MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Health and Human Services

Bulletin Number: MSA 16-07

Distribution: All Providers

Issued: March 1, 2016

Subject: Updates to the Medicaid Provider Manual; Code Updates; Clarification to Bulletin MSA 15-48; Medicaid Provider Manual – Changes in Mental Health/Substance Abuse Chapter

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 April 2016 update of the online version of the Medicaid Provider Manual. The manual will be available April 1, 2016 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.

Code Updates

- **Retroactive Coverage of Existing Code**

  Effective January 1, 2016, MDHHS will cover the following Healthcare Common Procedure Coding System (HCPCS) codes:

  G0477 – Drug test presump optical
  G0478 – Drug test presump opt inst
  G0479 – Drug test presump not opt
  G0480 – Drug test def 1-7 classes
  G0481 – Drug test def 8-14 classes
  G0482 – Drug test def 15-21 classes
  G0483 – Drug test def 22+ classes

  Effective January 1, 2016, MDHHS will cover the following HCPCS code for Healthy Michigan Plan only:

  81528 – Oncology colorectal scr

- **New Coverage of Existing Code**

  Effective April 1, 2016, MDHHS will cover the following HCPCS code:

  L2785 – Drop lock retainer each

- **Discontinuing Coverage of Existing Codes**

  MDHHS will discontinue coverage of the following codes effective April 1, 2016:

  76140, G0464

Clarification to Bulletin MSA 15-48

On December 1, 2015, bulletin MSA 15-48 was issued to revise and clarify ambulance policies. The effective date of this policy bulletin was January 1, 2016 and applies to services provided for Fee for Service (FFS) beneficiaries.

Medicaid Provider Manual – Changes in Mental Health/Substance Abuse Chapter

The title of the Mental Health/Substance Abuse chapter has been updated and changed to the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter. In addition, relevant information from bulletin MSA 15-44, issued October 30, 2015, regarding the enrollment of Psychologists, Social Workers, and Professional Counselors as Medicaid FFS providers of outpatient behavioral health services, will be incorporated as an appendix to this chapter.

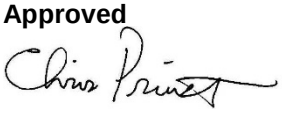
Manual Maintenance

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

Questions

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

Approved



Chris Priest, Director
Medical Services Administration

Michigan Department of Health and Human Services

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Throughout the Manual		References to/use of "Mental Health/Substance Abuse chapter" were revised to read: Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter	Update.
Beneficiary Eligibility	2.1 Benefit Plans	Revisions were made for the following benefit plans: **AUT:** the Benefit Plan Description was revised to read: This plan is for beneficiaries who are at least 18 months and less than **21** years of age who are diagnosed with Autism Spectrum Disorder. The benefit includes … **DHIP**: the Benefit Plan Description, 1st bullet point, was revised to read: • Incentive Payment 1 – is at least two different non-assessment **behavioral** health services were provided in the eligible month. **PIHP**: the Benefit Plan Description was revised to read: This benefit plan **provides specialty behavioral health** services for **individuals enrolled in** MA. **SED-DHS**: the Benefit Plan Description (last sentence) was revised to read: The SED-DHS Benefit Plan implements a collaborative agreement to expand **behavioral** health services for children in the foster care system.	Update.
Beneficiary Eligibility	10.1 Coverage	The 4th paragraph was revised to read: CSHCS does not cover substance abuse treatment services. A beneficiary who has both CSHCS and FFS Medicaid or CSHCS and MIChild benefits receives his Medicaid or MIChild covered substance abuse treatment services from the **regional PIHP**. A beneficiary …	Coordinating agencies no longer exist – all duties were moved to the PIHPs.
Coordination of Benefits	Section 1 – Introduction	In the 2nd paragraph, the last sentence was revised to read: If a beneficiary with Medicare or Other Insurance coverage is enrolled in a Medicaid Health Plan (MHP), or is receiving services under a Prepaid Inpatient Health Plan (PIHP) or Community Mental Health Services **Program (CMHSP), that** entity is responsible for the Medicaid payment liability.	Coordinating agencies no longer exist – all duties were moved to the PIHPs

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

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CHAPTER	SECTION	CHANGE	COMMENT
Coordination of Benefits	2.6.F. Medicaid Liability	The last paragraph was revised to read: Beneficiaries cannot be charged for Medicaid-covered services, except for approved copays or deductibles, whether they are enrolled as a FFS beneficiary, MDHHS is paying the HMO premiums to a contracted health plan, or services are provided under **PIHP/CMHSP capitation**. Refer to ...	Coordinating agencies no longer exist – all duties were moved to the PIHPs
Coordination of Benefits	3.3 Coinsurance/ Deductible and/or Copayment	The 2nd through 4th paragraphs were revised to read: MDHHS cannot be billed for copays, coinsurance, deductibles, or any fees for services provided to beneficiaries enrolled in a MHP, or who are receiving services under PIHP/**CMHSP capitation**. Beneficiaries are responsible for payment of all copays and deductibles allowed under the MHP/PIHP/**CMHSP contract** with MDHHS. If the beneficiary with other insurance coverage is enrolled in a MHP or receiving services under a PIHP/CMHSP capitation, the MHP/PIHP/**CMHSP assumes** the Medicaid payment liabilities. Beneficiaries cannot be charged for Medicaid-covered services, except for approved copays or deductibles, whether they are enrolled as a FFS beneficiary, MDHHS is paying the HMO premiums to a contracted health plan, or services are provided under PIHP/**CMHSP capitation**.	Coordinating agencies no longer exist – all duties were moved to the PIHPs
Billing & Reimbursement for Dental Providers	1.1 Claims Processing System	The 3rd paragraph was revised to read: MDHHS encourages providers to send claims **electronically. (Refer to the Electronic Submission Manual on the MDHHS website for additional information. Refer to the Directory Appendix for website information.)** Electronic filing is ...	Update.
Billing & Reimbursement for Dental Providers	3.1 Electronic Claims	The 1st paragraph was revised to read: Claims submitted electronically and accepted are received directly into CHAMPS, which results in faster payments and fewer claims that suspend or **reject. (Refer to the Electronic Submission Manual on the MDHHS website for additional information. Refer to the Directory Appendix for website information.)** Providers submitting claims electronically ...	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Dental Providers	8.2 Electronic Remittance Advice	The 3rd and 4th paragraphs were revised to read: The 835 transaction corresponds to one payment device (check or EFT). All claims associated with a single TIN processed in a weekly pay cycle report on a single 835, regardless of how the claims were submitted (e.g., some paper, some electronic, multiple billing agents, etc.). Providers choosing to receive the 835 transaction must authorize a **billing agent** to receive the 835 per TIN. An addition of and/or change to the identification of the **billing agent for the provider's 835** must be **changed through their CHAMPS enrollment application**. For more information regarding the 835 transactions issued by MDHHS, refer to the MDHHS **835** Companion Documents **(Data Clarification Documents)** on the MDHHS website. For general information about the 835, refer to the Implementation Guides for these transactions. The guides are available through the Washington Publishing Company. (Refer to the Directory Appendix for contact information.)	Update.
Billing & Reimbursement for Institutional Providers	1.1 Claims Processing System	The 3rd paragraph was revised to read: MDHHS encourages providers to send claims **electronically. (Refer to the Electronic Submission Manual on the MDHHS website for additional information. Refer to the Directory Appendix for website information.)** Electronic filing is ...	Update.
Billing & Reimbursement for Institutional Providers	2.1 Electronic Claims	The 1st paragraph was revised to read: Claims submitted electronically and accepted are received directly into CHAMPS, resulting in faster payments and fewer claims that suspend or **reject. (Refer to the Electronic Submission Manual on the MDHHS website for additional information. Refer to the Directory Appendix for website information.)** Providers submitting claims ...	Update.
Billing & Reimbursement for Institutional Providers	8.9 Cost Settled Provider Detail Report (FD-622)	In the last paragraph, the 1st sentence was revised to read: The detail portion of the FD-622 report is available in **an** electronic version.	Update (a paper version of FD-622 is no longer available).

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Billing & Reimbursement for Institutional Providers	12.2 Electronic Remittance Advice	The 3rd and 4th paragraphs were revised to read: The 835 transaction corresponds to one payment device (check or EFT). All claims associated with a single TIN processed in a weekly pay cycle report on a single 835, regardless of how the claims were submitted (e.g., some paper, some electronic, multiple billing agents, etc.). Providers choosing to receive the 835 transaction must authorize a **billing agent** to receive the 835 per TIN. An addition of and/or change to the identification of the **billing agent for the provider's 835** must be **changed through their CHAMPS enrollment application**. For more information regarding the 835 transactions issued by MDHHS, refer to the MDHHS **835** Companion Documents (Data Clarification Documents) on the MDHHS website. For general information about the 835, refer to the Implementation Guides for these transactions. The guides are available through the Washington Publishing Company. (Refer to the Directory Appendix for contact information.)	Update.
Billing & Reimbursement for Professionals	1.1 Claims Processing System	The 3rd paragraph was revised to read: MDHHS encourages providers to send claims **electronically. (Refer to the Electronic Submission Manual on the MDHHS website for additional information. Refer to the Directory Appendix for website information.)** Electronic filing is ...	Update.
Billing & Reimbursement for Professionals	2.1 Electronic Claims	The 1st paragraph was revised to read: Claims submitted electronically and accepted are received directly into CHAMPS, which results in faster payments and fewer claims that suspend or **reject. (Refer to the Electronic Submission Manual on the MDHHS website for additional information. Refer to the Directory Appendix for website information.)** Providers submitting claims ...	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Professionals	8.2 Electronic Remittance Advice	The 3rd and 4th paragraphs were revised to read: The 835 transaction corresponds to one payment device (check or EFT). All claims associated with a single TIN processed in a weekly pay cycle report on a single 835, regardless of how the claims were submitted (e.g., some paper, some electronic, multiple billing agents, etc.). Providers choosing to receive the 835 transaction must authorize a **billing agent** to receive the 835 per TIN. An addition of and/or change **to** the identification of the **billing agent for the provider's 835** must be **changed through their CHAMPS enrollment application**. For more information regarding the 835 transactions issued by MDHHS, refer to the MDHHS **835** Companion **Documents (Data Clarification Documents)** on the MDHHS website. For general information about the 835, refer to the Implementation Guides for these transactions. The guides are available through the Washington Publishing Company. (Refer to the Directory Appendix for contact information.)	Update.
Ambulance	1.1 General Information	In the 3rd paragraph, the last bullet point was revised to read: • Nonambulance, non-emergency medical transportation arranged by either **the local** MDHHS **office** or an MDHHS-contracted transportation broker who reimburses the beneficiary or the transportation provider directly.	Clarification.
Ambulance	1.2 Common Terms	Information for "Emergency Patient" was removed. Information for "Emergency Transport" was removed. "Helicopter (Rotary Wing) Air Ambulance" was revised to read "Helicopter Air Ambulance".	Clarification.
Ambulance	2.4.B. Basic Life Support (BLS) - Emergency	Text was revised to read: BLS is defined as the transportation by ground ambulance and when either a BLS or an ALS **licensed** provider renders BLS services as defined above within the context of an emergency response.	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Ambulance	2.11 Waiting Time	The following text replaces the 1st paragraph: Waiting time is covered only when the beneficiary's attending physician deems it medically necessary. Waiting time is reimbursable after the first 30 minutes.	Clarification.
Ambulance	2.12 Water Ambulance	Subsection was deleted.	Obsolete information.
Ambulance	Section 4 – Ambulance Coverage Exclusions	The 6th bullet point was revised to read: • Transport of correctional facility inmates to **or** from the correctional facility.	Clarification.
Children's Special Health Care Services	2.4.A. Explanation of Services	Subsection was deleted. Information was re-located to Section 9 – Benefits; 9.8 Children's Multi-Disciplinary Specialty (CMDS) Clinics, with new subsection titled: 9.8.A. Explanation of Services	Placing detailed information regarding CMDS clinics under the benefits section.
Children's Special Health Care Services	2.4.B. CMDS Clinic Staff Requirements	Subsection was deleted. Information was re-located to Section 9 – Benefits, with new subsection titled: 9.8.B. CMDS Clinic Staff Requirements	Placing detailed information regarding CMDS clinics under the benefits section.
Children's Special Health Care Services	2.4.C. CMDS Clinic Visit Types 2.4.C.1. Initial Comprehensive Evaluation 2.4.C.2. Basic and Ongoing Comprehensive Evaluation 2.4.C.3. Management/ Follow-Up Visits 2.4.C.4. Support Service Visits	Subsections were deleted. Information was re-located to Section 9 – Benefits, with new subsections titled: 9.8.C. CMDS Clinic Visit Types 9.8.C.1. Initial Comprehensive Evaluation 9.8.C.2. Basic and Ongoing Comprehensive Evaluation 9.8.C.3. Management/ Follow-Up Visits 9.8.C.4. Support Service Visits	Placing detailed information regarding CMDS clinics under the benefits section.

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CHAPTER	SECTION	CHANGE	COMMENT
Children's Special Health Care Services	2.4.D. Additional Responsibilities	Subsection was deleted. Information was re-located to Section 9 – Benefits, with new subsection titled: 9.8.D. Additional Responsibilities	Placing detailed information regarding CMDS clinics under the benefits section
Children's Special Health Care Services	9.8.A. Explanation of Services (new subsection)	New subsection, with text relocated from: 2.4.A. Explanation of Services	Information was re-located for more appropriate placement.
Children's Special Health Care Services	9.8.B. CMDS Clinic Staff Requirements (new subsection)	New subsection, with text relocated from: 2.4.B. CMDS Clinic Staff Requirements	Information was re-located for more appropriate placement.
Children's Special Health Care Services	9.8.C. CMDS Clinic Visit Types (new subsection) 9.8.C.1. Initial Comprehensive Evaluation 9.8.C.2. Basic and Ongoing Comprehensive Evaluation 9.8.C.3. Management/ Follow-Up Visits 9.8.C.4. Support Service Visits	New subsection, with text relocated from: 2.4.C. CMDS Clinic Visit Types 2.4.C.1. Initial Comprehensive Evaluation 2.4.C.2. Basic and Ongoing Comprehensive Evaluation 2.4.C.3. Management/ Follow-Up Visits 2.4.C.4. Support Service Visits	Information was re-located for more appropriate placement.
Children's Special Health Care Services	9.8.D. Additional Responsibilities (new subsection)	New subsection, with text relocated from: 2.4.D. Additional Responsibilities	Information was re-located for more appropriate placement.

