MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Health and Human Services

Bulletin Number: MSA 17-19

Distribution: All Providers

Issued: June 1, 2017

Subject: Updates to the Medicaid Provider Manual; New Coverage of Existing Code

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 July 2017 update of the online version of the Medicaid Provider Manual. The manual will be available July 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.

New Coverage of Existing Code

Effective for dates of service on and after January 1, 2017, MDHHS will cover Healthcare Common Procedure Coding System (HCPCS) code Q5102 (Injection, Infliximab, 10 mg) for Practitioners, Ambulatory Surgical Centers (ASC), and Outpatient Hospitals.

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*

<table>
<tr><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th><th>COMMENT</th></tr>
<tr>
<td>General Information for Providers</td>
<td>7.2 Borderland Providers
(new subsection)</td>
<td>New subsection text reads:

Borderland is defined as a county that is contiguous to the Michigan border. It also includes the five major cities beyond the contiguous county lines. The borderland area includes:
<table>
<tr><td>Indiana</td><td>Fort Wayne (city); Elkhart, LaGrange, LaPorte, St. Joseph, and Steuben (counties)</td></tr>
<tr><td>Minnesota</td><td>Duluth (city)</td></tr>
<tr><td>Ohio</td><td>Fulton, Lucas, and Williams (counties)</td></tr>
<tr><td>Wisconsin</td><td>Ashland, Green Bay, and Rhinelander (cities); Florence, Iron, Marinette, Forest, and Vilas (counties)</td></tr>
</table>
Note for Hospice Providers: An out-of-state/borderland hospice provider cannot cross over the border into Michigan to provide services to a Medicaid beneficiary unless:

The agency is licensed and Medicare-certified as a hospice in Michigan; or
The state in which the provider is licensed and certified has a reciprocal licensing agreement with the State of Michigan.

If one of these conditions is met and the hospice provides services across state lines, its personnel must be qualified (e.g., licensed) to practice in Michigan.

Medicaid will not cover services for a beneficiary who enters a hospice-owned residence outside of Michigan. The Community Health Automated Medicaid Processing System (CHAMPS) will not recognize the core-based statistical area (CBSA) code of another state. Additionally, when a Michigan Medicaid beneficiary voluntarily enters a hospice-owned residence in another state to receive routine hospice care, they are no longer considered a Michigan resident and, therefore, are not eligible for hospice benefits under Michigan Medicaid.</td>
<td>Reorganization of information within Chapter.</td>
</tr>
</table>

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		Note for Home Health Providers: An out-of-state/borderland home health provider cannot cross over the border into Michigan to provide services to a Medicaid beneficiary unless they are Medicare certified as a home health agency in Michigan. If this condition is met, and the home health agency provides services across state lines, its personnel must be qualified (e.g., licensed) to practice in Michigan. **Note for Nursing Facilities: An out-of-state/borderland nursing facility is not allowed to enroll with Michigan Medicaid. Historically, t**he only borderland nursing facilities that ~~are~~ **were** allowed to enroll with Michigan Medicaid ~~are~~ **were** those facilities where Michigan beneficiaries were admitted to the facilities prior to October 1, 2007 or were admitted where placement was approved by Medicaid due to closure of a Michigan facility. **The last of such placements and Medicaid facility enrollment ended August 1, 2016.** ~~**To ensure that these borderland nursing facilities serving Michigan Medicaid beneficiaries have a current standard Health Survey, a Life Safety Code Survey, and a current facility license, MDHHS requires this information be sent to MDHHS each year. The review of survey and license information by MDHHS will occur prior to December 31 of each year. This information must be received by the Medicaid Provider Enrollment Unit by November 1 of each year so the borderland nursing facility Medicaid enrollment continues. (Refer to the Directory Appendix for contact information.)**~~	Re: 'Note for Nursing Facilities': Michigan Medicaid no longer has borderland nursing facilities serving Michigan Medicaid beneficiaries.
General Information for Providers	7.3 Out of State/Beyond Borderland Providers	In the 1st paragraph, the 2nd sentence was revised to read: MDHHS reimburses out of state providers who are beyond the borderland area ~~**(defined below)**~~ if the service meets one of the following criteria: Paragraphs 2, 3, 4, 5, 6, and 14 were removed and relocated to subsection 7.2 Borderland Providers.	Reorganization of information within Chapter.
Beneficiary Eligibility	2.1 Benefit Plans	Under "MOMS", Service Type Code 82 was added to "Covered Services".	Update.

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Beneficiary Eligibility	2.3 Level of Care Codes	In the table after the 1st paragraph, • Text for the 1st entry for LOC Code 11 was revised to read: 11 – Beneficiary with Healthy Michigan Plan and enrolled in ~~**a Medicaid Health Plan**~~ **Managed Care** (began 4/1/2014) • text for the 2nd entry for LOC Code 11 was removed. ~~**11 – Beneficiary with Healthy Michigan Plan and enrolled in PACE (began 4/1/2014); Benefit Plan ID: PACE**~~	Clarification. Removal of obsolete information.
Coordination of Benefits	3.6 Exceptions to Medicaid Payer of Last Resort (new subsection)	New subsection text reads: There are a few exceptions to the general rule that Medicaid is the payer of last resort. In limited circumstances where there is a federal statute making Medicaid primary to a specific program, the Medicaid program must pay before the federally-administered health program. The following federally-administered programs are some examples of exceptions to Medicaid's payer of last resort rule: • Crime Victims Compensation Fund • Ryan White Program • Indian Health Services • Women, Infants and Children Program • Grantees under Title V of the Social Security Act (Maternal and Child Health Services Block Grant) • Veteran Benefits – emergency treatment provided in a non-VA facility • Veteran Benefits – non-VA nursing home per diem payments	Medicaid is payer of last resort for services covered under Medicaid, except in those limited circumstances where there is a federal statute making Medicaid primary to a specific program.

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Billing & Reimbursement for Institutional Providers	8.5 Ventilator Dependent Care and Complex Care	The subsection title was revised to read: Ventilator Dependent Care **Unit (VDCU)** and Complex Care The 1st paragraph was revised to read: When billing for approved ~~**ventilator dependent**~~ **VDCU** care or complex care: • Facilities must enter the PA number from the Medicaid authorization form on the claim. If a beneficiary is approved for both complex care and therapy services, one PA number is issued for both complex care and therapy**. If a beneficiary is approved for ventilator care and also requires therapy, prior authorization for the therapy must be obtained under the VDCU NPI. Both the therapy and VDCU prior authorization numbers may be reported on the same claim.** • Facilities must bill ….	Information from Letter L 17-06.
Billing & Reimbursement for Professionals	6.15 Maternity Care Services	Text for "Multiple Gestation" was revised to read: ~~**For twin gestation, report the service on two lines with no modifier on the first line and modifier 51 on the second line. If all maternity care was provided, report the global maternity package code for the first infant, and report the appropriate delivery-only code for the second infant using modifier 51. If multiple gestation for more than twins is encountered, report the first delivery on one line and combine all subsequent deliveries on the second line with modifiers 51 and 22. Provide information in the Remarks section or submit an attachment to the claim explaining the number of babies delivered.**~~ **Per Medicaid NCCI guidelines, if multiple infants were delivered vaginally, report the appropriate CPT code for the initial delivery (global maternity care or vaginal delivery-only) on line one. Code additional vaginal deliveries as vaginal delivery-only. It is appropriate to append the code with modifier 59 (Distinct procedural service).** **If one infant is delivered vaginally and one or more delivered by cesarean, report the appropriate CPT code for the cesarean delivery (global maternity or**	Updating billing information.

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		cesarean delivery-only) on line one and the appropriate CPT code for the vaginal delivery (delivery-only) on line two. It is appropriate to append modifier 51 (Multiple procedures) to the vaginal delivery code. **If multiple infants were delivered by cesarean delivery, report the appropriate CPT code for the cesarean delivery (global maternity care or cesarean delivery-only) on line one. When the delivery was significantly more difficult than usual, modifier 22 (Increased procedural service) may be appended to the delivery code. When modifier 22 is appended, documentation must support the substantial additional work and the reason for the additional work such as:** • **Increased intensity or time** • **Increased technical difficulty of performing the procedure** • **Severity of the patient's condition** • **Increased physical and mental effort required** **In instances of multiple births, providers should attach a copy of the medical records with the claim that supports the procedures performed. Providers must use a diagnosis code that represents the multiple birth.**	
Ambulance	1.2 Common Terms	Text for "Emergency Medical Condition" was removed.	Term not included in the chapter.
Ambulance	1.2 Common Terms	Text for "Emergency Response" was revised to read: A response that, at the time the ambulance provider is called, is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity **(including severe pain)** such that in the absence of immediate medical attention could reasonably be expected to result **in**: • placing the **health of the** ~~beneficiary's health~~ **beneficiary (or, with respect to pregnant women, the health of the woman or her unborn child)** in serious jeopardy, • ~~in~~ **serious** impairment to bodily functions, or • ~~in~~ serious dysfunction to any bodily organ or part.	Clarification.

