MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Health and Human Services

Bulletin Number: MSA 16-20

Distribution: All Providers

Issued: June 1, 2016

Subject: Updates to the Medicaid Provider Manual; New Coverage of Existing Code; Clarification to Bulletin MSA 15-44

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 July 2016 update of the online version of the Medicaid Provider Manual. The manual will be available July 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.

New Coverage of Existing Code

Effective for dates of service on and after July 1, 2016, HCPCS Code 83993 - Assay for calprotectin fecal will be activated for coverage. Affected providers are Laboratory and Outpatient Hospital.

Clarification to MSA Bulletin 15-44

Bulletin MSA 15-44, issued October 30, 2015, announced that 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 further clarify, enrollment is mandatory for the aforementioned providers who render, order or bill for services provided to Medicaid beneficiaries. As of January 1, 2016, services are no longer billed under the delegating/supervising physician's National Provider Identifier (NPI). The NPI of the psychologist, social worker or professional counselor must be uniquely identified on all claims.

Manual Maintenance

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

Questions

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

Approved

Chris Priest, Director
Medical Services Administration

Michigan Department of Health and Human Services

Medicaid Provider Manual
July 2016 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Throughout the Manual		References to Adult Benefits Waiver and ABW were removed.	Removal of obsolete information.
Throughout the Manual		References to Transitional Medical Assistance Plus, TMA-Plus, and TMA-Plus-E were removed.	Removal of obsolete information.
Throughout the Manual		References to County Health Plan and CHP were removed.	Removal of obsolete information.
Throughout the Manual		References to Benefit Plan IDs of INCAR and INCAR-ABW were removed.	Removal of obsolete information.
General Information for Providers	12.3 Billing Limitation	The following text was inserted as a textbox after the 5th paragraph: **Note:** Nursing Facilities – In cases where a nursing facility may need to submit a claim adjustment due to a change in the beneficiary's patient-pay amount and the claim has not had continuous active review, the adjustment must be submitted within six months from the date MDHHS made the change in the patient-pay amount. The Remarks section must note a reason for the adjustment.	Added for clarification.
Beneficiary Eligibility	2.1 Benefit Plans	For the Benefit Plan ID of HK-EXP, the Benefit Plan Description was revised to read: Benefits mirror Fee-for-Service Medicaid. This benefit plan covers children who are under the age of 19 from 100% FPL up to 160% FPL. This benefit plan is funded by CHIP.	Reflects change in age.
Beneficiary Eligibility	2.1 Benefit Plans	Removal of: Benefit Plan ID: INCAR Benefit Plan ID: INCAR-ABW Benefit Plan ID: TMA-PLUS Benefit Plan ID: TMA-PLUS-E	Removal of obsolete information.

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Medicaid Provider Manual
July 2016 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans	For the Benefit Plan ID of MA-MICHILD, the Benefit Plan Description was revised to read: MA-MIChild is a Medicaid program administered by …	Clarification.
Beneficiary Eligibility	2.1 Benefit Plans	Addition of Benefit Plan: **Benefit Plan ID**: HHMICARE **Benefit Plan Name**: Health Home MI Care Team **Benefit Plan Description**: MI Care Team services are intended for Medicaid beneficiaries with specific chronic behavioral and physical health conditions, which includes a diagnosis of depression and/or anxiety and at least one of the following: heart disease, COPD, hypertension, diabetes, or asthma. Individuals to whom these conditions apply may be determined by the State to be eligible to receive MI Care Team services. MI Care Team services include a personalized care management plan and intense care coordination that addresses the physical and social needs of the individual. **Type**: Managed Care Organization **Funding Source**: XIX **Covered Services**: CQ	New Benefit Plan.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans	Addition of Benefit Plan: **Benefit Plan ID**: TCMF **Benefit Plan Name**: Targeted Case Management **Benefit Plan Description**: The benefit describes Targeted Case Management (TCM) services provided to pregnant women and children up to age 21 with household income up to and including 400% of the federal poverty level (FPL) who were served by the Flint water system on or between April 1, 2014 and the date the water is deemed safe by the appropriate authorities. Pregnant women will remain eligible throughout their pregnancy and will receive two months of post-partum coverage. Once eligibility has been established for a child, including those children born to pregnant women, the child will remain eligible until age 21 as long as other eligibility requirements are met. TCM services assist individuals in gaining access to appropriate medical, educational, social, and/or other services. TCM services include assessments, planning, linkage, advocacy, coordination, referral, monitoring, and follow-up activities. **Type**: Fee-for-Service **Funding Source**: XIX and XXI **Covered Services**: CQ	New Benefit Plan.
Beneficiary Eligibility	2.3 Level Of Care Codes	Removal of: Level of Care (LOC) Code 13 Level of Care (LOC) Code 14	Removal of obsolete information.

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TECHNICAL CHANGES*

<table>
<tr><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th><th>COMMENT</th></tr>
<tr><td>Beneficiary Eligibility</td><td>2.3 Level Of Care Codes</td><td>The Description for LOC Code 11 was revised to include:
(began 4/1/2014)

Additions to table in 1st paragraph:
<table><tr><th>LOC Code and Description</th><th>Benefit Plan ID</th></tr><tr><td>03 – Person meets nursing facility LOCD and lives in community</td><td>ICO-MC</td></tr><tr><td>05 - Person resides in a nursing facility</td><td>ICO-MC</td></tr><tr><td>15 – Person resides in a county medical care facility (CMCF)</td><td>ICO-MC</td></tr></table></td><td>Update.</td></tr>
<tr><td>Beneficiary Eligibility</td><td>2.4 Scope/Coverage Codes</td><td>In the 1st paragraph, the following text was added:<table><tr><th>Scope Code</th><th>Program</th><th>Qualifying Information</th></tr><tr><td>7</td><td>MA-MICHILD (CHIP)</td><td>When used with Coverage Codes W or E</td></tr></table></td><td></td></tr>
</table>

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CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.4 Scope/Coverage Codes	Information in the table in the 2nd paragraph: Revision: **Coverage Code** / **Qualifying Information** E — Emergency or urgent Medicaid, MIChild, or Healthy Michigan Plan coverage only Addition: **Coverage Code** / **Qualifying Information** W — Full MA-MIChild	Update regarding MIChild.
Beneficiary Eligibility	3.1 CHAMPS Eligibility Inquiry	In the 3rd paragraph (NOTES:), 1st bullet point, the 2nd paragraph was revised to include MIChild.	Update.
Beneficiary Eligibility	4.1 Eligibility	The 5th bullet point and the textbox were revised to include the Benefit Plan ID of MA-HMP.	Update.
Beneficiary Eligibility	7.1 Facility Admission Notice	In the 1st paragraph, form instructions were removed.	Information has been incorporated into the Facility Admission Notice form (MSA-2565-C).
Beneficiary Eligibility	9.1 Enrollment	Under "Mandatory Enrollment", 4th bullet point, the last sentence was removed. ~~Mandatory enrollment for this group of pregnant women applies to those beneficiaries whose eligibility was determined on or after October 1, 2008.~~	Removal of obsolete information.
Beneficiary Eligibility	9.5 Health Plan Membership	Addition of Benefit Plan IDs of CSHCS-MC and MME-MC.	Update.

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Medicaid Provider Manual
July 2016 Updates

TECHNICAL CHANGES*

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Beneficiary Eligibility	12.1 Facility Admission Notice	Text was revised to read: In addition to the Application for Health Coverage & Help Paying Costs form (DCH-1426), the Facility Admission Notice (MSA-2565-C) is …	Update to form use.
Beneficiary Eligibility	12.1.B. State-Owned and -Operated Facilities and CMHSP Facilities	The 2nd paragraph was revised to read: A copy of the MSA-2565-C (and the completed DCH-1426, if necessary) must be …	Update to form use.
Beneficiary Eligibility	12.1.B. State-Owned and -Operated Facilities and CMHSP Facilities	The 4th paragraph (form instructions) was removed.	Information has been incorporated into the Facility Admission Notice form (MSA-2565-C).
Beneficiary Eligibility	12.2.A. Nursing Facility Determinations	In the 1st paragraph, the last sentence was revised to read: This monthly contribution by the beneficiary toward his care is called the Patient Pay Amount (PPA). Throughout the rest of the subsection, text was revised to reflect the use of the acronym 'PPA'.	Clarification.
Beneficiary Eligibility	12.2.A. Nursing Facility Determinations	In the 2nd paragraph, the following text was inserted as the 2nd bullet point: • Nursing facility's determination of potential PPA – A timely collection of the PPA is vital for nursing facilities as it helps eliminate the need to claim adjust Medicaid and the need to retroactively collect the PPA from the beneficiary. To help alleviate unneeded claim adjusting and to collect a PPA more timely, nursing facilities are encouraged to determine what a potential beneficiary's PPA will be and collect that PPA prior to receiving the DHS-3227. Subsequently, the facility would bill Medicaid showing that potential PPA as determined by the facility.	Incorporated language from Biller "B" Aware issued in 2012.

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TECHNICAL CHANGES*

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Billing & Reimbursement for Institutional Providers	8.2.B. Two Facilities – Two Claims in One Month	The 2nd bullet point was revised to read: If the first claim has not been submitted or is suspended or rejected, and the second facility submits its claim, the whole patient-pay amount is deducted from the amount due on the second claim. The second facility needs to void their claim in order for the first facility to bill their claim so the PPA may be applicable. Once that is complete, the second facility can rebill a new claim to receive its proper payment. **Note:** Nursing facilities must not contact the beneficiary's Michigan Department of Health and Human Services (MDHHS) case worker as the case worker cannot change the patient-pay amount in these situations nor is it warranted. Facilities must bill as outlined above.	Clarification.
Adult Benefits Waiver		Chapter was removed.	Program no longer exists.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	2.3 Location of Service	In the 5th paragraph, the bullet points were revised to read: • Assessment of a child's needs for the purpose of determining the community based services necessary to transition the child out of a CCI or Hawthorn Center. This should occur up to 180 days prior to the anticipated discharge from a CCI or Hawthorn Center. • Wraparound planning or case management. This should occur up to 180 days prior to discharge from a CCI or Hawthorn Center. The following was added as the last paragraph: Refer to the Amount and Scope of Service subsection for additional information regarding Wraparound program expectations.	Correction for consistency with Federal requirements.