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CHAPTER	SECTION	CHANGE	COMMENT
Dental	6.1.G.6. Copies of Full Mouth Series	Subsection text was revised to read: Dental providers are expected to provide a copy of full mouth x-rays taken within the previous 12 months to a subsequent provider as requested.	Reworded for clarity.
Dental	8.1 Covered Services	The 3rd paragraph was revised to read: Beneficiaries under age 21 who are dually-enrolled in Medicaid and Children's Special Health Care Services (CSHCS) and reside in **any county except Kent, Oakland and Wayne will** receive their **general** dental benefits through ***Healthy Kids Dental*** **up to age 21**. **In Kent, Oakland and Wayne counties, *Healthy Kids Dental* provides the general dental benefit to all dually-enrolled beneficiaries up to age 13. Dually-enrolled Medicaid and CSHCS beneficiaries over the age of 13 who reside in Kent, Oakland and Wayne counties receive dental benefits through Medicaid Fee-For-Service (FFS).** If the beneficiary's ...	Clarify ***Healthy Kids Dental*** parameters for CSHCS dual-enrollees.
Early and Periodic Screening, Diagnosis and Treatment	11.1 Psychotropic Medication Treatment	In the 1st paragraph, text beginning with the 2nd sentence was revised to read: When the physician determines that the child requires psychotropic medication treatment, the prescribing physician must obtain a written and signed informed consent from the child's **legal** parent (when the child is a temporary court ward), the child (if the child is at least 18 years of age), **the foster care worker (when the child is a ward of the state and is committed to the Michigan Children's Institute), or the court (when the child is a permanent court ward of the county)** before treatment with any psychotropic medication begins. **If a signed informed consent cannot be obtained (e.g., the parent is unable or unwilling to sign, and the physician documents a medical necessity), a court order is required prior to prescribing psychotropic medications to any child in foster care.** Foster care parents cannot ...	Clarification.
Early and Periodic Screening, Diagnosis and Treatment	12.1 Psychiatric Services	The 2nd sentence was revised to read: (Refer to the **Behavioral Health and Substance Use Disorder** Services **sub**section of the Practitioner Chapter for specific coverages.)	Reflects change in Section title.

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CHAPTER	SECTION	CHANGE	COMMENT
Early and Periodic Screening, Diagnosis and Treatment	12.2 Autism Spectrum Disorders	The 2nd sentence was revised to read: The PCP must refer the child to the PIHP in the geographic **service area.**	Clarification.
Federally Qualified Health Centers	Section 2 - Benefits	Text was revised to read: FQHC services subject to PPS reimbursement are FQHC services defined at Section 1861 (aa)(**3**)(A)-(**B**) of the Social Security Act.	Correction.
Federally Qualified Health Centers	3.4 Substance Abuse Coordinating Agency	The subsection title was revised to read: Substance Use Disorder Services	Coordinating agencies no longer exist – all duties were moved to the PIHPs.
Federally Qualified Health Centers	5.2 Documenting Encounters	The 1st paragraph was revised to read: FQHCs must document encounters when services have been provided to beneficiaries through Medicaid Health Plans, ***Healthy Kids Dental***, and/or **regional Prepaid Inpatient Health Plans (PIHP)**. The last paragraph was revised to read: Upon review and audit, MDHHS will reimburse the difference between the FQHC PPS rate and the amount received from the Medicaid Health Plans, ***Healthy Kids Dental***, and/or the **regional PIHP**.	Coordinating agencies no longer exist – all duties were moved to the PIHPs.
Federally Qualified Health Centers	5.3 Reconciliation of Quarterly Advances	In the 2nd paragraph, the 1st sentence was revised to read: Quarterly advances are an estimate of the difference between the payments that a MHP, **PIHP** and the ***Healthy Kids Dental*** contractor make to the FQHC, and the payments the FQHC would have received under the PPS.	Coordinating agencies no longer exist – all duties were moved to the PIHPs.

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Hospice	6.6 Categories of Care	In the table: For "Inpatient Respite Care", the 2nd sentence was revised to read: Hospice care may be provided in a **licensed hospice residence**, hospital, or NF meeting hospice standards for staffing and patient areas. For "General Inpatient Care", the 2nd sentence was revised to read: It is defined as short-term inpatient care provided in a licensed hospice **residence**, hospital, or NF meeting hospice standards for staffing and patient areas.	To make section consistent with policy as hospice residences are not considered "nursing homes."
Hospital	1.3.A. Medicare-Related Services	In the 1st paragraph, the 3rd sentence was revised to read: Medicare benefits must be used prior to billing MDHHS or any Medicaid-capitated plan (MHP, PIHP/**CMHSP) for** any portion of the claim.	Coordinating agencies no longer exist – all duties were moved to the PIHPs.
Hospital	1.3.B. Other Insurance	In the 2nd paragraph, the last sentence was revised to read: If a beneficiary is enrolled in a MHP or is receiving services through a PIHP/**CMHSP, the** MHP/PIHP/**CMHSP is** responsible for payment.	Coordinating agencies no longer exist – all duties were moved to the PIHPs.
Hospital	3.20.F. Substance Abuse	Subsection text was revised to read: For direct-billed laboratory services ordered by **a PIHP,** the referring provider NPI number must be appropriately reported on the appropriate paper or electronic claim format.	Coordinating agencies no longer exist – all duties were moved to the PIHPs.
Hospital	3.21.A. Acute Inpatient Medical Detoxification	In the 1st paragraph, the 3rd sentence was revised to read: Acute medical detoxification services may be provided by a Medicaid-enrolled hospital without authorization from a **PIHP.** The 2nd paragraph was revised to read: For additional substance abuse services, hospitals must refer beneficiaries seeking inpatient acute detox services to the **regional PIHP.**	Coordinating agencies no longer exist – all duties were moved to the PIHPs.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital	3.21.F. Coordinating Agencies	The subsection title was revised to read: Substance Use Disorder Services Through Prepaid Inpatient Health Plans Subsection text was revised to read: The **regional PIHP** may authorize the following specialized services: • Outpatient Substance Abuse Treatment • Assessment, Diagnosis, Beneficiary Placement and Referral • Intensive Outpatient Counseling • **Approved Pharmacological Supports (Methadone)** Questions regarding substance abuse services should be directed to the **regional PIHP.**	Coordinating agencies no longer exist – all duties were moved to the PIHPs. The FDA is no longer involved with pharmacological supports; therefore, that part was removed.
Local Health Departments	2.2.A. Initial Blood Lead Testing	In the 2nd paragraph, the 1st sentence was removed. The 3rd paragraph was deleted.	Language obsolete and not consistent with current payment limits.
Local Health Departments	4.3 Other Insurance Encounters	Text was revised to read: Medicaid services provided **to beneficiaries** with other commercial health insurance carriers are eligible for full cost, and the encounters are considered Medicaid encounters. Medicaid requires beneficiaries' other insurance resources and their network providers to be utilized for all services covered under the private coverage before billing Medicaid. Even if the other insurance payment for a specific service exceeds the amount Medicaid would pay, providers must still bill **the procedure code** and enter the other insurance payment on the claim. The claim showing other insurance reimbursement or zero payment must be processed through **the claim system** in order to be counted as a Medicaid encounter. (Refer to the Billing & Reimbursement for Professionals and the Coordination of Benefits Chapters of this manual for additional information.)	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Medicaid Health Plans	2.9.B. Emergency Services	The 3rd paragraph was revised to read: If the beneficiary is not admitted and the services provided in the emergency room (beyond screening and stabilization) are for the sole purpose of treating the substance abuse, e.g., conducting an intake interview for substance abuse treatment, the **regional PIHP** is responsible for those services. The **PIHP** is not responsible for the screening and stabilization or other medical treatment provided in the emergency room even if a beneficiary's substance abuse is the underlying cause of the medical problem.	Coordinating agencies no longer exist – all duties were moved to the PIHPs.
Mental Health/ Substance Abuse		The chapter title was revised to read: Behavioral Health and Intellectual and Developmental Disability Supports and Services	Update.
Mental Health/ Substance Abuse	1.5 Programs Requiring Special Approval	The last paragraph was removed.	Obsolete information.
Mental Health/ Substance Abuse	1.7 Definition of Terms	Under "Substance Abuse Treatment Specialist", In the 1st bullet point, the last paragraph was revised to read: and who has a registered development plan leading to certification and is timely in its implementation (Development Plan – Counselor (DP-C) – approved development plan in place); or who is functioning under a time-limited exception plan approved by the **regional PIHP**; or In the 3rd bullet point, the sub-bullet points were revised to read: ➢ for medical doctors: American Society of Addiction Medicine (ASAM) ➢ for psychologists: American Psychological Association (APA) specialty in addiction ➢ **for counselors/therapists: Certification through the Upper Midwest Indian Council on Addiction Disorders (UMICAD)** ➢ **for Licensed Professional Counselors: National Certified Counselor (NCC) with concurrent Master Addictions Counselor (MAC) certification**	Coordinating agencies no longer exist; all duties were moved to the PIHP. This reflects the current information that is listed in the Provider Qualifications Chart.