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Ambulatory Surgical Centers	Section 3 – ASC Reimbursement	The following text was added as a 2nd paragraph: Additional billing and reimbursement information is available on the MDHHS website. (Refer to the Directory Appendix for website information.)	Addresses OPPS/ASC updates.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	Section 7 – Home-Based Services	The following text was added: **NOTE:** This service is a State Plan EPSDT service when delivered to children under 21 years of age.	Update.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	7.1 Program Approval	In the 1st paragraph, the 1st sentence was revised to read: Applications for enrollment must identify home-based providers, either internal or contractual, who will serve children ~~**ages 0-17**~~ **under 21 years of age**.	Update.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	8.4 Medicare	Text was revised to read: For Medicare-covered services, the PIHP may only pay up to a Medicare-enrolled beneficiary's obligation to pay (i.e., coinsurance and deductibles). ~~**This limitation also applies if the beneficiary is eligible for, but not enrolled in, Medicare.**~~ (Refer to the Coordination of Benefits Chapter in this manual for more information.)	Removal of inaccurate information.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	14.3 Covered Waiver Services	In the table, 1st column, 4th and 5th categories, text was revised to read: Family Training ~~**(previously called Didactic Services)**~~ Non-Family Training ~~**(previously called Psychological/Behavioral Treatment)**~~	Removal of obsolete information.

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Behavioral Health and Intellectual and Developmental Disability Supports and Services	15.1 Waiver Supports and Services	Text was revised as follows: Under "Environmental Modifications", second-to-last paragraph, text was revised to read: Adaptations to the work environment are limited to those necessary to accommodate the person's individualized needs, and cannot be used to supplant the requirements of Section 504 of the Rehabilitation Act**,** ~~**or**~~ the Americans with Disabilities Act (ADA), or covered by ~~**the**~~ Michigan Rehabilitation Services **(MRS) or the Bureau of Services for Blind Persons (BSBP).** Under "Prevocational Services", the 6th paragraph was revised to read: Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for ~~**work activity or**~~ supported employment services provided by Michigan Rehabilitation Services (MRS) **or the Bureau of Services for Blind Persons (BSBP)**. Information must be updated when MRS **or BSBP** eligibility conditions change. Under "Supported Employment", 2nd paragraph, the last sentence was revised to read: When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting or for any services that are the responsibility of another agency, such as Michigan Rehabilitation Services **(MRS) or the Bureau of Services for Blind Persons (BSBP)**. Under "Supported Employment", the last paragraph was revised to read: Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for ~~**work activity or**~~ supported employment services provided by ~~**Michigan Rehabilitation Services (**~~MRS~~**)**~~ **or BSBP**. Information must be updated when MRS **or BSBP** eligibility conditions change.	(1) To align with current WIOA Rehab language. (2) To be inclusive of BSBP as another Michigan vocational rehabilitation partner.

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Behavioral Health and Intellectual and Developmental Disability Supports and Services	17.3.D. Environmental Modifications	In the 3rd paragraph, the last bullet point was revised to read: • Adaptations to the work environment that are the requirements of Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, or are the responsibilities of Michigan Rehabilitation Services **(MRS) or the Bureau of Services for Blind Persons (BSBP).**	To be inclusive of BSBP as another Michigan vocational rehabilitation partner.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	17.3.F. Housing Assistance	The 1st paragraph was revised to read: Housing assistance is assistance with short-term, interim, or one-time-only expenses **(not including room and board costs)** for beneficiaries transitioning from restrictive settings and homelessness into .... In the 3rd paragraph, the 2nd and 3rd bullet points were revised to read: • Limited term or temporary assistance with living expenses for beneficiaries transitioning from restrictive settings and homelessness. **Limited term or temporary assistance is defined as a total of six (6) occurrences of a funding need.** • Interim assistance with utilities, insurance or living expenses when the beneficiary already living in an independent setting experiences a temporary reduction or termination of his own or other community resources. **Interim assistance is defined as a total of three (3) occurrences of a funding need.** The 4th paragraph was revised to read: Coverage excludes: • Funding for ongoing housing costs. **Ongoing is defined as longer than a total of six (6) occurrences of a funding need.** • **Funding for any room and board costs (i.e., rental payments, mortgage payments, lease payments, land contract payments, hotel/motel stays, etc.).** • ~~**Costs for room and board that are not directly associated with transition arrangements while securing other benefits.**~~	Clarifies that Medicaid funds cannot be used for room and board costs.

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		• Home maintenance that is of general utility or cosmetic value and is considered to be a standard housing obligation of the beneficiary.	
Behavioral Health and Intellectual and Developmental Disability Supports and Services	17.3.J. Skill-Building Assistance	The 3rd paragraph was revised to read: Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for ~~**sheltered work services**~~ **supported employment services** provided by Michigan Rehabilitation Services (MRS) **or the Bureau of Services for Blind Persons (BSBP)**. Information must be updated when the beneficiary's MRS **or BSBP** eligibility conditions change.	(1) To align with current WIOA Rehab language. (2) To align with language for Pre-voc and Supported Employment in the 15.1 Section. (3) To be inclusive of BSBP as another Michigan vocational rehabilitation partner.
Children's Special Health Care Services	Section 2 – Approved/Authorized Providers	The title was revised to read: **CSHCS Providers:** Approved/Authorized ~~**Providers**~~ Text was revised to read: In addition to enrollment with the Michigan Medicaid Program, physicians and hospitals serving beneficiaries must meet ~~**approval**~~ criteria to serve as a CSHCS specialty care provider. The ~~**approval**~~ criteria are detailed in the CSHCS Approved Providers subsection below. ~~**Physicians and hospitals that meet the approval criteria, as well as other provider types noted in the CSHCS Authorized Providers subsection below, may request authorization from CSHCS to provide care to a specific beneficiary and receive reimbursement for services rendered. Services must be related to the beneficiary's CSHCS qualifying diagnosis. Refer to the CSHCS Authorized Providers subsection below for additional information.**~~	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
		All providers must comply with **Medicaid policies and requirements, including** prior authorization requirements ~~associated with specific services as~~ described **elsewhere** in this manual. **For beneficiaries without Medicaid/MIChild/Healthy Michigan Plan coverage, approved physicians and/or hospitals (including hospital-owned ambulance and hospice agencies) must also be authorized by CSHCS to provide medical services related to the beneficiary's CSHCS qualifying condition. (Refer to the CSHCS Authorized Providers subsection for authorization requirements.)**	
Children's Special Health Care Services	2.1.B. Hospitals	Text was revised to read: Hospitals desiring to be CSHCS approved must: • ~~Be approved by The Joint Commission;~~ • Be enrolled in the Michigan Medicaid program **(refer to the General Information for Providers Chapter of this manual for additional information)**; • Have an organized Pediatrics Unit with an average daily census of **six (6)** or greater; and • Have a **Pediatrics Department identified in the** medical staff structure~~, including an organized Pediatrics Department headed by a board certified pediatrician~~. **Exceptions:** • **Local laboratory and/or local imaging services ordered by the CSHCS subspecialist during the hospital visit and emergency care are not required to meet the organized Pediatrics Unit requirement, as stated above.** • **Emergency services do not require an order by the CSHCS subspecialist.**	Clarification.

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Children's Special Health Care Services	2.2 CSHCS Authorized Providers	Text was revised to read: ~~**Providers will be reimbursed for services provided to a beneficiary only if authorized by CSHCS to render services to that beneficiary. Refer to the MDHHS website for a listing of CSHCS authorized providers. (Refer to the Directory Appendix for website information.)**~~ ~~**To initiate the authorization process, affected providers must contact the CSHCS office in the local health department (LHD) in the beneficiary's county of residence. LHD contact information is available on the MDHHS website. (Refer to the Directory Appendix for website information.)**~~ ~~**Providers who do not need authorization to render services to a beneficiary must be enrolled in the Michigan Medicaid Program. These enrolled providers may render services when ordered or prescribed by a CSHCS-authorized provider and the services are related to the beneficiary's CSHCS qualifying diagnosis. The name and NPI of the CSHCS authorized ordering or prescribing provider must be entered in the appropriate field on the claim.**~~ **The following requirements apply only to providers serving CSHCS beneficiaries who do not also have Medicaid/MIChild/Healthy Michigan Plan coverage:** • **An authorized provider is an approved physician and/or hospital that is specifically identified on the CSHCS system as a provider for a specific beneficiary. (Refer to the CSHCS Approved Providers subsection for participation requirements.)** • **CSHCS authorization of a provider is the step that allows for reimbursement for medical services rendered that are related to the CSHCS qualified condition(s).** • **To become CSHCS authorized for a specific beneficiary, the family or the provider contacts the county health department in which the beneficiary lives.**	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
		Providers serving beneficiaries with CSHCS who also have Medicaid/MIChild/Healthy Michigan Plan coverages do not need to be authorized.	
Children's Special Health Care Services	2.3 Providers Who Do Not Need to be CSHCS Authorized (new subsection; following subsections were re-numbered)	New subsection text reads: Non-physician providers typically do not need CSHCS authorization to render services to a beneficiary (except for hospital-owned ambulances and hospice agencies). These providers may render services (and be reimbursed) when ordered or prescribed by a CSHCS authorized provider and the services are related to the beneficiary's CSHCS qualifying diagnosis. The National Provider Identifier (NPI) number of the CSHCS authorized ordering or prescribing provider must be entered in the appropriate field on the claim.	
Children's Special Health Care Services	~~2.3~~ **2.4** Verifying Provider Authorization	The 2nd sentence was revised to read: The CHAMPS Eligibility Inquiry and/or HIPAA 270/271 transaction will also indicate if the inquiring provider NPI number is authorized to render CSHCS services for the beneficiary on that ~~DOS~~ **date of service**.	Replacement of acronym.
Children's Special Health Care Services	~~2.4~~ **2.5** Children's Multi-Disciplinary Specialty (CMDS) Clinic Requirements	In the 1st paragraph, the last sentence was revised to read: Hospitals and medical universities that administer CMDS clinics require a separate National Provider Identifier (NPI) number with which to enroll and submit claims **specifically** for the CMDS clinic fee.	Clarification.
Children's Special Health Care Services	Section 4 – Application Process	The last paragraph was revised to read: When a medical report is submitted to CSHCS on behalf of ~~an individual~~ **a beneficiary** with full Medicaid ~~coverage~~, ~~or~~ MIChild, **or Healthy Michigan Plan coverage**, and the CSHCS medical consultant determines that the ~~individual~~ **beneficiary** is medically	Updates terminology and reflects addition of Healthy Michigan Plan coverage.

