MSA
MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Health and Human Services

Bulletin Number: MSA 15-53

Distribution: All Providers

Issued: December 1, 2015

Subject: Updates to the Medicaid Provider Manual; Native American/Alaska Native Cost-Sharing Exemption Modification; Healthy Michigan Plan Beneficiary Cost Sharing

Effective: As Indicated

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

Updates to the Medicaid Provider Manual

The Michigan Department of Health and Human Services (MDHHS) has completed the January 2016 quarterly update of the Michigan Medicaid Provider Manual. The Manual is maintained on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy and Forms >> Medicaid Provider Manual. A compact disc (CD) version of the Manual is available to enrolled providers upon request.

The January 2016 version of the Manual does not highlight changes made in 2015. Refer to the online version of this bulletin at www.michigan.gov/medicaidproviders >> Policy and Forms to view the attachments that describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change. Subsequent changes made for the April, July, and October 2016 versions of the manual will be highlighted within the text of the on-line manual.

Native American/Alaska Native Cost-Sharing Exemption Modification

Consistent with federal regulation, MDHHS revised its cost-sharing policies for Native Americans/Alaska Natives as defined in 42 CFR §447.51. As required by 42 CFR §447.56(a)(1)(x), any individual who meets the definition of Native American/Alaska Native and who is eligible to receive an item or service furnished by an Indian health care provider or through referral under contract health services is exempt from premiums. Additionally, any individual who meets the definition referenced above and is currently receiving or has ever received an item or service furnished by an Indian health care provider or through referral under contract health services is exempt from all cost-sharing.

Healthy Michigan Plan Beneficiary Cost Sharing

Per bulletin MSA 14-11, effective April 1, 2014, Healthy Michigan Plan beneficiaries are subject to cost sharing requirements in compliance with published policy and the Section 1115 waiver and related protocols approved by the Centers for Medicare & Medicaid Services (CMS). Cost sharing includes both co-pays and monthly contributions based on income, when applicable. Additional information regarding the Healthy Michigan Plan Section 1115 waiver, protocols, and beneficiary cost sharing can be found at www.michigan.gov/healthymichiganplan.

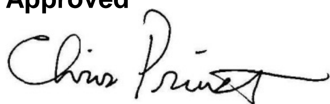
Manual Maintenance

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

Medicaid Provider Manual January 2016 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Throughout the manual		References to 'Department of Licensing and Regulatory Affairs (LARA) Bureau of Health Care Services (BHCS)' were revised to read 'Department of Licensing and Regulatory Affairs (LARA) Bureau of Community and Health Systems (BCHS)'.	Update.
Medicaid Provider Manual Overview	1.1 Organization	"Chapter Content" for "School Based Services – Random Moment Time Study" was revised to read: Random moment time study process for the School Based Services Direct Medical Services program.	Update.
General Information for Providers	Section 1 – Introduction	The 2nd paragraph was revised to read: The Michigan Department of Health and Human Services (MDHHS) acts as the fiscal intermediary for several health insurance programs including, but not limited to, Medicaid, Healthy Michigan Plan, Adult Benefits Waiver (ABW), Children's Special Health Care Services (CSHCS), the Refugee Assistance Program (RAP), Maternity Outpatient Medical Services (MOMS), and the Repatriate Program. Although coverage, ...	Revised to address Healthy Michigan Plan.
General Information for Providers	Section 3 – Maintenance of Provider Information	The 4th paragraph was deleted.	Duplication of information given in Section 2 of the chapter.
General Information for Providers	11.2.B. Refusal of Service Due to Non-Payment of Copayment	The 2nd paragraph was revised to read: Care or services cannot be denied unless the provider has first given the beneficiary: ...	Update.
Beneficiary Eligibility	Section 2 – mihealth Card	In the 1st paragraph, the following bullet point was added: • Healthy Michigan Plan The 5th paragraph was revised to read: The provider can use the **mihealth** card to access a beneficiary's eligibility information using the CHAMPS Eligibility Inquiry by entering the beneficiary ID number or swiping the card using a magnetic strip reader.	Revised to address Healthy Michigan Plan.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans	Revisions to benefit plan information (noted by Benefit Plan ID) were made as follows: 1. AUT – Benefit Plan Name was revised to read: Autism Related Services 2. CMH – Benefit Plan Description addition of "Discontinued as of December 31, 2015." 3. HK-Dental – Benefit Plan Description was revised to read: The Healthy Kids Dental program is a selective contract between the Michigan Department of Health and Human Services (MDHHS) and the Delta Dental Plan of Michigan to administer the Medicaid dental benefit in selected counties to beneficiaries under the age of 21. 4. HK-EXP – Benefit Plan Description was revised to read: This benefit plan covers children ages 16 through 18 from 100% Federal Poverty Level (FPL) up to 160% FPL. This benefit plan is funded by CHIP, and the benefits mirror Fee-for-Service Medicaid. 5. HK-EXP-ESO – Benefit Plan Name was revised to read: Healthy Kids – Expansion – Emergency Services Only 6. INCAR-ESO – Benefit Plan Name was revised to read: Incarceration – Emergency Services Only. Benefit Plan Description was revised to read: This benefit plan restricts services to inpatient hospital emergencies only while an otherwise ESO eligible member is incarcerated. Text in "Covered Services" was revised to include "Emergency Services Only". 7. INCAR-MA-E – Benefit Plan Name was revised to read: Incarceration – MA - Emergency Services Only. Benefit Plan Description was revised to read: This benefit plan restricts services to inpatient hospital emergencies only while an otherwise MA-ESO eligible member is incarcerated. Text in "Covered Services" was revised to include "Emergency Services Only". 8. MA-ESO – Benefit Plan Name was revised to read: Medical Assistance Emergency Services Only	Updates.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans	9. MA-HMP-ESO – Benefit Plan Name was revised to read: Healthy Michigan Plan Emergency Services Only 10. MA-HMP-INC – Benefit Plan Description was revised to read: This program restricts services to an inpatient hospital setting while an otherwise Healthy Michigan Plan eligible member is incarcerated. 11. MIChild - Benefit Plan Description addition of "Discontinued as of December 31, 2015." 12. MIChild-D - Benefit Plan Description addition of "Discontinued as of December 31, 2015." 13. MME-MC – Benefit Plan Name was revised to read: Medicaid-Medicare Dually Eligible – Managed Care 14. PIHP-HMP – Benefit Plan Name was revised to read: PIHP Healthy Michigan Plan. Benefit Plan Description was revised to read: This benefit plan provides managed care specialty behavioral health services for individuals enrolled in the Healthy Michigan Plan. 15. SA - Benefit Plan Description addition of "Discontinued as of December 31, 2015." 16. SLMB – Benefit Plan Name was revised to read: Specified Low Income Medicare Beneficiary. Under Benefit Plan Description, the 2nd sentence was revised to read: Under certain income limits, Medicaid pays the client's Medicare Part B premium only; Expanded Specified Low-Income Medicare Beneficiary (ESLMB): A client must ...	