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Medicaid Provider Manual
July 2016 Updates

TECHNICAL CHANGES*

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Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.29.B. Qualified Staff	In the 1st paragraph, the 1st bullet point was revised to read: • Complete the MDHHS three-day new facilitator training within 90 days of hire. The Medicaid encounter cannot be reported until after completion of the initial training. 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. If the supervisor is working directly with children and families, they must complete the initial training prior to reporting Medicaid encounters.	Additional clarification needed to support the fidelity of the Wraparound model.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	12.4 Residential Language	In the 3rd paragraph, the 3rd bullet point was removed. • ~~The PIHP may authorize up to 22 days of treatment.~~	Requirement is no longer applicable.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	18.3 Comprehensive Diagnostic Evaluations	In the 1st paragraph, text after the 3rd sentence was revised to read: ... Based on the evaluation, the practitioner determines the child's diagnosis, recommends general ASD treatment interventions, and refers the child for a behavior assessment which is provided or supervised by a BCBA to recommend more specific ASD treatment interventions. The diagnostic 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: ... In the 2nd paragraph, text after the 2nd sentence was revised to read: ... Other tools should be used if the clinician feels it is necessary to determine a diagnosis and medical necessity service recommendations. Other tools may include: ...	Clarification.

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Medicaid Provider Manual
July 2016 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services Non-Physician Behavioral Health Appendix	Section 2 – Provider Qualifications	The 1st paragraph was revised to read: Providers in Michigan must be currently licensed by the Department of Licensing and Regulatory Affairs (LARA). Licensed Psychologists (Master's Limited or Doctoral level), Social Workers (Master's level), and Professional Counselors (Master's or Doctoral level) who serve Medicaid beneficiaries are required to enroll as Medicaid providers. The NPI of the psychologist, social worker or professional counselor must be uniquely identified on all claims. (Refer to the Billing & Reimbursement for Professionals Chapter for billing information.) 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).	Clarification.
Children's Special Health Care Services	5.3 Payment Agreement	In the 2nd paragraph, "client's" was revised to read "beneficiary's".	Consistency in terminology.
Children's Special Health Care Services	9.8 Children's Multi-Disciplinary Specialty (CMDS) Clinics	In the 1st paragraph, the 2nd sentence was revised to read: Services are provided as a comprehensive package by a team of pediatric specialty physicians and other appropriate health care professionals.	Further clarification.
Children's Special Health Care Services.	9.8.C. CMDS Clinic Visit Types	The 2nd bullet point was revised to read: The CMDS clinic must collaborate with other CMDS clinics the family/beneficiary may be using regarding which CMDS clinic is the lead CMDS clinic (usually treating the most severe condition) and how the fee billing will occur in coordination between the CMDS clinics that are both serving the same beneficiary	Further clarification.
Children's Special Health Care Services	9.8.C.1. Initial Comprehensive Evaluation	In the 1st paragraph (1st sentence), "client's" was revised to read "beneficiary's".	Consistency in terminology.

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Children's Special Health Care Services	9.8.D. Additional Responsibilities	The 2nd paragraph was revised to read: The CMDS clinic fee is billed as a FFS claim through CHAMPS regardless of health plan status. CMDS clinic fees are not intended for sporadic users of the services available through the CMDS clinics such as support services only. CMDS clinic fees are intended for the comprehensive, coordinated and integrated services that CMDS clinics provide to beneficiaries that return for and continue to use the full package of services.	From bulletin MSA 15-21.
Dental	6.2.B. Topical Application of Fluoride	Text was revised to read: **Non-Varnish**: Topical application of fluoride is a benefit for beneficiaries under age 16. It is covered only once every six months and cannot be combined with topical application of fluoride varnish within the six month time period. The fluoride must be approved by the ADA Council on Dental Therapeutics and administered using tray application only if age appropriate. **Varnish**: Topical application of fluoride varnish is a benefit for beneficiaries under age 16. Frequency and parameters vary based on the age of the beneficiary as noted below: • Ages 0-2: Four times per 12 months as a therapeutic application for moderate to high caries risk patients. • Ages 3-15: One time per six months and cannot be combined with topical application of non-varnish fluoride within the six month period.	Clarification of age appropriate fluoride application and restrictions of combined applications.
Dental	8.2.A. Orthodontic Services	In the 4th paragraph, text after the 2nd sentence was revised to read: ... PA requests must be approved prior to the initiation of any treatment. Requests submitted after the initiation of services will result in the denial of the PA request and non-payment of services.	Clarification of all treatment, not just placement of bands.
Dental	8.2.A.4. Periodic Orthodontic Treatment	The 1st paragraph was revised to read: Periodic orthodontic treatment requires prior authorization (PA). For each six-month time period, a new PA request must be approved prior to the continuation of treatment.	Removal of time recommendation to emphasize that prior authorization requirement is needed before continuation of treatment.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Dental	9.2.A. Verification of Enrollment	The 1st paragraph was revised to read: Verification of beneficiary enrollment in Medicaid, MIChild or Healthy Kids Expansion may be obtained through CHAMPS Eligibility Inquiry. The CHAMPS Eligibility Inquiry and 270/271 response will report "FFS Dental" for beneficiaries who have Fee for Service Dental.	Addition of MIChild.
Federally Qualified Health Centers	2.4 Children's Health Insurance Program Services	The 2nd and 3rd paragraphs were revised to read: For beneficiaries enrolled in state CHIP-funded programs (MIChild, Healthy Kids–Expansion, and Maternity Outpatient Medical Services [MOMS]), providers must bill the program according to their existing processes. For beneficiaries enrolled in a health plan, the MDHHS HCRD will perform an annual reconciliation of these encounters provided by FQHCs. (Refer to the Medicaid Health Plans subsection of this chapter for additional information.) For Healthy Kids–Expansion, MIChild and MOMS beneficiaries, the HCRD will perform an annual reconciliation of these encounters provided by FQHCs. The FQHC PPS rates established for eligible CHIP services are equivalent to those applicable to Medicaid for each respective year they are in effect.	Reflects changes regarding MIChild.
Federally Qualified Health Centers	3.2 Medicaid Health Plans	In the 2nd paragraph, Benefit Plan IDs of CSHCS-MC and MME-MC were added.	Update.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Healthy Michigan Plan	5.6.B.3 Covered Supports and Services	The following text was added (prior to the bullet list): The following supports and services are designed to assist those with physical, cognitive and/or functional impairments. These supports and services shall be provided to beneficiaries with a substance use disorder diagnosis who meet the medical necessity criteria in the identified area. The supports and services would be indicated as part of the beneficiary's plan of service. Some interventions listed below (i.e., Assertive Community Treatment, Clubhouse, Hospital-Based Psychiatric Services, Intermediate Care Facilities, Peer Operated Drop In Centers and Supported Employment) are only indicated for a specified population (mental health or intellectual/developmental disability) and do not apply to those with a substance use disorder diagnosis, in which case beneficiaries would not be considered eligible for those services. Likewise, beneficiaries with a mental health or intellectual/developmental disability diagnosis would not be eligible for the services identified for substance use disorders (i.e., Residential, Sub-Acute Detoxification and Treatment Approved Pharmacological Supports).	Language added to help clarify what services a beneficiary with a substance use disorder can utilize.
Hospice	3.4.B. Nursing Facility	In the 5th paragraph, the 4th sentence was revised to read: If the patient is on antipsychotic or antidepressant medications for purposes of pain control/symptom relief for end of life, it should be noted on the DCH-3877.	Clarification.
Hospice	7.2 Medicaid Health Plan Enrollees	In the 1st paragraph, addition of Benefit Plan IDs of CSHCS-MC and MME-MC.	Update.
Hospital	5.8 Nursing Facility	In the 3rd paragraph: • 4th bullet point, 1st paragraph, addition of 'licensed professional counselor' • 4th bullet point, 3rd paragraph, removal of "PIHP"	Update.

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TECHNICAL CHANGES*

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Hospital Reimbursement Appendix	Section 5 – Capital	Text was revised in its entirety to read: Effective January 1, 2015, MDHHS will reimburse inpatient capital using a hospital-specific prospective rate. A prospective per-discharge amount will be calculated for medical/surgical hospitals, including critical access hospitals and children's hospitals. Freestanding rehabilitation hospitals and distinct part rehabilitation units will be reimbursed a prospective per diem capital rate. Transfer claims will not receive a prospective capital payment. When calculating the prospective capital rates, data from the second previous state fiscal year will be used. For example, to calculate January 1, 2015 capital rates, data from cost reports with fiscal years that end between October 1, 2012 and September 30, 2013 will be used. Fee-for-Service (FFS) data will be used to calculate capital amounts. The capital amount for the medical/surgical component of the hospital is established using the following lines (or comparable lines from succeeding cost reports) from the hospital's cost report. The data for routine capital costs is obtained from the CMS 2552-10, Worksheet D, Part I, Title XIX, Column 7, Lines 30-35 and 43. The ancillary capital costs are obtained from the CMS 2552-10, Worksheet D, Part II, Title XIX, Column 5, Lines 50-77 and 90-92. The sum of routine and ancillary cost for FFS is then divided by the medical/surgical FFS discharges for the same period to calculate the hospital-specific prospective per discharge rate for Managed Care Organizations (MCOs) and FFS.	General update.

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CHAPTER	SECTION	CHANGE	COMMENT
		The capital amount for freestanding rehabilitation hospitals or distinct part rehabilitation units is established using the following lines from the hospital's cost report. The data for routine capital costs is obtained from the CMS 2552-10, Worksheet D, Part I, Title XIX, Line 41. The ancillary capital costs are obtained from the CMS 2552-10, Worksheet D, Part II, Title XIX, Column 5, Lines 50-76.99 and 90-92. The sum of the routine and ancillary cost for FFS is then divided by the FFS rehabilitation Medicaid days for the same period to calculate the hospital-specific prospective per diem rate for MCOs and FFS. Current occupancy limits will remain when the hospital specific prospective capital rates are developed. Capital amounts will be set annually. Capital amounts may be adjusted due to significant changes in capital costs that are not reflected in the cost report utilized to set the rate. Hospitals may request a capital rate adjustment by submitting a written request to the MDHHS Hospital and Clinic Reimbursement Division (HCRD). (Refer to the Directory Appendix for contact information.) Hospitals may continue to receive capital interim payments, but only if they receive Medicaid interim payments. Otherwise, the hospital will receive its prospective rate when the inpatient claim is adjudicated. If the hospital receives capital interim payments, amounts will be reconciled 15 months after the hospital's fiscal year ends, and again at final settlement 27 months after the hospital's fiscal year ends.	
Hospital Reimbursement Appendix	5.3 Limits on Capital	Text was revised to read: The limits on capital described in this section apply for fiscal years beginning on and after October 1, 1990.	Removal of obsolete text.
Hospital Reimbursement Appendix	Section 6 – Medicaid Interim Payments and Capital Interim Payments	The 3rd paragraph was deleted. ~~The MIP rate is adjusted to reflect any significant change in DRG price, per diem rate, or reimbursement method that affects the amount of a hospital's reimbursement.~~ In the 4th paragraph, text after the 2nd sentence was revised to read: ... CIPs may be adjusted due to significant changes of at least 10% in capital costs that are not reflected in the most recent cost report. Hospitals wishing ...	Removal of obsolete text. Include enhanced detail.