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		eligible for CSHCS, the ~~individual~~ **beneficiary** is automatically enrolled in CSHCS without completing the CSHCS application.	
Children's Special Health Care Services	5.1 Financial Determination Process	The 1st and 2nd paragraphs were revised to read: Families/individuals are exempt from a payment agreement if at least one of the **following applies:** ~~**The individual to be covered:**~~ • **The beneficiary to be covered h**as full Medicaid coverage **or is enrolled in MI Child or the Healthy Michigan Plan**; • ~~**Is enrolled in MIChild.**~~ • **The beneficiary i**s a ward of the county or state; • **The beneficiary l**ives in a foster home or a private placement agency; • **The beneficiary h**as a court-appointed guardian; or • **The beneficiary i**s deceased (retroactive coverage).	Reflects addition of Healthy Michigan Plan coverage.
Children's Special Health Care Services	5.3 Payment Agreement	In the 4th paragraph, the 1st and 2nd sentences were revised to read: Beneficiaries who acquire full Medicaid**,** ~~**or**~~ MIChild, **or Healthy Michigan Plan** coverage after enrollment into CSHCS will be reimbursed in full for any money paid toward the payment agreement that is in place for the current CSHCS coverage period. Unpaid balances may be forgiven and CSHCS coverage continued when the beneficiary has acquired full Medicaid**,** ~~**or**~~ MIChild, **or Healthy Michigan Plan** coverage. Beneficiaries can call the local health department or the CSHCS Family Phone Line to request assistance with the CSHCS payment agreement. (Refer to the Directory Appendix for contact information.) In the 5th paragraph, the last sentence was revised to read: When death of a beneficiary occurs and **one or** more ~~**than one**~~ **of the surviving** family member**s have** ~~**has**~~ CSHCS coverage, the payment agreement remains intact **for the remaining family members**.	Reflects addition of Healthy Michigan Plan coverage. Clarification.

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		In the 7th paragraph, the 2nd sentence was revised to read: When a beneficiary acquires Medicaid**,** ~~or~~ MIChild**, or Healthy Michigan Plan** coverage after the beneficiary reaches the age of majority, the current payment agreement entered into by the family while the beneficiary was a minor does not qualify for forgiveness of balance or return of money.	
Children's Special Health Care Services	Section 8 – Coverage Period	The 2nd, 3rd and 4th paragraphs were revised to read: Families/beneficiaries are required to provide updated financial information during the annual renewal of the coverage period to determine financial participation with the CSHCS Program. Those with Medicaid**,** ~~or~~ MIChild**, or Healthy Michigan Plan coverage** are determined complete in the annual financial review each year those circumstances remain true. Beneficiaries are requested to provide updated information during the annual renewal of the coverage period regarding current providers, address, other insurance, etc. Beneficiaries are required to apply for MIChild/Healthy Kids**/Healthy Michigan Plan coverage** when the Income Review/Payment Agreement (MSA-0738) indicates the beneficiary may be eligible for one of these programs based on age and family income. The Income Review/Payment Agreement is submitted at the time of the initial CSHCS application or renewal (refer to the Payment Agreement subsection). A CSHCS temporary eligibility period (TEP) of 90 days is activated to allow the family time to complete the MIChild/Healthy Kids**/Healthy Michigan Plan** application process. Upon notification that the family has completed the MIChild/Healthy Kids**/Healthy Michigan Plan** application process, CSHCS coverage is extended to complete the full 12-month enrollment period from the initial coverage date (begin date of the TEP), regardless of the MIChild/Healthy Kids**/Healthy Michigan Plan** eligibility decision. CSHCS coverage terminates at the end of the 90-day TEP if the family fails to submit the application **for one of these programs**.	Reflects addition of Healthy Michigan Plan coverage.

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Children's Special Health Care Services	9.4 Case Management Benefit	Text was revised to read: Beneficiaries **with either CSHCS, CSHCS and Medicaid, or Medicaid only (no CSHCS)** may be eligible to receive Case Management services if they have **a CSHCS medically eligible diagnosis,** complex medical care needs and/or complex psychosocial situations which require that intervention and direction be provided by an outside, independent professional. ~~**These include, but are not limited to, the Private Duty Nursing (PDN) population.**~~ LHDs or ~~**their**~~ **approved** contractors may provide Case Management services. **When there is additional training criteria required to perform a specific Case Management role based upon the service being provided (e.g., Elevated Blood Lead services), the provider of the service must be trained and certified, and services must be performed according to the training and requirements specific to that role.** Case Management requires the development of a comprehensive plan of care (POC) ~~**meeting**~~ **which meets** the minimum elements**,** as determined by MDHHS**, and is monitored/revised as necessary**. All services must relate to objectives/goals documented in the POC. **Case Management services address complex needs and services and include an initial face-to-face encounter with the beneficiary/family.** Case Management requires that services be provided in the home setting or other ~~**noninstitutional**~~ **non-office** setting~~**s**~~ based on family preference~~**, and be provided face-to-face**~~. Beneficiaries are eligible for a maximum of six billing units per eligibility year. Services above the maximum of six ~~**would**~~ require prior approval by MDHHS. To request approval, the Case Management provider must ~~**send a detailed**~~ **submit an exception** request, including ~~**documentation and**~~ the rationale for additional services, to MDHHS. ~~**(Refer to the Directory Appendix for contact information.)**~~ **Limitations on the need for and number of Case Management service units are set by MDHHS and must be provided by a specific Case Management role, in accordance with training and certification requirements and as specified by the rules within that service type.**	Clarifies service and staffing requirements associated with care coordination, case management and targeted case management.

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		Each case manager must be licensed to practice as a registered professional nurse in the State of Michigan and be employed **by or contracted with a LHD** as a Public Health nurse at the entry level or above ~~**by a LHD**~~, or be able to demonstrate to MDHHS that comparable qualifications are met. Case Management **and Care Coordination services within a specific Case Management role cannot be billed** ~~**is not reimbursable for beneficiaries also receiving Care Coordination services**~~ during the same LHD billing period, which is usually a ~~**calendar**~~ **fiscal** quarter. ~~**In the event Case Management services are no longer required, but Care Coordination services would be of assistance, the change in billing may only be made at the beginning of the next billing period.**~~ Families/beneficiaries can contact the LHD for assistance in obtaining Case Management services.	
Early and Periodic Screening, Diagnosis and Treatment	6.2 Autism Screening	The subsection title was revised to read: Autism **Spectrum Disorder** Screening In the 1st paragraph, the 2nd sentence was revised to read: Proper assessment of autism **spectrum disorder** is accomplished by administering a validated and standardized screening tool, such as the Modified Checklist for Autism in Toddlers (M-CHAT), at 18 and 24 months of age as indicated by the AAP periodicity schedule.	Per new 2017 AAP Periodicity Schedule
Early and Periodic Screening, Diagnosis and Treatment	6.5 Alcohol and Drug Use Assessment	The subsection title was revised to read: **Tobacco**, Alcohol, ~~**and**~~ **or** Drug Use Assessment The 1st sentence was revised to read: A~~**n**~~ **tobacco**, alcohol, ~~**and**~~ **or** drug use assessment must be performed annually at each preventive health care well child ...	Per new 2017 AAP Periodicity Schedule

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CHAPTER	SECTION	CHANGE	COMMENT
Early and Periodic Screening, Diagnosis and Treatment	9.4 Hematocrit or Hemoglobin	The subsection title was revised to read: ~~Hematocrit or Hemoglobin~~ **Anemia** Text was revised to read: The **PCP must screen the** child~~'s hematocrit or hemoglobin must be tested~~ **for anemia** according to the AAP periodicity schedule.	Per new 2017 AAP Periodicity Schedule
Early and Periodic Screening, Diagnosis and Treatment	9.7 Dyslipidemia Screening	The 1st sentence was revised to read: All children and adolescents should undergo a **dyslipidemia (**cholesterol**)** screening once between 9 and 11 years of age and once between 17 and 21 years of age.	Per new 2017 AAP Periodicity Schedule
Early and Periodic Screening, Diagnosis and Treatment	Section 12 – Children in Foster Care	In the 7th paragraph, the 2nd sentence was revised to read: A developmental/behavioral assessment includes developmental screening; autism **spectrum disorder** screening; developmental surveillance; psychosocial/behavioral assessment; **tobacco,** alcohol, ~~and~~ **or** drug use assessment; and depression screening.	Per new 2017 AAP Periodicity Schedule
Home Health	Section 3 – Plan of Care	In the 1st paragraph, the 9th bullet point was revised to read: • ~~Environment status (e.g., electricity, telephone, indoor plumbing).~~ • **Safety measures to protect against injury (e.g., fall safety measures, medication management, infection control)**	Medicare specifies inclusion of "Safety measures" in the POC. Adheres to Medicare form CMS-485. Clarification.
Hospital Reimbursement Appendix	1.5 Payment Calculation	The following text was added: Additional billing and reimbursement information is available on the MDHHS website. (Refer to the Directory Appendix for website information.)	Addresses OPPS/ASC updates.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	7.1 Disproportionate Share Hospital Payments	The 2nd paragraph was revised to read: Indigent volume is measured as the percentage of inpatient indigent charges to a hospital's net hospital charges as reported on the Medicaid cost report. Indigent charges are the annual charges for services rendered to patients eligible for payments under Medicaid, CSHCS, ~~**Adult Benefits Waiver (ABW),**~~ MIChild, MOMS, and ~~**non-ABW Indigent Care Plans**~~ **Healthy Michigan Plan**, plus uncompensated care charges. Uncompensated care is limited by Medicare standards and is offset by any recoveries. The textbox was deleted. ~~**Effective April 1, 2014, the Adult Benefits Waiver has ended. All beneficiaries enrolled in the Adult Benefits Waiver have been transitioned to the Healthy Michigan Plan.**~~	Removal of obsolete information.
Hospital Reimbursement Appendix	7.3.B. University With Both a College of Allopathic Medicine and a College of Osteopathic Medicine	In the 1st paragraph, the 1st sentence was revised to read: ~~**A separate pool will be created annually in the amount of $2,764,340.**~~ **A separate pool will be created annually in the following amounts: $2,772,003 in fiscal year 2005, $2,764,340 for fiscal years 2006 – 2012, and $3,500,000 for each subsequent fiscal year.** The following text was added as a 3rd paragraph: **This agreement shall not require the hospital to donate money or service to the other party in the agreement.**	Information from Letter L 12-48

