MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Health and Human Services

Bulletin Number: MSA 17-08

Distribution: All Providers

Issued: March 1, 2017

Subject: Updates to the Medicaid Provider Manual; Clarification to Bulletin MSA 17-05

Effective: As Indicated

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 April 2017 update of the online version of the Medicaid Provider Manual. The manual will be available April 1, 2017 at www.michigan.gov/medicaidproviders >> Policy and Forms >> Medicaid Policy Manual.

If changes were made in a chapter, a note will appear in the affected section/subsection title of that chapter's table of contents. If both technical and bulletin incorporation changes apply to the section/subsection, color coding will be limited to reflect a bulletin-related change.

Please 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.

Clarification to Bulletin MSA 17-05

Bulletin MSA 17-05, issued February 1, 2017, announced the implementation of a targeted and time-limited health services initiative intended to complement other federal, state and local efforts to abate lead hazards from the homes of Medicaid and Children's Health Insurance Program (CHIP) eligible individuals. After release of the bulletin, the Centers for Medicare & Medicaid Services (CMS) provided guidance authorizing MDHHS to mirror the abatement practices established by the U.S. Department of Housing and Urban Development (HUD). This initiative will now permit the restricted use of funds for housing costs of eligible recipients during the abatement process.

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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CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans	In the chart, under 'Benefit Plan ID: DHIP', the Benefit Plan Name was revised to read: Foster Care and CPS Incentive Payment	Correction. (Text was removed in error.)
Behavioral Health and Intellectual and Developmental Disability Supports and Services	4.3 Essential Elements	Under 'Team Composition and Size', the 8th bullet point was revised to read: • Up to one FTE paraprofessional staff to work with ACT teams may be counted in the staff-to-beneficiary ratio. Paraprofessional staff may have a bachelor's degree or related training in a field other than behavioral sciences (e.g., certified occupational therapy assistance, home health care); or have a high school equivalency and work or life experience with adults with severe mental illness or co-occurring substance use disorders.	Including paraprofessional staff in the staff-to-beneficiary ratio aligns the Michigan ACT model to that of many other states while addressing workforce capacity and the difficulty of hiring sufficient and qualified staff.
Behavioral Health and Intellectual and Developmental Disability Supports and Services; Non-Physician Behavioral Health Appendix	Section 2 – Provider Qualifications	The 1st paragraph was revised to read: Providers in Michigan must be currently licensed by the Department of Licensing and Regulatory Affairs (LARA). Licensed psychologists (including Master's Limited or Doctoral Limited level), social workers (Master's level), professional counselors (Master's or Doctoral level), and marriage and family therapists (Master's or Doctoral level) who serve Medicaid Fee for Service beneficiaries are required to enroll as Medicaid providers. The NPI of the psychologist, social worker, professional counselor, or marriage and family therapist must be uniquely identified on all claims. (Refer to the Billing & Reimbursement for Professionals Chapter for billing information.) Individuals holding temporary or educational limited licenses or student interns in these professions are not eligible to enroll as providers or be directly reimbursed by Medicaid. (Refer to the General Information for Providers Chapter for enrollment information).	Clarification to bulletin MSA 15-44.
Dental	1.1.A. Early and Periodic Screening, Diagnosis and Treatment	The 2nd paragraph was revised to read: Primary Care Physicians (PCPs) should provide an oral health screening and caries risk assessment for beneficiaries under 21 years of age at each well child visit. As an oral health intervention, providers should apply fluoride varnish to all children from birth to 35 months of age up to four times in a 12-month time period.	Current AAP recommendations include fluoride varnish applications for all children.

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

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CHAPTER	SECTION	CHANGE	COMMENT
Dental	2.2 Completion Instructions	Text was revised to read: The Dental Prior Approval Authorization Request form (MSA-1680-B) is used to obtain authorization. (Refer to the Forms Appendix for instructions for completing the form.) When requesting authorization for certain procedures, dentists may be required to send specific additional information and materials. Based on the MSA-1680-B and the documentation attached, staff approves or disapproves the request and sends a letter of status to the dentist. Approved requests are ...	Letter sent instead of copy of form.
Dental	2.4 Approved Prior Authorization Requests	The 5th paragraph was revised to read: Providers may update the PA request by contacting the Dental Prior Authorization Unit by fax or mail if there are no treatment plan changes. (Refer to the Directory Appendix for contact information.)	
Dental	6.1.G.8. Returned Radiographs	The 2nd paragraph was revised to read: Radiographs are returned to the dentist with a letter of status of the PA.	Letter sent instead of copy of form.

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CHAPTER	SECTION	CHANGE	COMMENT
Dental	6.2.B. Topical Application of Fluoride	The 1st paragraph was revised to read: **Non-Varnish**: Topical application of fluoride is a benefit for beneficiaries under age 16. It is covered only once every six months and cannot be combined with topical application of fluoride varnish within the six month time period. The fluoride must be approved by the ADA Council on Dental Therapeutics and administered using tray application only if age appropriate. **Varnish**: Topical application of fluoride varnish is a benefit for beneficiaries under age 16. Frequency and parameters vary based on the age of the beneficiary as noted below: • Ages 0-2: Four times per 12 months as a therapeutic application for all children. • Ages 3-15: One time per six months and cannot be combined with topical application of non-varnish fluoride within the six month period.	Text remove for redundancy. Current AAP recommendations include fluoride varnish applications for all children regardless of risk status.
Dental	6.6.A. General Instructions	In the 1st paragraph, the last sentence was revised to read: An upper partial denture PA request must also include the prognosis of six sound maxillary teeth.	Clarification.
Dental	8.2.A. Orthodontic Services	In the 1st paragraph, the 1st sentence was revised to read: Orthodontic treatment is covered for CSHCS beneficiaries who have a qualifying dental diagnosis that includes orthodontia.	Consistency with terminology.
Dental	8.2.C. Implant Services	In the 3rd paragraph, the 2nd sentence was revised to read: Providers must be approved by CSHCS and authorized on the individual CSHCS beneficiary's authorized provider file to receive reimbursement.	Consistency with terminology.