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CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	3.29.B. Qualified Staff	In the 2nd paragraph, the 1st bullet point was revised to read: • Complete the MDHHS three-day Wraparound new facilitator training **within 90 days of hire** and one additional MDHHS supervisory training in their first year of supervision	Correction.
Mental Health/ Substance Abuse	10.1 Partial Hospitalization Admission Criteria: Adult	In the 1st paragraph, the 2nd sentence was revised to read: Treatment, services and supports are provided for six or more hours per day, **five days a week.**	LARA no longer requires that these programs have a license.
Mental Health/ Substance Abuse	10.2 Partial Hospitalization Admission Criteria: Children and Adolescents	In the 1st paragraph, the 2nd sentence was revised to read: Treatment, services and supports are provided for six or more hours per day, **five days a week.**	LARA no longer requires that these programs have a license.
Nursing Facility Coverages	Section 4 – Beneficiary Rights	In the 3rd paragraph, the 1st sentence was revised to read: In general, beneficiaries cannot be charged for Medicaid-covered services, **except for patient-pay a**mounts, copays or deductibles. **This applies to** whether they are enrolled as a fee-for-service beneficiary, MDHHS is paying their Health Maintenance Organization (HMO) premium to a contracted health plan, or services are provided under Community Mental Health Services Program (CMHSP) or **Pre-paid Inpatient Health Plan (PIHP)** capitation.	Coordinating agencies no longer exist – all duties were moved to the PIHPs. General clarification.
Nursing Facility Coverages	5.1.B. Correct/Timely Preadmission Screening/Annual Resident Review (PASARR)	The 3rd paragraph was revised to read: Placement options **for beneficiaries** who **were** determined through Level II Preadmission screening to have **either** (1) a mental illness or (2) an intellectual disability **(**or a **related condition) are** determined through the federal PASARR screening process requirements **as to whether or not they need nursing facility services, specialized services, and/or mental health services.**	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	Section 8 – PASARR Process	In the 4th paragraph, "Transfer Trauma" was revised to read: Transfer trauma **protections apply** to individuals with mental illness or intellectual disability who **were** determined during **a** PASARR Level II evaluation **to not need nursing facility services. Transfer trauma is evaluated by SSA, with consideration to the opinion of the individual's attending physician. (Refer to the Transfer Trauma subsection of this chapter for additional information.)**	Clarification.
Nursing Facility Coverages	9.1 Medicare-Covered Services	The 3rd paragraph was revised to read: If the beneficiary has a Medicare benefit available, that benefit must be utilized before Medicaid pays any portion of the claim. If a beneficiary who has Medicare coverage is receiving services under CMHSP or **PIHP** capitation, the CMHSP/**PIHP** assumes the MDHHS payment liability described in this section.	Coordinating agencies no longer exist – all duties were moved to the PIHPs.
Nursing Facility Coverages	9.4 Other Insurance	In the 2nd paragraph, the last sentence was revised to read: If a beneficiary with other insurance coverage is enrolled in a MHP or is receiving services under CMHSP or **PIHP** capitation, the MHP/CMHSP/**PIHP** assumes the MDHHS payment liabilities described in this section.	Coordinating agencies no longer exist – all duties were moved to the PIHPs.
Nursing Facility Certification, Survey & Enforcement Appendix	2.4.A. Bed Certification Process for Medicaid Enrolled Providers	The last paragraph was revised to read: If the request is denied, the provider will be notified of their appeal rights in writing. If the request is approved, the SSA will be **notified by the SMA of** the change. **The SSA will also notify the provider of the change.**	References to "Licensure/ Certification Action (LC-180)" were removed as the LC-180 no longer exists. Notification to the facility by the Department of Licensing and Regulatory Affairs will still occur via e-mail to the facility rather than the LC-180.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Certification, Survey & Enforcement Appendix	2.4.B. Bed Certification Process for Nursing Facilities Not Enrolled in Medicaid	In the 3rd paragraph, the last sentence was revised to read: If the request is approved, the SMA will **notify the provider** or SSA **of** the change. **The SSA will also notify the provider of the change.**	References to "Licensure/ Certification Action (LC-180)" were removed as the LC-180 no longer exists. Notification to the facility by the Department of Licensing and Regulatory Affairs will still occur via e-mail to the facility rather than the LC-180.
Nursing Facility Certification, Survey & Enforcement Appendix	2.4.C. Bed Certification Process During a Change In Ownership (CHOW)	In the 5th paragraph, the last sentence was revised to read: If the request is approved, the SMA will **notify** the **SSA of the change**. **The SSA will also notify the provider of the change.**	References to "Licensure/ Certification Action (LC-180)" were removed as the LC-180 no longer exists. Notification to the facility by the Department of Licensing and Regulatory Affairs will still occur via e-mail to the facility rather than the LC-180.
Nursing Facility Certification, Survey & Enforcement Appendix	2.4.D. Bed Certification Process for a New Nursing Facility or Newly Licensed Nursing Facility Beds	In the 3rd paragraph, the last sentence was revised to read: If the request is approved, the SMA will **notify** the **SSA of the change**. **The SSA will also notify the provider of the change.**	References to "Licensure/ Certification Action (LC-180)" were removed as the LC-180 no longer exists. Notification to the facility by the Department of Licensing and Regulatory Affairs will still occur via e-mail to the facility rather than the LC-180.
Nursing Facility Certification, Survey & Enforcement Appendix	2.6 Medicaid Provider Enrollment	In the 1st paragraph, the 3rd bullet point was deleted.	Obsolete information.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Certification, Survey & Enforcement Appendix	2.8 Nursing Facility Closure Protocol	The 1st sentence was revised to read: An interagency agreement exists, including the SMA, the **Aging and Adult Services Agency (AASA)**, the SSA, and MDHHS, to delineate the roles and responsibilities of the respective agencies when residents of licensed/certified nursing facilities must be relocated due to nursing facility involuntary or voluntary closure.	The Office of Services to the Aging (OSA) is now the Aging and Adult Services Agency (AASA) due to the merger.
Nursing Facility Cost Reporting & Reimbursement Appendix	8.8 Interest	The following text was added as a 9th bullet point: • Interest expense includes the cost of finance charges associated with borrowed funds. If the interest expense on borrowed funds is allowable or unallowable, this would include any applicable finance charges. Finance charges include, but are not limited to, expenses related to the maintenance of records, account maintenance fees, related transaction fees, administration, etc.	Clarification.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.7.A. Class I and Class III Nursing Facilities	In the 1st paragraph, the 1st and 2nd sentences were revised to read: The nursing facility will receive a **Quality Assurance Supplement (QAS)** payment as a monthly gross adjustment. The monthly gross adjustment for an individual nursing facility will be determined based on one-twelfth of the facility's annual historical Medicaid utilization (resident days) multiplied by the **facility's QAS** per resident day. In the 2nd paragraph, the first sentence was revised to read: A facility's QAS is equal to the lesser of **the facility's Variable Rate Base or Class Variable Cost Limit** times the Quality Assurance Assessment Factor (QAAF) determined by MDHHS**, except for Class III publicly owned facilities, in which the QAAF is multiplied by the lesser of the facility's Variable Cost Component or the Class I Variable Cost Limit**.	The first sentence of this section incorrectly calls the QAAP the payment; the supplemental payment to providers is the QAS. The QAAP is the provider tax assessment. Clarification and to align the language with language in the State Plan.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.12.G. Facility Innovative Design Supplemental (FIDS) Program	In the 2nd paragraph, the 2nd sentence was revised to read: FIDS participating facilities will be reviewed annually by the **Aging and Adult Services Agency (AASA)** to certify continued participation in the culture change.	The Office of Services to the Aging (OSA) is now the Aging and Adult Services Agency (AASA) due to the merger.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	10.12.G.1. Change of Ownership	In the 1st paragraph, the 3rd sentence was revised to read: If the new owner initially decides to discontinue participation as a FIDS facility and subsequently decides to participate as a FIDS facility, the provider must notify the LARA, Bureau of Health Care Services (BHCS) licensing officer and **AASA**.	The Office of Services to the Aging (OSA) is now the Aging and Adult Services Agency (AASA) due to the merger.
Nursing Facility Cost Reporting & Reimbursement Appendix	Section 11 - Appeal Process	In the 4th paragraph, the 1st sentence was revised to read: The review and hearings process for providers has been promulgated in the administrative rules **located on LARA's website. The process** is explained in **more detail in** the MDHHS Administrative Hearing **pamphlet** on the MDHHS website.	Clarification added on where to find the relevant administrative hearing rules.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	Section 14 - Cost Reporting and Reimbursement Descriptions and Classifications	Throughout the section, each instance of "Minor Equipment – Less than $500" and "Minor Equipment – More than $500" had the dollar amount revised to read $5,000. • 14.4 Administrative & General = 2 instances • 14.5 Plant Operation & Maintenance = 2 instances • 14.7 Laundry = 2 instances • 14.8 Housekeeping = 2 instances • 14.9 Dietary = 2 instances • 14.10 Nursing Administration = 2 instances • 14.11 Central Supplies = 2 instances • 14.12 Medical Supplies = 2 instances • 14.13 Medical Records & Library = 2 instances • 14.14 Social Services = 2 instances • 14.15 Diversional Therapy = 2 instances • 14.16.A. Radiology = 2 instances • 14.16.B. Laboratory = 2 instances • 14.16.C. Intravenous Therapy = 2 instances • 14.16.D. Inhalation Therapy (Oxygen) = 2 instances • 14.16.E. Physical Therapy = 2 instances • 14.16.F. Speech Therapy = 2 instances • 14.16.G. Occupational Therapy = 2 instances • 14.16.H. Electroencephalography = 2 instances • 14.16.I. Pharmacy = 2 instances • 14.16.J. Physician Services = 2 instances • 14.17.A. Medicare SNF Unit = 2 instances	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
		• 14.17.B. Medicaid Routine Care Unit #1 = 2 instances • 14.17.C. Medicaid Routine Care Unit #2 = 2 instances • 14.17.D. Medicaid Special Care Unit #1 = 2 instances • 14.17.E. Medicaid Special Care Unit #2 = 2 instances • 14.17.F. Home for Aged Unit = 2 instances • 14.17.G. Non-LTC Apartment/Housing Unit = 2 instances • 14.17.H. Non-Medicare and Non-Medicaid Licensed Only = 2 instances • 14.17.I. Non-LTC Nursing Services = 2 instances • 14.18.C. Special Dietary = 2 instances	
Nursing Facility Cost Reporting & Reimbursement Appendix	Section 14 - Cost Reporting and Reimbursement Descriptions and Classifications	The following lines are added to each of the subsections listed: **Salaries & Wages – In-service Training ... Support** **Employee Benefits – In-service Training ... Support** **Payroll Taxes – In-service Training ... Support** • 14.17.A. Medicare SNF Unit • 14.17.B. Medicaid Routine Care Unit #1 • 14.17.C. Medicaid Routine Care Unit #2 • 14.17.D. Medicaid Special Care Unit #1 • 14.17.E. Medicaid Special Care Unit #2 • 14.17.H. Non-Medicare and Non-Medicaid Licensed Only	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	14.2 Plant Costs – Rent/Leases	The subsection title was revised to read: Plant Costs The 1st category was revised to read: **Rent /** Leases The following text was added as the 1st line under "Rent/Leases": Leases ..... Plant 1	Update.
Nursing Facility Cost Reporting & Reimbursement Appendix	14.4 Administrative & General	The 23rd line was revised to read: Quality Assurance Assessment **– Long Term Care**.....Support The following text was added as the 24th line: **Quality Assurance Assessment – Hospital (non-Long Term Care) ..... Support**	Update.
Nursing Facility Cost Reporting & Reimbursement Appendix	14.9 Dietary	The following line is added: Dietary Supplies (non-ingested) ... Base	Update.
Outpatient Therapy	4.1 Emergency Prior Authorization	The 1st paragraph was revised to read: A provider may contact MDHHS to obtain a verbal PA when the physician/physician **assistant providing** ...	Correction. Prescriptions/referrals for therapy services are not currently within the nurse practitioner scope of practice.

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CHAPTER	SECTION	CHANGE	COMMENT
Outpatient Therapy	5.1.F. Prescription Requirements	In the 1st paragraph, the 1st sentence was revised to read: MDHHS requires a prescription from a physician/**physician assistant for** an ...	Correction. Prescriptions/referrals for therapy services are not currently within the nurse practitioner scope of practice.
Outpatient Therapy	5.2.F. Prescription Requirements	In the 1st paragraph, the 1st sentence was revised to read: MDHHS requires a prescription from a physician/**physician assistant for** a ...	Correction. Prescriptions/referrals for therapy services are not currently within the nurse practitioner scope of practice.
Outpatient Therapy	5.3.C. Referral for Speech Therapy	In the 1st paragraph, the 1st sentence was revised to read: A referral from a physician/**physician assistant is** required for ...	Correction. Prescriptions/referrals for therapy services are not currently within the nurse practitioner scope of practice.
Practitioner	17.1 Telemedicine Services	In the 1st paragraph, the 3rd bullet point was revised to read: • **Behavioral** Health and/or Substance **Use Disorder** Treatment	Consistency in terminology.
Rural Health Clinics	Section 3 – Benefits	The 1st sentence was revised to read: RHC services subject to PPS reimbursement are RHC services defined at Section 1861 (aa)(1)(A)-(C) of the Social Security Act.	Clarification.
Rural Health Clinics	Section 8 – Reconciliation Reporting	The last paragraph was revised to read: Upon review and audit, MDHHS will reimburse the difference between the RHC PPS rate and the amount received from the Medicaid Health Plans, ***Healthy Kids Dental***, and/or the **regional Prepaid Inpatient Health Plan (PIHP)**.	Coordinating agencies no longer exist – all duties were moved to the PIHPs.

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CHAPTER	SECTION	CHANGE	COMMENT
School Based Services	6.1.D. Cost Reconciliation and Settlement	The 3rd paragraph was revised to read: To report direct service-related costs, providers will utilize the Medicaid Allowable Expenditure Report. This cost report template may be obtained from the School Based Services Provider Specific webpage. (Refer to the Director Appendix for website information.) An Excel printable version of the cost report is also available on the website for those providers in need of a paper version. Cost reports from the Local Educational Agencies will be submitted to their Intermediate School District for summation utilizing the Michigan Medicaid Forms (MMF) summary software (available to providers via the **File Transfer Service**). Providers must register and have access to the secure Single Sign On (SSO) in order to utilize the MMF summary software. SSO registration instructions are also available on the School Based Services Provider Specific webpage.	Update.
Tribal Health Centers	Section 4 – Substance Abuse	The 1st sentence was revised to read: Outpatient substance abuse services provided by physicians, clinical social workers, clinical psychologists, and **substance abuse treatment specialists** are reimbursed.	Update.
Tribal Health Centers	4.2 Authorization	Text was revised to read: Services provided at the THC to American Indian and Alaska Native beneficiaries do not require the authorization of **the regional Prepaid Inpatient Health Plan (PIHP)**.	Coordinating agencies no longer exist – all duties were moved to the PIHPs.
Tribal Health Centers	4.3 American Indian and Alaska Native Services	Text was revised to read: American Indians and Alaska Natives who are Medicaid beneficiaries can obtain substance abuse services directly from the THC. These services are not included in the MDHHS **§1915(b) Managed Specialty Services and Supports** Waiver for **PIHPs** and **substance use disorder s**ervices. THCs should contact their regional **PIHP** to determine the appropriate process for accessing other funding sources or other service providers for those individuals requiring substance abuse services not covered by the THC.	Coordinating agencies no longer exist – all duties were moved to the PIHPs. Clarification in waiver title.

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CHAPTER	SECTION	CHANGE	COMMENT
Tribal Health Centers	5.3 American Indian and Alaska Native Services	The 2nd sentence was revised to read: THC services are not included in the MDHHS **§1915(b) Managed Specialty Services and Supports** Waiver for **PIHPs** and **substance use disorder s**ervices	Coordinating agencies no longer exist – all duties were moved to the PIHPs. Clarification in waiver title.
Acronym Appendix		The following text was removed: CA - Coordinating Agency (re: Substance Abuse) CAC - Certified Addictions Counselor FAODP - Fundamentals of Alcohol and Other Drug Problems OSA – ~~**Office of Services to the Aging;**~~ Obstructive Sleep Apnea	Update.
Acronym Appendix		The following text was added: AASA - Aging and Adult Services Agency CADC – Certified Alcohol and Drug Counselor MAC - Master Addictions Counselor NCC - National Certified Counselor QAAF - Quality Assurance Assessment Factor	Update.
Directory Appendix	Eligibility Verification - CHAMPS 270/271 Batch Transaction	Text for "Information Available/Purpose" was revised to read: A HIPAA 270/271 Batch option is available in CHAMPS for providers and/or their contracted clearinghouse vendors to verify **eligibility. Refer** to the HIPAA 5010 270/271 Inquiry Response Companion Guide for more information **and/or the Electronic Submission Manual for upload availability**.	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Eligibility Verification – Medicare DSH Audits - Eligibility Verification for Dates Of Service Over 12 Months for Hospital Providers	References/information for **Emdeon** were removed.	MDHHS is no longer affiliated with Emdeon; providers can use any clearinghouse/eligibility vendor they want if they do not want to use the free options (CHAMPS and/or MPHI).
Directory Appendix	Eligibility Verification – Medicare DSH Audits - Eligibility Verification for Dates Of Service Over 12 Months for Hospital Providers	MPHI website information was revised to read: **MPHI:** Website: HIPAA X12 270/271 Realtime/batch Transaction **website = http://www.mihealth.org/#HIPAA >>'HIPAA 270/271 Transactions for Michigan Medicaid**	Update.
Directory Appendix	Appeals	The following text was added: Contact/Topic: Appeals (Provider) Web Address: http://www.michigan.gov/lara >> Office of Regulatory Reinvention >> Publications >> Michigan Administrative Code >> Select the Department >> Health and Human Services >> Medical Services Administration >> MSA Provider Hearings Information Available/Purpose: Review and hearings process for providers promulgated in the administrative rules.	Update.
Forms Appendix	MSA-1380; 835 – Electronic Remittance Advice Request for Billing Agent Change/Update	The form was removed.	Form is obsolete.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 15-19	6/1/2015	Pharmacy	14.3 Physician-Administered Injectable Drugs (new subsection; following subsection re-numbered)	New subsection text reads: 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. (Refer to the Directory Appendix for website information.) • 17 Alpha Hydroxyprogesterone Caproate (17P and Makena) 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). The rates for drug product reimbursement are outlined in the Michigan Medicaid State Plan. Professional or institutional claims for physician-administered injectable drugs are also a covered benefit. Pharmacies and prescribing practitioners must ensure that claims are not duplicated. This policy applies to Fee-for-Service claims. Pharmacy providers may not dispense a physician-administered injectable drug directly to the beneficiary. To ensure the content and integrity of the drug administered to the beneficiary, the drug must be delivered from the pharmacy directly to the physician for administration. The method of delivery of the injectable drug to the physician should be agreed upon by the pharmacy and physician. The refrigeration, stabilization, and other storage and handling requirements of the drug must be met during delivery and at all points of the transaction. The costs associated with the delivery of the injectable drug to the physician are not reimbursable by MDHHS. The injectable drug must be administered to the beneficiary within 14 days of the arrival of the drug to the physician's office. For multi-dose vials, the first dose must be administered to the beneficiary within 14 days of the arrival of the drug to the physician's office. For the safety of beneficiaries and to minimize waste, procedures should be established to return unused medications to the pharmacy when appropriate. Restocking returned products should be compliant with Michigan Board of Pharmacy guidelines.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Practitioner	3.13.A. Coverage of the Injectable	The 3rd paragraph was revised to read: **With the exception of the physician-administered injectable drugs listed in the Special Product Coverage section of the Pharmacy Chapter that are eligible to be billed as pharmacy claims, f**or any injections given by the physician in the office, clinic setting, or the beneficiary's home, the injectable drug is considered a physician service rather than a pharmacy benefit. The physician must not send the beneficiary to a pharmacy to obtain an injectable drug. **In addition, unless the physician-administered injectable drug is listed in the Special Product Coverage section of the Pharmacy Chapter as being eligible to be billed as pharmacy claims, the physician may not** have the pharmacy bill directly to MDHHS for injectable drugs under the pharmacy benefit if the physician is administering the drug in the office, clinic, or beneficiary's home. If a pharmacy sells injectable drug products to a physician, the pharmacy must obtain payment directly from the purchasing physician. If the beneficiary has other insurance that allows the injectable drug product to be obtained at the pharmacy by the beneficiary, then the other insurance rules (e.g., Medicare Part D) must be followed; however, the reimbursement of the beneficiary's liability (i.e., coinsurance/deductible/copay) may be covered as a physician service.
		Directory Appendix	Provider Resources	Addition of: Contact/Topic: Medicaid State Plan Web Address: www.michigan.gov/medicaidproviders >> Medicaid State Plan
MSA 15-31	9/1/2015	Hospital Reimbursement Appendix	Section 5 – Capital	The 1st paragraph was revised to read: Reimbursement for capital costs is made using prospective capital payments. The prospective capital payment amount is calculated using fee-for-service **and managed care** data from the second previous state fiscal year with occupancy limits as described below. Transfer claims will not receive a prospective capital payment.