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CHAPTER	SECTION	CHANGE	COMMENT
Local Health Departments	3.3.C. Cost Allocation Plans	Text was revised to read: MDHHS requires LHDs to certify that their existing cost allocation plan is in compliance with OMB ~~**Circular A-87**~~ **Title 2 CFR Part 200** and that the plan identifies Medicaid outreach activities as a specific element of the plan. The certification is accepted by MDHHS as documentation to continue this administrative claiming. Each cost allocation plan is subject to MDHHS review for compliance with ~~**A-87**~~ **OMB Title 2 CFR Part 200**.	Update.
Maternal Infant Health Program	1.1 Program Services	The following text was added at the end of the 1st paragraph: All physician orders for MIHP services must be in compliance with state and federal laws prohibiting self-referral.	Per recommendation from the OIG.
Maternal Infant Health Program	1.2 Staff Credentials	The following text was added at the end of the last paragraph: All physician orders for MIHP services must be in compliance with state and federal laws prohibiting self-referral.	Per recommendation from the OIG.
MI Choice Waiver	8.5 Financial Audit Requirements	The 2nd paragraph was revised to read: Waiver agencies that expend $500,000 or more in federal awards during the agency's fiscal year must submit to MDHHS a Single Audit that is consistent with the Single Audit Act Amendments of 1996 and Office of Management and Budget (OMB) ~~**Circular A-133, "Audits of States, Local Governments, and Non-Profit Organizations" (as revised)**~~ **Title 2 CFR Part 200 titled Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards Subparts A, B, and F**. The last paragraph was revised to read: Waiver agencies and each of their contractors are subject to the provisions of, and must comply with, the cost principles set forth in OMB ~~**Circular A-87, "Cost Principles for State, Local, and Indian Tribal Governments" (as revised) and OMB Circular A-122, "Cost Principles for Non-Profit Organizations"**~~ **Title 2 CFR Part 200 titled Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards Subparts A, B, and E**.	Update.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Non-Emergency Medical Transportation	Section 1 – Introduction	The last paragraph was revised to read: Forms referenced in this chapter are ~~accessible~~ **accessed via the beneficiary's case worker and are maintained** on MI Bridges. **The MSA-4674 is also available** ~~or~~ on the Michigan Department of Health and Human Services (MDHHS) website. (Refer to the Directory Appendix for website information.)	Clarification.
Non-Emergency Medical Transportation	Section 2 – Common Terms	The definition for "Medi-Van" was revised to read: A vehicle **owned by a commercial or nonprofit provider** used to transport a beneficiary who is able to ambulate and transfer into and out of the vehicle, but requires door-to-door or curb-to-curb service due to their medical condition. Drivers of these vehicles are expected to assist and escort the beneficiary. This definition also includes demand response paratransit transportation services. The definition for "Wheelchair Lift Equipped Vehicle" was revised to read: A vehicle **owned by a commercial or nonprofit provider** that is equipped for a beneficiary who requires a wheelchair and that provides door-to-door service due to their inability to ambulate. Drivers of these vehicles are expected to assist and escort the beneficiary. This definition also includes demand response paratransit transportation services.	Clarification.
Non-Emergency Medical Transportation	4.1 Volunteer Drivers	The 2nd bullet point was revised to read: • Cannot physically reside in the same household as the beneficiary **they are transporting**;	Clarification.
Nursing Facility Coverages	8.4 Level II Evaluation Completion	The 6th paragraph was revised to read: The local CMHSP notifies the attending physician, nursing facility, and discharging hospital of the results of the evaluation and the MDHHS determination in writing within ~~30~~ **five (5)** days of the review. A copy of ...	Update.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	10.36.D. Prior Approval for Therapies	The following text (formatted as a textbox) was added at the beginning of the subsection: If a beneficiary is approved for ventilator care and also requires therapy, prior authorization for the therapy must be obtained under the VDCU NPI.	Information from Letter L 17-06.
Nursing Facility Coverages	12.2.B. Authorization for VDCU Placement	The following text (formatted as a textbox) was added at the end of the subsection: If a beneficiary is in need of therapy, prior authorization for the therapy must be obtained under the VDCU's NPI. (Refer to the Nursing Facility Claim Completion section of the Billing & Reimbursement for Institutional Providers chapter for additional information.)	Information from Letter L 17-06.
Nursing Facility Cost Reporting & Reimbursement Appendix	Section 3 - Definitions	Under "Available Bed", the 3rd bullet point was revised to read: • Beds temporarily unoccupied due to renovation or construction where the SSA has deemed the beds unacceptable for occupancy**, for example beds which are a part of a Building Program Agreement**.	Clarifying the procedure used by LARA.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.12.F. Out of State Nursing Facility (Nonenrolled Michigan and Borderland Providers)	The subsection was deleted. The following sub-sections were re-numbered.	Removal of obsolete information. (Michigan Medicaid no longer has borderland nursing facilities serving Michigan Medicaid beneficiaries.)
Nursing Facility Cost Reporting & Reimbursement Appendix	14.16.I. Medical Supplies Charged to Patient (new subsection; following subsections were re-numbered)	New subsection text reads: Medical Supplies – Chargeable... Support Minor Equipment – Less Than $5,000... Support Minor Equipment – More Than $5,000... Plant 2 Equipment Rental – Less Than 12 Months... Support Equipment Rental – More Than 12 Months... Plant 2	To conform to the cost report.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
		Direct Allocation – Fixed Assets Depreciation... Plant 1 Direct Allocation – Movable Equipment Depreciation... Plant 2 Direct Allocation – Interest & Property Taxes... Plant 3 Other... Support	
Nursing Facility Cost Reporting & Reimbursement Appendix	14.17.E. Medicaid Special Care Unit #2	The subsection was given a new title: ~~**Medicaid Special Care Unit #2**~~ **Adult Daycare Program** The following lines were removed from the subsection: ~~**Salaries & Wages – In-service Training... Support**~~ ~~**Employee Benefits – In-service Training ... Support**~~ ~~**Payroll Taxes – In-service Training... Support**~~	To conform to the cost report.
Pharmacy	13.4 Product Cost Payment Limits	The 2nd paragraph was revised to read: Entities ~~**or their contracted pharmacies**~~ that participate in the Federal 340B program must bill the 340B price.	Clarification.
Pharmacy	14.14.A. Synagis (new subsection)	New subsection text reads: Enrolled pharmacy providers may bill for the injectable drug Synagis.	Update.
Pharmacy	15.2 Dispensing Fee	A pharmacy may receive a maximum of ~~**one**~~ **13** dispensing fee**s** for the same drug entity per ~~**month**~~ **365-day billing period**.	Consistency in language.
Pharmacy	19.1 Documentation Requirements	In the table after the 2nd paragraph, under "Dispensing Fees", the 1st sentence was revised to read: Pharmacies may not bill in a pattern that would lead to more than 13 dispensing fees in a ~~**year**~~ **365-day billing period** for the same drug entity.	Consistency in language.