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CHAPTER	SECTION	CHANGE	COMMENT
Early and Periodic Screening, Diagnosis and Treatment	Section 1 – General Information	The following text was added at the end of the 5th paragraph: Refer to the Special Coverage Provisions section of the Healthy Michigan Plan chapter for the definition of "habilitative services".	
Hearing Aid Dealers	2.2.B. Standards of Coverage - Unilateral Hearing Loss	Under 'Age Under 21 Years', the 3rd bullet point was revised to read: • The beneficiary may be receiving hearing impaired services through the school system.	
Hearing Aid Dealers	2.2.C. Documentation	In the 2nd paragraph, under 'Age Under 21 Years', the 3rd bullet point was revised to read: • Documentation from the educational system if the child is receiving hearing impaired services.	
Hearing Aid Dealers	2.2.D. Prior Authorization Requirements	In the 4th paragraph, under 'Age Under 21 Years', the 3rd bullet point was revised to read: • Documentation provided by the educational system if the child is receiving hearing impaired services.	
Hearing Aid Dealers	2.3.A. Standards of Coverage	In the 2nd paragraph, under 'Age Under 21 Years', the 1st bullet point was revised to read: • The beneficiary may be receiving hearing impaired services through the school system.	
Hearing Aid Dealers	2.3.B. Documentation	In the table, under 'Age Under 21 Years', the 1st bullet point was revised to read: • Documentation from the educational system if the child is receiving hearing impaired services.	

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CHAPTER	SECTION	CHANGE	COMMENT
Hearing Aid Dealers	2.3.C. Prior Authorization Requirements	In the table, under 'Age Under 21 Years', the 1st bullet point was revised to read: • Documentation from the educational system if the child is receiving hearing impaired services.	
Hospital	1.4 Copayments	In the 2nd paragraph, 3rd bullet point, the sub-bullet points were re-formatted to read: ➢ Perform appropriate medical screening under 42 CFR §489.24 Subpart G to determine the individual does not need emergency services. ➢ Before providing nonemergency services: • inform the individual of the amount of cost sharing responsibility for non-emergency service(s); • Provide the individual with the name and location of an available and accessible alternative nonemergency services provider; • determine that the alternative provider can provide services in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the person is otherwise exempt from cost sharing; and • provide a referral to coordinate scheduling for treatment with the alternative provider.	Correction to formatting.
Hospital Reimbursement Appendix	3.3 Michigan State-Owned Hospitals	The last sentence was deleted. ~~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.

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Local Health Departments	2.4 Administrative Services	The 2nd paragraph was revised to read: LHDs providing Medicaid administrative services should report costs for these services on their quarterly Financial Status Report in accordance with federal regulation to qualify for Federal matching funds. These reports must be submitted to the MDHHS Bureau of Purchasing, Grants Division/Electronic Grants Section. Questions regarding reimbursement of administrative services should be directed to the MDHHS Bureau of Purchasing, Grants Division/Electronic Grants Section. (Refer to the Directory Appendix for contact information.)	Update to Bureau and Section name.
Local Health Departments	3.3.D. Certifications	1st paragraph: The LHD Cost Allocation Plan certifications are kept on file and should be submitted to the MDHHS Bureau of Purchasing, Grants Division/Electronic Grants Section. (Refer to the Directory Appendix for contact information.)	Update to Bureau and Section name.
Local Health Departments	6.6 Accounting and Record Keeping	2nd paragraph: Medicaid supplemental documents must be filed using the modified accrual method of accounting. These documents must be forwarded to MDHHS Bureau of Purchasing, Grants Division/Electronic Grants Section. (Refer to the Directory Appendix for contact information.)	Update to Bureau and Section name.
MI Choice Waiver	2.2.C. Retrospective Review and Medicaid Recovery	The following text was added to the 1st paragraph: The Retrospective Review process (defined in the Beneficiary Eligibility and Admission Process Section of the Nursing Facility Coverages Chapter) is applicable to MI Choice providers.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	5.1.D.5. Retrospective Review and Medicaid Recovery	The following text was added: If a provider, upon receipt of an adverse LOCD retrospective review notice from the MDHHS designee, conducts a subsequent LOCD to redetermine the beneficiary's LOCD eligibility for the purpose of re-establishing Medicaid reimbursement, the provider may request the subsequent LOCD be audited through the MDHHS retrospective review process. This additional audit applies only to an LOCD conducted subsequent to receipt of an adverse retrospective review notice of LOCD ineligibility from a given date forward (in continuance) for the same beneficiary, during the same stay, with the same provider.	Clarification.
Nursing Facility Coverages	Section 8 – PASARR Process	In the 4th paragraph, "Transfer Trauma", the 1st sentence was revised to read: Transfer trauma protections apply to individuals with mental illness or intellectual disability who were determined during a PASARR Level II evaluation to not need nursing facility services.	Clarification.
Nursing Facility Cost Reporting & Reimbursement Appendix	9.13.C. Life of an Approved Plan	In the 10th paragraph, the 1st sentence was revised to read: Nursing facilities holding a written agreement with an accredited medical school instructing students in providing geriatric care may request consideration for an exception to policy in this subsection (Life of an Approved Plan).	Clarifying that this sentence only applies to the specified section and not other provisions of policy in section 9.13.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.5.D. Class Variable Cost Limit (VCL)	The 2nd paragraph was revised to read: **Example:** The VCL for October 1, 2016, which is used for the rate year October 1, 2016 to September 30, 2017, is based on variable costs per resident day reported in cost reports ending in calendar year 2015 indexed to October 1, 2015.	Correcting the year in the example.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.7.A. Class I and Class III Nursing Facilities	In the 3rd paragraph, the 2nd sentence was revised to read: In aggregate, the quality assurance assessment fee may not exceed 6 percent of total industry revenue for the fiscal year.	Correction. Pursuant to 42 CFR 433.68(f)(3)(i)(A), provider taxes are not to exceed 6% of that provider type's revenues. It was 5.5% from January 1, 2008 through September 30, 2011 only. The Michigan Public Health Code also sets a ceiling of 6%.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	10.7.B. Class V Nursing Facilities – Ventilator Dependent Care (VDC) Units	In the 3rd paragraph, the 2nd sentence was revised to read: In aggregate, the quality assurance assessment tax may not exceed 6 percent of total industry revenue for the fiscal year.	Correction. Pursuant to 42 CFR 433.68(f)(3)(i)(A), provider taxes are not to exceed 6% of that provider type's revenues. It was 5.5% from January 1, 2008 through September 30, 2011 only. The Michigan Public Health Code also sets a ceiling of 6%.
Program of All Inclusive Care for the Elderly	3.7 Retrospective Review and Medicaid Recovery	The following text was added: The Retrospective Review process (defined in the Beneficiary Eligibility and Admission Process Section of the Nursing Facility Coverages Chapter) is applicable to PACE organizations.	Clarification.
School Based Services	2.2.A. Occupational Therapy Services	Under 'Procedure Codes': Deletion of code 97003. ~~**97003** – Occupational therapy evaluation. This code can be used by itself or with the HT, TL, or TM modifiers.~~ Addition of: **97165** – Occupational therapy evaluation: low complexity. This code can be used by itself or with the HT, TL, or TM modifiers. Addition of: **97166** – Occupational therapy evaluation: moderate complexity. This code can be used by itself or with the HT, TL, or TM modifiers. Addition of: **97167** – Occupational therapy evaluation: high complexity. This code can be used by itself or with the HT, TL, or TM modifiers. Addition of: **97168** – Re-evaluation of occupational therapy established plan of care, typically 30 minutes. This code can be used by itself or with the HT, TL, or TM modifiers.	Code deleted 12/31/2016. Codes added 1/1/2017.