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans	Addition of: Benefit Plan ID: MA-MIChild Benefit Plan Name: MIChild Program (CHIP) Benefit Plan Description: MA-MIChild is a health care program administered by the Department of Health and Human Services (MDHHS). It is for the low income uninsured children of Michigan's working families. Like Healthy Kids, MIChild is for children who are under age 19. Members are generally assigned to this benefit plan upon receipt of their eligibility information and remain active even if eventually assigned to MA Managed Care (MA-MC). Once assigned to a Managed Care Organization, the health plan is the primary payer. Type: Fee-for-Service Funding Source: XXI Covered Services: 1, 33, 35, 47, 48, 50, 71, 86, 88, 98, AL, MH, UC (35: FFS dental only if HK-Dental is not assigned for DOS)	Update.
Beneficiary Eligibility	2.1 Benefit Plans	Addition of: Benefit Plan ID: MIChildESO Benefit Plan Name: MIChild Program – Emergency Services Only (CHIP) Benefit Plan Description: Benefits mirror HK-EXP-ESO. Aliens who are not otherwise eligible for full coverage because of citizenship status may be eligible for Emergency Services Only (ESO). This benefit plan is funded by CHIP.[2] Type: Fee-for-Service Funding Source: XXI Covered Services: 86; 1, 47, 48, 50, 88, 91, 92 MH, UC (Emergency Services Only)	Update.