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CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	7.6 Multiple Gestation	Text was revised to read: In the case of multiple gestation, Medicaid covers the services provided. Payment follows the multiple procedure rules. **(Refer to the Billing & Reimbursement for Professionals Chapter, Maternity Care Services subsection, for additional information.)** Providers must use a diagnosis code representing multiple gestation.	Clarification.
Practitioner	Section 18 - Certified Registered Nurse Anesthetist	The last paragraph was revised (and reformatted) to read: To enroll as a Medicaid provider, a CRNA must **meet all of the following requirements:** • Be currently licensed in Michigan as a **registered professional** nurse; • Be certified by the State as a CRNA; and • Complete an on-line application through the CHAMPS Provider Enrollment subsystem. (Refer to the Provider Enrollment Section of the General Information for Providers Chapter for additional enrollment information, and the Directory Appendix for contact information.)	Clarification.
Practitioner Reimbursement Appendix	Section 3 – Primary Care Provider Rate Increase	Section 3 – Primary Care Provider Rate Increase was deleted. The following section/subsections were re-numbered.	Removal of obsolete information.
Practitioner Reimbursement Appendix	~~4.1~~ **3.1** Provider Eligibility	The 5th paragraph was revised to read: Practitioners who participate in the MDHHS Physician Adjustor Program are eligible for the ~~**primary care provider rate increase**~~ **primary care practitioner services incentive payment**. For these participating providers, MDHHS calculates the Physician Adjustor Program payment adjustment consistent with the existing methodology.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
School Based Services	Section 1 - General Information	In the table after the last paragraph, "Claims Development Software" was revised to read: The claims development software is a custom-developed software that ~~**utilizes scanning hardware and software and spreadsheet software to**~~ automate**s** the school district claiming process. The claims development ~~**software**~~ **process** is comprised of three components: sampling, training, and costs/claim generation.	Clarification.
School Based Services	2.6 Developmental Testing	Under "Documentation", the 3rd bullet point was revised to read: • ~~**Summary of testing results;**~~ • **A completed quarterly claim breakdown, produced by the claims development software;**	Clarification.
School Based Services	6.1.B. Random Moment Time Study	The 2nd paragraph was revised to read: The quarterly RMTS sampling results are produced by the State Contractor who converts them to percentages. This percentage is applied to program costs to determine reimbursement ~~**and entered onto the first sheet of the claims development software Workbook**~~. Once complete, the ~~**workbooks**~~ **time study results** are ~~**forwarded**~~ **provided** to MDHHS where they are uploaded into the cost settlement program.	Clarification.
School Based Services	7.1 Indirect Costs	The 1st sentence was revised to read: The ISD/LEA unrestricted indirect cost rate is calculated using the Federal Office of Management and Budget **(OMB)** ~~**Circular A-87 "Indirect Cost Allocation Principles."**~~ **Title 2 CFR Part 200.**	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
School Based Services Administrative Outreach Program Claims Development	1.1 Claims Development Enrolled Providers	The 2nd paragraph was revised to read: The State Claims Development Contractor will develop an implementation plan on behalf of its ISDs/DPS to conduct the statewide time studies each quarter, utilizing the claims development software, as well as complete all other key functions required for valid claim development. ~~**The Contractor must assign only one person as the designated coder for the program. MDHHS will oversee the Contractor and ISDs/DPS participating in this option to assure their compliance with all aspects of the program policy. The ISDs/DPS must also cooperate with MDHHS financial auditing systems.**~~	Update.
School Based Services Administrative Outreach Program Claims Development	1.2 Overview of Claims Development Process	In the 2nd paragraph, the 1st and 2nd bullet points were revised to read: • The quarterly RMTS sampling results are produced by the State's RMTS and Claims Development Contractor, who converts them to percentages. The percentages are applied to program costs to determine reimbursement ~~**and entered onto the first sheet of the claims workbook**~~. • The cost/claim generation component ~~**automates nine Excel spreadsheets and links the spreadsheets where possible. The**~~ **of the claims development software uses** ISD/DPS costs ~~**are entered onto the appropriate worksheets and the software**~~ **and other claim factors to** calculate~~**s**~~ and produce~~**s**~~ the claim.	Clarification.
School Based Services Administrative Outreach Program Claims Development	2.9 Non-Salary Expenditures	The 2nd sentence was revised to read: The principles for claiming expenditures and cost allocation, including correct depreciation of assets as published in the Federal Office of Management and Budget (OMB) ~~**Circular A-87**~~ **Title 2 CFR Part 200**, must be followed.	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
School Based Services Administrative Outreach Program Claims Development	2.10 Indirect Costs	The 2nd sentence was revised to read: The ISD/LEA unrestricted indirect cost rate is calculated using the Federal Office of Management and Budget **(OMB)** ~~**Circular A-87 "Indirect Cost Allocation Principles."**~~ **Title 2 CFR Part 200.**	Update.
School Based Services Random Moment Time Study	1.3 Staff Pools and Confidence Levels	In the 1st paragraph, the 1st sentence was revised to read: The RMTS is carried out utilizing **customized** ~~**developed**~~ claims development software ~~**which is integrated with scanning hardware/software and spreadsheet capabilities to create a system**~~ that automates **aspects of** the school district time study process.	Clarification.
School Based Services Random Moment Time Study	3.1.A. Long-Term Substitutes	The 4th bullet point was deleted. • ~~**The substitute's name must be listed in parentheses behind the name of the regular staff person on the staff pool list.**~~ The 6th bullet point was revised to read: • ~~**Financial worksheets must reflect the name of the regular staff and the substitute in parentheses.**~~ The cost reflected should be the sum of the cost of the regular staff on leave and the long-term substitute staff.	Update.
School Based Services Random Moment Time Study	3.2 Random Moment Time Study Form Completion	The 2nd paragraph was deleted. ~~**At this point, the time study form is completed and can be scanned into the claims development software by the Contractor.**~~	Update.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
School Based Services Random Moment Time Study	Section 4 – Administrative Outreach and Direct Medical Activity Code Summary	In the 2nd paragraph, the 4th bullet point was removed. • ~~**"N/A" - The code is no longer used per directive from CMS**~~ In the table in the 3rd paragraph, text relative to Activity Codes 8 and 11 was removed. ~~**8 [Code no longer utilized]**~~ ... ~~**11 [Code no longer utilized]**~~ ...	Removal of obsolete information.
School Based Services Random Moment Time Study	Section 7 – Summary of Time Study Steps	The 3rd bullet point was revised to read: • Generate printed **or electronic** RMTS forms for each moment. The following text was added as bullet points 6 and 7: • **Code the time study responses.** • **Calculate activity percentages for each of the activity codes.**	Clarification.
School Based Services Random Moment Time Study	8.2.A. Part I – July 1 to the Individual ISD Date That Students Return to School	The 3rd bullet point was revised to read: • ~~**RMTS – average of the previous three quarters time study results**~~ • **A weighted average of the October-December, January-March, April-June, and the summer time study results.**	Update.
Tribal Health Centers	5.1 Nonenrolled Providers	The 2nd paragraph was deleted. ~~**See billing instructions for nonenrolled providers listed in the Uniform Billing of Paper and Electronic Formats Section of this chapter.**~~	Removal of obsolete text.
Acronym Appendix		Obsolete text was removed from the definition for MIHP: MIHP - Maternal Infant Health Program ~~**(formerly known as Maternal and Infant Support Services)**~~	Removal of obsolete information.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Nursing Facility Resources; MDHHS, LTC Services	The telephone number was revised to read: ~~**517-241-4293**~~ **517-373-6313**	Update.
Directory Appendix	Nursing Facility Resources; Provider Enrollment Contact Information for Borderland Nursing Facilities	Information was deleted.	Removal of obsolete information. (Michigan Medicaid no longer has borderland nursing facilities serving Michigan Medicaid beneficiaries.)
Acronym Appendix		Addition of: BSBP - Bureau of Services for Blind Persons MRS – Michigan Rehabilitation Services	Update.
Forms Appendix		The "Instructions Included" column was removed.	

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 17-12	3/31/2017	Pharmacy	14.14 Physician-Administered Injectable Drugs	The 1st paragraph was revised to read: Pharmacy claims for the following physician-administered injectable drugs ~~administered on an outpatient basis~~ are reimbursable under Michigan Medicaid and the Healthy Michigan Plan: • Mental health and substance abuse injectable drugs, as listed on the Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) Physician Injectable Drug Coverage database available on the MDHHS website**, administered in an outpatient setting or residential treatment center.** (Refer to the Directory Appendix for website information.) • 17 Alpha Hydroxyprogesterone Caproate (17P and Makena) **administered in an outpatient setting**. In the 2nd paragraph, the 1st sentence was revised to read: Pharmacy providers may be reimbursed for these injectable drugs for administration ~~in an outpatient setting~~ using a rate based on the National Drug Code (NDC).
MSA 17-07	3/1/2017	Billing & Reimbursement for Institutional Providers	7.18 Injections	The 7th paragraph was revised to read: If an injectable or non-injectable drug is obtained at a lower than normal cost (e.g., through 340B program), the lower than normal cost (actual acquisition cost) must be reported on the claim in place of the cost of charge. **In addition, drugs purchased through the 340B program must be indicated on the institutional claim using the modifier U6.**
		Billing & Reimbursement for Professionals	6.4 Ancillary Medical Services	Under "Injectable Drugs", the following text was added at the end of the 1st paragraph: **In addition, injectable drugs purchased through the 340B program must be indicated on the CMS 1500 or in the appropriate field in the electronic format using the modifier U6.** Under "Chemotherapy Drugs", the following text was added at the end of the 1st paragraph: **In addition, chemotherapy drugs purchased through the 340B program must be indicated on the CMS 1500 or in the appropriate field in the electronic format using the modifier U6.**

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Billing & Reimbursement for Professionals	6.21 Surgery	Under "Hysterectomy and Sterilization Procedures", the following text was added at the end of the 2nd paragraph: **In addition, drugs purchased through the 340B program must be indicated on the claim using the modifier U6.**
		Family Planning Clinics	5.1 Special Billing Instructions	Text was revised to read: If a pharmaceutical, contraceptive supply, or medical device is purchased at the 340B price, the actual acquisition cost must be billed to Medicaid. **In addition, drugs purchased through the 340B program must be indicated as such on the claim. Professional/institutional claims for drugs purchased through the 340B program must be indicated on the claim using the modifier U6. Pharmacy claims for outpatient drugs purchased through the 340B program must be indicated on the claim using a Submission Clarification Code of 20.** (Refer to the Billing & Reimbursement for Professionals Chapter for additional information.)
		Pharmacy	Section 16 – Public Health Service and Disproportionate Share Hospitals	The last paragraph was revised to read: Covered entities or their contracted pharmacies, or disproportionate share hospital participating entities that are enrolled as Medicaid pharmacy providers who bill 340B prices, must ~~**contact the MDHHS Drug Rebate Specialist**~~ **indicate on the claim that the drug was purchased through the 340B program** so their claims can be excluded from the drug rebates. ~~**(Refer to the Directory Appendix for contact information.)**~~ **Professional/institutional claims for drugs purchased through the 340B program must be indicated on the claim using the modifier U6. Pharmacy claims for outpatient drugs purchased through the 340B program must be indicated on the claim using a Submission Clarification Code of 20.**
		Pharmacy	19.1 Documentation Requirements	In the table following the 2nd paragraph, under "340B Drug Pricing Program", text was revised to read: Billing ingredient costs may not be higher than actual acquisition costs for drugs procured under the 340B Drug Pricing Program. **Pharmacy claims for outpatient drugs purchased through the 340B program must be indicated on the claim using a Submission Clarification Code of 20.**