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CHAPTER	SECTION	CHANGE	COMMENT
School Based Services	2.3.A. Physical Therapy Services	Under 'Procedure Codes': Deletion of code 97001. ~~**97001** – Physical therapy evaluation. This code can be used by itself or with the HT, TL, or TM modifiers.~~ Addition of: **97161** – Physical therapy evaluation: low complexity. This code can be used by itself or with the HT, TL, or TM modifiers. Addition of: **97162** – Physical therapy evaluation: moderate complexity. This code can be used by itself or with the HT, TL, or TM modifiers. Addition of: **97163** – Physical therapy evaluation: high complexity. This code can be used by itself or with the HT, TL, or TM modifiers. Addition of: **97164** – Re-evaluation of physical therapy, typically 20 minutes. This code can be used by itself or with the HT, TL, or TM modifiers.	Code deleted 12/31/2016 Codes added 1/1/2017.
Directory Appendix	Prior Authorization	Under 'Program Review Division, Benefits Monitoring Program', the phone number was revised to read: 1-855-808-0312	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Provider Resources	Information for 'MDHHS Grants and Purchasing Division/Grants Section' was revised to read: **Contact Name:** MDHHS Bureau of Purchasing, Grants Division/Electronic Grants Section **Phone #:** 517-241-8764 **Mailing Address:** MDHHS Bureau of Purchasing Grants Division Electronic Grants Section 235 S. Grand Ave., Ste. 1201 Lansing, MI 48933 **Information Available/Purpose:** Local Health Department Agreements	Update.

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MSA 16-47	1/1/2017	Beneficiary Eligibility	2.1 Benefits Plans	In the chart, under the Benefit Plan ID of 'MOMS', the Benefit Plan Description was revised to read: The Maternity Outpatient Medical Services (MOMS) program provides immediate health coverage for the unborn child of an undocumented pregnant woman. The MOMS program is available to provide immediate prenatal care. Prenatal health care services will be covered by MOMS for the entire pregnancy and for two calendar months after the pregnancy ends. Family Planning Services and supplies are covered under this plan using State of Michigan General Funds. 'Funding Source' was revised to read: XXI, GF
		Maternity Outpatient Medical Services	Section 1 – General	The 1st paragraph was deleted. The 2nd paragraph was revised to read: The Maternity Outpatient Medical Services (MOMS) program covers outpatient pregnancy-related services for the unborn child of an undocumented pregnant woman during the prenatal and postpartum period, as well as inpatient delivery-related services. MOMS will also cover family planning services for the mother during the postpartum period.
			1.1 Eligibility Determination	The 1st paragraph was revised to read: Women who are pregnant and meet the following criteria may apply for MOMS coverage: • Income at or below 195 percent of the Federal Poverty Level. • Covered by the Medicaid Emergency Services Only (ESO) program. The 3rd paragraph was deleted.

*Bulletin inclusion updates are color-coded to the quarter in which the update was made (April 1 = Blue; July 1 = Pink; October 1 = Green; January 1 = Orange)

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			2.1 Covered Services	Subsection text was revised to read: The following services are covered consistent with current MOMS policy: • Prenatal period services, including: ➢ Prenatal care and pregnancy-related care ➢ Condoms (covered in the prenatal period for sexually transmitted infection [STI] prevention) ➢ Pharmaceuticals and prescription vitamins ➢ Laboratory services ➢ Radiology and ultrasound ➢ Maternal Infant Health Program (MIHP) - for prenatal services only ➢ Childbirth education ➢ Outpatient hospital care • Labor and delivery services (including all professional and inpatient hospital services) are covered. • Postpartum care is limited to medically necessary ambulatory postpartum services. • Family planning services, including: ➢ Office visits for family planning related services, including preventive evaluation and management office visits and other outpatient visits for family planning services. ➢ Contraceptives, including oral contraceptives and injectables. ➢ Contraceptive supplies and devices for voluntarily preventing or delaying pregnancy. ➢ Diagnostic evaluation and pharmaceuticals related to contraceptive management or the initial treatment of STIs. ➢ Sterilizations completed in accordance with current Medicaid policy. ➢ Counseling for family planning services, including sterilization, as a part of the family planning visit.