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

Michigan Department of Health and Human Services

Medicaid Provider Manual January 2016 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	3.1 CHAMPS Eligibility Inquiry	In the 3rd paragraph (NOTES), the 1st bullet point was revised to read: • Dental coverage information is identified by using the Benefit Plan ID data provided in the eligibility response. For Healthy Michigan Plan beneficiaries enrolled in a health plan, dental benefits must be verified through the health plan. (Refer to the Benefit Plans subsection …	Revised to address Healthy Michigan Plan.
Beneficiary Eligibility	9.1 Enrollment	Under 'Voluntary Enrollment', the 2nd bullet point was revised to read: • Native American Indians of Federally recognized tribes	Need to add the wording 'Federally recognized tribes' in accordance with 42 CFR 438.50 (d) (2)
Beneficiary Eligibility	9.2 Michigan Enrolls	The following bullet point was added to the 3rd paragraph: • Provide the Special Disenrollment –For Cause Request form (MSA-0176).	Update.
Beneficiary Eligibility	Section 10 – Children's Special Health Care Services	In the 2nd paragraph, the 3rd sentence was revised to read: An individual may be eligible for CSHCS and eligible for other medical programs such as Medicaid, Healthy Michigan Plan, Medicare or MIChild.	Revised to address Healthy Michigan Plan.
Beneficiary Eligibility	11.1 Hospitals and Nursing Facilities	The 1st and 2nd paragraphs were revised to read: The individual or his authorized representative should sign applications when possible. The local MDHHS office must determine Medicaid eligibility even if the individual is receiving Supplemental Security Income (SSI) benefits. An individual is not automatically eligible for Medicaid just because he has SSI benefits and resides in a nursing facility. For state-owned and -operated facilities, if the individual is unable to sign and the authorized representative is not available, the Reimbursement Office's authorized representative may sign the application using his personal signature and position title.	Correction/clarification.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Dental Providers	1.2 Predictive Modeling	In the 1st paragraph, text after the 3rd sentence was revised to read: Providers must submit the requested records within 45 days of the date on the request for documents letter to avoid denials for lack of documentation. Records should not be submitted prior to receiving a request for documentation letter.	Update.
Billing & Reimbursement for Institutional Providers	Section 1 – General Information	In the 1st paragraph, the 2nd sentence was revised to read: It contains information needed to submit institutional claims to the Michigan Department of Health and Human Services (MDHHS) for Medicaid programs, Children's Special Health Care Services (CSHCS), and the Adult Benefits Waiver (ABW).	Revised to address Healthy Michigan Plan.
Billing & Reimbursement for Institutional Providers	1.2 Predictive Modeling	In the 1st paragraph, text after the 3rd sentence was revised to read: Providers must submit the requested records within 45 days of the date on the request for documents letter to avoid denials for lack of documentation. Records should not be submitted prior to receiving a request for documentation letter.	Update.
Billing & Reimbursement for Professionals	Section 1 – General Information	In the 1st paragraph, the 2nd sentence was revised to read: It contains information needed to submit professional claims to the Michigan Department of Health and Human Services (MDHHS) for Medicaid programs, Children's Special Health Care Services (CSHCS), and the Adult Benefits Waiver (ABW).	Revised to address Healthy Michigan Plan.
Billing & Reimbursement for Professionals	1.2 Predictive Modeling	In the 1st paragraph, text after the 3rd sentence was revised to read: Providers must submit the requested records within 45 days of the date on the request for documents letter to avoid denials for lack of documentation. Records should not be submitted prior to receiving a request for documentation letter.	Update.
Billing & Reimbursement for Professionals	Section 6 – Special Billing	In the 1st paragraph, the 3rd sentence was revised to read: Some services may require additional billing information in order to receive correct reimbursement from Medicaid programs, CSHCS and ABW.	Revised to address Healthy Michigan Plan.

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

Medicaid Provider Manual January 2016 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Professionals	Section 7 – Modifiers	In the 3rd paragraph, the 2nd sentence was revised to read: Modifiers affect the processing and/or reimbursement of claims billed to MDHHS for Medicaid programs, CSHCS and ABW beneficiaries.	Revised to address Healthy Michigan Plan.
Dental	1.1.C. Adult Dental Program	Text was revised to read: Beneficiaries age 21 and older receive dental benefits that are more limited in coverage. Dental benefits are provided for adult Medicaid and Medicaid Health Plan (MHP) beneficiaries through the Medicaid Fee-For-Service (FFS) Program. Healthy Michigan Plan (HMP) beneficiaries will receive their dental benefits through the Medicaid FFS program until they are enrolled in a health plan. The health plan becomes responsible for the beneficiary's dental services on the enrollment effective date. Upon enrollment in a health plan, beneficiaries must obtain dental services through the health plan's dental provider network. The Program of All-Inclusive Care for the Elderly (PACE) is responsible for the coverage of dental benefits for PACE enrollees.	Revised to address Healthy Michigan Plan.
Dental	1.1.D. Healthy Michigan Plan Dental (new subsection)	New subsection text reads: Beneficiaries enrolled in a health plan will receive their dental coverage through their health plan. Each health plan contracts with a dental provider group or vendor to provide dental services administered according to the contract. The contract is between the health plan and the dental provider group or vendor, and beneficiaries must receive services from a participating provider to be covered. Questions regarding eligibility, prior authorization or the provider network should be directed to the beneficiary's health plan. It is important to verify eligibility at every appointment before providing dental services. Dental services provided to an ineligible beneficiary will not be reimbursed. For those beneficiaries who are not enrolled in a health plan, dental services will be provided by enrolled dental providers on a FFS basis.	Adding the dental information from the Healthy Michigan Plan chapter to the dental chapter for reference.
Dental	1.1.E. CSHCS Program	Re-numbered (previously 1.1.D.)	