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			5.1 Distinct Part Rehabilitation Units and Freestanding Rehabilitation Hospitals	Text was revised to read: For distinct part rehabilitation units and freestanding rehabilitation hospitals, a separate inpatient capital rate will be calculated. The sum of the **Medicaid fee-for-service (FFS) and managed care organization (MCO)** routine and ancillary costs **are** divided by the FFS **and MCO** rehabilitation Medicaid days to calculate the hospital-specific prospective per diem rate.
			5.2 Medical/Surgical Hospitals	Text was revised to read: For medical/surgical hospitals, a separate inpatient capital rate will be calculated. The sum of **the Medicaid FFS and MCO** routine and ancillary costs **are** divided by the medical/surgical FFS **and MCO** discharges to calculate the hospital-specific prospective per discharge rate.
MSA 15-43	10/30/2015	Maternal Infant Health Program	Section 2 – Program Components	Subsection text was revised to read: The assessment visit is the initial visit with the beneficiary. **It is conducted in person with the beneficiary and either a registered nurse or licensed social worker. The assessment visit should be billed using the appropriate place of service code.** **The Risk Identifier is a mandatory tool utilized during the assessment visit. The Risk Identifier assures all appropriate services are identified prior to initiation of professional visits, child birth education, parenting education or transportation services.** If **a** Risk Identifier indicates a need for MIHP services, an appropriate **Plan of Care (**POC**)** must be developed that clearly outlines the beneficiary's problems/needs, objectives/outcomes, and the intervention(s) to address the problem(s). The Risk Identifier and **the** POC must be completed and **the Risk Identifier** entered into the MIHP database before **further MIHP services** are initiated.

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				If the Risk Identifier does not indicate the need for MIHP services **or when, after completion of the Risk Identifier the beneficiary refuses services, then the** POC is not developed and the Discharge Summary is completed accordingly. No follow-up services should be provided; however, the beneficiary **should** receive the informational packet. **On the rare occasion when the Risk Identifier does not indicate the need for MIHP services but professional observation suggests the beneficiary would benefit from MIHP services, the MIHP provider must obtain written authorization from the MIHP consultant to proceed with MIHP services. Documentation must support how the beneficiary may benefit from MIHP services.**
			2.1 Maternal Risk Identifier	The following text was added at the end of the 1st paragraph: Reimbursement for the Maternal Risk Identifier is limited to one Maternal Risk Identifier for each eligible Medicaid beneficiary for each pregnancy.
			2.2 Infant Risk Identifier	The following text was inserted after the 1st paragraph: The MIHP provider must respond to all referrals promptly to identify the beneficiary's needs. Documentation must indicate attempts to visit or contact the beneficiary within a maximum of seven calendar days for the infant. For referrals received prior to the infant's discharge from the inpatient setting, the Risk Identifier should be conducted within two (2) business days following the hospital discharge. If the MIHP provider is unable to visit the beneficiary within the stated time frame, documentation must clearly support all attempts to contact or visit the infant beneficiary. When infant services are initiated, an Infant Risk Identifier may be billed as a separate visit from a maternal postpartum professional visit when these services are performed on the same date of service. Documentation must substantiate why it was necessary to perform both visits on the same date of service. Servicing the maternal/infant dyad, all subsequent visits for that family should be "blended visits" and billed as "blended visits" under either the mother's or the infant's Medicaid ID.

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				The following text was added as the 5th paragraph: The goal of the MIHP is to promote healthy infant growth and development. Screening tools and educational materials utilized by the MIHP are designed for use with infants. For this reason, if risks are identified that may necessitate a Risk Identifier for a child older than 12 months of age or a MIHP professional visit beyond 18 months of age, the MIHP provider must obtain written authorization from the MIHP consultant prior to the visit. The last paragraph was removed.
			2.7 Professional Visits	The 3rd paragraph was replaced with the following text: Medicaid reimbursement for a professional visit includes related care coordination activities. MIHP providers are eligible for Medicaid reimbursement for one professional visit per beneficiary on the same date of service, regardless of the place of service. When beneficiary needs arise, the MIHP provider must coordinate all necessary MIHP related services with the appropriate community agencies. Visits beyond the established limit cannot be billed to the beneficiary or Medicaid.
MSA 15-44	10/30/2015	Medicaid Provider Manual Overview	1.1 Organization	In the chart for the Mental Health/Substance Abuse (Behavioral Health and Intellectual and Developmental Disability Supports and Services) Chapter, the following revisions were made: **Affected Providers** Revised to read: Mental Health and Substance Abuse **providers, Fee for Service – Psychologists, Social Workers and Counselors** **Chapter Content**: The following text was added: **Includes Fee for Service Non-Physician Behavioral Health.**

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Behavioral Health and Intellectual and Developmental Disability Supports and Services *(previously known as Mental Health/ Substance Abuse)*		Addition of a 'landing page', with text reading: **Behavioral Health and Intellectual and Developmental Disability Supports and Services** This chapter is comprised of two parts: The **Behavioral Health and Intellectual and Developmental Disability Supports and Services** portion of the chapter outlines the PIHP requirements and services for specialty behavioral health and intellectual and developmental disability supports and services. The **Non-Physician Behavioral Health Appendix** portion of the chapter includes requirements for psychologists, social workers and professional counselors providing behavioral health services for fee for service beneficiaries.
		Behavioral Health and Intellectual and Developmental Disability Supports and Services Non-Physician Behavioral Health *(new appendix)*	Section 1 – General Information	New section text reads: This chapter applies to non-physician behavioral health providers, psychologists, social workers and counselors. Information is included to assist the practitioner in determining how the Michigan Department of Health and Human Services (MDHHS) covers specific services. This information should be used in conjunction with the Billing & Reimbursement for Professionals Chapter of this manual, as well as the Medicaid Code and Rate Reference tool, MDHHS Practitioner and Medical Clinic Fee Schedule, and other related procedure databases/fee schedules located on the MDHHS website. (Refer to the Directory Appendix for website information.) For beneficiaries not enrolled in Medicaid Health Plans and services not included in the capitation payments to the PIHP/CMHSP, behavioral health services are covered through Medicaid FFS.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			Section 2 – Provider Qualifications	New section text reads: Providers in Michigan must be currently licensed by the Department of Licensing and Regulatory Affairs (LARA). Licensed Psychologists (Master's Limited or Doctoral level), Social Workers (Master's level), and Professional Counselors (Master's or Doctoral level) are eligible to enroll as Medicaid providers to provide behavioral health services. Individuals holding other limited licenses or student interns in these professions are not eligible to enroll as providers or be directly reimbursed by Medicaid. (Refer to the General Information for Providers Chapter for enrollment information). Services performed by limited licensed psychologists (except as noted in Section 333.18223 of the Public Health Code), social workers, and professional counselors, or student interns must be performed under the supervision of an enrolled, fully-licensed provider of the same profession. Supervision is defined by Section 333.16109 of the Public Health Code (Act 368 of 1978). Services are billed to Medicaid under the National Provider Identifier (NPI) of the supervising psychologist, social worker, or professional counselor. A student intern is an individual who is currently enrolled in a health profession training program for counseling, psychology, or social work that has been approved by the appropriate board, is performing the duties assigned in the course of training, and is appropriately supervised according to the standards set by the appropriate board and the training program. Social work student interns must be pursuing a Master's degree in social work and be supervised by a Licensed Master's Social Worker in a manner that meets the requirements of a Council on Social Work Education (CSWE) accredited education program curriculum that prepares an individual for licensure. To comply with 42 CFR 431.110, licensed health professionals employed by a Tribal Health Program must be licensed in good standing in at least one state, but do not need to be licensed in the state where they are practicing. This Federal regulation supersedes any licensing requirements of individual states.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			Section 3 – Covered Services	New section text reads: The Medicaid FFS benefit allows 20 combined outpatient behavioral health visits in a 12-month period by all FFS providers. Behavioral health professionals may receive direct reimbursement for Medicaid covered services when provided within their specific profession's scope of practice guidelines as defined by State law. Services covered by the PIHPs/CMHSPs are available and reimbursed through the PIHP/CMHSP. Providers should refer to the Medicaid Code and Rate Reference tool and the Non-Physician Behavioral Health Provider fee schedule on the MDHHS website for the current list of covered procedure codes. The list of allowable services is reviewed annually and updated as applicable.
			Section 4 – Telemedicine	New section text reads: Behavioral health services may be delivered via telemedicine in accordance with current Medicaid policy. In compliance with the Michigan Insurance Code of 1956 (Act 218 of 1956), telemedicine services must be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in his or her health care profession in the state where the patient is located. Refer to the Practitioner Chapter for additional information regarding telemedicine services.
			Section 5 – Claims Processing	New section text reads: Information regarding claims processing is available in the Billing & Reimbursement for Professionals chapter of this manual.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Federally Qualified Health Centers	1.1.A. Non-Physician Behavioral Health Services (new subsection)	New subsection text reads: Licensed Psychologists (Master's Limited or Doctoral level), Social Workers (Master's level), and Professional Counselors (Master's or Doctoral levels) are eligible to enroll as Medicaid providers to provide behavioral health services. Professional services provided by psychologists, social workers and counselors are reimbursed under the FQHC PPS or MOA. These services must be billed using the appropriate evaluation and management (E/M) codes listed in the American Medical Association's Current Procedural Terminology (CPT) Book or Healthcare Common Procedure Coding System (HCPCS) codes. Providers should refer to the Non-Physician Behavioral Health provider database on the MDHHS website for covered procedure codes. The list of allowable services is reviewed annually and updated as applicable. Refer to the Additional Code/Coverage Resource Materials Section of the General Information for Providers Chapter for additional information regarding coverage parameters. For information relating to service coverage and authorization requirements, refer to the Practitioner and the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapters of this manual.
			1.4 Nonenrolled Provider Services	The 1st paragraph was revised to read: Professional services **performed** by **limited licensed psychologists (except as noted in Section 333.18223 of the Public Health Code),** social workers and **professional counselors, or student interns must be performed under the supervision of an enrolled, fully-licensed provider of the same profession. These services** are reimbursed under the **FQHC** PPS or MOA. Since MDHHS does not directly enroll these providers, claims for their services must be billed using the NPI of the supervising **provider** responsible for ensuring the medical necessity and appropriateness of the services. Claims submitted ...
		Practitioner	Section 14 - Psychiatric and Substance Abuse Services	The section title was revised to read: Behavioral Health and Substance Use Disorder Services

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			14.1 Psychiatric Services	The subsection title was revised to read: Behavioral Health Services
				Subsection text was revised as follows: The 1st paragraph was revised to read: Medicaid covers **behavioral health** services for diagnostic or active treatment purposes. **Behavioral health** services are covered by the local PIHP/CMHSP for services included under the capitation payments to the PIHPs/CMHSPs, and a limited outpatient benefit is covered for beneficiaries enrolled in MHPs. **(Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter for additional information.) For beneficiaries not enrolled in Medicaid Health Plans and for services not included in the capitation payments to the PIHP/CMHSP, behavioral health services are covered through FFS Medicaid.** The FFS **benefit allows 20 combined outpatient behavioral health visits in a 12-month period by all FFS providers.** Under FFS, **behavioral health** services **may be provided** by a physician (MD or DO**), psychologist, social worker or counselor (as defined in the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, Non-Physician Behavioral Health Appendix)**. (Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding covered services.) The 2nd paragraph was revised to read: **Beneficiaries enrolled in an MHP will receive behavioral health services through the health plan.** (Refer to the Medicaid Health Plans Chapter of this manual for additional information.

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				The 3rd paragraph was revised to read: (Refer to the **Behavioral Health and Intellectual and Developmental Disability Supports and Services** Chapter of this manual for services covered by the PIHPs/CMHSPs and authorization requirements.)
				In the 4th paragraph (grid), text was revised as follows: **Psychological Testing** The 3rd sentence was revised to read: Psychological testing must be ordered by a physician (MD or DO) and **may** be performed by a psychologist who is fully licensed, limited-licensed, or temporary limited-licensed. The 2nd paragraph was deleted. **Inpatient Psychiatric Admissions** The 2nd paragraph was revised to read: All psychiatric admissions and continued stays must be authorized by the local PIHP/CMHSP. (Refer to the **Behavioral Health and Intellectual and Developmental Disability Supports and Services** Chapter of this manual for specific coverages and authorization requirements.)
			14.2 Substance Abuse Services	The subsection title was revised to read: Substance Use Disorder Services The 1st paragraph was revised to read: Most substance use disorder services provided to Medicaid beneficiaries are covered through the local PIHP/CMHSP. PIHPs/CMHSPs are responsible for direct payment for inpatient psychiatric or partial hospitalization services, related physician services, and specialized community mental health clinical and rehabilitation services that the PIHP/CMHSP has prior authorized. Providers should not bill MDHHS for these services.