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 17-06	3/1/2017	Pharmacy	11.3 Refills	The following text was added after the 2nd paragraph: **Early refill overrides may be granted once per drug per 12 months for any of the following circumstances:** • **To replace medication that has been lost, stolen or destroyed.** • **For the purposes of vacation or travel.** **The early refill will not exceed a 34-day supply. MDHHS or its designee may limit the number of instances early refill overrides are approved in cases of suspected fraud or abuse, and may request additional documentation before an override is authorized.**
MSA 17-04	2/1/2017	General Information for Providers	Section 7-Sanctioned, Nonenrolled, Borderland, and Out-of-State/Beyond Borderland Providers	The section title was revised to read: Sanctioned, ~~**Nonenrolled,**~~ Borderland, and Out-of-State/Beyond Borderland Providers
		General Information for Providers	7.2 Nonenrolled Michigan and Borderland Providers	The subsection was deleted.
MSA 17-03	2/1/2017	Non-Emergency Medical Transportation (new chapter)		Incorporation of new chapter. (Note technical changes included within the Technical Changes document.)

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Acronym Appendix		Addition of: CDL – Commercial Driver's License NEMT - Non-Emergency Medical Transportation
MSA 17-02	2/1/2017	General Information for Providers	11.1 General Information	In the 1st paragraph, the 1st bullet point was revised to read: • A Medicaid copayment is required. (Refer to the Beneficiary Copayment Requirements subsection of this chapter ~~**and to the provider specific chapters**~~ for additional information about copayments.) ~~**However, a provider cannot refuse to render service if the beneficiary is unable to pay the required copayment on the date of service.**~~
		General Information for Providers	11.2 Beneficiary Copayment Requirements	The last paragraph was revised to read: ~~**For specific copayment information, refer to the copayment portions of the provider-specific chapters in this manual.**~~ A list of current copayments is ~~**also**~~ available on the MDHHS website. (Refer to the Directory Appendix for website information.) Different copayment requirements may apply for beneficiaries enrolled in a Medicaid Health Plan. Contact the appropriate plan for copayment information.
		Beneficiary Eligibility	9.9 Copayments	The 1st paragraph was revised to read: Health plan beneficiaries may be charged a copayment for physician and outpatient hospital evaluation and management visits, non-emergency visits to the emergency department, the first day of an inpatient hospital stay (with the exception of emergent admissions), and pharmacy, podiatric, chiropractic, vision, or hearing services as described in this manual. ~~**Enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from co-pays. Native American Indians/Alaska Natives are exempt from co-pays consistent with federal regulations at 42 CFR §447.56(a)(1)(x).**~~

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Chiropractor	1.2 Beneficiary Copayment	The 1st and 2nd paragraphs were revised to read: A copayment ~~of $1~~ for each Medicaid reimbursable chiropractic visit may be required for beneficiaries age 21 years and older. (Refer to the General Information for Providers Chapter for information ~~on exceptions to Medicaid~~ **about** copayment**s**. ~~requirements.~~) **Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)** When more than one reimbursable service is provided during one visit (e.g., spinal manipulation and x-ray on the same date of service [DOS]), only a single ~~$1~~ copayment may be charged to the beneficiary.
		Dental	Section 3 - Copayment	Text was revised to read: A copayment ~~of $3~~ for each separately reimbursable Medicaid visit may be required for beneficiaries age 21 years and older with the following limitations: • When more than one reimbursable service is provided during a visit, only one $3 copayment may be charged. • Where several visits are required to complete a service (such as dentures), only one $3 copayment may be charged. • Beneficiaries cannot be charged a copayment for procedures that are considered part of normal office operations. A provider cannot refuse to render service if the beneficiary is unable to pay the required copayment on the date of service. Some beneficiaries, programs, and places of service are exempt from co-payment requirements. (Refer to the General Information for Providers Chapter for information on ~~exceptions to~~ Medicaid copayment requirements.) **Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)**

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Federally Qualified Health Centers	4.5 Copayments	Text was revised to read: Medicaid copayments for chiropractic, dental, physician, podiatry, and vision services are waived under the FQHC benefit as part of the reconciliation. ~~**(Services requiring copayment are listed in the General Information for Providers Chapter of this manual.)**~~
		Healthy Michigan Plan	Section 3 – Cost Sharing Information	In the 2nd paragraph, text after the 4th sentence was revised to read: For general information on copayment requirements and exemptions, providers should refer to the Billing Beneficiaries Section of the General Information for Providers Chapter of this manual. **Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)** Beneficiaries may not be denied care or services based on inability to pay a copayment, except as outlined in that section.
		Healthy Michigan Plan	3.2 Fee-For-Service Beneficiaries	The 2nd and 3rd paragraphs were revised to read: Copayments may be required and due at the point of service ~~**for office visits, pharmacy, inpatient hospital stays, outpatient hospital visits, and non-emergency visits to the Emergency Department**~~ for beneficiaries age 21 years and older. The MDHHS ~~**Beneficiary Copayment**~~ **Healthy Michigan Plan Copay Requirements t**able, available on the MDHHS website, provides detailed information regarding the specific services to which the copays are applied. (Refer to the Directory Appendix for website information.)
		Hearing Aid Dealers	1.6 Copayments	The 1st paragraph was revised to read: A copayment ~~**of $3**~~ for a hearing aid may be required for beneficiaries age 21 years and older. **Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)** ~~**Enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from co-pays. Native American Indians/Alaska Natives are exempt from co-pays consistent with federal regulations at 42 CFR §447.56(a)(1)(x).**~~

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Hospital	1.4 Copayments	The 1st paragraph was revised to read: Copayments may be required for inpatient hospital stays, outpatient hospital visits, and non-emergency visits to the Emergency Department for beneficiaries age 21 years and older. **Refer to the General Information for Providers Chapter for information about copayments. Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)** ~~Enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from co-pays. Native American Indians/Alaska Natives are exempt from co-pays consistent with federal regulations at 42 CFR §447.56(a)(1)(x).~~ The 2nd paragraph was revised to read: Copayments for the first day of an inpatient stay apply to the DRG or first day per diem payment. A copay will not be applied to emergent admissions, transfers between acute care hospitals, from acute care to rehab, or to readmits within 15 days for the same DRG/diagnosis. Federal regulations at 42 CFR §447.54 specify the cost sharing requirements for services provided in a hospital emergency department. To impose cost sharing for non-emergency services provided in a hospital emergency department, the hospital must: • Perform appropriate medical screening under 42 CFR §489.24 Subpart G to determine the individual does not need emergency services. • Before providing non-emergency 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 non-emergency 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. Hospitals providing emergency department services are expected to develop cost sharing policies and procedures consistent with the federal requirement.

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Michigan Department of Health and Human Services

Medicaid Provider Manual
July 2017 Updates

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Nursing Facility Coverages	10.26.D.1. Beneficiary Liability Under Medicare Part D	In the 1st paragraph, the last two sentences were removed. **~~Enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from co-pays. Native American Indians/Alaska Natives are exempt from co-pays consistent with federal regulations at 42 CFR §447.56(a)(1)(x).~~**
		Pharmacy	1.7 Medicaid Health Plans	In table after the 3rd paragraph, text for "Copayment" was revised to read: Copayments may differ. **~~Enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from co-pays. Native American Indians/Alaska Natives are exempt from co-pays consistent with federal regulations at 42 CFR §447.56(a)(1)(x).~~**
		Pharmacy	13.6.A. Medicaid Copayments	The 1st paragraph was revised to read: A **~~$1~~** copayment for each generic/preferred drug dispensed, and **~~a $3 copayment~~** for each brand name/non-preferred drug dispensed, may apply for Medicaid beneficiaries age 21 years and older. A **~~$1~~** copayment may apply to certain brand name drugs that are preferred. **Refer to the General Information for Providers Chapter for information about copayments. Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)** **~~Enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from co-pays. Native American Indians/Alaska Natives are exempt from co-pays consistent with federal regulations at 42 CFR §447.56(a)(1)(x).~~**

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Practitioner	1.3 Copayments	The 1st and 2nd paragraphs were revised to read: A copayment ~~of $2~~ may be required for physician office (evaluation and management) visits for beneficiaries age 21 years and older. ~~**Enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from co-pays. Native American Indians/Alaska Natives are exempt from co-pays consistent with federal regulations at 42 CFR §447.56(a)(1)(x).**~~ The office visit copayment applies to services provided in the physician's office, urgent care center, or other appropriate setting. It does not apply to professional services provided in the outpatient hospital or inpatient hospital **settings. Refer to the General Information for Providers Chapter for information about copayments. Current copayment amounts are listed on the MDHHS website.** ~~**The MDHHS Beneficiary Copayment Table, available on the MDHHS website, provides detailed information regarding the specific services to which the copays are applied.**~~ (Refer to the Directory Appendix for website information.)
		Practitioner	20.1 Copayment	Text was revised to read: A ~~**$2.00**~~ copayment is required for each separately covered visit for beneficiaries age 21 and older ~~**who are not residents in a nursing facility or are not receiving services covered by Medicare**~~. If more than one separately covered service is rendered on the same day, such as an office visit and laboratory services, only one copayment is required. If a procedure such as a surgery with a global period is rendered, only one copayment is required. **Refer to the General Information for Providers Chapter for information about copayments. Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)** ~~**Enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from co-pays. Native American Indians/Alaska Natives are exempt from co-pays consistent with federal regulations at 42 CFR §447.56(a)(1)(x).**~~