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Dental	6.3.C. Indirect Restorations	The 1st paragraph was revised to read: Limited crown coverage is a covered benefit for beneficiaries under age 21. Crowns are covered only once per five years by any provider. Limited crown coverage includes: ...	To clarify the limitations as stated in the code/coverage resource materials subsection.
Early and Periodic Screening, Diagnosis and Treatment	12.4.B. Blood Lead Nursing Assessment Visits	The following text was added at the end of the 2nd paragraph: Blood lead nursing visits provided through a MHP are covered by the individual MHP.	Return of information removed in error.
Hearing Services	1.5 CSHCS Requirements	Subsection text was revised to read: NOTE: The following information is regarding beneficiaries who are enrolled in CSHCS but not also enrolled in Medicaid. Those with CSHCS-only are served through the CHAMPS FFS system. Once a beneficiary is enrolled in the CSHCS program for a condition that requires hearing services, a pediatric specialist (usually an ENT) is authorized by CSHCS to serve the beneficiary. CSHCS does not cover hearing services for all CSHCS beneficiaries. The pediatric subspecialist coordinates treatment and services relating to the beneficiary's CSHCS-qualifying diagnosis regarding the hearing needs. However, referral by the pediatric specialist to an audiologist is not required. Before billing for audiology services, the enrolled provider(s) must verify that they have been authorized to provide services to the beneficiary. (Refer to the Children's Special Health Care Services Chapter for further CSHCS information.) These requirements do not apply to services provided to Medicaid-only or dual Medicaid/CSHCS beneficiaries.	Update.
Home Health	Section 4 – Outcome and Assessment Information Set	In the 1st paragraph, the 3rd sentence was revised to read: This means beneficiaries under Medicaid traditional fee-for service (FFS), MHP, Children's Waiver, Home and Community Based Services Waiver for the Elderly and Disabled (MI Choice Waiver), Habilitation Supports Waiver, Healthy Michigan Plan, and CSHCS who receive home health services are to have OASIS information collected by the HHA.	Correction. Revised to address Healthy Michigan Plan.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	2.1 Diagnosis Related Group Assignment	The last paragraph was revised to read: Inpatient services are reimbursed based on the rates and Grouper Version in effect on the patient's date of discharge.	Policy was changed with bulletin MSA 12-61 (effective 1/1/2013) from date of admission to date of discharge. This paragraph did not previously fully address the change, and this change removes ambiguity about inpatient reimbursement.
Hospital Reimbursement Appendix	7.1.A. Indigent Volume Report and Disproportionate Share Hospital Eligibility Form	In the 5th paragraph, the example of the Disproportionate Share Hospital (DSH) Eligibility status verification form was revised.	Update.
Local Health Departments	2.2.B. Blood Lead Poisoning Follow-Up Services	The following text was added to the 2nd paragraph: Blood lead poisoning follow-up services can be billed directly to Medicaid FFS regardless if the beneficiary is enrolled in a MHP.	Correction.
Local Health Departments	3.1.A. Medicaid Outreach and Public Awareness	In the 2nd paragraph, the 1st bullet point was revised to read: • Informing families and distributing literature about the services and availability of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and the many different Michigan Medicaid programs.	Revised to address Healthy Michigan Plan.
Medicaid Health Plans	1.1 Services Covered by Medicaid Health Plans (MHPs)	The following text was added as a 2nd paragraph: The covered services provided to Healthy Michigan Plan enrollees under the contract include all those listed above and the following additional services: • Additional preventive services required under the Patient Protection and Affordable Care Act as outlined by MDHHS • Habilitative services • Dental services • Hearing aids for persons 21 and over	Revised to address Healthy Michigan Plan.

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

Medicaid Provider Manual January 2016 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	7.1 Program Approval	The 1st paragraph was revised to read: Applications for enrollment must identify home-based providers, either internal or contractual, who will serve children ages 0-17. Home-based services can be provided by one or more providers who serve one or more age groups. Once enrolled, a program must … In the 2nd paragraph, under "Organizational Structure", the 1st bullet point was revised to read: • Enrolled home-based services providers are available and sufficient to ensure that home-based services are provided to children ages 0-17 and meet the need across the entire catchment area.	Update.
Nursing Facility Coverages	Section 1 – General Information	In the 2nd paragraph, the 5th bullet point was revised to read: • Certificate of Need Commission Act 368 of 1978, as amended – Part 222	Clarification.
Nursing Facility Coverages	11.4 Married Couples	The 4th sentence was revised to read: For example, if both spouses wish to share a room in a nursing facility, in order for Medicaid to cover both of them in the facility, they must both require nursing facility services.	Consistency with wording.
Nursing Facility Certification, Survey & Enforcement Appendix	2.4.C. Bed Certification Process During a Change in Ownership (CHOW)	In the 1st paragraph, the 1st sentence was revised to read: A provider seeking a change in ownership of a nursing facility must first receive approval through the CON process within MDHHS.	Correction.
Nursing Facility Certification, Survey & Enforcement Appendix	2.4.D. Bed Certification Process for a New Nursing Facility or Newly Licensed Nursing Facility Beds	The 1st paragraph was revised to read: A provider seeking to build a new nursing facility, build a new section of a nursing facility, significantly remodel, or newly license nursing facility beds must first receive approval through the CON process within MDHHS.	Correction.