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			2.2 Noncovered Services	The 1st sentence was deleted. ~~Family planning and sterilization services are not covered.~~
			3.1 Submitting Medical Claims	The following text was added as a 3rd paragraph: Providers must use the appropriate Z30 International Classification of Diseases (ICD) diagnosis code as the primary diagnosis on claims for family planning services.
			3.2 Submitting Pharmacy Claims	The following text was added as a 2nd paragraph: Family planning supplies not furnished by the practitioner as part of the medical services must be prescribed by a Medicaid enrolled practitioner and dispensed by a pharmacy. Exceptions include condoms and similar supplies that do not require a prescription.

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MSA 16-46	12/29/2016	Early and Periodic Screening, Diagnosis and Treatment	Section 7 - Trauma Services (Addition of new section; following sections were re-numbered.)	New section text reads as follows: Children under 21 years of age are covered for trauma-related services under the EPSDT benefit. Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and has lasting adverse effects on the child's functioning and physical, social, or emotional well-being. According to adverse childhood experiences (ACEs), adverse early trauma experiences are related to increased rates of health problems in adulthood, including obesity, cardiovascular disease, substance use, mental health problems, social risk factors, and poor health-related quality of life. "Toxic stress" is described as a type of unremitting stress that ultimately compromises a child's ability to regulate their stress response system effectively and can lead to adverse long-term structural and functional changes in the brain and elsewhere in the body. Trauma-specific interventions should be identified to reduce the prevalence and consequences of ACEs and trauma. Trauma-specific interventions generally recognizes the following: • The child's need to be respected, informed, connected, and hopeful regarding their own recovery; • The interrelation between trauma and symptoms of trauma such as substance use, eating disorders, depression, and anxiety; and • The need to work in a collaborative way with the child, family and friends of the child, and other human services agencies. The primary care provider (PCP) should: • Strengthen their provision of anticipatory guidance to support children's social-emotional-linguistic skills and to encourage the adoption of positive parenting techniques; • Actively screen for precipitants of toxic stress that are common in their particular practices; • Assess the child's exposure to trauma and risk of exposure to trauma using a questionnaire or screening tool. Screening tools are available through the American Academy of Pediatrics (AAP); and • Identify (or advocate for the development of) local resources that address risks for toxic stress that are prevalent in their communities.

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				Providers may use current best practices to screen for precipitants of toxic stress. Examples of current trauma screening tools, as indicated by the AAP, include: • Adverse Childhood Experiences Questionnaire (ACE-Q) • Resilience Questionnaire • Pediatric Intake Form History of trauma may or may not be disclosed by the family or child. The PCP may need to ask about possible current or past exposure to traumatic events and assess for the child's safety. Questions may be targeted when there are unexplained somatic complaints or other indicators that may be associated with exposures to trauma or adversity. The PCP may consider asking the caregiver and/or child explicitly about the exposure to trauma. Providers may refer to the AAP policy statement for questions to ask parent/caregivers. Examples of those questions include: • "Has your home life changed in any significant way (e.g., moving, new people in the home, people leaving the home)?" • "Do you have any concerns about your child's behavior at home, child care or school, or in the neighborhood? Has your child's teacher mentioned any concerns?" • "Many children are exposed to violence at home, in the neighborhood, at school or with friends. Do you think your child may have been exposed to violence?" • "All children are exposed to stress. Sometimes stress can make a child sad or scared. Do you have any concerns about your child's stress?" Examples of questions to ask the school-aged child include: • "Are you having any problems at home, at school, or in the neighborhood?" • "Do you feel safe at home and/or at school?" • "How do you deal with stress?"

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			7.1 Referrals for Behavioral Health Services/Therapy	New subsection text reads as follows: If the screening is positive, the PCP should refer the child to a mental health professional trained to provide trauma assessment, treatment using a trauma-specific model, and/or support. Behavioral health services are a Medicaid covered service. Behavioral health services are covered by the local Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) for the services included under the capitation payments to the PIHPs/CMHSPs. A limited outpatient benefit is covered for children enrolled in a Medicaid Health Plan (MHP) or through Fee-for-Service (FFS) Medicaid. In general, MHPs are responsible for outpatient mental health treatment when the child is experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior. For children not enrolled in a MHP, behavioral health services are covered through FFS Medicaid. Under the MHP or through FFS, 20 combined outpatient behavioral health visits in a 12-month period are allowed. Under FFS, behavioral health services may be provided by a physician (MD or DO), physician assistant, nurse practitioner, psychologist, social worker, professional counselor, or marriage and family therapist working within their scope of practice under State law. In general, PIHPs/CMHSPs are responsible for outpatient mental health treatment for a child with a serious emotional disturbance as indicated by the diagnosis, intensity of current signs and symptoms, and substantial impairment in ability to perform daily living activities. The child may experience substantial interference in achievement or maintenance of developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills. In addition, the PIHPs/CMHSPs may be responsible for outpatient mental health treatment when the child has been treated by the MHP or through FFS for mild/moderate symptomatology, the child has exhausted the 20-visit maximum for the calendar year, and additional treatment is deemed to be medically necessary. For children not enrolled in an MHP and for services not included in the capitation payments to the PIHP/CMHSP, behavioral health services are covered through FFS Medicaid. (Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter for additional information. Additional information is also available on the MDHHS website; refer to the Directory Appendix for website information.)

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		Directory Appendix	Provider Resources	**Contact/Topic:** Michigan's Great Start Trauma Informed System **Mailing/Email/Web Address:** www.michigan.gov/traumatoxicstress **Information Available/Purpose:** To add a trauma informed approach into the comprehensive early childhood system known as Great Start.