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				In the 2nd paragraph (grid), text was revised as follows: **Acute Care Detoxification** **Acute detoxification services are reimbursed directly by MDHHS for both MHP enrollees and FFS beneficiaries.** Admission to the acute care setting for a diagnosis of substance **use** must meet at least one of the following criteria as reflected in the physician's orders and patient care plans: ...
		Rural Health Clinics	2.1.A. Non-Physician Behavioral Health Services (new subsection)	New subsection text reads: Licensed Psychologists (Master's Limited or Doctoral level), Social Workers (Master's level), and Professional Counselors (Master's or Doctoral levels) are eligible to enroll as Medicaid providers to provide behavioral health services. Professional services provided by psychologists, social workers and counselors are reimbursed under the RHC PPS. These services must be billed using the appropriate evaluation and management (E/M) codes listed in the American Medical Association's Current Procedural Terminology (CPT) Book or Healthcare Common Procedure Coding System (HCPCS) codes. Providers should refer to the Non-Physician Behavioral Health provider database on the MDHHS website for the current list of covered procedure codes. The list of allowable services is reviewed annually and updated as applicable. Refer to the Additional Code/Coverage Resource Materials Section of the General Information for Providers Chapter for additional information regarding coverage parameters. For information relating to service coverage and authorization requirements, refer to the Practitioner and the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapters of this manual.

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			2.2 Nonenrolled Providers	Text was revised to read: Professional services **performed** by **limited licensed psychologists (except as noted in Section 333.18223 of the Public Health Code),** social workers and **professional counselors, or student interns must be performed under the supervision of an enrolled, fully-licensed provider of the same profession. These services** are reimbursed under the RHC PPS. Since MDHHS does not directly enroll these providers, claims for their services must be billed using the NPI of the supervising **provider** responsible for ensuring the medical necessity and appropriateness of the services. Claims submitted with the non-enrolled provider's NPI in the rendering provider field will reject.
			2.2.A. Clinical Psychologist and Clinical Social Worker Services	Subsection was deleted. Information is now found in 2.1.A. Non-Physician Behavioral Health Services.
			2.2.B. Limitations for Clinical Social Worker and Clinical Psychologist Services	Subsection was deleted. Information is now found in 2.1.A. Non-Physician Behavioral Health Services.
		Tribal Health Centers	2.1.A. Non-Physician Behavioral Health Services (new subsection)	New subsection text reads: Licensed Psychologists (Master's Limited or Doctoral level), Social Workers (Master's level), and Professional Counselors (Master's or Doctoral levels) are eligible to enroll as Medicaid providers to provide behavioral health services. Professional services provided by psychologists, social workers and counselors are reimbursed under the THC MOA. These services must be billed using the appropriate evaluation and management (E/M) codes listed in the American Medical Association's Current Procedural Terminology (CPT) Book or Healthcare Common Procedure Coding System (HCPCS) codes. Providers should refer to the Non-Physician Behavioral Health provider database on the MDHHS website for the current list of covered procedure codes. The list of allowable services is reviewed annually and updated as applicable. Refer to the Additional Code/Coverage Resource Materials Section of the General

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				Information for Providers Chapter for additional information regarding coverage parameters.
			2.2 Nonenrolled Providers	Text was revised to read: Professional services **performed** by **limited licensed psychologists (except as noted in Section 333.18223 of the Public Health Code),** social workers and **professional counselors, or student interns must be performed under the supervision of an enrolled, fully-licensed provider of the same profession. These services** are reimbursed under the THC **MOA**. Since MDHHS does not directly enroll these providers, claims for their services must be billed using the NPI of the supervising **provider** responsible for ensuring the medical necessity and appropriateness of the services. Claims submitted with the non-enrolled provider's NPI in the rendering provider field will reject.
			5.1 Nonenrolled Providers	The 1st paragraph was revised to read: Professional services provided by **limited licensed psychologists (except as noted in Section 333.18223 of the Public Health Code),** social workers and **professional counselors, or student interns** are covered **but must be performed under the supervision of an enrolled, fully-licensed provider of the same profession**. Individuals who meet Michigan licensure/certification requirements for social workers and psychologists may provide services.
MSA 15-45	12/1/2015	Children's Special Health Care Services	Section 1-General Information	The following text replaces current language in its entirety: CSHCS is mandated by the Michigan Public Health Code, Public Act 368 of 1978, Part 58, children and youth with special health care needs (MCL 333.5801 – 333.5879), in cooperation with the federal government under Title V of the Social Security Act, Sec. 501. [42 U.S.C. 701] (a) 1 (D) and the annual Michigan Department of Health and Human Services (MDHHS) Appropriations Act. This makes CSHCS a separate program from Medicaid. However, CSHCS partners closely with the Medicaid program regarding the use of the Medicaid system. This allows for greater efficiency in administering the two programs and allows both programs to collaborate on the care of a beneficiary to avert

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				duplication of services. CSHCS does not pay for Medicaid-covered services that have been denied by Medicaid. CSHCS is charged by the Social Security Act, Title V, Maternal and Child Health Office with promoting the development of systems of care that are family-centered, community-based, coordinated, and culturally-competent with a focus on health equity. CSHCS strives for having the most appropriate pediatric subspecialists and services that are identified by combining the family's expertise regarding their child and the condition, the medical services provider, MDHHS medical expertise, and CSHCS policy and program intent. CSHCS increases access to resources and supports for the families and beneficiaries. Services occur in partnership, recognizing the family as the constant in the child's life. The goal is to reduce or eliminate barriers that are inherent to the condition. This, in turn, is intended to increase the quality of life for the beneficiary and the family. This family-centered approach impacts the level of independence most beneficiaries are able to achieve. CSHCS identifies children with special health care needs when the child appears to have a condition that CSHCS may cover. CSHCS does not cover behavioral, developmental or mental health conditions. The child's pediatric subspecialist submits medical reports to CSHCS for determination of medical eligibility. When the child does not have a pediatric subspecialist and there is no other option to obtain a medical report (i.e., private insurance, Medicaid, etc.), CSHCS pays for a diagnostic evaluation of medical conditions that are likely to be covered by CSHCS. The beneficiary may be diagnosed with a CSHCS covered condition, which is the first step toward CSHCS eligibility but is not the only criterion. The condition must also meet chronicity, medical severity criteria, and the need for treatment by a pediatric subspecialist before the beneficiary can be determined medically eligible for CSHCS. Unlike other programs, there are no financial criteria that would limit eligibility for CSHCS. Eligibility is determined based upon medical circumstances and not on financial circumstances. Medical eligibility (and allowable citizenship/permanent residency status) must be established by MDHHS before the beneficiary can enroll in CSHCS.

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				Once enrolled, CSHCS covers pediatric specialty medical treatment (adult specialty for the few enrolled adults) related to the qualifying condition. Care is limited to the qualifying diagnosis and related conditions. The limitation occurs by authorizing particular specialty providers for each child and having the authorized provider(s) order additional services, such as therapies, lab tests, etc., as needed as related to their specialty. Providers who are not CSHCS-authorized are not eligible for reimbursement. CSHCS does not cover primary care or condition-related care delivered by a primary care provider. **NOTE: CSHCS and Medicaid interface** – CSHCS follows Medicaid policy except where specified in this chapter. Many of the CSHCS processes (e.g., prior authorizations, medical determinations, claims, etc.) are integrated into the Medicaid system and processes for CSHCS beneficiaries. CSHCS strives to enroll CSHCS beneficiaries into Medicaid when they are eligible in order to access the broader range of medical services that are covered by Medicaid. CSHCS also partners with Medicaid when beneficiaries have both CSHCS and Medicaid. Most beneficiaries who also have Medicaid are required to enroll with a Medicaid Health Plan. Under this situation, medical coverage is subject to the Medicaid rules. CSHCS can, at times, provide additional services beyond what is available through the Medicaid benefit package. These services include care coordination, the development of a plan of care in which the family participates, referral to appropriate medical providers, and assistance with locating, accessing, and navigating community support services, etc.
			11.3 Travel Reimbursement Process	The following text was added at the end of the 1st paragraph: New enrollees may be reimbursed retroactive to the date of CSHCS enrollment when applicable.

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MSA 15-48	12/1/2015	Ambulance	1.2 Common Terms	The following definitions were revised: **Advanced Life Support (ALS) Assessment** **A**n assessment performed by an ALS crew **(minimum level Emergency Medical Technician-Specialist [EMT-S], Advanced Emergency Medical Technician [AEMT], or Paramedic)** as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment to determine whether the patient's condition requires an ALS level of care. **The completion of an** ALS assessment does not necessarily result in a determination that the patient requires an ALS **intervention**. **Medically Necessary Transport** The 2nd sentence was deleted. **Transfer** **The movement of a beneficiary from one health care facility to another in a licensed ground or air ambulance because a medically necessary service was not available at the primary location.**
				The following definitions were added: **Advanced Life Support Intervention** A procedure in accordance with state and local laws that is required to be performed by minimum level Emergency Medical Technician-Specialist [EMT-S], Advanced Emergency Medical Technician [AEMT], or Paramedic. **Base Rate** A payment rate associated with the level of service provided. Included in the base rate is oxygen, equipment and supplies essential to the provision of services, and accompanying personnel.

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				Emergency Medical Technician (EMT) An individual licensed by the state of Michigan to provide BLS services. **Emergency Medical Technician Specialist (EMT-S)** An individual licensed by the state of Michigan to provide limited ALS services. **Neonate** An infant less than four weeks old. **Neonate Return Transfer** An ambulance transport that returns a stabilized neonate from a Level III or Level IV NICU back to the Level I Well Born Nursery or Level II Special Care Nursery from which the neonate was originally transferred. **Neonatal Transport Team** A team of experienced, specialized, multidisciplinary health care providers (established and defined by a health care facility) who are trained for, and immediately available to respond to, calls for high risk neonatal transports. **Paramedic** An individual licensed by the state of Michigan to provide ALS services. **Waiting Time** When an ambulance provider waits at a hospital while a beneficiary is being stabilized, with the intent of continuing transport to a more appropriate hospital for care, or back to the beneficiary's point of origin.
			2.1 Air Ambulance	Text was revised to read: MDHHS reimburses air ambulance providers who are licensed by the State of Michigan and properly enrolled with MDHHS. Providers must indicate on the enrollment application that they are requesting either fixed-wing air ambulance or helicopter air

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				ambulance status. **Coverage of the air ambulance services includes the base rate, loaded mileage, and waiting time.** **Medicaid reimburses air ambulance services only when a beneficiary requires medical or surgical (not diagnostic) procedures, and their condition requires rapid transportation to a treatment facility. One of the following requirements must be met:** • **Great distance or obstacles preclude such delivery to the most appropriate facility; or,** • **The beneficiary is inaccessible by either ground or water ambulance.** **Hospital-to-hospital emergent transfers performed by either a helicopter or fixed-wing air ambulance require clinical documentation (i.e., the History and Physical [H & P] report]) from the beneficiary's attending physician validating the need for the air, rather than ground, transportation. (Refer to the Emergency subsection of this chapter for more information on emergent transports.)** **Non-emergent air ambulance transports require an order from the beneficiary's attending physician and must be prior authorized. (Refer to the Ambulance Services subsection of this chapter for documentation requirements for emergency and medically necessary services.)**
			2.1.A. Fixed Wing Air Ambulance	The 2nd and 3rd paragraphs were deleted.
			2.1.B. Helicopter Air Ambulance	The 2nd and 3rd paragraphs were deleted.

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			2.2 Base Rate	Text in the 1st and 2nd paragraphs was revised to read: The ambulance provider may bill one base rate procedure code: • **Advanced Life Support 1 (ALS 1) Non-emergency;** • **ALS 1 Emergency;** • **Advanced Life Support 2 (ALS 2);** • **Basic Life Support (BLS) Non-emergency;** • **BLS Emergency;** • Neonatal Emergency Transport; • Helicopter Air Ambulance; or • Fixed Wing Air Ambulance Transport. **The determination to respond emergently with either an ALS or BLS ambulance vehicle is dependent upon local 911 or equivalent service dispatch protocol. Where the dispatch was inconsistent with this standard of protocol, or where no protocol was used, the beneficiary's condition at the time of ambulance arrival determines the appropriate level of reimbursement.** Even if a local government **or medical control authority** requires an **ALS** response to all calls, the base rate billed must reflect the level of service rendered **and** not the type of vehicle in which the beneficiary was transported. Medicaid will only pay for the level of service required and provided.
			2.3 Advanced Life Support	The 2nd sentence was deleted.
			2.3.A. Advanced Life Support, Level 1 (ALS1) – Non-Emergency	Text was revised to read: ALS1 is defined as the transportation by ground ambulance vehicle, and the provision of medically necessary supplies and services, which includes an **ALS assessment or the furnishing** of at least one ALS intervention **within the context of a non-emergency response**.