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

Medicaid Provider Manual January 2016 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	2.1 Prerequisite	The 2nd sentence was revised to read: MDHHS administers the CON Program.	Correction.
Nursing Facility Cost Reporting & Reimbursement Appendix	4.3 Cost Report Requirements	Subsection text was revised to read: The RARSS will send a notice electronically through the File Transfer application to the facility or business office as designated by the provider soon after the end date of the nursing facility's cost reporting period on record. The notice specifies the nursing facility's county and license number coding, fiscal reporting period end date, cost report due date, and other pertinent data necessary for the completion of the cost report. The provider will have access to the specific information required to file an acceptable Medicaid Cost Report package in File Transfer. File Transfer has the applicable electronic cost report template, completion instructions, construction cost index for asset acquisitions, and other pertinent information in downloadable form. The completed cost report package submitted to RARSS must include: • The standardized electronic cost report (ECR) data in accordance with specified formatting and software. • An electronic copy of the Certification Statement (Worksheet A), which has been prepared and printed from the completed ECR file, and physically signed by an authorized representative of the nursing facility certifying to the accuracy of the prepared cost report. • A copy of the nursing facility's trial balance of revenues and expenses. • A completed cost report submission checklist. The completed cost report package must be delivered electronically through File Transfer to RARSS as indicated in the notice.	RARSS no longer mails the notice with the cost reporting information; everything is done electronically. The cost report package is no longer mailed to RARSS; it is submitted electronically through File Transfer.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	9.4 Capital Asset Expenditure	The 2nd paragraph was revised to read: A nursing facility provider anticipating capital expenditures should contact the CON Evaluation Section to make application for a CON. (Refer to the Directory Appendix for contact information.)	Update.
Pharmacy	Section 1 – General Information	In the 1st paragraph, the 1st sentence was revised to read: Michigan Department of Health and Human Services (MDHHS) administers the fee-for-service (FFS) programs for Medicaid, Healthy Michigan Plan, Children's Special Health Care Services (CSHCS), Maternity Outpatient Medical Services (MOMS), Adult Benefits Waiver (ABW), and Plan First!. The 2nd paragraph was revised to read: Throughout this chapter the terms Medicaid and MDHHS are used to refer to the Michigan Medicaid FFS, Healthy Michigan Plan, CSHCS, MOMS, ABW, and Plan First! programs unless otherwise noted.	Revised to address Healthy Michigan Plan.
Rural Health Clinics	4.2 Eligibility Groups Subject to PPS Methodology	Information for "Healthy Kids" was removed from the group list. Under "Medicaid Health Plan Enrollees", the last sentence was removed.	Revised to address Healthy Michigan Plan.
School Based Services	Throughout the chapter	Use of "Fee for Service" and "FFS" was removed; text now reflects use of "Direct Medical Services".	Update.
School Based Services Random Moment Time Study	Throughout the chapter	Use of "Fee for Service" and "FFS" was removed; text now reflects use of "Direct Medical Services".	Update.
Acronym Appendix		Addition of: MA - Medicaid	Update.

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

Medicaid Provider Manual
January 2016 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix		Websites and e-mail addresses were revised as needed to address change in Department names ('Michigan Department of Community Health' and 'Michigan Department of Human Services' to 'Michigan Department of Health and Human Services' and use of 'MDCH' and 'DHS' to 'MDHHS').	Update.
Directory Appendix	Beneficiary Assistance - Beneficiary Help Line	Hours were revised to read: M-F 8 AM to 7PM	Update.
Directory Appendix	Beneficiary Assistance - Beneficiary Help Line (Pharmacy)	"Contact/Topic" was revised to read: Beneficiary Pharmacy Help Line	Update.
Directory Appendix	Beneficiary Assistance - MI Enrolls Row	Hours were revised to read: M-F 8 AM to 7 PM	Update.
Directory Appendix	Beneficiary Assistance - MIChild/MOMS	The following information was added: TTY: 888-263-5897 "Information Available/Purpose" was revised to read: MIChild health plan enrollment, MIChild provider participation information, and MIChild health plan change.	Update.
Directory Appendix	Eligibility Verification – Michigan Public Health Institute (MPHI)	Under "Information Available/Purpose", the 1st bullet point was revised to read: https://healthplanbenefits.mihealth.org >> Enrollment Form	Update.
Directory Appendix	Eligibility Verification – Medicare DSH Audits ...	The website for MPHI was revised to read: http://www.mihealth.org/#HIPAA >> Michigan HIPAA 270/271 Enrollment & Transactions	Update.