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MSA 16-45	12/29/2016	Medical Supplier	2.19 Incontinent Supplies	Under "Standards of Coverage (Not Applicable to CSHCS Only Beneficiaries), text for 'Pull-On Briefs' was revised to read: **Pull-on Briefs a**re primarily considered a short-term transitional product for beneficiaries with a medical condition causing incontinence of bowel and/or bladder. **Pull-on brief coverage for ages 3 through 20:** Pull-on briefs are covered when there is the presence of a medical condition causing bowel/bladder incontinence and one of the following applies: • **For short term use:** The beneficiary is actively participating in a bowel/bladder training plan and is demonstrating consistent measurable progress in the plan (i.e., consistent reduction in the amount of pull-on briefs used, successful completion of the bowel/bladder training in three years or less, etc.); **or** • **For long term use:** The beneficiary has a permanent medical condition (such as Muscular Dystrophy, Spina Bifida, etc.) that will prevent the beneficiary from ever achieving bowel and bladder continence; however, the beneficiary has the cognitive and physical ability to care for his/her toileting needs independently or with minimal assistance. **Bowel/Bladder Training Plan** A bowel/bladder training plan must be designed and implemented within the school and home environments in order to achieve optimum success. **Initial Nursing Assessment and Reassessment** The use of pull-on briefs requires an initial nursing assessment and reassessment every six months thereafter or a time determined by MDHHS. Reassessments must detail measurable progress the beneficiary has made in the training plan since the last assessment. Long-term use requires an initial nursing assessment and reassessment every 24 months thereafter or a time determined by MDHHS. Documentation of the initial nursing assessment and reassessment(s) must be kept in the beneficiary file.

				If the beneficiary no longer has a medical condition causing bowel/bladder incontinence and he/she has not achieved continence within three years of the start of the bowel/bladder training program, the pull-on briefs will no longer be a covered benefit. **Pull-on brief coverage for ages 21 and older:** Pull-on briefs are covered when there is the presence of a medical condition causing bowel/bladder incontinence and the beneficiary is able to care for his/her toileting needs independently or with minimal assistance from a caregiver and one of the following applies: • **For short term use:** The beneficiary has a temporary medical condition (including recent discharge from a nursing home or hospital) causing bowel/bladder incontinence; **or** • **For long term use:** The beneficiary has a permanent medical condition (such as Muscular Dystrophy, Spina Bifida, etc.) that will prevent the beneficiary from ever achieving bowel and bladder continence. **Initial Nursing Assessment and Reassessment** The use of pull-on briefs requires an initial nursing assessment. Reassessment is required whenever there is a prior authorization request for a change in quantity or a medical condition resulting in continued need beyond established policy timelines. Recent discharge from a nursing home or hospital is considered a qualifying condition for short-term use of pull-on briefs. Beneficiaries with medical conditions which result in permanent incontinence or who have product needs over established policy quantities must be re-assessed every 12 months or a time determined by MDHHS. Documentation of the initial nursing assessment and reassessment(s) must be kept in the beneficiary file. Pull-on briefs are **not** covered for the following: • Beneficiaries under three years of age. • A medical condition causing incontinence of bowel/bladder is not present. • For children who have an occasional bowel or bladder accident. • Night time incontinence of bowel or bladder.

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				Under 'Documentation', text was revised to read: Documentation must be less than 30 days old, kept in the beneficiary file, and include the following: • Diagnosis of condition causing incontinence (primary and secondary diagnosis). • Item to be dispensed. • Duration of need. • Quantity of item and anticipated frequency the item requires replacement. In addition to the above documentation requirements, pull-on briefs require the following: • An initial nursing assessment for all ages, regardless of whether the pull-on briefs will be used short or long term. • A six-month reassessment is required for under 21 years of age or a time determined by MDHHS. • If the beneficiary has a medical condition that results in permanent incontinence, reassessment is required annually or a time determined by MDHHS. • For under age 21 and attending school, a copy of the teacher's continence report or a letter from the school detailing the bowel/bladder plan. The reassessment must have a copy of the teacher's plan or school letter detailing any changes to the plan and progress made since the last assessment.
MSA 16-43	12/1/2016	General Information for Providers	9.1 Prior Authorization Certification Evaluation Review (PACER)	In the 1st paragraph, the 2nd sentence was revised to read: This includes transfers between an acute care hospital, an enrolled distinct part rehabilitation unit of the same hospital, or a Long Term Acute Care Hospital (LTACH).
			9.1 A. Admissions/ Readmissions/Transfers That Require a PACER Number	The following bullet point was added: • Transfer to an LTACH or admission from an LTACH to an acute care hospital

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			9.7 Admission/Transfer for Long-Term Acute Care Hospital (LTACH) (new subsection; following subsection re-numbered)	New subsection text reads as follows: A transfer or admission from an acute care hospital or inpatient rehabilitation unit to an LTACH requires a PACER number. • The acute care hospital or inpatient rehabilitation unit is responsible for obtaining the PACER number before the discharge to an LTACH. • If the LTACH admission meets InterQual LTACH criteria, a PACER number will be issued for no more than 30 days. • Subsequent prior authorization and continued stay approvals must be obtained by the LTACH. • A transfer from the LTACH to an acute care hospital will require an inpatient PACER number.

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<table>
<tr><th>BULLETIN NUMBER</th><th>DATE ISSUED</th><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th></tr>
<tr><td></td><td></td><td>Billing & Reimbursement for Institutional Providers</td><td>4.1 Authorization of Admissions and Services</td><td>In the 1st paragraph, the 6th bullet point was revised to read:
If a beneficiary is transferred from an acute care inpatient hospital to an inpatient rehabilitation hospital or a long term acute care hospital (LTACH), this constitutes a discharge. The new payer assumes payment responsibility upon admission to the inpatient rehabilitation hospital or LTACH.
In the table following the 1st paragraph, text was revised to read:<table><tr><th>Change in Setting</th><th>Payer Responsibility in New Setting</th></tr><tr><td>Acute care inpatient hospital to another acute care inpatient hospital</td><td>Payer at admission remains the responsible party while the beneficiary is in the acute care inpatient hospital level setting. Exception: CSHCS enrollment.</td></tr><tr><td>Acute care inpatient hospital to inpatient rehabilitation hospital or LTACH</td><td>New payer is responsible party upon admission to the inpatient rehabilitation hospital or LTACH.</td></tr><tr><td>Inpatient rehabilitation hospital or LTACH to acute care inpatient hospital</td><td>New payer is responsible party upon admission to the acute care inpatient hospital.</td></tr></table></td></tr>
<tr><td></td><td></td><td>Hospital</td><td>Section 2 - Prior Authorization</td><td>The following information was added to the chart:

Service: Long Term Acute Care Hospital (LTACH)
PA Obtained by: Hospital
Obtained Via: ACRC
Documentation for Claim: Billing Authorization Number</td></tr>
<tr><td></td><td></td><td>Acronym Appendix</td><td></td><td>Addition of:

LTACH – Long Term Acute Care Hospital</td></tr>
</table>

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		Directory Appendix	Prior Authorization (Authorization of Services)	The following text was added: **Contact/Topic:** Prior Authorization (PACER) Acute Care Hospital to Long Term Acute Care Hospital (LTACH) **Phone # Fax #:** 800-727-7223 **Mailing/Email/Web Address:** Michigan Peer Review Organization 22670 Haggerty Rd., Ste. 100 Farmington Hills, MI 48335-2611 **Information Available/Purpose:** Prior authorization for Medicaid, Healthy Michigan Plan, and CSHCS admissions.
MSA 16-41	12/1/2016	Hospital Reimbursement Appendix	13.4.B. Medicaid Eligible Patient Volume	The 5th sentence was revised to read: MDHHS will select the hospital quarter with the highest Medicaid eligible patient volume (90-day continuous period) from the applicable calendar year's Medicaid Quarterly Report to derive program eligibility.
			13.5.A Timing	The 1st and 2nd paragraphs were revised to read: EHs that adopt, implement, and/or upgrade a certified EHR system or are meaningful users can begin receiving incentive payments in any year from 2011 to 2016. The Medicaid EHR Incentive Program operates a calendar year (CY) reporting period (January 1 through December 31). While the statute defines a payment year in terms of a CY, a hospital does not have to begin receiving incentive payments in CY 2011. However, the last year a hospital can first receive an initial Medicaid incentive program payment is CY 2016. EHs are paid up to 100% of the calculated aggregate EHR hospital incentive payment amount over a three-year period. Data utilized to calculate the aggregate EHR hospital incentive amount is derived from filed hospital cost reports (CMS 2552 and MMF) from the hospital CY that ends during the CY prior to the hospital CY that serves as the first payment year.

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			13.6 Payment Notification and Gross Adjustments	The 1st paragraph was revised to read: EH Medicaid Incentive payments are made annually via gross adjustment. EHs cannot receive more than one incentive payment in each State CY year.
MSA 16-40	11/30/2016	Beneficiary Eligibility	8.7.B. BMP Authorized Providers	In the 1st paragraph, text was revised to read: The BMP assigns Authorized Providers who are responsible for supervising the case management and coordination of all prescribed drugs, specialty care, and ancillary services. These responsibilities encompass patient-centered care and do not amount to separate reimbursement. Reimbursement for any …

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MSA 16-38	12/1/2016	Dental	6.2.B.1. Interim Caries Arresting Medicament (new subsection)	New subsection text reads: CDT D1354 - Interim Caries Arresting Medicament Application is a Medicaid covered dental benefit for all ages. Advantage Arrest™ by Elevate Oral Care -Silver Diamine Fluoride (SDF) at 38% is the only Food and Drug Administration (FDA) approved SDF for use in the United States. It is also the only caries arresting medicament allowed by Medicaid policy. SDF is billable once per date of service, regardless of the number of teeth treated, up to a maximum of five teeth per visit. There is a maximum of six applications per lifetime. Direct application to the tooth is required to arrest active carious lesions; however, application to sound teeth is not necessary for the additional anti-caries benefit. Application of SDF has an antimicrobial effect on the entire oral cavity in addition to the teeth being treated for caries arrest. (Refer to the Billing and Reimbursement for Dental Providers chapter for additional billing information.) D1354 is considered a temporary measure to arrest and slow the progression of caries. It should be used only when traditional methods of restoration are not available or are contraindicated. A minimum of two applications per year has been shown to increase the caries arresting effectiveness. Treated lesions must be monitored over time to assess caries arrest. Additional applications may not be necessary or recommended if caries arrest is still in effect. SDF is not meant to be used as a full-mouth fluoride varnish therapy. SDF application does not eliminate the need for tooth restoration, nor does it preclude the ability to restore the tooth. It is not used as a base prior to restoration and it has the disadvantage of darkening the carious area of the tooth. SDF will not stain non-carious tooth structure. The darkened tooth structure can be removed with restoration of the tooth.

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				Indications for use include: • high-caries risk • behavioral or medical management issues • dentinal hypersensitivity • caries stabilization • xerostomia from cancer treatment or multiple hyposalivatory medications • treating vulnerable surfaces, such as roots exposed from periodontal attachment loss, overdenture and partial denture abutments, or partially exposed third molars • difficult-to-treat caries lesions (e.g., furcations, margins of fixed bridges) • patients without access to restorative dental services • cognitive disabilities (e.g., patients with autism or dementia) • physical disabilities • dental phobias Contraindications for SDF use: • allergy to silver or other heavy-metal ions • oral ulcerations, stomatitis, or ulcerative gingivitis present at the time of application • more than five teeth treated on the same date of service. Education and Informed Consent: SDF application requires education of providers and staff on the application process, benefits, risks and projected outcomes. Also required is education of the beneficiary and informed consent signed by the beneficiary or guardian. • Treatment with SDF requires more than one application to effectively arrest decay • Treatment with SDF does not eliminate the need for restorations to repair function or esthetics. • Affected areas will stain black permanently until replaced with a restoration. • Tooth-colored restorations may discolor from SDF but can generally be removed with polishing.

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				• SDF accidentally applied to the skin or gum tissue may stain white or brown if not immediately washed off but will disappear within a couple of weeks. • Although SDF has been proven to be highly successful, application does not guarantee caries arrest.
		Acronym Appendix		Addition of: SDF – Silver Diamine Fluoride
MSA 16-37	11/30/2016	General Information for Providers	12.3 Billing Limitation	The subsection title was revised to read: Timely Filing Billing Limitation In the 2nd paragraph, the 1st bullet point was revised to read: • For claims using the institutional format and MHPs, it is the "To" or "Through" date indicated on the claim. The 3rd and 4th paragraphs were deleted. The following text was added as the 3rd paragraph: All claims must be resolved within one year from the date of service unless an exception exists as noted below. It will no longer be necessary to maintain continuous activity through multiple claim submissions. Claim replacements requesting additional payment must meet exception criteria to be considered beyond one year from DOS. The 5th paragraph was revised to read: Only the following types of claims require documentation of previous activity in the Remarks section of the claim (e.g. previous TCNs): … The 6th paragraph was deleted.