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TECHNICAL CHANGES*

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Hospital Reimbursement Appendix	6.6 Monitoring	The 2nd paragraph was revised to read: MIP is monitored based on the quarterly reports submitted by the provider. These reports are due 30 calendar days after the end of the quarter.	Removal of obsolete text.
Hospital Reimbursement Appendix	7.7 Special Payment Adjustments	The 4th paragraph was deleted. ~~Each hospital's paid claim file is reviewed and appealed at the time the data are submitted with the hospital's cost report. No further appeal of the inpatient hospital paid claims data will be allowed. These reductions will be included in the hospital's settlement.~~	Removal of obsolete text.
Hospital Reimbursement Appendix	8.3 Distribution of GME Funds	The 2nd paragraph was revised to read: Only intern and resident full time equivalents (FTEs) in approved programs as specified in Federal Regulations (see 42 CFR §413.75-83) are eligible for inclusion in the data used to calculate the distribution of the Dental and Podiatry, the GME Funds and the Primary Care Pools. The 2nd paragraph, 2nd bullet point was revised to read: • Annually, each hospital reporting dental and podiatry FTEs is reimbursed the average dental and podiatry FTE payment, as calculated above, for each dental and podiatry FTE it reports. Data for each hospital's dental and podiatry FTE count is drawn from the hospital cost report (Worksheet E-4, Title XVIII, Line 10, Column 2). If the cost report is changed, ... The 3rd paragraph was revised to read: To distribute funds from the GME Funds and the Primary Care Pools, data is drawn from accepted hospital cost reports for the most recent fiscal year that data is available. For the GME Funds Pool, the unweighted FTE count is used (Worksheet E-4, Title XVIII, Line 6). For the Primary Care Pool, the weighted FTE count for primary care physicians is used (Worksheet E-4, Title XVIII, Line 8, Column 3). If the cost report is changed, equivalent data is used.	Update references.

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TECHNICAL CHANGES*

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Hospital Reimbursement Appendix	Section 9 – Cost Reporting Requirements	In the 1st paragraph: • "Medicaid" was revised to read "MDHHS" • "hospital's interim payments" was revised to read "hospital's payments" Text beginning with the 3rd paragraph was revised to read: Hospitals with subacute ventilator dependent care units must obtain MDHHS approval to file cost report packages treating the unit as a subprovider in accordance with the HIM-15 2336, 2336.1, 2336.2, and 2336.3. MDHHS approval must be requested in writing from the HCRD and must be obtained prior to the start of the first hospital fiscal year during which the exemption applies. Each hospital's cost report data must include an itemized list of all expenses recorded from the formal and permanent accounting records of the facility. The accrual method of accounting is mandated for all facilities not owned by government. Generally accepted accounting principles must be followed. All of the hospital's accounting and related records, including the general ledger, books of original entry, and statistical data, must be maintained for at least three years after receipt of final settlement (42 CFR §413.20 and Provider Reimbursement Manual §2304; 42 CFR §405.1885). These records must be made available for verification during onsite visits by state or federal audit staff. All cost report packages are retained by MDHHS for at least three years following the date of settlement.	MDHHS has replaced Medicaid as MDHHS covers more than Medicaid products, i.e., Healthy Michigan Plan. Removal of obsolete text. General update.

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		MDHHS electronically notifies all providers of the specific information needed to file an acceptable MDHHS cost report package. The cost report package must be sent to MDHHS HCRD. The cost report package must include: • The CMS 2552 Medicare standardized electronic cost report (ECR) filed in the manner required by MDHHS for MDHHS programs reporting. • MDHHS specific filed cost report with worksheets including, but not limited to: General Hospital Information, Settlement Summary Page, Capital Cost, GME, Rehab Unit Settlement, Outpatient Education Settlement, the Indigent Volume Report form for Title V and Title XIX, Healthy Michigan Plan, and Managed Care Organization (MCO). • A signed Provider Certification page produced by the MDHHS filed Cost Report Application for Title V, Title XIX and Healthy Michigan Plan. • The hospital's audited Financial Statements. The cost report package is accepted only if all of the following conditions are met: • All submitted documents are in a usable format. • MDHHS can generate a full CMS 2552 cost report from the electronic cost report file. MDHHS uses the KPMG/CompuMax system to generate viewable cost reports. • The signed, error-free Provider Certification page. • Data is provided for all authorized MDHHS units and programs (Medical/Surgical, Rehabilitation, Outpatient, Psychiatric, Clinic, Title V, Title XIX and Healthy Michigan Plan). • Data meet a set of reasonableness checks, or variances are explained.	
Hospital Reimbursement Appendix	Section 10 - Audits	Text was revised to read: The audit and settlement process determines the amount of reimbursement to which an individual hospital is entitled. Cost settlements are made to assure payment of the MDHHS share of reimbursable cost. The audit and settlement process begins with the receipt of the hospital's annual cost report and ends with the electronic issuance of the Notice of Amount of Program Reimbursement that conveys the results of the audit.	MDHHS has replaced Medicaid as MDHHS covers more than Medicaid products, i.e., Healthy Michigan Plan. States how providers are contacted.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	10.1 Desk Audit	Text was revised to read: The audit process includes desk audit procedures and audit scope determinations for both MDHHS program(s) audit verification purposes and, under the Common-Audit Agreement with the Medicare fiscal intermediary, determination of allowable costs. All cost reports are examined to: • Verify the completeness and arithmetic accuracy of all schedules in the report; • Reconcile reported hospital program data with MDHHS approved data; and • Identify the need for supporting documentation and arrange to receive same.	MDHHS has replaced Medicaid as MDHHS covers more than Medicaid products, i.e., Healthy Michigan Plan. Removal of obsolete text.
Hospital Reimbursement Appendix	10.2 Malpractice	Subsection was deleted.	Removal of obsolete text.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	Section 11 – Settlements	Section was revised in its entirety. The following subsections were deleted. • 11.1 Settlement Inpatient • 11.2 Settlement Outpatient • 11.3 Settlement Outpatient Direct Medical Education • 11.4 Initial Settlement(s) o 11.4.A. Underpayments to a Hospital o 11.4.B. Overpayments to a Hospital • 11.5 Final Settlement o 11.5.A. Underpayments to a Hospital o 11.5.B. Overpayments to a Hospital • 11.6 Post Audit Conference • 11.7 Audit Adjustment Report • 11.8 Notice of Amount of Program Reimbursement • 11.9 Settlement Appeal • 11.10 Hospital Accepts Audit Adjustment Report • 11.11 Hospital Rejects Audit Adjustment Report • 11.12 Hospital Does Not Respond to Audit Adjustment Report • 11.13 Reopening of Settlements	Rearranging structure for better understanding. MDHHS has replaced Medicaid as MDHHS covers more than Medicaid products, i.e., Healthy Michigan Plan. Removal of obsolete text. Enhanced description. Clarification. States how providers are contacted.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
		New structure consists of: • 11.1 Initial Settlement(s) • 11.2 Hospital Underpayments and Overpayments o 11.2.A. Underpayments to a Hospital o 11.2.B. Overpayments to a Hospital • 11.3 Final Settlement(s) • 11.4 Responses to the Audit Adjustment Report(s) • 11.5 Reopening of Settlements	
Hospital Reimbursement Appendix	Section 11 – Settlements	Text was deleted.	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	11.1 Initial Settlement(s) (new subsection)	New subsection text reads: Settlement is based upon processed non-zero dollar MDHHS programs liability invoices for services rendered to MDHHS beneficiaries during the cost report period and remitted prior to the paid claim report run date. Initial settlements may be calculated using the cost information determined from the cost report and from charges for services to MDHHS beneficiaries as accumulated by MDHHS. Inpatient MDHHS applicable programs upper payments limit is allowable inpatient charges. Outpatient MDHHS applicable programs upper payments limit is allowable outpatient costs. Total payments for inpatient services are limited to the lesser of operating amount approved (DRG, per diem, and the operating portion of any percent of charge payments), plus capital less any limits that apply, or full charges. This limitation is applied separately by program against the aggregate operating payment amounts approved and capital payments. Final reimbursement is limited to the lesser of outpatient payment amounts approved, allowable outpatient charges, or allowable outpatient costs.	
Hospital Reimbursement Appendix	11.2 Hospital Underpayments and Overpayments (new subsection heading)		
Hospital Reimbursement Appendix	11.2.A. Underpayments to a Hospital (new subsection)	New subsection text reads: MDHHS pays a determined amount of an initial settlement due a hospital after notice has been furnished to the hospital. However, MDHHS retains the right to withhold a portion of an initial payment based on individual circumstances.	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	11.2.B. Overpayments to a Hospital (new subsection)	New subsection text reads: Once a determination of overpayment has been made, the amount so determined is a debt owed to the State of Michigan and is recovered by MDHHS after notice has been furnished to the hospital.	
Hospital Reimbursement Appendix	11.3 Final Settlement(s) (new subsection)	New subsection text reads: Settlement is based upon processed non-zero dollar MDHHS liability claims for services rendered to MDHHS beneficiaries during the cost report period and remitted prior to the paid claim report run date. MDHHS calculates the final settlement amount to be reimbursed 27 months after the period covered by the cost report and sends the hospital MDHHS programs audit adjustment reports. Once the final settlement MDHHS audit adjustment reports are transmitted to the hospital, the Medicare/Medicaid CMS 2552 report and/or the Michigan Medicaid Forms (MMF) will not be amended unless specific cost report changes are approved by MDHHS. The total amount paid for inpatient capital is settled 27 months after the hospital's fiscal year ends. For testing against the Medicare upper payment limits, inpatient payments are limited by allowable inpatient charges and outpatient payments are limited by allowable outpatient costs. Total payments for inpatient services are limited to the lesser of operating amount approved (DRG, per diem, and the operating portion of any percent of charge payments), plus capital less any limits that apply, or full charges. This limitation is applied separately by program against the aggregate operating payment amounts approved and capital payments. Final reimbursement is limited to the lesser of outpatient payment amounts approved, allowable outpatient charges, or allowable outpatient costs. Separate settlements are made for each program and each unique outpatient NPI.	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	11.4 Responses to the Audit Adjustment Report(s) (new subsection)	New subsection text reads: The Audit Adjustment Report contains a descriptive list of all program data adjustments made to a cost report by the MDHHS HCRD audit staff. The Notice of Amount of Program Reimbursement is the notice of final determination and is considered the offer of settlement for all reimbursement issues for the cost reporting period under consideration. The process is initiated by the hospital after the receipt of the Audit Adjustment Report. The MDHHS HCRD concludes the process on the day the Notice of Amount of Program Reimbursement is electronically transmitted to the hospital. The Audit Adjustment Report must be accepted or rejected by the hospital within 30 calendar days of the Notice of Amount of Program Reimbursement is electronically transmitted to the hospital. The hospital may take the following actions: • **Hospital Accepts the Notice of Amount of Program Reimbursement Report** If the hospital accepts the findings contained in the Audit Adjustment Report, an appropriate officer of the hospital must sign the Audit Adjustment Report and transmit it to the MDHHS HCRD. (Refer to the Directory Appendix for contact information.) MDHHS programs Notice of Amount of Program Reimbursement will be electronically transmitted to the hospital. No further administrative appeal rights will be available for the adjustments contained in the Audit Adjustment Report. • **Hospital Does Not Respond to the Notice of Amount of Program Reimbursement Report** If the hospital does not respond within this time period, MDHHS shall electronically transmit a Notice of Amount of Program Reimbursement, which is the final determination of an adverse action. No further administrative appeal rights are available.	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
		• **Hospital Rejects the Notice of Amount of Program Reimbursement Report** If the hospital rejects any or all of the findings contained in the Audit Adjustment Report within 30 calendar days of the transmit date of the Notice of Amount of Program Reimbursement, then an informal appeal can be requested. An informal appeal process involves the audit staff and the hospital working to resolve differences prior to a formal appeal. The hospital may request a formal appeal hearing which must be filed within 180 calendar days after the Notice of Amount of Program Reimbursement is electronically transmitted by MDHHS to the hospital. Upon the timely receipt by MDHHS of an Application to Appeal Amount of Program Reimbursement, rules R400.3408 through R400.3424 shall be invoked.	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	11.5 Reopening of Settlements (new subsection)	New subsection text reads: For all MDHHS final settlement reopenings, MDHHS has adopted and follows all applicable provisions of the Medicare Provider Reimbursement Manual (HIM-15), Part 1, Sections 2931 and 2932, as well as all applicable provisions of 42 CFR Section 405.1885 et. seq. For all reopenings, there is a three-year statute of limitations that begins on the date of the original MDHHS Notice of Amount of Program Reimbursement. The three-year time period ends on the third anniversary of that date. A separate Notice of Reopening will be required for each provider and each cost year. If MDHHS electronically notifies a provider of its Notice of Reopening before the expiration of the three-year period, the three-year requirement will be considered met. After this point, the reopened settlement should be completed in a timely fashion. Neither the existence of a Common Audit Agreement between MDHHS and the Medicare Intermediary nor whether the Medicare Intermediary provides timely notice of a Medicare settlement reopening will affect the application of the three-year time limit on MDHHS settlement reopenings. Once the final settlement has been calculated and the MDHHS audit adjustment report has been sent to the hospital, the Medicare/Medicaid CMS 2552 report will not be amended without specific CMS 2552 changes being approved by MDHHS. New laws, regulations, policy directives, or the interpretation of such issued subsequent to a settlement will not serve as basis to reopen a settlement. Nor can any of the above be introduced as part of a reopened settlement. The sole exception is when MDHHS is directed to do so by court order.	
Hospital Reimbursement Appendix	12.4 Administrative Hearings	Text was revised to read: Hearings conducted by the Michigan Administrative Hearing System (MAHS) follow the MDHHS Provider Reviews and Hearings Rules found at R400.3406 through R400.3424.	General update.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	12.5 State Hospital Appeal Panel	Subsection was deleted.	Text was outdated/unneeded.
Nursing Facility Coverages	3.3 Quality of Care	In the 1st paragraph, the last sentence was removed. ~~(Refer to the Nursing Facility section of the Directory Appendix for specific website links for Best Practice Information.)~~	Removal of obsolete information.
Nursing Facility Coverages	5.1.D.1. Michigan Medicaid Nursing Facility Level Of Care Determination	The following text was added as a textbox (between the 1st and 2nd paragraphs): **Change of Ownership** If a **new** National Provider Identification (NPI) will be issued to a provider who is going through a change of ownership, the provider must conduct the hard copy version of the LOCD and Freedom of Choice (FOC). The hard copy LOCD must be conducted according to policy outlined in this chapter. The FOC must be signed and dated, and completed according to policy outlined in this chapter. Once the provider is given full access to CHAMPS under their new NPI, the provider must enter all of the information on the hard copy LOCD into the online version of the LOCD in CHAMPS under their new NPI. The provider must then submit to Provider Support all hard copy FOCs. The online LOCD will be backdated to the date on a signed and dated FOC that corresponds to the beneficiary's online LOCD. If the new owner will not be issued a new NPI, the new owner must continue to conduct online LOCDs according to policy outlined in this chapter.	Provides additional information.
Nursing Facility Coverages	Section 8 - PASARR Process	In the 3rd paragraph, last bullet point, 2nd paragraph, the 2nd sentence was revised to read: If the patient is on antipsychotic or antidepressant medications for purposes of pain control/symptom relief for end of life, note that information on the DCH-3877.	Update.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	8.3 Level II Evaluation Exemption	In the 1st paragraph, the last sentence was revised to read: The DCH-3878 may be completed by a registered nurse, licensed Bachelor's or Master's Social Worker, licensed professional counselor, psychologist, physician's assistant or physician and must be signed by a physician's assistant or physician.	Physician Assistant has been added to the DCH-3878 form.
Nursing Facility Coverages	8.3 Level II Evaluation Exemption	In the 2nd paragraph, the 2nd bullet point was revised to read: The individual has a primary diagnosis of dementia (such as Alzheimer's disease or another dementing illness). An exemption due to dementia cannot be claimed for any individual who is also identified as having an intellectual disability or having a related condition, or for any individual with another primary psychiatric diagnosis. For example, an individual diagnosed with dementia and a primary diagnosis of depression may not be exempted. A physician's assistant or physician must certify that the individual meets the clinical criteria for dementia and does not have another primary psychiatric diagnosis, intellectual disability, or a related condition.	According to OBRA rules, the dementia exemption cannot be used if the person has a primary diagnosis of a serious mental illness. Physician Assistant has been added to the DCH-3878 form.