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

Medicaid Provider Manual January 2016 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Billing Resources – MDHHS Sanctioned Providers List	The U.S. Department of Health & Human Services (HHS) website was revised to read: https://exclusions.oig.hhs.gov/	Update.
Directory Appendix	Healthy Michigan Plan – Preventive and Wellness Services	The United States Preventive Services Task Force grade A and B services website was revised to read: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/	Update.
Directory Appendix	Maternal Infant Health Program Resources – Text4baby	The website was revised to read: https://ww.text4baby.org	Correction.
Directory Appendix	Nursing Facility Resources – Certificate of Need Commission	The mailing address was revised to read: MDHHS CON Evaluation Section 320 S. Walnut St., 3rd floor Lansing, MI 48913	Update.
Directory Appendix	Nursing Facility Resources – Nursing Facility Rate Setting	The following e-mail address was added: DARS@michigan.gov	Update.
Directory Appendix	Pharmacy Resources – List of Rebate-Participating Labelers	The website was revised to read: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/prescription-drugs/medicaid-drug-rebate-program-data.html	Update.

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

Medicaid Provider Manual January 2016 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Pharmacy Resources – List of Participating Entities in 340B Program	The website was revised to read: https://opanet.hrsa.gov/340B/Views/CoveredEntity/CESearch	Update.
Directory Appendix	Pharmacy Resources – Centers for Medicare & Medicaid Services	The website address was revised to read: https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/trp.html.	Update.
Directory Appendix	Miscellaneous Contact Information – Federal Registers	The website was revised to read: http://www.ecfr.gov	Update.

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

Michigan Department of Health and Human Services

Medicaid Provider Manual
January 2016 Updates

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 15-41	10/30/2015	Medicaid Provider Manual Overview	1.1 Organization	Addition of MI Health Link chapter information.
		MI Health Link		Incorporation of new chapter.
		Acronym Appendix		Additions relative to MI Health Link chapter.
		Directory Appendix		Additions relative to MI Health Link chapter.
MSA 15-40	10/1/2015	Medical Supplier	2.29 Osteogenesis Stimulators	**"Definition"** was revised to read: An Osteogenesis Stimulator is a device that provides electrical or ultrasonic signal stimulation to augment bone repair. Osteogenesis stimulators include: • Noninvasive electrical stimulator characterized by an external power source which is attached to a coil or electrodes placed on the skin or on a cast or brace over a fracture or fusion site; or • Noninvasive electrical multi-level spinal stimulator which involves three or more vertebrae (e.g., L3-L5, L4-S1, etc.); or • Noninvasive low intensity ultrasound stimulator which produces pulsed ultrasonic signals rather than electricity to stimulate bone repair by applying the signal to the skin surface at the fracture site. A long bone is limited to the clavicle, humerus, radius, ulna, femur, tibia, fibula, metacarpal, or metatarsal. The FDA classifies osteogenesis stimulators as Class III devices.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				"Standards of Coverage" In the first section/first paragraph, the 1st sentence was revised to read: A **noninvasive, nonspinal electrical or low intensity ultrasonic osteogenesis stimulator** may be covered when other treatment methods have been ineffective and when one of the following applies: The following text was added after the bullet list: Treatment using the above stimulators may not be provided concurrently. In the second section (**spinal electrical osteogenesis stimulator**), the following text was added after the bullet list: Treatment using the above stimulator may not be provided concurrently with nonspinal osteogenesis stimulators.

<table>
<tr><th>BULLETIN NUMBER</th><th>DATE ISSUED</th><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th></tr>
<tr><td></td><td></td><td></td><td></td><td>"Covered Conditions" (new/addition)

The current International Classification of Diseases (ICD) code related to the type and location of the fracture must be reported by the physician on the prescription/order and in the medical documentation.

<table>
<tr><td>Long Bone Fractures</td><td>• Clavicle
• Humerus
• Radius* and ulna
• Femur
• Fracture of other and unspecified parts of femur
• Tibia* and fibula
• Metacarpal bones (hands)
• One or more tarsal and metatarsal* bones</td></tr>
<tr><td>Other Fractures</td><td>• Ankle
• Closed navicular (scaphoid*) of wrist
• Malunion of fracture
• Nonunion of fracture
• Acquired spondylolisthesis
• Congenital spondylolisthesis</td></tr>
<tr><td colspan="2">*Coverage of fresh fractures is limited to tibia, radius, scaphoid, and fifth metatarsal.</td></tr>
</table>
</td></tr>
</table>