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				In the 7th paragraph, the 1st sentence was revised to read: Exceptions may be made to the timely filing billing limitation policy in the following circumstances. In the 7th paragraph, 1st bullet point, the last sentence was revised to read: Retroactive provider enrollment is not considered an exception to the timely filing billing limitation. In the 7th paragraph, the 3rd bullet point was revised to read: • Judicial Action/Mandate: A court or MAHS administrative law judge ordered payment of the claim. A copy of the judicial action or court order may be required to support this exception. In the 7th paragraph, the 4th bullet point was revised to read: • Medicare processing was delayed: The claim must reflect that Medicaid was billed within 120 days of the date of payment, rejection or retroactive recovery of funds by Medicare. (Refer to the Coordination of Benefits Chapter in this manual for further information.) In the 7th paragraph, the following text was added as 5th and 6th bullet points: • Provider returning overpayment: A claim replacement should be submitted with a comment that the provider is returning money. The replacement should be completed to reflect the return of money (e.g., including primary payer's payment or, if returning all the money, zeroing out the money fields). • Primary insurance taking back payment after timely filing limitation has passed: Must submit a copy of insurance letter or EOB from primary insurance showing date money was taken back from paid claim. The claim must be submitted within 120 days of the primary insurance letter or remit date.

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		Coordination of Benefits	2.6.G. Exceptions to the Billing Limitation	The subsection title was revised to read: Exceptions to the Timely Filing Billing Limitation The 1st sentence was revised to read: When a delay in payment from Medicare causes a delay in billing Medicaid, an exception may be made if the provider can document that Medicare was billed within one year of the date of service and Medicaid was billed within 120 days of the date of payment, rejection or retroactive recovery of funds by Medicare.
		Billing & Reimbursement for Professionals	4.2 Void/Cancel Claims (Adjustments)	The last paragraph was revised to read: The MDHHS 12-month timely filing billing limitation policy applies to void/cancel claims. Refer to the Timely Filing Billing Limitation subsection of the General Information for Providers Chapter for additional information.
		Federally Qualified Health Centers and Tribal Health Centers	3.1 Definition	In the 5th paragraph, the last bullet point was revised to read: • The same timely filing billing limitations identified in the General Information for Providers Chapter of this manual apply to claims submitted for FQHC encounters.
		Tribal Health Centers	7.5 Billing Limitation	The subsection title was revised to read: Timely Filing Billing Limitation Text was revised to read: The same timely filing billing limitations explained in the General Information for Providers Chapter of this manual pertain to encounters as well as claim submission.
MSA 16-33	11/1/2016	Maternal Infant Health Program	1.4 Medicaid Health Plans	Text was revised to read: MIHP services provided to individuals enrolled in a MHP are administered by the MHP in adherence to the program components as outlined in this chapter. All MIHP services provided to MHP enrollees are coordinated and reimbursed by the MHPs.

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			1.4.A. Contractual Agreements (new subsection)	New subsection text reads: MIHP providers must establish and maintain provider contractual agreements with the MHPs in their service area to receive payment for in-network services provided to MHP enrollees unless the MHP indicates otherwise. MIHP providers are encouraged to contract with the MHPs in their service area.
			1.4.B. Care Coordination Agreements (new subsection)	New subsection text reads: MIHP providers are encouraged to establish Care Coordination Agreements (CCAs) with all MHPs in their service area. MIHP providers and MHPs must also establish and maintain a CCA for in-network and out-of-network services. The intent of the CCA is to explicitly describe the services to be coordinated and essential aspects of collaboration between the MHP and the MIHP provider. (Refer to the Forms Appendix for an example of a Care Coordination Agreement.)
			1.4.C. Freedom of Choice (new subsection)	New subsection text reads: MIHP services are voluntary and participants must be allowed the freedom of choice of MIHP providers, including the opportunity to: • select an in-network provider; • maintain a current service relationship which extends services to the infant by the same provider who rendered maternal services; • change providers within the MHP network of providers; or • decline services.

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			1.4.D. Referral to an MIHP (new subsection)	New subsection text reads: Within one month of when the MHP determines a pregnant or infant enrollee is eligible for MIHP services, the MHP must refer the enrollee to an MIHP provider. MHPs are not required to refer enrollees to an MIHP provider if the enrollee is already participating in an MDHHS approved equivalent evidence-based home visiting program that provides pregnancy-related or infant support services. This may be evidenced by enrollee self-attestation. MHPs may be required to present MDHHS evidence of MIHP referral and care coordination, evidence of participation in an equivalent evidence-based home visiting program, or refusal of MIHP services upon request.
			1.4 E. Prior Authorization of Services (new subsection)	New subsection text reads: MHPs may not require prior authorization for the Initial Risk Assessment visit, professional visits, drug-exposed infant visits, MIHP lactation support visits, childbirth education classes, or parenting education classes when provided within the criteria and limits established in policy. MIHP services in excess of limits established in policy may be subject to MHP prior authorization requirements.
			1.4.F. Out-of-Network MIHP Services (new subsection)	New subsection text reads: It is incumbent upon MIHP providers to check eligibility and MHP enrollment at every visit. Relationships established during previous pregnancies with out-of-network MIHP providers are not required to be covered by the MHP. Non-contracted MIHP providers, including those who have a current MIHP relationship with a pregnant woman or infant, are required to contact the enrollee's MHP to discuss operational details before providing out-of-network services.