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Special Programs	2.1.A. Eligible Beneficiaries	Text was revised to read: The Breast and Cervical Cancer Control Program (BCCCP) covers uninsured low-income women of all ages especially, but not limited to, women aged 40-64. Certain income restrictions do apply. Enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from copays. **~~Native American Indians/Alaska Natives are exempt from co-pays consistent with federal regulations at 42 CFR §447.56(a)(1)(x).~~** • Insured women may apply if certain insurance, age, and income requirements are met. • Women who are enrolled in a managed care program, health maintenance organization (HMO) or have Medicare Part B are not eligible.
		Urgent Care Centers	4.1 Copay Requirements	Text was revised to read: A copayment **~~of $2.00~~** may be required for office evaluation and management (E&M) visits for beneficiaries age 21 years and older. **~~Enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from co-pays. Native American Indians/Alaska Natives are exempt from co-pays consistent with federal regulations at 42 CFR §447.56(a)(1)(x).~~** **Refer to the General Information for Providers Chapter for information about copayments. Current copayment amounts are listed on the MDHHS website.** **~~The MDHHS Co-Payments Requirements document, available on the MDHHS website, provides detailed information regarding the specific services to which the copays are applied.~~** (Refer to the Directory Appendix for website information.)

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Vision	1.1 Beneficiary Eligibility and Copayments	The 2nd paragraph was revised to read: A ~~$2~~ copayment may be required for Medicaid beneficiaries age 21 and older for each separately reimbursable: • Ophthalmological service performed by an optometrist or ophthalmologist; and • Dispensing service for glasses or contact lenses billed by dispensing ophthalmologists or optometrists. (Refer to the General Information for Providers Chapter ~~of this manual~~ for information ~~on exceptions to Medicaid~~ **about** copayments ~~requirements~~.) **Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)** The textbox was deleted. ~~Refer to the Billing Beneficiaries Section of the General Information for Providers Chapter of this manual for additional information regarding copayment requirements. Beneficiaries may not be denied care or services based on inability to pay a copayment, except as outlined in that section.~~
		Directory Appendix	Billing Resources	Under "Beneficiary Co-Payments", the following website address was added: **Healthy Michigan Plan:** www.michigan.gov/healthymichiganplan >> Healthy Michigan Plan Provider Information
MSA 16-39	11/30/2016	Behavioral Health and Intellectual and Developmental Disabilities Supports and Services	17.3.G.4. Peer Mentoring Services (new subsection)	New subsection text reads: Peer Mentoring services provide adults with intellectual and developmental disabilities with opportunities to support, mentor and assist beneficiaries to achieve community inclusion and participation, independence, and productivity. Peer Mentors are individuals with intellectual and developmental disabilities who have a unique skill level from their experience in utilizing services and supports to achieve their goals. Peer Mentors offer the benefit of their personal experiences, passing along encouragement and support to help others construct their own advocacy. Beneficiaries utilizing Peer Mentoring services must freely choose the individual who is providing Peer Mentoring services from available trained Peer Mentors.

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				Activities provided by Peer Mentors are completed in partnership with beneficiaries for the specific purpose of achieving increased beneficiary community inclusion and participation, independence, and productivity by: • sharing personal stories of advocacy for the purpose of supporting self-advocacy and independence, person-centered planning goals, and arrangements that support self-direction; • navigating transportation systems; • building bridges to people and resources within the community; • identifying recreation opportunities; • providing information on entitlements; • assisting beneficiaries to move towards independence; • providing housing information by helping to identify affordable and accessible housing for achieving independent living; finding and choosing roommates; making applications for Section 8 Housing vouchers; managing budgets; • providing vocational information to beneficiaries who are seeking post-secondary education and/or training opportunities, finding a job, and achieving successful employment. Requirements Individuals who are functioning as Peer Mentors serving beneficiaries with intellectual and developmental disabilities must: • be 18 years of age. • have an intellectual/developmental disability. • attend the Michigan Developmental Disabilities Council's Peer Mentor 101 training by referral from their local CMHSP. • complete a supervised 90-120 hour internship at their local CMHSP. (The CMHSP is expected to hire the individual after certification.) • share their personal experiences to guide and support beneficiaries. • participate in annual continuing education trainings to maintain skills and expand knowledge base. The use of the Peer Mentor code for billing purposes is permissible only after the individual is certified by the Michigan Developmental Disabilities Council.

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MSA 16-35	11/1/2016	Hospice	6.9.D. MI Health Link	The 2nd paragraph was deleted. ~~When a beneficiary who is enrolled in MI Health Link elects hospice, the hospice agency will submit a Hospice Membership Notice (DCH-1074) to the MDHHS Enrollment Services Section. However, the hospice must indicate within the DCH-1074 Remarks section the last date of the beneficiary's participation in MI Health Link (the last day of the month) and the start date of FFS Medicaid (the first day of the following month). The level of care (LOC) 16 will be placed on the beneficiary's file on the first day of the following month; however, a beneficiary does not need to wait until they are disenrolled from MI Health Link to receive hospice services. Hospice services may begin at the time of hospice election and will be reimbursed based on the beneficiary's location. Medicare will pay for hospice services in the home setting between the time that a MI Health Link beneficiary elects hospice services and the time they are disenrolled from MI Health Link. If a MI Health Link beneficiary resides in a nursing facility when hospice is elected, Medicare will pay for hospice services and the MI Health Link health plan will continue to pay for the nursing facility stay until disenrollment from MI Health Link has occurred.~~
		Hospice	6.9.D. MI Health Link	The following text was added after the 1st paragraph: Effective November 1, 2016, individuals enrolled in the MI Health Link program who elect hospice services may remain enrolled in the MI Health Link program if they choose. When a MI Health Link beneficiary elects hospice services, the hospice agency must notify the beneficiary's Integrated Care Organization (ICO) for initiation of care management and authorization of nursing facility room and board, if indicated. The hospice agency will bill Medicare for hospice services and other Medicare Part A and Part B services not related to the terminal illness and bill the ICO for room and board when hospice is rendered in a nursing home setting. If the beneficiary is receiving hospice services while residing in a nursing facility, the hospice provider must provide to the beneficiary's ICO the Hospice Membership Notice (form DCH-1074) indicating the nursing facility information and when hospice services started. If hospice services end, or the beneficiary moves to a community setting to receive hospice services, the hospice provider must provide the ICO with an updated DCH-1074 indicating the beneficiary is no longer receiving hospice services, or is no longer residing in the nursing facility, as applicable.

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				The hospice agency does **not** submit a DCH-1074 to the MDHHS Enrollment Services Section because the beneficiary will remain in MI Health Link at the current level of care (LOC) of 03, 05, 07, or 15. When the individual is enrolled in MI Health Link and receiving hospice services, the LOC code 16 will not be reflected in the Community Health Automated Medicaid Processing System (CHAMPS). A beneficiary has the option of disenrolling from MI Health Link at any time by contacting Michigan's contracted enrollment broker. During the month when disenrollment occurs, the beneficiary will remain with MI Health Link until the first day of the following month, at which time Fee-for-Service (FFS) Medicaid will become effective. Hospice agencies will need to monitor MI Health Link beneficiary enrollment status. If a beneficiary receiving hospice is disenrolled from MI Health Link, a DCH-1074 will need to be submitted by the hospice agency to the MDHHS Enrollment Services Section. The last date of a beneficiary's participation in MI Health Link (the last day of the month) and the start date of FFS Medicaid (the first day of the following month) must be included within the DCH-1074 Remarks section. This will allow the LOC of 16 (hospice) to be placed on the beneficiary's file once the disenrollment is reflected in CHAMPS.
		MI Health Link	Section 2 – Eligibility and Service Areas	The last bullet point was revised to read: • Individuals with elected hospice services **prior to MI Health Link program enrollment**
		MI Health Link	Section 5 – Covered Services	The 2nd paragraph was deleted. ~~**Hospice is not a covered benefit. If an individual elects to receive hospice services, the individual is disenrolled from the ICO effective the last day of the same month in which the hospice enrollment is effective. For example, if the individual elects to receive hospice services on March 15, he/she will be disenrolled from MI Health Link effective April 1. The ICO is responsible for non-hospice related services until the individual is disenrolled from the ICO (the remainder of the month). After disenrollment from the ICO, the individual's option for Medicaid services in the demonstration regions will be through fee-for-service (FFS). Medicare will cover the hospice services as well as any other non-hospice related services traditionally covered by Medicare. Individuals will not be eligible for the MI Health Link program as long as they continue to be enrolled in hospice.**~~