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				"Payment Rules" was revised to read: Osteogenesis stimulators are **rental only** items (up to three months) and are inclusive of the following: • All accessories needed to use the unit (e.g., electrodes, wires, cables, coupling gel, etc.). • Education on the proper use and care of the equipment. • Routine servicing and all necessary repairs or replacements to make the unit functional based on manufacturer warranty. For consideration of rental beyond the initial three months, a new MSA-1653-B must be submitted, along with physician documentation establishing medical reason(s) for continued need.
MSA 15-38	9/1/2015	General Information for Providers	11.2.A. Beneficiaries Excluded from Copayment Requirements	In the 1st paragraph, the 10th bullet point was revised to read: • Native American Indians/Alaska Natives consistent with federal regulations at 42 CFR §447.56(a)(1)(x)
		Beneficiary Eligibility	9.9 Copayments	In the 1st paragraph, text after the first sentence was revised to read: 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).
		Adult Benefits Waiver	1.5 Copayment	In the 1st paragraph, text after the second sentence was revised to read: 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).
		Federally Qualified Health Centers	4.5 Copayments	The last sentence was deleted.
		Hearing Aid Dealers	1.6 Copayments	In the 1st paragraph, text after the first sentence was revised to read:

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				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).
		Hospital	1.4 Copayments	In the 1st paragraph, text after the first sentence was revised to read: 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). In the 2nd paragraph, the last bullet point was revised to read: • $3 for non-emergency visit to the Emergency Department 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 nonemergency services, inform the individual of the amount of cost sharing responsibility for non-emergency service(s). ➢ Provide the individual with the name and location of an available and accessible alternative nonemergency services provider; determine that the alternative provider can provide services in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the person is otherwise exempt from cost sharing; and provide a referral to coordinate scheduling for treatment with the alternative provider. Hospitals providing emergency department services are expected to develop cost sharing policies and procedures consistent with the federal requirement.
		Nursing Facility	10.26.D.1. Beneficiary Liability Under Medicare	In the 1st paragraph, the last sentence was revised to read:

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Coverages	Part D	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 and ABW County Health Plans	In the 4th paragraph (Pharmacy Aspects of MHP & CHP: Quick Reference table), under 'Copayment', the second sentence was revised to read: 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	In the 1st paragraph, the last sentence was revised to read: 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).
		Practitioner	1.3 Copayments	In the 1st paragraph, the last sentence was revised to read: 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).
		Practitioner	20.1 Copayment	In the 1st paragraph, the last sentence was revised to read: 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).
		Rural Health Clinics	6.6 Copayments	The last sentence was deleted.

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

Medicaid Provider Manual January 2016 Updates

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Special Programs	2.1.A. Eligible Beneficiaries	In the 1st paragraph, the last sentence (prior to bullet points) was revised to read: 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).
		Tribal Health Centers	7.4 Copayments	The 1st paragraph was revised to read: Medicaid copayments for chiropractic, dental, physician, podiatry and vision services are waived under the THC benefit as part of the reconciliation. (Refer to the General Information for Providers chapter for a list of services requiring copayments.)
		Urgent Care Centers	4.1 Copay Requirements	In the 1st paragraph, the last sentence was revised to read: 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).
MSA 15-34	9/1/2015	Dental	9.1 Coverage and Service Area Information	The 1st paragraph was revised to read: MDHHS contracts for the administration of the Medicaid dental benefit called ***Healthy Kids Dental***. For all counties except Kent, Oakland and Wayne, the contractor administers the Medicaid dental benefit to all Medicaid beneficiaries under age 21. In Kent, Oakland and Wayne, the contractor administers the Medicaid dental benefit to all Medicaid beneficiaries age 0 through 12. The dental services provided through the contractor are the same services provided through the Medicaid FFS program. (Refer to the Directory Appendix for contact information.) The table after the 2nd paragraph was deleted.
			9.2 Enrollment Information	The last sentence was revised to read: Foster care children whose service living arrangement places them out of the state or into a facility do not have the Benefit Plan ID of HK-Dental.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			9.3 Loss of Enrollment	Subsection text was revised to read: Beneficiaries are enrolled in ***Healthy Kids Dental*** until the last day of the month in which they turn age 21 (age 13 in Kent, Oakland and Wayne counties). If the beneficiary loses enrollment and is in active treatment that requires multiple appointments, the provider may bill the contractor for the treatment as long as it is completed within 60 days of the loss of eligibility. When a beneficiary loses ***Healthy Kids Dental*** enrollment eligibility, the dental benefit is no longer administered by the contractor. Eligible Medicaid beneficiaries will have dental services provided through the Medicaid FFS program.
MSA 15-33	9/1/2015	Dental	9.2.A. Healthy Michigan Plan Beneficiaries -- Ages 19 and 20	The subsection was deleted. The following sub-section was re-numbered.
		Healthy Michigan Plan	5.1 Dental	The 2nd paragraph was revised to read: For those beneficiaries who are not enrolled in a health plan, dental services will be provided by enrolled dental providers through the Medicaid FFS program.
MSA 15-29	7/31/2015	Children's Special Health Care Services	9.7 Insurance Premium Payment Benefit	Subsection text was revised in its entirety to read: CSHCS may be able to assist in paying the beneficiary's portion of an insurance premium cost (as related to the CSHCS qualifying diagnosis) for private insurance, Medicare Part B, or Medicare Part D. Premium payment assistance may also be available when the beneficiary has lost or is about to lose insurance coverage. Depending on the timing of the event, CSHCS may be able to assist the family in reactivating or maintaining that coverage. The cost-effectiveness requirements described below always apply.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				Premium payment assistance may be available when: • The current cost of the premium payment is determined to be cost-effective for CSHCS. Cost-effectiveness is defined as when the cost of the insurance premium is less than the projected cost to CSHCS for covering the CSHCS-related care; and • The family/beneficiary lacks sufficient financial resources to pay for the beneficiary's part of the premium. The lack of ability to pay the insurance premium is defined as follows: ➢ When the family has an Income Review/Payment Agreement (MSA-0738) that is within the two lowest payment agreement categories, the financial need is automatically established. ➢ When the family has an Income Review/Payment Agreement (MSA-0738) that is above the two lowest categories, the family must describe the reason for the lack of resources that is impacting the ability to pay for insurance. Examples include: • The additional out-of-pocket expenses to address only the special needs of the beneficiary(ies) is 10% or more of the gross family income. Documentation is required; or • The family income has dropped and a revised MSA-0738 still results in a payment agreement that is above the two lowest payment agreement categories but extenuating financial circumstances interfere with the family's ability to pay insurance premiums, etc. Documentation is required. To apply for CSHCS insurance premium payment assistance, the following documents are required from all applicants: • A completed Application for Payment of Health Insurance Premiums (MSA-0725); • A copy of a billing statement from the insurance carrier or a statement from the employer or Notice of Medicare Premium Payment Due (CMS-500) that verifies the cost of the premium; • Copies of previous Explanation of Benefits (EOB) statements or expenditure