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			Section 2 - Program Components	The last paragraph was revised to read: On the rare occasion when the Risk Identifier does not indicate the need for MIHP services but professional observation suggests the beneficiary would benefit from MIHP services, the MIHP provider must obtain written authorization from the MIHP consultant to proceed with MIHP services for FFS beneficiaries. MHPs may require prior authorization to proceed with MIHP services to MHP enrollees. Documentation must support how the beneficiary may benefit from MIHP services.
			2.2 Infant Risk Identifier	The 5th paragraph was revised to read: The goal of the MIHP is to promote healthy infant growth and development. Screening tools and educational materials utilized by the MIHP are designed for use with infants. For this reason, if risks are identified that may necessitate a Risk Identifier for a child older than 12 months of age or a MIHP professional visit beyond 18 months of age, the MIHP provider must obtain written authorization from the MIHP consultant prior to the visit for all FFS beneficiaries. MHPs may require prior authorization for MHP enrollees.
			2.10 Transportation	Subsection text was revised to read: Transportation services are available to help MIHP-enrolled pregnant and infant beneficiaries access their health care and pregnancy-related appointments and for a mother to visit her hospitalized infant. Pregnancy-related appointments include those for oral health services, WIC services, behavioral or substance use disorder treatment services, and childbirth and parenting education classes. Through the completion of the Risk Identifier, the MIHP provider must assess each MIHP beneficiary's need for transportation services. Beneficiaries in the Nurse Family Partnership (NFP) do not need a Risk Identifier completed to receive transportation services. Transportation is the only MIHP service available to NFP beneficiaries.

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			2.10.A. Transportation for MIHP Medicaid Health Plan Enrollees (new subsection)	New subsection text reads: MHPs are responsible for providing transportation for pregnancy-related appointments for MHP enrolled MIHP and NFP participants. MIHPs are subject to MHP internal processes for the coordination of transportation services for MHP enrollees.

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			2.10.B. Transportation for MIHP Fee-for-Service Beneficiaries (new subsection)	New subsection text reads: The MIHP may provide transportation to MIHP Fee-for-Service (FFS) beneficiaries for medical/health care services and pregnancy related appointments when no other means of transportation are available, including transportation from the local MDHHS office. Transportation services provided to the pregnant beneficiary should be billed utilizing the Medicaid ID number of the pregnant woman, and transportation services provided for infant services should be billed utilizing the infant's Medicaid ID number. 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. 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 MIHP provider must maintain documentation of transportation for each beneficiary for each trip billed. The record must specify: • The name and address of the beneficiary; • The date of service (DOS); • The trip's starting point and destination (address, city); • The purpose of the trip;

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				• The number of tokens or miles required for the trip; and • The amount that the beneficiary or transportation vendor was reimbursed. The MIHP provider must ensure the beneficiary kept the appointments for which transportation tokens or funds were provided. Medicaid does not pay for transportation not provided. The MIHP provider may give transportation tokens or funds to the pregnant woman or to the caregiver of the infant. In situations where funds are provided, it is recommended that the pregnant woman or the caregiver sign a receipt and that the receipt be retained in the case records. The MIHP may also contract for transportation services. Transportation services should be billed for each date of service it was provided. 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.)
			Section 3 - Reimbursement	The 2nd paragraph was revised to read: All services provided by MIHP providers to MHP enrollees should be billed directly to the MHP. All services provided by MIHP providers to Fee-for-Service beneficiaries should be billed directly to MDHHS. MIHP services are a Medicaid only benefit. MIHP providers are not required to secure other insurance adjudication response(s) for claims for MIHP services prior to billing Medicaid FFS or MHPs, as the parameters of other carriers would never cover MIHP services. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for additional billing information.)
		Medicaid Health Plans	1.1 Services Covered By Medicaid Health Plans (MHPs)	In the 1st paragraph, the following bullet point was added: • Maternal Infant Health Program (MIHP)
			1.2 Services Excluded From MHP Coverage But Covered By Medicaid	The 6th bullet point was deleted: • ~~Maternal Infant Health Program (MIHP)~~

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			2.5 Maternal Infant Health Program (MIHP)	Text was revised to read: Effective for dates of service on or after January 1, 2017, MIHP services provided to individuals enrolled in an MHP are administered by the MHP as outlined in the Maternal Infant Health Program Chapter of this manual. All MIHP services provided to MHP enrollees are coordinated and reimbursed by the MHPs. Only MDHHS certified providers may deliver MIHP services to MHP enrollees. To maintain fidelity of the program and to facilitate compliance with the reporting requirements of Public Act 291 of 2012, it is the expectation that MIHP providers and MHPs will adhere to program components, including but not limited to: MDHHS program certification, the required professional qualifications of staff, and the use of MDHHS MIHP forms. MHPs must establish and maintain a Care Coordination Agreement (CCA) with MIHP providers for both in-network and out-of-network services. Within one month of when the MHP determines a pregnant or infant enrollee is eligible for MIHP services, the MHP must refer the enrollee to an MIHP provider. MHPs are not required to refer enrollees to an MIHP provider if the enrollee is already participating in an MDHHS approved equivalent evidence-based home visiting program that provides pregnancy-related or infant support services. MHPs work cooperatively with the local MDHHS office to maintain a referral protocol for those enrollees who need the assistance of MDHHS Children's Protective Services. MIHP providers must work with the MHP and MDHHS Children's Protective Services to ensure appropriate care for MHP enrollees. (Refer to the Maternal Infant Health Program Chapter of this manual for additional information.)
			2.6.A. Professional Services	In the 1st paragraph, the following bullet point was added: • Certain MIHP services (refer to the Maternal Infant Health Program Chapter of this manual for additional information).
		Forms Appendix	Sample 3 – MIHP Provider and MHP Care Coordination Agreement	Updated form.

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MSA 15-62	12/30/2015	Hospital Reimbursement Appendix	7.6.D.2. Outpatient Distribution Data	Text was revised to read: To determine each hospital's share of a pool, MDHHS will use paid claims for the fiscal year ending two years prior to the current fiscal year. Claims will be restricted to those paid by June 30 of the following fiscal year (e.g., paid claims from FY 2014 will be used to calculate payments in FY 2016, with claims limited to those paid by June 30, 2015). The paid claims file will include all Medicaid FFS payments made for both Medicaid and dual CSHCS eligible beneficiaries through the CHAMPS System. Outpatient services will include both acute and rehabilitation services. Payments made outside CHAMPS, such as capital, graduate medical education (GME), or disproportionate share hospital (DSH), will not be included in the payments used to distribute the MACI pools.