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TECHNICAL CHANGES*

<table>
<tr><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th><th>COMMENT</th></tr>
<tr><td>Nursing Facility Coverages</td><td>8.5 Distribution of PASARR Documentation</td><td>Text was revised to read:

<table><tr><th colspan="2">Level II Evaluation Documentation</th></tr><tr><td>Electronic Record</td><td>MDHHS OBRA Office</td></tr><tr><td>Copy</td><td>CMHSP</td></tr><tr><td>Copy</td><td>Individual or their legal representative</td></tr><tr><td>Copy</td><td>Nursing facility</td></tr><tr><td>Copy</td><td>Hospital, attending physician</td></tr></table>
<table><tr><th colspan="2">MDHHS Determination</th></tr><tr><td>Electronic Record</td><td>MDHHS OBRA Office</td></tr><tr><td>Copy</td><td>CMHSP</td></tr><tr><td>Copy</td><td>Individual or their legal representative</td></tr><tr><td>Copy</td><td>Hospital, attending physician</td></tr><tr><td>Copy</td><td>Nursing facility</td></tr></table></td><td>Change made as the Level II is no longer a paper evaluation but is submitted electronically to the State from the local CMHSP.</td></tr>
<tr><td>Nursing Facility Coverages</td><td>10.9 End of Life Care</td><td>The last two sentences were removed.

~~Best Practice Information for end-of life care and pain management for nursing facilities and hospital LTC units is available on the MDHHS website. (Refer to the Directory Appendix for website information.)~~</td><td>Removal of obsolete information.</td></tr>
</table>