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				Ambulance providers must secure a physician's written order indicating the medical necessity of the elevated level of transport and retain it in their files. (Refer to the the Non-emergency subsection of this chapter for additional information.)
			2.3.B. Advanced Life Support, Emergency Transport, Level 1 (ALS1) – Emergency	Text was revised to read: ALS1 is defined as the transportation by ground ambulance and the provision of ALS1 **services within** the context of an emergency response. **The furnishing of an ALS assessment, without a medically necessary ALS intervention, is sufficient to bill the ALS base rate if the beneficiary's condition at the time of dispatch indicated an ALS level of service was required.**
			2.3.C. Advanced Life Support, Level 2 (ALS2)	The 1st paragraph was revised to read: ALS2 is defined as the transportation by ground ambulance vehicle, and the provision of medically necessary supplies and services, including an ALS assessment, and: • **at least** three **separate administrations of one or more** medications **by intravenous push/bolus or by continuous infusions (excluding crystalloid fluids);** or • one or more of the following ALS2 procedures: ➢ Manual defibrillation/cardioversion ➢ Endotracheal intubation, **or the monitoring and maintenance of an endotracheal tube that was previously inserted prior to the transport** ➢ Central venous line ➢ ...
			2.4 Basic Life Support	In the 1st paragraph, the 1st sentence was revised to read: Ambulance operations and ambulance staff must be licensed **to render BLS services** by the State **of Michigan** and properly enrolled with MDHHS**.**

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			2.4.A. Basic Life Support (BLS) – Non-Emergency	Text was revised to read: BLS – Non-emergency is defined as the transportation **by ground ambulance as** defined above **within the context of a non-emergency response. The BLS service must be provided by either a BLS or an ALS licensed provider.** **Ambulance providers must secure a physician's written order indicating the medical necessity of the transport and retain it in their files. (Refer to the Non-emergency subsection of this chapter for additional information.)**
			2.6 Emergency	The 2nd paragraph was revised to read: Claims for emergency ambulance transports must be coded with both an emergency procedure code and an appropriate ICD diagnosis code whenever the service results in transport to **a hospital**, or assessment and treatment/stabilization determines that no further transport is necessary. Claims for emergency transports without this information will be rejected. Documentation supporting the emergency diagnosis code must be retained in the ambulance provider's records for audit purposes.
			2.8 Neonatal	The 1st through 4th paragraphs were revised to read: Coverage of neonatal transport includes **the** neonatal base rate, loaded mileage, and waiting time. The cost of the transfer isolette use is included in the neonatal base rate. The intensive care transport of critically ill neonates **to an approved, designated Level III or Level IV** Neonatal Intensive Care Unit (NICU), as approved and designated by Certificate of Need (CON) review standards, is covered. A **neonatal transport** team must accompany the **neonate. The neonatal transport team has primary responsibility for the neonate and the hospital is reimbursed for these services. The designated ambulance** provider may bill the neonatal base rate and mileage for the transport. **A neonate return transfer from a NICU to a Level I Well Newborn Nursery or a Level II Special Care Nursery (after the neonate's condition is stabilized)**

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				is covered if the transportation is ordered by the neonate's attending physician. A physician's order indicating the medical necessity of the return trip must be retained in the beneficiary's file as detailed in the Ambulance Services subsection of this chapter.

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			2.9 Non-emergency	The 1st through 4th paragraphs were revised to read: A claim may be made to MDHHS for a medically necessary non-emergency transport only when: • the transport is ordered by the beneficiary's attending physician; • the ambulance provider obtains a written order (e.g., physician certification statement) from the beneficiary's attending physician certifying the medical necessity of the transport; and, • the transport is provided in a licensed BLS, ALS, **or air (PA is required) ambulance** vehicle. Ambulance providers must retain appropriate documentation of the medical necessity of the transport in their files. A copy of the physician's order for non-emergency ambulance transport in the patient's medical record is acceptable documentation. The written order must contain, at a minimum, the following information: • beneficiary's name and Medicaid identification (ID) number; • attending physician's NPI number and attending physician or provider signature; • type of transport necessary; • explanation of the medical necessity for ambulance transport (i.e., why other means of transport could not be used); • origin and destination; • diagnosis; • frequency of needed transports (required for ongoing, planned treatment); • type of ongoing treatment (required for ongoing, planned treatment); **and** • **explanation of why ground transportation is not appropriate (required when transported by air ambulance).**

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				A separate physician's order is required for each individual **round trip** transport, unless a beneficiary has a chronic medical condition that requires planned treatment. For chronic conditions, a physician may order non-emergency transportation for a maximum time period of up to 60 days in a single order. The physician's order for ongoing treatment must state the frequency of the transport and the type of ongoing treatment necessary.
			3.4 Nursing Facilities	The 2nd paragraph was revised to read: When the resident's attending physician orders **non-emergency ambulance transportation** (due to the need for a stretcher or other emergency equipment), the ambulance provider may bill MDHHS directly. The ambulance provider must maintain the physician's written order as documentation of medical necessity. **(Refer to the Nursing Facility Coverages Chapter of this manual for additional information.)**
MSA 15-54	12/30/2015	General Information for Providers	Section 2 - Provider Enrollment	The 5th paragraph was revised to read: Providers electing to appoint another person to enter their MDHHS enrollment information in the CHAMPS PE subsystem on their behalf **must** complete and retain a copy of **the MDHHS Provider Electronic Signature Agreement Cover Sheet (MDHHS-5405) and** the MDHHS Electronic Signature Agreement (DCH-1401). **Both forms must be submitted to the Provider Enrollment Section per instructions provided on the cover sheet.** (Refer to the Forms Appendix for a copy of the **MDHHS-5405 and the** DCH-1401.)
		Forms Appendix		The following form was added: MDHHS-5405 - MDHHS Provider Electronic Signature Agreement Cover Sheet The following form was revised: DCH-1401 – MDHHS Electronic Signature Agreement

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MSA 15-56	12/1/2015	Practitioner	Section 14 – Psychiatric and Substance Abuse Services	The section title was revised to read: Behavioral Health and Substance Use Disorder Services
			14.1 Psychiatric Services	The subsection title was revised to read: Behavioral Health Services The following information was added to the table: **Office-Based Opioid Treatment (OBOT)** OBOT services are reimbursed directly by MDHHS for both MHP enrollees and FFS beneficiaries. Physician and non-physician practitioner (Physician Assistant [PA] and Nurse Practitioner [NP]) services related to opioid dependence may be reimbursed through the Medicaid Fee-for-Service (FFS) program. Working within their scope of practice, physician and non-physician practitioner (PA and NP) services related to OBOT will be considered for reimbursement through the FFS program when the beneficiary meets the American Society of Addiction Medicine (ASAM) criteria for outpatient treatment. Providers are required to provide services consistent with clinical practice guidelines established by the Substance Abuse and Mental Health Services Administration (SAMHSA) and ASAM. The following services related to opioid treatment qualify for FFS reimbursement when a beneficiary has a primary diagnosis of opioid dependence: • Evaluation and Management services • Consultation services. Physicians and non-physician practitioners (PA and NP) seeking FFS reimbursement for OBOT services must be enrolled in the Community Health Automated Medicaid Processing System (CHAMPS) as a FFS provider. Enrolled providers cannot duplicate and/or be reimbursed through the PIHP/CMHSP for the same service.

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				According to SAMHSA opioid treatment standards, use of medication with counseling is crucial to successful treatment for individuals with opioid dependence. Beneficiaries must be actively involved in their treatment and, as such, it is important that all providers coordinate care. OBOT providers should ensure beneficiaries have access and receive referral to PIHPs for further assessment and treatment and any of the other supports and services that are available (i.e., PIHP specialty services, community based services, and natural supports). PIHP/CMHSP, FFS and Managed Care must partner in overseeing and coordinating the treatment plan knowing that OBOT is only part of the services necessary to achieve successful outcomes. (Refer to the General Information for Providers Chapter for additional information on enrollment in CHAMPS.)
			14.2 Substance Abuse Services	The subsection title was revised to read: Substance Use Disorder Services In the table, "Other Substance Abuse Services" was revised to read "Additional Substance Use Disorder Services" and text was revised to read: Medicaid covers **additional** substance **use disorder** services **through** capitation payments to the PIHPs/CMHSPs. (Refer to the **Behavioral Health and Intellectual and Developmental Disability Supports and Services** Chapter of this manual for coverage details and authorization requirements.)
MSA 15-57	12/1/2015	Tribal Health Centers	Section 1 – General Information	The last paragraph was revised to read: Under the Michigan Medicaid State Plan, THCs have the option of choosing from one of three reimbursement mechanisms. The THC may elect to be reimbursed under only one of the options listed below, and the selected option applies to all beneficiaries receiving services at the THC. The options are:

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				• A THC may choose to be certified as an IHS facility, sign the THC MOA and receive the IHS encounter rate in accordance with the terms of the MOA. • **Upon federal approval by the Health Resources and Services Administration, THCs may be reimbursed as a Federally Qualified Health Center (FQHC) by signing the FQHC Memorandum of Agreement. THCs choosing this option will receive the FQHC encounter rate set by the State in accordance with the Michigan Medicaid State Plan and federal regulations. The FQHC encounter rate applies to encounters for both native and non-native beneficiaries. A THC electing to be reimbursed as an FQHC is not required to have a contract with the managed care entity. If a THC chooses to be reimbursed as a FQHC, the entity would be required to adhere to the same requirements specified in the Federally Qualified Health Centers Chapter.** • **A THC may be reimbursed as a fee-for-service provider. THCs choosing this option receive payment for covered services. No additional reimbursement or settlement is made.**
			3.4 Services Provided to Medicaid Health Plan Enrollees	Text was revised to read: For Medicaid-covered services provided to Medicaid beneficiaries enrolled in a Medicaid Health Plan (MHP), THCs receive payment from the MHP based on an agreement or contract with the MHP. **In the absence of an agreement or contract, payment is based on the Medicaid fee-for-service (FFS) rates in effect on the date of service (DOS). Approved services provided to MHP enrollees are then recognized as encounters for reimbursement purposes under the THC MOA**.
			6.2 MHP Enrollees	The subsection was deleted. The following subsection was re-numbered.

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			7.6 Place of Service	The 2nd paragraph was revised to read: The THC may **bill for services** that are not provided at the THC. **These** services must be billed with the appropriate **Place of Service (**POS**)** code in compliance with the coverages and limitations specified in the Practitioner Chapter of this manual. **Covered services provided off-site to beneficiaries temporarily homebound because of a medical condition that prevents the beneficiary from traveling to the THC are eligible to receive the all-inclusive rate. The services must be provided by a practitioner employed by the THC, and the appropriate POS code must be used on the claim form when billing. A complete list of POS codes can be found in the Billing & Reimbursement for Professionals Chapter of this manual.**
MSA 15-59	12/2/2015	Behavioral Health and Intellectual and Developmental Disability Supports and Services *(previously known as the Mental Health/Substance Abuse Chapter)*	3.1 Applied Behavior Analysis	The subsection title was revised to read: **Behavioral Health Treatment Services /** Applied Behavior Analysis Text was revised to read: Refer to the **Behavioral Health Treatment Services /** Applied Behavior Analysis Section of this chapter for specific program requirements.
			Section 18 - Applied Behavior Analysis 18.1 Screening 18.2 Referral 18.3 Diagnosis/ Determination of Eligibility for Target Group	Section and it's subsections were removed and replaced with Section 18 - Behavioral Health Treatment Services/Applied Behavior Analysis. (See following information.)

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			18.3.A. Criteria for Autistic Disorder 18.3.B. Criteria for Asperger's Disorder 18.3.C. Criteria for Pervasive Developmental Disorder – Not Otherwise Specified 18.4 Independent Evaluation 18.4.A. Needs Based Criteria 18.5 Independent Assessment 18.6 ABA Intervention 18.6.A. Early Intensive Behavioral Intervention (EIBI) 18.6.B. Applied Behavioral Intervention 18.7 Provider Qualifications	
			Section 18 - Behavioral Health Treatment Services/Applied Behavior Analysis (new section)	New section text reads: The purpose of this policy is to provide for the coverage of Behavioral Health Treatment (BHT) services, including Applied Behavior Analysis (ABA), for children under 21 years of age with Autism Spectrum Disorders (ASD). All children, including children with ASD, must receive EPSDT services that are designed to assure that children receive early detection and preventive care, in addition to medically necessary

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				treatment services to correct or ameliorate any physical or behavioral conditions, so that health problems are averted or diagnosed and treated as early as possible. According to the U.S. Department of Health & Human Services, autism is characterized by impaired social interactions, problems with verbal and nonverbal communication, repetitive behaviors, and/or severely limited activities and interests. Early detection and treatment can have a significant impact on the child's development. Autism can be viewed as a continuum or spectrum, known as ASD, and includes Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS). The disorders on the spectrum vary in severity and presentation, but have certain common core symptoms. The goals of treatment for ASD focus on improving core deficits in communication, social interactions, and restricted behaviors. Changing these fundamental deficits may benefit children by developing greater functional skills and independence. BHT services prevent the progression of ASD, prolong life, and promote the physical and mental health and efficiency of the child. Medical necessity and recommendation for BHT services is determined by a physician, or other licensed practitioner working within their scope of practice under state law. Direct patient care services that treat or address ASD under the state plan are available to children under 21 years of age as required by the EPSDT benefit.

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			18.1 Screening (new subsection)	New subsection text reads: The American Academy of Pediatrics (AAP) endorses early identification of developmental disorders as being essential to the well-being of children and their families. Early identification of developmental disorders through screening by health care professionals should lead to further evaluation, diagnosis, and treatment. Early identification of a developmental disorder's underlying etiology may affect the medical treatment of the child and the parent's/guardian's intervention planning. Screening for ASD typically occurs during an EPSDT well child visit with the child's primary care provider (PCP). EPSDT well child visits may include a review of the child's overall medical and physical health, hearing, speech, vision, behavioral and developmental status, and screening for ASD with a validated and standardized screening tool. The EPSDT well child evaluation is also designed to rule out medical or behavioral conditions other than ASD, and include those conditions that may have behavioral implications and/or may co-occur with ASD. A full medical and physical examination must be performed before the child is referred for further evaluation.
			18.2 Referral (new subsection)	New subsection text reads: The PCP who screened the child for ASD and determined a referral for further evaluation was necessary will contact the Prepaid Inpatient Health Plan (PIHP) directly to arrange for a follow-up evaluation. The PCP must refer the child to the PIHP in the geographic service area for Medicaid beneficiaries. The PIHP will contact the child's parent(s)/guardian(s) to arrange a follow-up appointment for a comprehensive diagnostic evaluation and behavioral assessment. Each PIHP will identify a specific point of access for children who have been screened and are being referred for a diagnostic evaluation and behavioral assessment of ASD. If the PCP determines the child who screened positive for ASD is in need of occupational, physical, or speech therapy, the PCP will refer the child directly for the service(s) needed. After a beneficiary is screened and the PCP determines a referral is necessary for a follow-up visit, the PIHP is responsible for the comprehensive diagnostic evaluation, behavioral assessment, BHT services (including ABA) for eligible Medicaid beneficiaries, and for the related EPSDT medically necessary Mental Health Specialty Services. Occupational therapy, physical therapy, and speech therapy for children