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		MI Health Link	5.4 Hospice (new subsection)	New subsection text reads as follows: Effective November 1, 2016, individuals enrolled in the MI Health Link program who elect hospice services may remain enrolled in the MI Health Link program if they choose. When a MI Health Link beneficiary elects hospice services, the hospice agency must notify the beneficiary's Integrated Care Organization (ICO) for initiation of care management and authorization of nursing facility room and board, if indicated. The hospice agency will bill Medicare for hospice services and other Medicare Part A and Part B services not related to the terminal illness and bill the ICO for room and board when hospice is rendered in a nursing home setting. If the beneficiary is receiving hospice services while residing in a nursing facility, the hospice provider must provide to the beneficiary's ICO the Hospice Membership Notice (form DCH-1074) indicating the nursing facility information and when hospice services started. If hospice services end, or the beneficiary moves to a community setting to receive hospice services, the hospice provider must provide the ICO with an updated DCH-1074 indicating the beneficiary is no longer receiving hospice services, or is no longer residing in the nursing facility, as applicable. The hospice agency does **not** submit a DCH-1074 to the MDHHS-Enrollment Services Section because the beneficiary will remain in MI Health Link at the current level of care (LOC) of 03, 05, 07, or 15. When the individual is enrolled in MI Health Link and receiving hospice services, the LOC code 16 will not be reflected in the Community Health Automated Medicaid Processing System (CHAMPS). A beneficiary has the option of disenrolling from MI Health Link at any time by contacting Michigan's contracted enrollment broker. During the month when disenrollment occurs, the beneficiary will remain with MI Health Link until the first day of the following month, at which time Fee-for-Service (FFS) Medicaid will become effective. Hospice agencies will need to monitor MI Health Link beneficiary enrollment status. If a beneficiary receiving hospice is disenrolled from MI Health Link, a DCH-1074 will need to be submitted by the hospice agency to the MDHHS Enrollment Services Section. The last date of a beneficiary's participation in MI Health Link (the last day of the month) and the start date of FFS Medicaid (the first day of the following month) must be included within the DCH-1074 Remarks section. This will allow the LOC of 16 (hospice) to be placed on the beneficiary's file once the disenrollment is reflected in CHAMPS.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Acronym Appendix		Addition of: ICO – Integrated Care Organization
MSA 16-30	11/1/2016	School Based Services	2.2.A. Occupational Therapy Services	Under "Prescription", the following text was added: Services supported by an Individualized Education Program can precede the signed prescription by up to 90 days; however, the active period of the prescription cannot be longer than one year.
		School Based Services	2.2.B. Orientation and Mobility Services	Under "Prescription", the following text was added: Services supported by an Individualized Education Program can precede the signed prescription by up to 90 days; however, the active period of the prescription cannot be longer than one year.
		School Based Services	2.3.A. Physical Therapy Services	Under "Prescription", text was revised to read: Physical therapy services must be prescribed by a physician ~~**or licensed physician's assistant**~~ and updated annually. A stamped physician signature is not acceptable.
		School Based Services	2.4.A. Speech, Language and Hearing Therapy	Under "Prescription", the following text was added: Services supported by an Individualized Education Program can precede the signed referral by up to 90 days; however, the active period of the referral cannot be longer than one year.
MSA 16-29	9/1/2016	Billing & Reimbursement for Institutional Providers	7.11 Diabetes Self-Management Education (DSME) Training Program	Text was revised to read: MDHHS follows Medicare's DSME Training (initial and follow-up) billing guidelines as closely as possible. Providers must bill appropriately. All documentation must support that services furnished are provided by a ~~**certified,**~~ Medicaid enrolled provider **who meets Michigan Medicaid DSME program requirements** in the appropriate place of service. **Refer to the Hospital Chapter for information regarding DSME program requirements.**

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		Hospital	3.7.B. Diabetes Self-Management Education (DSME) Training Program	Text was revised to read: ~~**MDHHS covers diabetes self-management education (DSME) when ordered by a physician and provided by diabetes educators (e.g., nurse, dietitian) in a Medicaid enrolled outpatient hospital or a Local Health Department (LHD) which has been certified by MDHHS Public Health Administration. Certification information must be provided to MDHHS via the CHAMPS Provider Enrollment on-line system. (Refer to the Directory Appendix for contact information.)**~~ ~~**This service is not covered if rendered by a physician in the office setting, rendered by a nonenrolled provider, or rendered by a non-CPH certified provider.**~~ ~~**MDHHS follows Medicare's DSME training billing guidelines.**~~ **DSME is intended to educate beneficiaries in the successful self-management of their diabetes. MDHHS covers DSME when ordered by a physician or qualified non-physician medical practitioner responsible for the beneficiary's diabetic care and provided by diabetes educators (e.g., nurse, dietitian) in a Medicaid-enrolled outpatient hospital or Local Health Department (LHD) that meets one of the following requirements:** • **Certified as a DSME program by MDHHS, Population Health Administration; or** • **American Association of Diabetes Educators (AADE) accreditation by the Diabetes Education Accreditation Program (DEAP); or** • **American Diabetes Association (ADA) recognition by the Education Recognition Program (ERP).** **DSME program requirement information must be provided to MDHHS via the CHAMPS Provider Enrollment on-line system. (Refer to the Directory Appendix for contact information.) DSME services may not be rendered to eligible beneficiaries or billed for payment until the appropriate requirement information is on file and approved.**

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				The physician or qualified non-physician medical practitioner treating the beneficiary's diabetes must maintain a documented diabetes diagnosis in the medical record for initial and follow-up education and training. They must also document any special needs supported by medical necessity. **MDHHS aligns with Medicare's DSME training billing guidelines when possible. Medical Nutrition Therapy (MNT) is not a separately covered or reimbursed DSME Medicaid covered service.** **Medicaid-enrolled DSME programs are expected to submit the MDHHS Annual Statistical Data Report following the reporting requirements located on the MDHHS website. This information is used for statewide reporting of statistical information to the Centers for Disease Control and Prevention (CDC). (Refer to the Directory Appendix for website information.)** **DSME is not covered if rendered by a physician in the office setting, rendered by a nonenrolled provider, or rendered by a provider who does not meet Michigan Medicaid DSME program requirements.**
		Practitioner	3.7 Diabetes Patient Education	Text was revised to read: Medicaid covers diabetes self-management education **for beneficiaries diagnosed with diabetes** when ordered by a**n enrolled** physician **or qualified non-physician medical practitioner responsible for the beneficiary's diabetic care.** ~~**and**~~ **Services must be** provided by diabetes educators (e.g., nurse, dietitian) in a Medicaid enrolled outpatient hospital or ~~**a**~~ LHD ~~**which has been certified by MDHHS Public Health Administration**~~ **that meets Michigan Medicaid DSME program requirements**. ~~**This service is not covered if rendered by a physician in the office setting, rendered by a nonenrolled provider, or rendered by a non-CPH certified provider.**~~ **The physician or qualified non-physician medical practitioner treating the beneficiary's diabetes must maintain a documented diabetes diagnosis and any special needs supported by medical necessity in the medical record.** **Refer to the Hospital Chapter of this manual for information about DSME program requirements.**

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Acronym Appendix		Addition of: AADE - American Association of Diabetes Educators ADA - American Diabetes Association DEAP - Diabetes Education Accreditation Program ERP - Education Recognition Program MNT - Medical Nutrition Therapy
		Directory Appendix	Provider Resources	Addition of: **Contact/Topic:** MDHHS Diabetes and Other Chronic Diseases Section/Diabetes and Kidney Unit; Diabetes Self-Management Education Certification Program – Annual Statistical Data Report **Phone # Fax #:** phone 517-373-2818; fax 517-335-9461 **Mailing/Email/Web Address:** MDHHS Diabetes and Kidney Unit WSB – 7th Floor P.O. Box 30195 Lansing, MI 48909-0001 www.michigan.gov/diabetes >> Diabetes Self-Management Education Certification Program **Information Available/Purpose:** Information about DSME certification, including the Annual Statistical Data Report

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MSA 16-28	9/1/2016	MI Choice Waiver	4.1.M. Non-Emergency Medical Transportation (new subsection; following subsections were re-numbered)	New subsection text reads: NEMT is defined in 42 CFR 431.53 and 42 CFR 440.170 and includes expenses for transportation and other related travel expenses determined necessary to secure medical examinations, documentation, or treatment for a MI Choice participant. Waiver agencies will ensure MI Choice participants have access to NEMT as needed to obtain medical services. Utilization of family, friends, or community agencies who provide transportation services without charge must be explored before MI Choice will authorize NEMT. Additionally, delivery services for medical items, such as medical supplies or prescriptions, should be utilized before authorizing NEMT through the MI Choice program. NEMT includes, but is not limited to, transportation to obtain the following medical services: • Chronic and ongoing treatment, • Prescriptions, • Medical supplies and devices, • One time, occasional and ongoing visits for medical care, and • Services received at a Veterans Affairs hospital. Travel expenses related to the provision of NEMT include: • The cost of transportation for the MI Choice participant by wheelchair vans, taxis, bus passes and tickets, secured transportation containing an occupant protection system that addresses safety needs of disabled or special needs individuals, and other forms of transportation; • Mileage reimbursement for individuals or volunteers with a valid driver's license utilizing personal vehicles to transport the MI Choice participant; • The cost of meals and lodging en route to and from medical care, and while receiving medical care; • The cost of an attendant to accompany the MI Choice participant, if necessary; • The cost of the attendant's transportation, meals, and lodging; and • The attendant's salary, if the attendant is not a volunteer or a member of the MI Choice participant's family.

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				NEMT provider standards differ from other waiver service provider standards and will be outlined in the contract between MDHHS and waiver agencies.
		MI Choice Waiver	4.1.~~M.~~ **N.** Non-Medical Transportation	The 2nd paragraph was revised to read: **~~Non-Medical Transportation services offered through MI Choice are in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State Plan, defined at 42 CFR 440.170(a), and does not replace State Plan services. MI Choice transportation services cannot be substituted for the transportation services that MDHHS is obligated to provide under the listed citations. Such transportation, when provided for medical purposes, is not reimbursable through MI Choice.~~** When the costs of transportation are included in the provider rate for another waiver service (e.g., Adult Day Health), there must be mechanisms to prevent the duplicative billing of Non-Medical Transportation services.

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