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	10.30 Private Room	In the 4th paragraph, the 4th sentence was revised to read: (Refer to the Forms Appendix for a copy of MSA-1580.)	Clarification.
Nursing Facility Cost Reporting & Reimbursement Appendix	2.5 Termination of Medicaid Participation	In the 1st paragraph, the last sentence was revised to read: Refer to the Cost Reporting Section in this appendix and to the Notification Process for Regulatory Actions, Nursing Facility Closure Protocol, or Voluntary Withdrawal From Participation in the Medicaid Program or Voluntary Nursing Facility Closure subsections in the Certification, Survey & Enforcement Appendix of this chapter for relevant information.	Updated to refer to the correct sections.
Nursing Facility Cost Reporting & Reimbursement Appendix	Section 3 - Definitions	The definition for 'Non-Medicare Nursing Facility Days' was revised to read: Nursing Facility days for which Medicare (Part A [Fee for Service] and Part C [Medicare Advantage, including MI Health Link days where Medicare is the primary payer]) is not the primary source of reimbursement.	Language revised to provide clarification on MI Health Link days where Medicare is the primary payer.
Nursing Facility Cost Reporting & Reimbursement Appendix	4.4 Cost Report Acceptance	In the 1st paragraph, the 5th bullet point was revised to read: An electronic copy of the Certification Statement is completed and signed, and agrees with the submitted ECR file.	Updated because the process is now done electronically.
Nursing Facility Cost Reporting & Reimbursement Appendix	4.9 Cost Report Delinquency	In the 2nd paragraph, the 1st sentence was revised to read: If the nursing facility cost report is delinquent, RARSS will share a delinquency and Medicaid payment termination notice with the nursing facility or the provider's designated business office through File Transfer.	Updated because the process is now done electronically.
Nursing Facility Cost Reporting & Reimbursement Appendix	4.11 Home Office, Chain Organization, or Related Party Cost Reporting	In the 3rd paragraph, the 2nd sentence was revised to read: An electronic copy of MSA-1578 will be available to providers in File Transfer.	Updated because the process is now done electronically.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	5.2 Plant Cost Certification Submission	In the 5th paragraph, the 1st sentence was revised to read: The completed information and supporting documentation may be sent to RARSS by mail, delivery, or File Transfer.	Updated because the process can be done electronically.
Nursing Facility Cost Reporting & Reimbursement Appendix	5.2.B. Plant Cost Certification Submission Waiver	The 3rd sentence was revised to read: Settlement adjustments for plant costs for the cost reporting period will automatically apply to non-available bed plan periods.	Clarification.
Nursing Facility Cost Reporting & Reimbursement Appendix	7.2 Initial Settlement	In the 5th paragraph, the 3rd sentence was revised to read: After the time period afforded the provider to review the Notice of Program Reimbursement, a notice stating the payment adjustment date(s) is shared with the provider through File Transfer. In the 6th paragraph, the 2nd sentence was revised to read: After the time period afforded the provider to review the Notice of Program Reimbursement, a notice stating the recovery payment date(s) is shared with the provider through File Transfer.	Updated because the process is now done electronically.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	7.3 Final Settlement	In the 3rd paragraph, the 1st sentence was revised to read: RARSS shares a Notice of Program Reimbursement with the provider through File Transfer. In the 4th paragraph, the last sentence was revised to read: After the time period afforded the provider to review the Notice of Program Reimbursement, a notice stating the payment adjustment date(s) is shared with the provider through File Transfer. In the 5th paragraph, the last sentence was revised to read: After the time period afforded the provider to review the Notice of Program Reimbursement, a notice stating the recovery payment date(s) is shared with the provider through File Transfer. In the 6th paragraph, the last sentence was revised to read: After the time period afforded the provider to review the Notice of Program Reimbursement, a notice stating the payment adjustment date(s) is shared with the provider through File Transfer.	Updated because the process is now done electronically.
Nursing Facility Cost Reporting & Reimbursement Appendix	7.5.B. Criteria for Determining Extended Payment Arrangements	In the 2nd paragraph, the 1st sentence was revised to read: RARSS will share the notification of the provider's repayment schedule and the repayment recovery dates and dollar amounts through File Transfer.	Updated because the process is now done electronically.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.12.B. Complex Care	In the 2nd paragraph, the 1st sentence was revised to read: Reimbursement is made for prior authorized services/care to residents who have specialized and concentrated nursing and support service needs and who have been transferred from an acute care hospital setting to an approved nursing facility.	No other instances of “skilled nursing facility” used in this chapter. “Nursing facility” is the proper Medicaid term for nursing homes.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	10.13.E. Withdrawal of Rate Relief Agreement	The 2nd sentence was revised to read: If the citation(s) is for immediate jeopardy or substandard quality of care, or the provider is not spending the money in accordance with the plan filed for special rate relief, the rate relief agreement may be withdrawn.	CMS replaced the term "serious and immediate threat" with "immediate jeopardy" for surveys.
Pharmacy	1.7 Medicaid Health Plans (title revised due to removal of ABW and CHP)	Addition of Benefit Plan IDs of CSHCS-MC and MME-MC.	Update.
Practitioner Reimbursement Appendix	Section 2 - Enhanced Practitioner Payments	Text was revised to read: MDHHS makes payment adjustments for practitioner services payable under Medicaid Fee-For-Service (FFS) through entities identified in the Medicaid State Plan, Attachment 4.19-B, page 1a. (The Medicaid State Plan is available on the MDHHS website; refer to the Directory Appendix for website information.)	Refers reader to the Medicaid State Plan if additional information is needed.
Rural Health Clinics	3.4 Children's Health Insurance Program Services	The 2nd and 3rd paragraphs were revised to read: For beneficiaries enrolled in state CHIP-funded programs (MIChild, Healthy Kids–Expansion, and Maternity Outpatient Medical Services [MOMS]), providers must bill the program according to their existing processes. For beneficiaries enrolled in a health plan, the MDHHS HCRD will perform an annual reconciliation of these encounters provided by RHCs. (Refer to the Eligibility Groups Subject to PPS Methodology subsection of this chapter for additional information.) For Healthy Kids–Expansion, MIChild and MOMS beneficiaries, the HCRD will perform an annual reconciliation of these encounters provided by RHCs. The RHC PPS rates established for eligible CHIP services are equivalent to those applicable to Medicaid for each respective year they are in effect.	Reflects changes regarding MIChild.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
School Based Services Random Moment Time Study	4.1.A. Code 1 – Medicaid Outreach and Public Awareness	In the 2nd paragraph, the 1st bullet point was revised to include MIChild.	Addition of MIChild.
School Based Services Random Moment Time Study	4.1.B. Code 2 – Non-Medicaid Outreach	In the 1st paragraph, MIChild was removed from the last sentence.	Removal of MIChild.
Acronym Appendix		Addition of: MMF – Michigan Medicaid Forms	General information.
Directory Appendix	Eligibility Verification – CHAMPS Eligibility Inquiry	Text was revised to read: Information Available/Purpose: For Medicaid providers to verify eligibility for the Medicaid, CSHCS, MOMS, MIChild, and Plan First! programs. Refer to ...	Removed duplicate language.
Directory Appendix	Eligibility Verification – Web-DENIS	Text was revised to read: Information Available/Purpose: (2nd paragraph) Medicaid providers can verify eligibility for the Medicaid, CSHCS, MOMS, MIChild, and Plan First! programs at no cost. Eligibility response ...	Removed duplicate language.
Directory Appendix	Eligibility Verification – Eligibility Verification (out-of-state providers)	Text was revised to read: Information Available/Purpose: For out-of-state providers without internet access to verify eligibility for Medicaid, CSHCS, MOMS, MIChild, and Plan First! programs within the last 12 months.	Removed duplicate language.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Eligibility Verification – Michigan Public Health Institute (MPHI)	Text was revised to read: Information Available/Purpose: (1st paragraph) For Medicaid providers to verify eligibility for the Medicaid, CSHCS, MOMS, MIChild, and Plan First! programs at no cost. Eligibility response data ...	Removed duplicate language.
Directory Appendix	Billing Resources – Electronic Healthcare Transactions	The e-mail address was removed.	Obsolete information.
Directory Appendix	Claim Submission/ Payment – MDHHS Cashier's Unit	The mailing address was revised to read: MDHHS Cashier Unit 235 S. Grand Ave., Ste. 801 PO Box 30437 Lansing, MI 48933	Update.
Directory Appendix	Policy/Forms/ Publications – Medicaid Policy Division	E-mail address was revised to read: MSAPolicy@michigan.gov	Correction.
Directory Appendix	Policy/Forms/ Publications – Draft Medicaid Policy	E-mail address was revised to read: MSADraftPolicy@michigan.gov	Correction.
Directory Appendix	Policy/Forms/ Publications – Medicaid Policy Manuals and Bulletins	E-mail address was revised to read: MSAPolicy@michigan.gov	Correction.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Policy/Forms/ Publications – Michigan Medicaid Provider Manual (CD version)	E-mail address was revised to read: MSA-Forms@michigan.gov	Correction.
Directory Appendix	School Based Services – SBS Administrative Outreach Program Policy Specialist	E-mail address was revised to read: MSAPolicy@michigan.gov	Correction.
Directory Appendix	School Based Services -- SBS Fee for Service Program Policy Specialist	E-mail address was revised to read: MSAPolicy@michigan.gov	Correction.
Forms Appendix	MSA-1550; Beneficiary Verification of Coverage	Field name reflects removal of “MIChild Number”.	Removal of obsolete information.
Forms Appendix	MSA-4240; Certification for Induced Abortion	Field name reflects removal of “MIChild Number”.	Removal of obsolete information.
Forms Appendix	MSA-2565-C; Facility Admission Notice	• Special form instructions for Newborn Child Eligibility (Beneficiary Eligibility Chapter; Facility Admission Notice) and for State-Owned and -Operated Facilities and CMHSP Facilities (Beneficiary Eligibility Chapter; State-Owned and -Operated Facilities and CMHSP Facilities) were incorporated into the form. • Item 12.B.: “Provider I.D. Number” revised to read “Medicaid Provider ID Number”. • Item 15: last checkbox was revised to read ‘Inpatient Psychiatric Care (in DHHS) Facility)’ • Form was also revised to address formatting issues.	Miscellaneous updates/revisions. No change in use of form.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Forms Appendix	DCH-3878; Mental Illness/Intellectual Disability/Related Condition Exemption Criteria Certification (For Use in Claiming Exemption Only)	Instruction Sheet revisions: • This form must be completed by a registered nurse, licensed bachelor or master social worker, licensed professional counselor, psychologist, physician's assistant, or physician, **and signed and dated by a physician's assistant or physician.** Dementia: • Review the 5 criteria listed under the dementia exemption category. Do NOT check this exemption unless the individual meets all 5 criteria. Any individual who meets some, but not all 5 criteria will be subject to a LEVEL II evaluation. If the individual under consideration meets this exemption category, specify the type of dementia. • Do not mark the Dementia Exemption if there is a primary diagnosis of a serious mental illness. Do not mark Dementia Exemption if there is a diagnosis of intellectual disability, developmental disability or a related condition.	A physician's assistant can now sign and date the DCH-3878 form. This sentence was added to further stress the importance of what constitutes a dementia exemption.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
		Form revisions: **INSTRUCTIONS:** • This form must be completed by a registered nurse, licensed bachelor or master social worker, licensed professional counselor, psychologist, physician's assistant or physician and signed and dated by a physician's assistant or physician. • The patient being screened shall require a comprehensive LEVEL II evaluation UNLESS any of the exemption criteria below is met and certified by a physician's assistant or physician. Indicate which exemption applies. Exemption Criteria for 'Dementia' was revised to read: Yes, I certify the patient under consideration has dementia as established by clinical examination and evidence of meeting ALL 5 criteria below. Yes, I certify the patient under consideration does not have another primary psychiatric diagnosis of a serious mental illness. Yes, I certify the patient under consideration does not have an intellectual disability, developmental disability or a related condition. Signature block was revised to read: Physician/Physician Assistant Signature	A physician's assistant can now sign and date the form. Added this sentence to stress the need for an exemption to be marked if this form is utilized. The three sentences were separated to stress that all three components need to be met before a Dementia Exemption can be marked. A physician's assistant can now sign and date the DCH-3878 form.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Forms Appendix	DCH-3877; Preadmission Screening (PAS)/ Annual Resident Review (ARR) (Mental Illness/ Intellectual Disability/Related Conditions Identification)	Instructions were revised: Under Section II – Screening Criteria #4. **Presenting evidence** means the individual currently manifests symptoms of mental illness or dementia, which suggest the need for further evaluation to establish causal factors, diagnosis and treatment recommendations. Further evaluation may need to be completed if evidence of suicidal ideation, hallucinations, delusion, serious difficulty completing tasks or serious difficulty interacting with others. #6. **Presenting evidence** means the individual manifests deficits in intellectual functioning or adaptive behavior, which suggests the need for further evaluation to determine presence of a developmental disability, causal factors, and treatment recommendations. These deficits appear to have manifested before the age of twenty-two (22).	Text added as the form was found incomplete by a federal review of the forms. Based on a federal review by PTAC, the form needed text inserted to meet compliance.

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CHAPTER	SECTION	CHANGE	COMMENT
		Form revisions: Upper right corner addition of “Hospital Exempted Discharge”.	Hospital Exempted Discharge is another type of Level II and needed to be added to the form.
		Section II – Screening Criteria #4. There is presenting evidence of mental illness or dementia including significant disturbances in thought, conduct, emotions, or judgment. Presenting evidence may include but not limited to suicidal ideations, hallucinations, delusions, serious difficulty completing tasks or serious difficulty interacting with others.	Text added as the form was found incomplete by a federal review of the forms.
		#5. The person has a diagnosis of an intellectual disability or a related condition including, but not limited to, epilepsy, autism, or cerebral palsy and this diagnosis manifested before the age of twenty-two (22). #6. There is presenting evidence of deficits in intellectual functioning or adaptive behavior which suggests that the person may have an intellectual disability or a related condition. These deficits appear to have manifested before the age of twenty-two (22).	Based on a federal review by PTAC, the form needed text inserted to meet compliance.
		‘Note’ was revised to include physician’s assistant.	A physician assistant can now sign the form; form needed to reflect this change.
Forms Appendix	MSA-1580; Request for Authorization of Private Room Supplemental Payment for Nursing Facility	Form was revised to include fields for entry of ‘Facility Contact’ and ‘Facility Fax Number’.	Updated for the sake of efficiency.