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				summaries over the past 12 months from the private health insurance carrier or Medicare; and • A pharmacy report(s) documenting the cost of the prescriptions and the amount paid by the private health insurance carrier or Medicare, or written evidence that the coverage does not include a prescription benefit. The following additional documentation is required under two specific circumstances: • When the family obtained private insurance through the Federally Facilitated Marketplace (FFM) and has a subsidy, proof is required that the subsidy arrangement is the Advanced Premium Tax Credit. Any other subsidy through the FFM enrollment is not eligible for the insurance premium payment assistance; or • A Consolidated Omnibus Budget Reconciliation Act (COBRA) Election Form is required if the beneficiary lost insurance coverage within three (3) months before application due to termination of employment, death of the policy holder, divorce, etc., and may be eligible for the insurance to remain in place due to COBRA. The family/beneficiary may contact the Local Health Department CSHCS office to obtain and receive assistance in completing the MSA-0725.
			9.7.A. Effective Date of Insurance Premium Payment Assistance (new subsection)	New subsection text reads: When premium payment assistance has been approved, the effective date for the coverage is the first day of the month in which the MSA-0725 was received by CSHCS. Insurance premium payments are not covered retroactively for periods before the application was received. NOTE: Retroactive assistance for premium payment is limited to a one-time-only event when: • Existing insurance coverage is still active; and • The private insurance will be terminated due to non-payment; and • Termination will occur within 30 days of receipt of the MSA-0725 by CSHCS. The assistance when approved for past coverage is applicable:

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				• For the beneficiary's portion of the unpaid premium; and • If those payments will make it possible for the family to pay the remainder of back-payments; and • When the family can maintain the insurance policy.
			9.7.B. Annual Review for Renewal of Eligibility (new subsection)	New subsection text reads: The MSA-0725 must be submitted each year. The annual eligibility review for continuing premium payment assistance occurs after CSHCS renewal has been completed based on program requirements at that time.
			9.7.C. Requirement to Repay CSHCS for Funds Expended on Terminated Policies (new subsection)	New subsection text reads: In the event that an inappropriate premium payment has been sent to the family (either directly from MDHHS/CSHCS or as a refund to the family by the insurance company), the family is required to return those funds to CSHCS. CSHCS sends the family a letter requesting these funds be submitted to the state. If the funds are not submitted within 60 days from the date on the letter, the Michigan Department of Treasury may collect the funds from the family.
MSA 15-27	7/1/2015	Hospital Reimbursement Appendix	7.3.B. Indigent Care Agreements Pool	Subsection was deleted. This pool was eliminated effective 10/1/15, and the SPA addressing it was just recently approved. The following subsections were re-numbered.
MSA 15-26	7/1/2015	Hospital Reimbursement Appendix	3.3 Michigan State-Owned Hospitals	Subsection text was revised to read: Michigan state-owned hospitals are reimbursed for their services using a prospective per diem rate. Each facility, in aggregate, will not receive payments in excess of the cost it incurs providing services to its Medicaid patients.

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