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				with ASD who do not meet the eligibility requirements for developmental disabilities by the PIHP are covered by the Medicaid Health Plan or by Medicaid Fee-for-Service.
			18.3 Comprehensive Diagnostic Evaluations (new subsection)	New subsection text reads: Accurate and early diagnosis of ASD is critical in ensuring appropriate intervention and positive outcomes. The comprehensive diagnostic evaluation must be performed before the child receives BHT services. The comprehensive diagnostic evaluation is a neurodevelopmental review of cognitive, behavioral, emotional, adaptive, and social functioning, and should include validated evaluation tools. Based on the evaluation, the practitioner determines the child's diagnosis, recommends general ASD treatment interventions, and refers the child for a behavior assessment. The provider who conducts the behavior assessment recommends more specific ASD treatment interventions. These evaluations are performed by a qualified licensed practitioner working within their scope of practice and who is qualified and experienced in diagnosing ASD. A qualified licensed practitioner includes: • a physician with a specialty in psychiatry or neurology; • a physician with a subspecialty in developmental pediatrics, developmental-behavioral pediatrics or a related discipline; • a physician with a specialty in pediatrics or other appropriate specialty with training, experience or expertise in ASD and/or behavioral health; • a psychologist; • an advanced practice registered nurse with training, experience, or expertise in ASD and/or behavioral health; • a physician assistant with training, experience, or expertise in ASD and/or behavioral health; or • a clinical social worker, working within their scope of practice, and is qualified and experienced in diagnosing ASD. The determination of a diagnosis by a qualified licensed practitioner is accomplished by direct observation and utilizing the Autism Diagnostic Observation Schedule-Second Edition (ADOS-2), and by administering a comprehensive clinical interview including a

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				developmental symptom history (medical, behavioral, and social history) such as the Autism Diagnostic Interview-Revised (ADI-R) or clinical equivalent. In addition, a qualified licensed practitioner will rate symptom severity with the Clinical Global Impression Severity Scale. Other tools may be used if the clinician feels it is necessary to determine a diagnosis and medical necessity service recommendations. Other tools may include: • cognitive/developmental tests, such as the Mullen Scales of Early Learning, Wechsler Preschool and Primary Scale of Intelligence-IV (WPPSI-IV), Wechsler Intelligence Scale for Children-IV (WISC-IV), Wechsler Intelligence Scale for Children-V (WISC-V), or Differential Ability Scales-II (DAS-II); • adaptive behavior tests, such as Vineland Adaptive Behavior Scale-II (VABS-II), Adaptive Behavior Assessment System-III (ABAS-III), or Diagnostic Adaptive Behavior Scale (DABS); and/or • symptom monitoring, such as Social Responsiveness Scale-II (SRS-II), Aberrant Behavior Checklist, or Social Communication Questionnaire (SCQ).
			18.4 Medical Necessity Criteria (new subsection)	New subsection text reads: Medical necessity and recommendation for BHT services is determined by a physician or other licensed practitioner working within their scope of practice under state law. The child must demonstrate substantial functional impairment in social communication, patterns of behavior, and social interaction as evidenced by meeting criteria A and B (listed below); and require BHT services to address the following areas: A. The child currently demonstrates substantial functional impairment in social communication and social interaction across multiple contexts, and is manifested by all of the following: 1. Deficits in social-emotional reciprocity ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation, to reduced sharing of interests, emotions, or affect, to failure to initiate or respond to social interactions.

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				2. Deficits in nonverbal communicative behaviors used for social interaction ranging, for example, from poorly integrated verbal and nonverbal communication, to abnormalities in eye contact and body language or deficits in understanding and use of gestures, to a total lack of facial expressions and nonverbal communication. 3. Deficits in developing, maintaining, and understanding relationships ranging, for example, from difficulties adjusting behavior to suit various social contexts, to difficulties in sharing imaginative play or in making friends, to absence of interest in peers. B. The child currently demonstrates substantial restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least two of the following: 1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, and/or idiosyncratic phrases). 2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, and/or need to take same route or eat the same food every day). 3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects and/or excessively circumscribed or perseverative interest). 4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, and/or visual fascination with lights or movement).
			18.5 Determination of Eligibility for BHT (new subsection)	New subsection text reads: The following is the process for determining eligibility for BHT services for a child with a confirmed diagnosis of ASD. Eligibility determination and recommendation for BHT

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				must be performed by a qualified licensed practitioner through direct observation utilizing the ADOS-2 and symptom rating using the Clinical Global Impression Severity Scale. BHT services are available for children under 21 years of age with a diagnosis of ASD from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), and who have the developmental capacity to clinically participate in the available interventions covered by BHT services. A well-established DSM-IV diagnosis of Autistic Disorder, Asperger's Disorder or PDD-NOS should be given the diagnosis of ASD. Children who have marked deficits in social communication but whose symptoms do not otherwise meet criteria for ASD should be evaluated for social (pragmatic) communication disorder. The following requirements must be met: • Child is under 21 years of age. • Child received a diagnosis of ASD from a qualified licensed practitioner utilizing valid evaluation tools. • Child is medically able to benefit from the BHT treatment. • Treatment outcomes are expected to result in a generalization of adaptive behaviors across different settings to maintain the BHT interventions and that they can be demonstrated beyond the treatment sessions. Measurable variables may include increased social-communication, increased interactive play/age-appropriate leisure skills, increased reciprocal communication, etc. • Coordination with the school and/or early intervention program is critical. Collaboration between school and community providers is needed to coordinate treatment and to prevent duplication of services. This collaboration may take the form of phone calls, written communication logs, participation in team meetings (i.e., Individual Education Plan/Individual Family Service Plan [IEP/IFSP], Individual Plan of Service [IPOS], etc.). • Services are able to be provided in the child's home and community, including centers and clinics.

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				• Symptoms are present in the early developmental period (symptoms may not fully manifest until social demands exceed limited capacities, or may be masked by learned strategies later in life). • Symptoms cause clinically significant impairment in social, occupational, and/or other important areas of current functioning that are fundamental to maintain health, social inclusion, and increased independence. • A qualified licensed practitioner recommends BHT services and the services are medically necessary for the child. • Services must be based on the individual child and the parent's/guardian's needs and must consider the child's age, school attendance requirements, and other daily activities as documented in the IPOS. Families of minor children are expected to provide a minimum of eight hours of care per day on average throughout the month.
			18.6 Prior Authorization (new subsection)	New subsection text reads: BHT services are authorized for a time period not to exceed 365 days. The 365-day authorization period for services may be re-authorized annually based on recommendation of medical necessity by a qualified licensed practitioner working within their scope of practice under state law.
			18.7 Re-evaluation (new subsection)	New subsection text reads: An annual re-evaluation by a qualified licensed practitioner to assess eligibility criteria must be conducted through direct observation utilizing the ADOS-2 and symptoms rated using the Clinical Global Impression Severity Scale. Additional tools may be used if the clinician feels it is necessary to determine medical necessity and recommended services. Other tools may include cognitive/developmental tests, adaptive behavior tests, and/or symptom monitoring.
			18.8 Discharge Criteria (new subsection)	New subsection text reads: Discharge from BHT services is determined by a qualified BHT professional for children who meet any of the following criteria:

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				• The child has achieved treatment goals and less intensive modes of services are medically necessary and appropriate. • The child is either no longer eligible for Medicaid or is no longer a State of Michigan resident. • The child has not demonstrated measureable improvement and progress toward goals, and the predicted outcomes as evidenced by a lack of generalization of adaptive behaviors across different settings where the benefits of the BHT interventions are not able to be maintained or they are not replicable beyond the BHT treatment sessions through a period of six months. • Targeted behaviors and symptoms are becoming persistently worse with BHT treatment over time or with successive authorizations. • The child no longer meets the eligibility criteria as evidenced by use of valid evaluation tools administered by a qualified licensed practitioner. • The child and/or parent/guardian is not able to meaningfully participate in the BHT services, and does not follow through with treatment recommendations to a degree that compromises the potential effectiveness and outcome of the BHT service.
			18.9 BHT Services (new subsection header)	
			18.9.A. Behavioral Assessment (new subsection)	New subsection text reads: Behavioral assessments must use a validated instrument and can include direct observational assessment, observation, record review, data collection, and analysis by a qualified provider. Examples of behavior assessments include function analysis and functional behavior assessments. The behavioral assessment must include the current level of functioning of the child using a validated data collection method. Behavioral assessments and ongoing measurements of improvement must include behavioral outcome tools. Examples of behavioral outcome tools include Verbal Behavior-Milestones Assessment and Placement Program (VB-MAPP), Assessment of Basic

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				Language and Learning Skills -Revised (ABLLS-R), and Assessment of Functional Living Skills (AFLS).
			18.9.B. Behavioral Intervention (new subsection)	New subsection text reads: BHT services include a variety of behavioral interventions which have been identified as evidence-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence. BHT services are designed to be delivered primarily in the home and in other community settings. Behavioral intervention services include, but are not limited to, the following categories of evidence-based interventions: • Collecting information systematically regarding behaviors, environments, and task demands (e.g., shaping, demand fading, task analysis); • Adapting environments to promote positive behaviors and learning while discouraging negative behaviors (e.g., naturalistic intervention, antecedent based intervention, visual supports, stimulus fading); • Applying reinforcement to change behaviors and promote learning (e.g., reinforcement, differential reinforcement of alternative behaviors, extinction); • Teaching techniques to promote positive behaviors, build motivation, and develop social, communication, and adaptive skills (e.g., discrete trial teaching, modeling, social skills instruction, picture exchange communication systems, pivotal response training, social narratives, self-management, prompting, chaining, imitation); • Teaching parents/guardians to provide individualized interventions for their child for the benefit of the child (e.g., parent/guardian implemented/mediated intervention); • Using typically developing peers (e.g., individuals who do not have ASD) to teach and interact with children with ASD (e.g., peer mediated instruction, structured play groups, peer social interaction training); and • Applying technological tools to change behaviors and teach skills (e.g., video modeling, tablet-based learning software).

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				In addition to the above listed categories of interventions, covered BHT treatment services may also include any other intervention supported by credible scientific and/or clinical evidence, as appropriate for each individual. Based on the behavioral plan of care which is adjusted over time based on data collected by the qualified provider to maximize the effectiveness of BHT treatment services, the provider selects and adapts one or more of these services, as appropriate for each individual.
			18.9.C. Behavioral Observation and Direction (new subsection)	New subsection text reads: Behavioral observation and direction is the clinical direction and oversight provided by a qualified provider to a lower level provider based on the required provider standards and qualifications regarding the provision of services to a child. The qualified provider delivers face–to-face observation and direction to a lower level provider regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for each child. This service is for the direct benefit of the child and provides a real time response to the intervention to maximize the benefit for the child. It also informs of any modifications needed to the methods to be implemented to support the accomplishment of outcomes in the behavioral plan of care.
			18.9.D. Telepractice for BHT Services (new subsection)	New subsection text reads: All telepractice services must be prior authorized by the Michigan Department of Health and Human Services (MDHHS). Telepractice is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of services. Telepractice must be obtained through real-time interaction between the child's physical location (patient site) and the provider's physical location (provider site). Telepractice services are provided to patients through hardwire or internet connection. It is the expectation that providers, facilitators, and staff involved in telepractice are trained in the use of equipment and software prior to servicing patients. Qualified providers of behavioral health services are able to arrange telepractice services for the purposes of teaching the parents/guardians to provide individualized interventions to their child and to engage in behavioral health clinical observation and direction. Qualified providers of behavioral health services include Board Certified Behavior Analysts (BCBA), Board Certified Assistant Behavior Analysts

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				(BCaBA), Licensed Psychologists (LP), Limited Licensed Psychologists (LLP), and Qualified Behavioral Health Professionals (QBHP). The provider of the telepractice service is only able to monitor one child/family at a time. The administration of telepractice services are subject to the same provision of services that are provided to a patient in person. Providers of telepractice services must be currently certified by the Behavior Analyst Certification Board (BACB), be a QBHP enrolled in a BACB degree program, be licensed in the State of Michigan as a fully licensed psychologist, or be a practitioner who holds a limited license and is under the direction of a fully licensed psychologist. Providers must ensure the privacy of the child and secure any information shared via telemedicine. The technology used must meet the requirements of audio and visual compliance in accordance with current regulations and industry standards. Refer to the General Information for Providers Chapter of this manual for the complete Health Insurance Portability and Accountability Act (HIPAA) compliance requirements. The patient site may be located within a center, clinic, at the patient's home, or any other established site deemed appropriate by the provider. The room must be free from distractions that would interfere with the telepractice session. A facilitator must be trained in the use of the telepractice technology and be physically present at the patient site during the entire telepractice session to assist the patient at the direction of the qualified provider of behavioral health. Occupational, physical, and speech therapy are not covered under telepractice services. Refer to the Telemedicine Services database on the MDHHS website for appropriate or allowed telemedicine services that may be covered by the Medicaid Health Plan or by Medicaid Fee-for-Service. (Refer to the Directory Appendix for website information.)
			18.10 BHT Service Level (new subsection)	New subsection text reads: BHT services are available for Medicaid beneficiaries diagnosed with ASD and are provided for all levels of severity of ASD. The behavioral intervention should be provided at an appropriate level of intensity in an appropriate setting(s) within their community for an appropriate period of time, depending on the needs of the child and their parents/guardians. Clinical determinations of service intensity, setting(s), and duration are designed to facilitate the child's goal attainment. These supports may

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				serve to reinforce skills or lessons taught in school, therapy, or other settings, but are not intended to supplant services provided in school or other settings, or to be provided when the child would typically be in school but for the parent's/guardian's choice to home-school their child. Each child's IPOS must document that these services do not include special education and related services defined in the Individuals with Disabilities Education Act (IDEA) that are available to the child through a local education agency. The recommended service level, setting(s), and duration will be included in the child's IPOS, with the planning team and the parent(s)/guardian(s) reviewing the IPOS at regular intervals (minimally every three months) and, if indicated, adjusting the service level and setting(s) to meet the child's changing needs. The service level includes the number of hours of intervention provided to the child. The service level determination will be based on research-based interventions integrated into the behavioral plan of care with input from the planning team. Service intensity will vary with each child and should reflect the goals of treatment, specific needs of the child, and response to treatment. The PIHP's Utilization Management will authorize the level of services prior to the delivery of services. • **Focused Behavioral Intervention:** Focused behavioral intervention is provided an average of 5-15 hours per week (actual hours needed are determined by the behavioral plan of care and interventions required). • **Comprehensive Behavioral Intervention:** Comprehensive behavioral intervention is provided an average of 16-25 hours per week (actual hours needed are determined by the behavioral plan of care and interventions required).
			18.11 BHT Service Evaluation (new subsection)	New subsection text reads: As part of the IPOS, there is a comprehensive, individualized behavioral plan of care that includes specific targeted behaviors, along with measurable, achievable, and realistic goals for improvement. BCBA and other qualified providers develop, monitor, and implement the behavioral plan of care. These providers are responsible for effectively evaluating the child's response to treatment and skill acquisition. Ongoing determination of the level of service (minimally every six months) requires evidence of measurable and ongoing improvement in targeted behaviors that are demonstrated