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Medicaid Provider Manual
July 2016 Updates

BULLETINS INCORPORATED*

<table>
<tr><th>BULLETIN NUMBER</th><th>DATE ISSUED</th><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th></tr>
<tr><td>MSA 16-09</td><td>3/31/2016</td><td>Maternal Infant Health Program</td><td>1.2 Staff Credentials</td><td>Text was revised to read:<table><tr><td>Nurses</td><td>All nurses must possess:
current Michigan licensure as a registered nurse by the Michigan Department of Licensing and Regulatory Affairs; and
at least one year of experience providing community health, pediatric or maternal/infant nursing services.</td></tr><tr><td>Social Workers</td><td>All social workers must possess:
current Michigan licensure as a licensed social worker by the Michigan Department of Licensing and Regulatory Affairs; and
at least one year of experience providing social work services to families.</td></tr></table></td></tr>
<tr><td rowspan="2">MSA 16-08</td><td rowspan="2">3/24/2016</td><td>Medicaid Provider Manual Overview</td><td>1.1 Organization</td><td>‘Chapter Content’ for the ‘Plan First! Family Planning Waiver’ chapter was revised to read:
The Plan First! waiver is set to expire June 30, 2016. MDHHS stopped accepting new applications for Plan First! effective April 1, 2014 as part of a planned phase-out of the waiver.</td></tr>
<tr><td>Plan First! Family Planning Waiver</td><td>Table of Contents page</td><td>The burst box was revised to read:
The Plan First! Waiver is set to expire June 30, 2016. MDHHS stopped accepting new applications for Plan First! effective April 1, 2014 as part of a planned phase-out of the waiver.

MDHHS has taken steps to review eligibility for all current Plan First! enrollees to determine whether they are eligible for any other Michigan Medicaid programs, including the Healthy Michigan Plan. Plan First! coverage for all enrollees will end when their eligibility for other programs has been determined. If the determination is not final or if there is a timely appeal pending, Plan First! eligibility for some individuals may extend past June 30, 2016.</td></tr>
</table>

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BULLETINS INCORPORATED*

<table>
<tr><th>BULLETIN NUMBER</th><th>DATE ISSUED</th><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th></tr>
<tr><td rowspan="2">MSA 15-46</td><td rowspan="2">3/1/2016</td><td>Billing and Reimbursement for Professionals</td><td>6.15 Maternity Care Services</td><td>The following text was added:

Outpatient Lactation Support Provided by an Internationally Board Certified Lactation Consultant (IBCLC)

Claims are to be submitted utilizing the mother's Medicaid beneficiary identification number.

Medicaid will reimburse for evidence-based lactation support services provided up to and through 60 days post-delivery. A maximum of two visits per pregnancy will be reimbursed for either a single or multiple gestation pregnancy. One visit is reimbursable per date of service. Medicaid will reimburse for the first eligible claims submitted for these services.

IBCLC services may be billed as a separate and distinct service on the same date as which other services are rendered by a provider. Documentation must support a separately identifiable visit.</td></tr>
<tr><td>Maternal Infant Health Program</td><td>1.1 Program Services</td><td>The 1st and 2nd paragraphs were revised to read:

MIHP services are preventive health services provided by an agency that is certified by the Michigan Department of Health and Human Services (MDHHS). MIHP services are provided by a licensed social worker and a licensed registered nurse. Licensed social workers and licensed registered nurses who are certified as an Internationally Board Certified Lactation Consultant (IBCLC) may provide services. An infant mental health specialist with an Infant Mental Health endorsement may be included. A registered dietitian may also provide services with a physician order.

Program services include social work, nursing services (including health education and nutrition education), breast feeding support, nutritional counseling, and beneficiary advocacy services. MIHP services include: .....</td></tr>
</table>

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BULLETINS INCORPORATED*

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			1.2 Staff Credentials	The following text was added to the 2nd paragraph: **Internationally Board Certified Lactation Consultant (IBCLC)**: All IBCLCs must possess: • current Michigan licensure as a registered nurse or licensed social worker by the Michigan Department of Licensing and Regulatory Affairs; and • credentialing by the International Board of Lactation Consultant Examiners (IBCLE) and a valid and current IBCLC certification.
			2.1 Maternal Risk Identifier	In the 1st paragraph, the 1st sentence was revised to read: The Maternal Risk Identifier covers multiple domains, including basic care, drug and alcohol use, smoking, shelter, depression, transportation needs, intent to breast feed, and support systems.
			2.4 Psychosocial and Nutritional Assessment-Risk Identifier	The last paragraph was revised to read: The beneficiary must be assessed (Risk Identifier completed) for the need for transportation assistance, childbirth/parenting education classes, health education, breast feeding support, and family planning services. The completion of the Risk Identifier must precede any professional or IBCLC visits. The Risk Identifier must be completed by the licensed registered nurse or the licensed social worker.
			2.13 Lactation Support and Counseling Services (new subsection; following subsections were re-numbered)	Subsection text reads: Medicaid will reimburse for evidence-based lactation support services provided to post-partum women in the outpatient setting up to and through 60 days post-delivery when services are provided by a qualified licensed MIHP registered nurse or licensed social worker in possession of a valid and current IBCLC certification. A maximum of two visits per pregnancy will be reimbursed for either a single or multiple gestation pregnancy. One visit is reimbursable per date of service. Before initiating MIHP IBCLC services, the initial assessment visit, appropriate Risk Identifier (infant or maternal), and Plan of Care (infant or maternal) must be completed and the Risk Identifier entered into the MIHP database.

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BULLETINS INCORPORATED*

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				Although MIHP serves the mother-infant dyad, a distinction is made between maternal and infant services for billing purposes. IBCLC services are considered a component of pregnancy related services. Claims for IBCLC services are to be submitted utilizing the mother's Medicaid beneficiary identification number. Documentation must include the need for maternal lactation support, a begin time and end time of services provided, and a comprehensive description of the professional interventions provided. For all IBCLC rendered services, a copy of the current, valid IBCLC certification is to be maintained by the MIHP organization in accordance with the record keeping requirements of the Medicaid program. Refer to the Billing & Reimbursement for Professionals Chapter of this manual for additional billing information. Refer to the Practitioner Chapter of this manual for additional information related to the service component requirements.
			5.2 Staffing	Text was revised to read: Required staff for the MIHP is comprised of licensed registered nurses and licensed social workers. Optional staff may include a registered dietitian, infant mental health specialist, or an IBCLC. All staff must meet the qualifications as stated in the Staff Credentials subsection of this chapter.
		Maternity Outpatient Medical Services Program	2.2 Noncovered Services	Text was revised to read: Family planning and sterilization services are not covered. Postpartum outpatient lactation support and counseling services provided by an IBCLC are not covered. MIHP coverage is limited to the prenatal period only.
		Practitioner	7.9 Lactation Support Services (new subsection; following subsection was re-numbered)	Subsection text reads: Medicaid will reimburse for evidence-based lactation support services provided to Medicaid eligible post-partum women in the outpatient setting up to and through 60 days post-delivery. Services must be rendered by a licensed, qualified health professional as outlined. A maximum of two visits per pregnancy will be reimbursed for either a single or multiple gestation pregnancy. One visit is reimbursable per date of service.

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BULLETINS INCORPORATED*

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			7.9.A. Provider Criteria (new subsection)	Subsection text reads: Lactation support and counseling services must be rendered by an Internationally Board Certified Lactation Consultant (IBCLC) credentialed by the International Board of Lactation Consultant Examiners (IBLCE) with possession of a valid and current IBCLC certification. Rendering IBCLC providers must be Medicaid-enrolled physicians, nurse practitioners, physician assistants or nurse midwives. When a Medicaid-enrolled practitioner provides delegation and supervision, within the confines of his/her scope of practice, to an individual with possession of a valid and current IBCLC certification, that Medicaid-enrolled health professional may bill for comprehensive lactation support services. For all IBCLC rendered services, a copy of the current, valid IBCLC certification is to be maintained by the supervising physician or employing organization, where applicable, in accordance with the record keeping requirements of the Medicaid program.
			7.9.B. Covered Supports and Services (new subsection)	Subsection text reads: Comprehensive lactation counseling services must include the following: • A face-to-face encounter with the beneficiary lasting a minimum of 30 minutes. • Comprehensive maternal, infant and feeding assessment related to lactation. • Provision of evidence-based interventions that, at a minimum, include: ➢ Instruction in positioning techniques and proper latching to the breast; ➢ Counseling in nutritive suckling and swallowing, milk production and release, frequency of feedings, and reasons to contact a health care professional; and ➢ The provision of community support resource referrals, such as the Women, Infants, and Children (WIC) program, as indicated. • Evaluation of outcomes from interventions. Documentation must include a begin time and end time of services and a comprehensive description of the professional interventions provided. Documentation may be subject to review and post-payment audit.

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BULLETINS INCORPORATED*

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				Prenatal lactation education and support services are provided as part of the curriculum of childbirth education programs and will not be separately reimbursed. Reimbursement for lactation education and support received by beneficiaries post-delivery in the inpatient hospital is included in the inpatient hospital payment and will not be separately reimbursed. Refer to the Billing & Reimbursement for Professionals Chapter of this manual for additional billing information.
		Acronym Appendix		Addition of: IBCLC - Internationally Board Certified Lactation Consultant IBCLE - International Board of Lactation Consultant Examiners
MSA 15-51	12/1/2015	Special Programs	5.1 Eligible Beneficiaries	Text was revised in its entirety to read: Effective January 1, 2016, the Michigan Department of Health and Human Services (MDHHS) converted the MIChild program to a Medicaid expansion program. Although individuals are enrolled in a Medicaid expansion program, the program will continue to be referred to as the MIChild program. All Medicaid coverages and conditions will apply in accordance with current Medicaid policy. The MIChild Medicaid program provides health care coverage for children who: • Are age 0 through 18 • Have income at or below 212% of the Federal Poverty Level under the Modified Adjusted Gross Income (MAGI) methodology • Do not have other comprehensive medical insurance (this includes insurance that covers inpatient and outpatient hospital services, laboratory, x-ray, pharmacy and physician services) • Do not qualify for other MAGI related Medicaid programs • Are residents of the State of Michigan

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				The child's eligibility for MIChild is determined through the MAGI methodology. All criteria for MAGI eligibility must be met to be eligible for MIChild. Families enrolled in the MIChild program are required to pay a premium of $10 per month per family to maintain coverage for their children. Children enrolled in MIChild are exempt from copay for services.
			5.2 Covered Services	Text was revised in its entirety to read: Children enrolled in MIChild are considered Medicaid beneficiaries and are entitled to all Medicaid covered services.
MSA 15-42	10/30/2015	Behavioral Health and Intellectual and Developmental Disability Supports and Services	Section 5 – Clubhouse Model Programs (Section 5 was replaced in its entirety; was Clubhouse Psychosocial Rehabilitation Programs)	Revised language reads: A Clubhouse is a community-based program organized to support individuals living with mental illness. Participants are known as Clubhouse members, and member choice is a key feature of the model. Clubhouses are vibrant, dynamic communities where meaningful work opportunities drive the need for member participation, thereby creating an environment where empowerment, relationship-building, skill development and related competencies are gained. Through what is referred to as the work-ordered day, the Clubhouse provides opportunities for member involvement and ownership in all areas of Clubhouse operation. Members and staff work side-by-side in the program as colleagues. Comprehensive opportunities are provided within the Clubhouse, including supports and services related to employment, education, housing, community inclusion, wellness, community resources, advocacy, and recovery. In addition, members participate in the day-to-day decision-making and governance of the program. Through Clubhouse involvement, members achieve or regain the confidence and skills necessary to lead satisfying, meaningful lives and successfully manage their mental illness. The Clubhouse model is included in the National Registry of Evidence-based Programs and Practices (NREPP), which can be found on the NREPP website. (Refer to the Directory Appendix for website information.)

