reimbursed. The appropriate HCPCS code(s) must be reported for the component part that is being replaced. The reason for the repair must be documented in the beneficiary's file and made available upon request. If a provider determines that eyeglasses are repairable, the provider must guarantee the repair for a minimum of 30 days. Subsequent repair for the same issue within 30 days is the responsibility of the provider. If replacement eyeglasses are needed within the 30 day time frame following a repair, the provider must return the reimbursement received for the repair to MDHHS.

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				Eyeglasses that are broken beyond repair may be eligible for replacement by the contractor. Eyeglass replacement requires prior authorization if replacement limits have been exceeded.
MSA 15-30	9/1/2015	Billing & Reimbursement for Institutional Providers	8.8 Hospital Swing Beds	In the 1st bullet point, the sub-bullet point was revised to read: ➢ The admission date to the swing bed is not included in the billing period if the admission date to the swing bed is within the DRG coverage period.
		Hospital Reimbursement Appendix	Section 2 – Inpatient	Extensive revisions were made throughout Section 2. Revisions include: • re-numbering of subsections • addition of content • re-organization of content.
			3.2 Subacute Ventilator-Dependent Care	In the 1st paragraph, the 3rd sentence was revised to read: The negotiated per diem rate is not to exceed the average outlier per diem rate that would be paid for outlier days between DRG 004X and DRG 005X.
			4.1 Medicaid Health Plan Payments to Out of Network Hospitals	In the 1st paragraph, the last sentence was revised to read: MHPs are to use the DRG Grouper in use by Medicaid for the date of service to process out of network inpatient hospital claims and assign DRGs to determine relative weights, outliers, and average lengths of stay.

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