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				with the use of reliable and valid assessment instruments (i.e., VB-MAPP, ABLLS-R, AFLS) and other appropriate documentation of analysis (i.e., graphs, assessment reports, records of service, progress reports, etc.).
			18.12 BHT Service Provider Qualifications (new subsection)	New subsection text reads: BHT services are highly specialized services that require specific qualified providers who are available within PIHP/CMHSP provider networks and have extensive experience providing specialty mental health and behavioral health services. BHT services must be provided under the direction of a BCBA, another appropriately qualified LP or LLP, or a Master's prepared QBHP. These services must be provided directly to, or on behalf of, the child by training their parents/guardians, behavior technicians, and BCaBAs to deliver the behavioral interventions. The BCBA and other qualified providers are also responsible for communicating progress on goals to parents/guardians minimally every three to six months; clinical skill development and supervision of BCaBA, QBHP, and behavior technicians; and collaborating with support coordinators/case managers and the parents/guardians on goals and objectives with participation in development of the IPOS that includes the behavioral plan of care.
			18.12.A. BHT Supervisors (new subsection)	New subsection text reads: Board Certified Behavior Analyst-Doctoral (BCBA-D) or Board Certified Behavior Analyst (BCBA) • Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction. • License/Certification: Current certification as a BCBA through the BACB. The BACB is the national entity accredited by the National Commission for Certifying Agencies (NCCA). • Education and Training: Minimum of a master's degree from an accredited institution conferred in a degree program in

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				which the candidate completed a BACB approved course sequence.
				Licensed Psychologist (LP)
				• Must be certified as a BCBA by September 30, 2020 • Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction. • License/Certification: LP means a doctoral level psychologist licensed by the State of Michigan. Must complete all coursework and experience requirements. • Education and Training: Minimum doctorate degree from an accredited institution. Works within their scope of practice and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented coursework at the graduate level from an accredited university in at least three of the six following areas: ➢ Ethical considerations. ➢ Definitions and characteristics; and principles, processes and concepts of behavior. ➢ Behavioral assessment and selecting interventions outcomes and strategies. ➢ Experimental evaluation of interventions.

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				➢ Measurement of behavior, and developing and interpreting behavioral data. ➢ Behavioral change procedures and systems supports. • A minimum of one year experience in treating children with ASD based on the principles of behavior analysis. Works in consultation with the BCBA to discuss the caseload, progress, and treatment of the child with ASD.
				Limited License Psychologist (LLP) • Must be certified as a BCBA by September 30, 2020 • Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction. • License/Certification: LLP means a doctoral or master level psychologist licensed by the State of Michigan. Limited psychologist master's limited license is good for one two (2)-year period. Must complete all coursework and experience requirements. • Education and Training: Minimum of a master's or doctorate degree from an accredited institution. Works within their scope of practice and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented coursework at the graduate level from an accredited university in at least three of the six following areas:

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					➢ Ethical considerations. ➢ Definitions and characteristics and principles, processes and concepts of behavior. ➢ Behavioral assessment and selecting interventions outcomes and strategies. ➢ Experimental evaluation of interventions. ➢ Measurement of behavior and developing and interpreting behavioral data. ➢ Behavioral change procedures and systems supports. • A minimum of one year experience in treating children with ASD based on the principles of behavior analysis. Works in consultation with the BCBA to discuss the progress and treatment of the child with ASD.
				Board Certified Assistant Behavior Analyst (BCaBA)	• Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction. • License/Certification: Current certification as a BCaBA through the BACB. The BACB is the national entity accredited by the NCCA. • Education and Training: Minimum of a bachelor's degree from an accredited institution conferred in a degree program in which the candidate completed a BACB approved course sequence.

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				• Other Standard: Works under the supervision of the BCBA.
				Qualified Behavioral Health Professional (QBHP) • Must be certified as a BCBA by September 30, 2020 • Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction. • License/Certification: A license or certification is not required, but is optional. • Education and Training: QBHP must meet one of the following state requirements: ➢ Must be a physician or licensed practitioner with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD. ➢ Minimum of a master's degree in a mental health-related field from an accredited institution with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD. Works within their scope of practice, works under the supervision of the BCBA, and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented coursework at the graduate level from an accredited

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					university in at least three of the six following areas: o Ethical considerations. o Definitions and characteristics; and principles, processes and concepts of behavior. o Behavioral assessment and selecting interventions outcomes and strategies. o Experimental evaluation of interventions. o Measurement of behavior and developing and interpreting behavioral data. o Behavioral change procedures and systems supports.
				Behavior Technician	• Services Provided: Behavioral intervention. • License/Certification: A license or certification is not required. • Education and Training: Will receive BACB Registered Behavior Technician (RBT) training conducted by a professional experienced in BHT services (BCBA, BCaBA, LP, LLP, and/or QBHP), but is not required to register with the BACB upon completion in order to furnish services. • Works under the supervision of the BCBA or other professional (BCaBA, LP, LLP or QBHP) overseeing the behavioral plan of care, with minimally one hour of clinical

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				observation and direction for every 10 hours of direct treatment. • Must be at least 18 years of age; able to practice universal precautions to protect against the transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedure and to report on activities performed; and be in good standing with the law (i.e., not a fugitive from justice, a convicted felon who is either under jurisdiction or whose felony relates to the kind of duty to be performed, or an illegal alien). Must be able to perform and be certified in basic first aid procedures and is trained in the IPOS/behavioral plan of care utilizing the person-centered planning process.
		Acronym Appendix		Addition of: ABAS-III - Adaptive Behavior Assessment System-III AFLS - Assessment of Functional Living Skills BCBA-D - Board Certified Behavior Analyst-Doctoral BHT - Behavioral Health Treatment DABS - Diagnostic Adaptive Behavior Scale LP - Licensed Psychologists NCCA - National Commission for Certifying Agencies QBHP - Qualified Behavioral Health Professionals RBT - Registered Behavior Technician SCQ - Social Communication Questionnaire SRS-II - Social Responsiveness Scale-II WISC-IV - Wechsler Intelligence Scale for Children-IV

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				WISC-V - Wechsler Intelligence Scale for Children-V
MSA 15-60	12/16/2015	Billing & Reimbursement for Institutional Providers	11.1 Billing Instructions for Hospice Claim Completion	The 1st bullet point was revised to read: • Admission Date: The Certification (start) date must be reported on every hospice claim. Use Occurrence Code 27 and the applicable date. Hospice claims submitted to MDHHS must be in date sequence order. Ensure payment is received for the initial hospice month prior to submitting claims for subsequent months. The following text was added as the 5th bullet point: • Effective for dates of service on or after January 1, 2016, hospice routine home care is reimbursed as a two-tiered reimbursement rate: ➢ A higher rate is paid for the first 60 days of hospice care ➢ A decreased rate is paid for hospice days 61 and beyond A day of hospice is counted when any level of hospice care is provided (i.e., Routine Home Care, Continuous Home Care, General Inpatient Care, and Inpatient Respite Care). If a beneficiary is discharged from hospice but the discharge is not due to death, and the individual returns to hospice within 60 days of the discharge, the hospice day count will resume from the point that the beneficiary left hospice. If a beneficiary is discharged from hospice but returns after more than 60 days have elapsed, the count will reset to day one and the higher hospice routine home care rate for days 1 to 60 will be reimbursed. The count of hospice days does not reset if the beneficiary transfers to a different hospice provider. The following text was added after the last bullet point: • Billing for Service Intensity Add-on (SIA): Effective for dates of service on and after January 1, 2016, the SIA rate will be reimbursed for a minimum of 15 minutes but not more than four hours daily during the last seven days of a beneficiary's life for in-person visits made by a Registered Nurse (RN) and/or Social Worker when the beneficiary is receiving routine home care. However, the

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				total of combined time rendered by an RN and Social Worker will not be reimbursed more than four hours per day. For example, if an RN provides three hours of care and a Social Worker provides two hours during a given day, four hours will be reimbursed. The following items must be documented on the claim in order for the SIA to be paid: ➢ Occurrence Code 55 with date of death ➢ Appropriate discharge status code for death ➢ Revenue Codes and Healthcare Common Procedure Coding System (HCPCS) combinations representative of the RN or Social Worker visit: o RN: 0551 and G0299 o Social Worker: 0561 and G0155 ➢ Time of visit(s) recorded in units for the respective RN or Social Worker visit(s); one unit equals 15 minutes
		Hospice	7.3.A. Rate Methodology	The following text was inserted after the 1st sentence: Effective for dates of service on or after January 1, 2016, a severity intensity add-on (SIA) rate will be reimbursed for a minimum of 15 minutes but not more than four hours daily during the last seven days of a beneficiary's life for in-person visits made by an RN and/or Social Worker when the beneficiary is receiving routine home care. (This payment is made in addition to the routine home care rate for the day.) However, the total of combined time rendered by an RN and Social Worker will not be reimbursed for more than four hours a day.
MSA 15-61	12/16/2015	Practitioner Reimbursement Appendix	1.1 Practitioner Fee Screens	In the 1st paragraph, the following text was added after the 2nd sentence: The Practitioner fee schedule is updated annually following the CMS January release of the RBRVS.

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MSA 16-01	1/15/2016	Early and Periodic Screening, Diagnosis and Treatment	Section 1 - General Information	In the 1st paragraph, the 2nd sentence was revised to read: The intent of EPSDT is to **provide necessary health care, diagnostic services, treatment, and other measures according to section 1905(a) and 1905(r) [42 U.S.C. 1396d] of the Social Security Act (1967) to** correct or ameliorate defects and physical and mental illnesses and conditions discovered **whether or not such services are covered under the state plan. State Medicaid programs are required to provide for any services that are included within the mandatory and optional services that are determined to be medically necessary for children under 21 years of age**. The following text was inserted after the 1st paragraph: EPSDT visits cover any medically necessary screening and preventive support services for children, including nutritional and at-risk assessments as well as resulting health education and mental health services. These services are available to all children for the purpose of screening and identifying children who may be at risk for, but not limited to, drug or alcohol abuse, child abuse or neglect, trauma, failure to thrive, low birth weight, low functioning/impaired parent, or homeless or dangerous living situations. EPSDT visits are to be performed in accordance with the American Academy of Pediatrics (AAP) periodicity schedule, its components, and medical guidelines. Michigan recognizes the AAP definition of "medical necessity" as: *Health care interventions that are evidence based, evidence informed, or based on consensus advisory opinion and that are recommended by recognized health care professionals to promote optimal growth and development in a child and to prevent, detect, diagnose, treat, ameliorate, or palliate the effects of physical, genetic, congenital, developmental, behavioral, or mental conditions, injuries, or disabilities.*

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				EPSDT requires the coverage of medically necessary inter-periodic screenings outside of the AAP periodicity schedule. Coverage for such screenings is required based on an indication of a medical need to diagnose an illness or condition that was not present at the regularly scheduled screening or to determine if there has been a change in a previously diagnosed illness or condition that requires additional services. Medically necessary services include habilitative or rehabilitative services that are expected to attain, maintain, or regain functional capacity and to achieve maximum health and function. A service need not cure a condition in order to be covered under EPSDT, and maintenance services or services that improve the child's current health condition are also covered in EPSDT because they ameliorate a condition. The common definition of ameliorate is "to make more tolerable." Thus, services such as physical and occupational therapy are covered when they have an ameliorative, maintenance purpose. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. It is important to identify illnesses and conditions early and to treat any health problems discovered in children before they become worse and more costly. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. EPSDT includes a broad range of services that can be covered and includes: • licensed practitioners services; • speech, occupational, and physical therapies; • physician services; • private duty nursing; • personal care services; • home health; • medical equipment and supplies; • rehabilitative services; • vision services; • hearing services; and • dental services.

				In addition, the coverage of other diagnostic, screening, preventive and rehabilitative services is required, and includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level. The coverage of EPSDT services is particularly important for children with disabilities, because such services can prevent conditions from worsening, reduce pain, and avert the development of more costly illnesses and conditions. Other less common examples include items of durable medical equipment, such as decubitus cushions, bed rails and augmentative communication devices. Such services are a crucial component of a good, comprehensive child-focused health benefit. The determination of whether a service is medically necessary must be made on a case-by-case basis, taking into account the particular physical, behavioral, mental, or dental health needs of the child. While the treating provider is responsible for determining or recommending that a particular service is needed to correct the child's condition, both the Michigan Department of Health and Human Services (MDHHS) and a child's treating provider play a role in determining whether a service is medically necessary. If there is a disagreement between the treating provider, health plan, and/or Medicaid as to whether a service is medically necessary for a particular child, Medicaid is responsible for making a decision for the individual child based on information presented to departmental staff. The MDHHS Office of Medical Affairs consists of a panel of physicians, including pediatricians, who will review the medical necessity of a particular service when there is a disagreement between the treating provider, health plan or Medicaid. These physicians review, on a case-by-case basis, the particular needs of the child based on the medical standards and literature, and in consultation with subspecialists when appropriate in accordance with Michigan Medicaid policy. A medically necessary treatment service should not be denied to a child based on cost alone, but the relative cost effectiveness of alternative services may be considered as part of the prior authorization process. Services may be covered in the most cost effective mode as long as the less expensive service is equally effective and actually available. Prior authorization must be conducted on a case-by-case basis, evaluating each child's needs individually. Prior authorization is not required for medically necessary screenings.

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				In the last paragraph, the 1st bullet point was revised to read: • Well child visits, including immunizations and developmental screening, using a validated and standardized screening tool at specified intervals as defined in the periodicity schedule **by the AAP** (hereafter referred to as the "AAP periodicity schedule"). A copy of the AAP periodicity schedule is available on the AAP website. (Refer to the Directory Appendix for website information.) NOTE: The AAP periodicity schedule requires a risk assessment to be performed for vision, hearing, and blood lead screening at the specified intervals. **MDHHS requires** vision, hearing, and blood lead testing to be performed at the specific ages indicated on the AAP periodicity schedule. A parent/guardian ... ...

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