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			5.1 Program Approval	Revised language reads: • PIHPs must seek approval for providers of Clubhouse services from the MDHHS Behavioral Health Developmental Disabilities Administration (BHDDA). • To ensure fidelity to the model of the evidence-based practice of Psychosocial Rehabilitation, Clubhouses must acquire and maintain Clubhouse International accreditation. Additional information regarding Clubhouse International accreditation is available on the International Center for Clubhouse Development (ICCD) website. (Refer to the Directory Appendix for website information.) • All new Clubhouses must participate in the Clubhouse International's New Clubhouse Development Training. • MDHHS approval will be based on adherence to the requirements outlined below. Requests for approval of Clubhouse services may be submitted to the MDHHS-BHDDA Community Practices and Innovation Section, Division of Quality Management & Planning. (Refer to the Directory Appendix for contact information.)
			5.2 Target Population	Revised language reads: Clubhouse programs are appropriate for adults with a serious mental illness who wish to participate in a structured community with staff and peers and who desire to work on the goal areas reflected in the Core Psychiatric Rehabilitation Components subsection of this document. The beneficiary must be able to participate in, and benefit from, the activities necessary to support the program and its members.
			5.3 Essential Elements of the Clubhouse Model (was Essential Elements)	Revised language reads: **Member Choice/ Involvement**: Member choice and involvement are an ongoing essential process imbedded in all aspects of the Clubhouse model. • Membership is voluntary. • Clubhouse Membership is without time-limits; access to an intentional community supports the recovery process. • All members have access to the services/supports and resources with no differentiation based on diagnosis or level of functioning.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE

	• Members establish their own schedule of attendance and choose a work unit that they will regularly participate in during the work-ordered day. • Members are actively engaged and supported on a regular basis by Clubhouse staff in the activities and tasks that they have chosen. • Membership in the program and access to supportive services reflects the beneficiary's preferences and needs, building on the person-centered planning process. • Both formal and informal decision-making opportunities are part of the Clubhouse work units and program structures. Members can influence and shape program operations. Clubhouse decisions are generally made by consensus. • Staff and members work side-by-side to generate and accomplish individual/team tasks and activities necessary for the development, support, and maintenance of the program.
Work-Ordered Day	• The work-ordered day is a primary component of the program and provides an opportunity for members to regain self-worth, purpose, and confidence. It consists of tasks and activities necessary for the operation of the Clubhouse and typically occurs during normal business hours. • Although participation in the work-ordered day provides opportunities to develop a variety of interpersonal and vocationally related skills, it is not intended to be job-specific training. • Member participation in the work-ordered day provides experiences that will support members' recovery, and is designed to assist members to acquire personal, community and social competencies and to establish and navigate environmental support systems. • The program's structure and schedule identifies when the various program components occur (e.g., work-ordered day, vocational/educational). Other activities, such as self-help groups and social activities, are scheduled before or after the work-ordered day.

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				Employment Services • The work done in the Clubhouse is exclusively the work generated by the Clubhouse in the operation and enhancement of the Clubhouse community. No work for outside individuals or agencies, whether for pay or not, is acceptable work in the Clubhouse. Members are not paid for any Clubhouse work, nor are there any artificial reward systems. • The amount, scope, and variety of tasks are sufficient enough to engage the membership in meaningful activities throughout the work-ordered day. • All staff are Clubhouse generalists. Their responsibilities are housed in a unit and they routinely work side-by-side with members to complete unit work. • Staff help to identify meaningful work opportunities for members and are able to facilitate workgroups. • Staff are dynamic and skilled at developing relationships with members. Staff utilizes a strengths-based approach and promotes an equal culture with members, thereby allowing members to experience themselves as valued colleagues in the Clubhouse community. **Employment Services** • The Clubhouse provides its own employment services, including Transitional Employment (TE), Supported Employment (SE), and Independent Employment (IE), consistent with Clubhouse International standards and guidelines, which are available on the ICCD website. (Refer to the Directory Appendix for website information.) • Additional resources for benefits planning are available. **Educational Services** • The Clubhouse provides resources and connections to assist members with goals to return to formal educational settings. This should include some of the following supports: ➢ Connections with local colleges and General Educational Development (GED) centers, ➢ assistance with admission and financial aid applications, ➢ tutoring assistance with fellow members when appropriate,

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	➢ formal education groups, and ➢ other activities that support member success. Educational programming should be individualized and should enhance the Clubhouse work-ordered day.
Community Supports	• Community support services are provided by members and staff of the Clubhouse. Community support activities are centered in the work unit structure of the Clubhouse and include outreach, entitlements, housing, advocacy, promoting wellness, as well as assistance in finding quality medical, psychological, pharmacological and substance use disorder treatment services in the community. • The Clubhouse has an advisory board that meets regularly to provide support. Advisory board composition includes individuals from the local community who are able to assist with connections and/or advice in areas such as employment, education, legal assistance, finances, and advocacy. The board also includes member leaders. • The Clubhouse must engage with the local community. Activities may include speaking engagements, connections with media outlets, awareness-raising, political advocacy, community service projects, open houses, participating with the statewide Clubhouse coalition, and relevant conferences. • The Clubhouse ensures that access to the building, Clubhouse-sponsored community activities, and employment sites are available through public transportation or other alternative modes of transportation. The Clubhouse provides or arranges for effective alternatives whenever access to public transportation is limited.

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Social Supports	• Opportunities are available for members to develop a sense of a community through planning and organizing Clubhouse social activities. This may include opportunities to explore recreational resources and activities in the community. The interests and desires of the membership determine both spontaneous and planned activities. • Members may have access to the Clubhouse programming during times other than the work-ordered day, including evenings, weekends, and holidays (New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day). Access during these times should be based on the needs of the Clubhouse community and decided by members and staff.
Wellness Supports	• The Clubhouse supports and encourages physical wellness. This may include enhanced nutrition, weight loss, exercise, smoking cessation, and promoting wellness throughout the Clubhouse. Wellness opportunities occur both within the Clubhouse and through connections with community resources. • The voluntary nature of the Clubhouse is respected for all wellness activities. Wellness programming should enhance the Clubhouse work-ordered day rather than detract from it.
Community Setting	• The program is designed as an intentional community, rather than a clinical setting. The Clubhouse does not include clinical personnel such as psychiatrists, nurses, or therapists, nor does it include classes or groups that are of a clinical nature. • The Clubhouse is located in its own physical space. It is separate from any mental health center or institutional settings, and is impermeable to other programs. The Clubhouse is designed to facilitate the work-ordered day and at the same time be attractive, adequate in size, and convey a sense of respect and dignity. • To promote pride and ownership, the Clubhouse has its own identity, including its own name, mailing address, fax, e-mail, and telephone number.

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				• All Clubhouse space is member and staff accessible. There are no staff-only or members-only spaces. • There are no staff-only or members-only meetings where program decisions are made.

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			5.4 Core Psychiatric Rehabilitation Components (was Psychosocial Rehabilitation Components)	Revised language reads: The Clubhouse model is not limited to a narrow set of components. A broad contextual perspective is present throughout the Model.

Broad Context	• The Clubhouse model is embedded in the overarching goals of psychiatric rehabilitation. The aims and objectives of Clubhouse communities are to support the access to preferred living, learning, working, and socialization roles for members in their communities. • Outcomes that move beyond the clinical condition and facilitate the recovery process from mental illness are more relevant, such as social role functioning (e.g., meaningful roles in society; social inclusion), establishing relationships, social support networks and social capital, work, recreation, and improved quality of life.
Personal Goal Development	Each Clubhouse member has goals based on his or her Individual Plan of Service (IPS) developed through the Person-Centered planning process and carried out throughout the member's participation in the Clubhouse. Staff may also work informally with members on individual recovery goals while working side-by-side in the Clubhouse.
Psychiatric Rehabilitation Components, Goals and Objectives	Clubhouse environments support recovery in a variety of ways. Generally, expected outcomes associated with accredited Clubhouse participation include greater personal and interpersonal competencies, links with community resources, access to social support networks, increased illness and symptom management, vocational and educational competencies and opportunities, and overall increased personal independence and psychosocial functioning. • Competency Building Community living competencies (e.g., self-care, cooking, money management, personal grooming, maintenance of living environment) are built and include: ➢ Social and interpersonal competencies (e.g., conversational competency, developing and/or maintaining positive self-image, interpersonal problem-solving, regaining the ability to evaluate the motivation and feelings of others to establish and maintain positive relationships).

				➢ Personal adjustment competencies (e.g., developing and enhancing intrapersonal abilities and problem-solving in everyday experiences, resolving crises, or managing stress with the goal of facilitating self-efficacy and personal independence). ➢ Vocational competencies (e.g., focused tasks that teach how to apply for jobs, conduct employment interviews, provide opportunities of graded steps to promote job entry or reentry, improve co-worker communication and relationships, and task focus and completion). ➢ Cognitive competency (e.g., task-oriented activities to develop and maintain cognitive abilities, maximize independent functioning such as increased attention, improved concentration, better memory, and enhanced empathy). • Community Support, Inclusion, and Participation Identification of support, inclusion and participation through existing natural supports is necessary to: ➢ Achieve optimal levels of community membership ➢ Increase satisfaction with living environment ➢ Support community participation and integration/inclusion ➢ Reduce stigma through education, community awareness, and community networking ➢ Facilitate social capital via peer and social networks, both internal and external to Clubhouse ➢ Promote utilization of organizational support, community resources, and other collateral support systems, as well as linking with community resources, supports, and services for continuity of care. • Illness Management and Recovery The identification and management of situations and prodromal symptoms to reduce the frequency, duration, and severity of psychiatric relapses include the following:

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					➢ Gaining competence regarding how to respond to and manage a psychiatric crisis (includes working in partnership with members who express desire to develop a recovery plan and incorporate natural supports in crisis planning). ➢ Gaining competence in understanding the role psychotropic medication plays in the stabilization of the members' well-being or recovery. ➢ Working in partnership to increase confidence and personal self-efficacy through Clubhouse participation. ➢ Gaining access to holistic approaches to recovery that includes education, information and support for health and personal wellness. ➢ Gaining access to information to support decision making and increased empowerment through Clubhouse participation. • Recovery Enhancing Environment An environment that fosters strength and resilience and practices the inclusion of the following: ➢ Is collaborative and non-hierarchical; ➢ Supports work and high levels of activity; ➢ Respects choice and control; and ➢ Provides access to social and peer support.

			5.5 Documentation (new subsection)	Subsection text reads: Documentation of members' progress in the Clubhouse modality differs from documentation requirements in individual treatment modalities and is demonstrated in the following process. • Recovery progress can be documented in a variety of ways and, at a minimum, should be documented on at least a monthly basis. • The documentation process, regardless of the established frequency or process, should be streamlined to minimally disrupt the work-ordered day. • Progress note processing should be integrated into unit work. • Members have the opportunity to write his or her own progress notes. • Generally, all notes should be signed by both members and staff.
			5.6 Eligibility (new subsection)	Subsection text reads: Clubhouse services are intended for beneficiaries with a primary diagnosis of serious mental illness. Clubhouse is not an appropriate service for beneficiaries with a primary intellectual/developmental disability. Clubhouse services are not appropriate for beneficiaries who exhibit: • Behaviors that would threaten or pose a current health and safety risk to themselves or others. • A severity of symptoms requiring a more intensive level of treatment. • Behaviors that disrupt the daily work of the Clubhouse. • Behaviors that require excessive redirection and/or monitoring. The Clubhouse director has the responsibility to ensure the safety of the Clubhouse. All changes to a member's service provision must follow due process and all policies and procedures at local, state, and federal levels. Discharge criteria are only met if the member moves on voluntarily or if one or more of the above criteria are met. Cessation or control of symptoms alone is not sufficient criteria for discharge from the Clubhouse.

			5.7 Staff Capacity (re-numbered)	Revised language reads: Clubhouse staff effectively facilitate the program with direct, inclusive and collegial member involvement. Sufficient staffing ratios allow for employment development, Transitional Employment management/coverage, supported education, and consistent engagement of the membership throughout the work-ordered day. Clubhouse staff shall include: • One full-time on-site Clubhouse director who has a minimum of: ➢ A bachelor's degree in a health or human services field and is licensed, certified or registered by the State of Michigan or a national organization to provide health care services, with two years' experience working at a Clubhouse accredited by Clubhouse International; or ➢ A master's degree in a health or human services field with appropriate licensure and one year experience working at a Clubhouse. • Other diverse and uniquely qualified professional staff, typically with a bachelor's education level. If staff are not licensed, certified or registered by the State of Michigan or a national organization to provide health care services, they shall operate under a qualified professional. All Clubhouse staff function as generalists sharing Clubhouse duties such as employment, social recreation, evening, weekend, and holiday coverage. All Clubhouse generalist staff should be paid at a level commensurate with like staff at the auspice agency. The Clubhouse director is responsible for all aspects of Clubhouse operations. Members are actively involved in the hiring process for both directors and generalists. Exceptions may be requested to the above staffing requirements and/or qualifications and must be submitted in writing to MDHHS for review and potential approval.

			5.8 Training Requirements (new subsection)	Subsection text reads: All Clubhouse staff must have a basic knowledge of the Clubhouse Model acquired through MDHHS approved Clubhouse-specific training within six months of hire, and then at least one MDHHS-approved Clubhouse specific training annually. In addition, as part of the accreditation process, the Clubhouse director, members, staff and other appropriate persons participate in a comprehensive training program in the Clubhouse Model at an accredited training base. This team will also schedule a six-month follow-up site visit with the Training Base Clubhouse. • This training requires the development of an action plan for developing the Clubhouse; and upon returning from training, all Clubhouses will submit their action plan to MDHHS. • Exceptions may be requested to the above training requirements and must be submitted in writing to MDHHS for review and potential approval.
		Acronym Appendix		Addition of: GED - General Educational Development ICCD - International Center for Clubhouse Development (d/b/a Clubhouse International) IE – Independent Employment NREPP - National Registry of Evidence-based Programs and Practices SE – Supported Employment TE – Transitional Employment

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		Directory Appendix	Mental Health/ Substance Abuse Resources	Addition of:

Contact/Topic	Phone # Fax #	Mailing/Email/Web Address	Information Available/Purpose
International Center for Clubhouse Development (ICCD)		http://www.iccd.org/certification.html	Information regarding Clubhouse International accreditation
		http://www.iccd.org/images/employment_guidelines_2012.pdf	Clubhouse International standards and guidelines
MDHHS-BHDDA Community Practices and Innovation Section, Division of Quality Management & Planning	Phone: 517-335-0499	MDHHS-BHDDA Community Practices and Innovation Section Division of Quality Management & Planning 320 S. Walnut St. Lansing, MI 48913	Requests for approval of Clubhouse services
National Registry of Evidence-based Programs and Practices (NREPP)		www.samhsa.gov/nrepp.	Clubhouse model

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BULLETINS INCORPORATED*

MSA 15-27	7/1/2015	Hospital Reimbursement Appendix	7.3.C. Outpatient Uncompensated Care DSH Pool	The following text was inserted after the 6th paragraph: Beginning in FY 2015, $5,000,000 of the Large-Urban Component of the pool will be distributed to reward and incentivize hospitals providing low cost and high quality Medicaid services. The Medicare Value Based Purchasing (VBP) Adjustment Factor will be obtained annually from the Federal Register. Each hospital's respective payment from the $5,000,000 pool component will be calculated as follows: • (Hospital's Outpatient Uncompensated DSH Hospital Pool Factor) x (Hospital's VBP Adjustment Factor) = (Hospital's Outpatient Uncompensated DSH Value Adjustment Factor) • (Hospital Outpatient Uncompensated DSH Value Adjustment Factor)/(∑All Hospital Outpatient Uncompensated DSH Value Adjustment Factors) x (Total Pool Amount) = (Outpatient Uncompensated DSH Value Payment)
		Acronym Appendix		Addition of: VBP – Value Based Purchasing
MSA 15-17 and MSA 15-32	5/29/2015 & 9/1/2015	Hospital Reimbursement Appendix	Section 14 – Short-Stay Hospital Reimbursement (new section)	Section text reads: The State utilizes a Short Hospital Stay (SHS) rate of reimbursement for certain outpatient and inpatient hospital stays. The SHS encompasses funding for both operating and capital costs. The SHS rate will be identical for inpatient and outpatient services, and will apply to all services billed on the claim. The SHS rate is published on the MDHHS website. (Refer to the Directory Appendix for website information.) The SHS rate of reimbursement does not modify billing requirements for hospitals. If the patient meets criteria for an inpatient admission, the claim must be submitted as an inpatient claim. Conversely, if the patient does not meet criteria for an inpatient admission, the claim must be submitted as an outpatient claim. In either case, if the criteria for the SHS rate are met, the hospital will receive the same reimbursement for services rendered. The SHS rate only applies to discharges from a facility, and does not apply to transfers, leaving against medical advice (AMA), or other discharge statuses. The SHS logic will apply to both emergent and elective claims. For purposes of this reimbursement structure, SHSs will be defined using the following criteria.

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			14.1 Diagnoses	Subsection text reads: In order to qualify for a SHS rate, a claim must include one of the primary diagnosis codes list. This list is maintained on the MDHHS website. (Refer to the Directory Appendix for website information.) The list of eligible codes will be evaluated annually and updated as necessary. For outpatient dates of service and inpatient dates of discharge on or after July 1, 2015 and before October 1, 2015, ICD-9 diagnosis codes will be used. For outpatient dates of service and inpatient dates of discharge on or after October 1, 2015, ICD-10 diagnosis codes will be used.
			14.2 Outpatient Hospital Claims Qualification	Subsection text reads: An outpatient hospital claim will qualify for the SHS reimbursement if all of the following criteria are met: • The primary diagnosis code billed on the outpatient claim is listed on the primary diagnosis codes list referenced above. • The claim does not include a surgical revenue code (36x) billed on any line of the outpatient claim. • The claim does not include cardiac catheterization lab revenue code 481. • The claim includes observation revenue code 762.
			14.3 Inpatient Hospital Claims Qualification	Subsection text reads: An inpatient hospital claim will qualify for the SHS reimbursement if all of the following criteria are met: • The primary diagnosis code billed on the inpatient claim is listed on the primary diagnosis codes list referenced above. • The claim does not include a surgical revenue code (36x) billed on any line of the inpatient claim. • The claim has a date of discharge equal to or one day greater than the date of admission. • The claim does not include cardiac catheterization lab revenue code 481.

			14.4 Exclusions	Subsection text reads: The SHS logic will not apply to inpatient or outpatient claims with the following conditions: • Claims where Medicaid is the secondary payer. MDHHS will follow the rules of the primary payer, and MDHHS will be responsible for payment up to co-insurance and/or deductible. • Hospital discharges with discharge status codes other than 1, 6, 9, 21, 30, 50, or 51. • Claims for patients who leave the hospital AMA. • Claims for deceased patients. • Claims that include primary diagnoses that are not on the diagnosis list referenced above, including claims for births and deliveries, for example.
			14.5 Short Hospital Stay Rate and Methodology	Subsection text reads: A single SHS rate will be developed for certain outpatient and inpatient hospital stays. This rate will encompass funding for both operating and capital costs, will be identical for inpatient and outpatient services, and will encompass all services billed on the claim. The rate will be established using Medicaid hospital Fee-for-Service paid claims and managed care encounters that meet the SHS criteria. To calculate the rate, the following process will be employed: • Aggregate Fee-for-Service operating payments on qualifying claims with dates of service during the second previous fiscal year will be identified. • Aggregate Fee-for-Service capital payments will be calculated by multiplying the Fee-for-Service inpatient claims count for qualifying claims with dates of service during the second previous fiscal year by the current year statewide capital rate. • Aggregate managed care operating and capital payments on qualifying encounters with dates of service during the second previous fiscal year will be identified. • Fee-for-Service and managed care operating and capital payments will be aggregated and divided by the number of claims and encounters that meet the SHS criteria. The resulting quotient will be the SHS rate. MDHHS will monitor the diagnosis code sets and reimbursement to ensure budget neutrality is maintained or to maintain consistency with future reimbursement changes.
		Acronym Appendix		Addition of: AMA - against medical advice SHS – short hospital stay

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