MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Health and Human Services

Bulletin Number: MSA 16-26

Distribution: All Providers

Issued: September 1, 2016

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

Effective: As Indicated

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

Updates to the Medicaid Provider Manual

The Michigan Department of Health and Human Services (MDHHS) has completed the October 2016 update of the online version of the Medicaid Provider Manual. The manual will be available October 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 October 1, 2016, Current Procedural Technology (CPT) Code 69220 will be activated for coverage for physicians, practitioners and medical clinic providers.

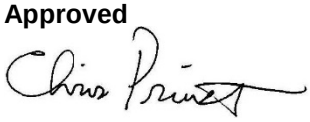
Manual Maintenance

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

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Coordination of Benefits	2.2 Automobile Insurance (Accident, No Fault)	In the 1st paragraph, text after the 6th sentence was revised to read: Providers must bill the automobile insurance carrier prior to billing Medicaid **or the Medicaid managed care plan. Billing Medicaid or a Medicaid managed care plan prior to exhausting other insurance resources may be considered fraud under the Medicaid False Claim Act if the provider is aware that the beneficiary had other insurance coverage for the services rendered.**	This additional language clarifies that Medicaid managed care plans must follow Medicaid policy regarding TPL. Adding the last sentence to reiterate the importance of exhausting other insurance resources before billing Medicaid.
Coordination of Benefits	2.2 Automobile Insurance (Accident, No Fault)	The 3rd paragraph was revised to read: Medicaid **or the Medicaid managed care plan** must be billed within six months from the date of filing the no-fault claim to keep the claim active. Providers must bill …	This additional language clarifies that Medicaid managed care plans must follow Medicaid policy regarding TPL. The deletion of "with Medicaid" simply removes the redundancy in the sentence structure.
Coordination of Benefits	2.2 Automobile Insurance (Accident, No Fault)	In the 4th paragraph, text after the 2nd sentence was revised to read: Medicaid or the Medicaid managed care plan pursues reimbursement from the other insurance through subrogation. For the purposes of this section, a Medicaid managed care plan must follow Medicaid policy regarding TPL.	This additional language clarifies that Medicaid managed care plans must follow Medicaid policy regarding TPL. The addition of the last sentence further clarifies the intent of the language and is taken directly from the plans' contracts. This is already standard practice for most managed care plans. The word "then" is deleted for clarity.

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

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CHAPTER	SECTION	CHANGE	COMMENT
Coordination of Benefits	2.3 Workers' Disability Compensation	The following text was added to the 1st paragraph: Billing Medicaid or a Medicaid managed care plan prior to exhausting other insurance resources may be considered fraud under the Medicaid False Claim Act if the provider is aware that the beneficiary had other insurance coverage for the services rendered. In the 2nd paragraph, text after the 2nd sentence was revised to read: Medicaid **or the Medicaid managed care plan** may bill the compensation carrier, or may follow up in hearings as to redemption or settlement. **For the purposes of this section, a Medicaid managed care plan must follow Medicaid policy regarding TPL.**	This additional language clarifies that Medicaid managed care plans must follow Medicaid policy regarding TPL. The addition of the last sentence further clarifies the intent of the language and is taken directly from the plans' contracts. This is already standard practice for most managed care plans.
Ambulance	1.2 Common Terms	Definitions were revised as follows: **Ambulance** A motor vehicle or aircraft that is primarily used or designated as available to provide transportation and basic life support or advanced life support. **Fixed Wing Air Ambulance** An aircraft, such as an airplane**,** that is licensed as a fixed wing air ambulance, and such ancillary services as may be medically necessary. **Rotary Wing Air Ambulance** An aircraft, such as a helicopter**,** that is licensed as a rotary wing air ambulance, and such ancillary services as may be medically necessary.	Air ambulances are not certified, they are licensed.
Ambulance	Section 4 – Ambulance Coverage Exclusions	The 6th bullet point was revised to read: • Transport of inmates to or from a correctional facility.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Children's Special Health Care Services	9.4 Case Management Benefit	In the 4th paragraph, the 2nd sentence was revised to read: In the event Case Management services are no longer required, but Care Coordination services would be of assistance, the change **in billing** may only be made at the beginning of the next billing period.	Clarification.
Early and Periodic Screening, Diagnosis and Training	Section 1 – General Information	In the 6th paragraph, the 8th bullet point was revised to read: • **habilitative and** rehabilitative services;	The list should include "habilitative" services in addition to "rehabilitative" services.
Federally Qualified Health Centers	5.2 Documenting Encounters	In the 2nd paragraph, the 1st bullet point was revised to read: • **Rendering** Provider NPI	Consistency in wording
Hearing Aid Dealers	Throughout the chapter	The following terms were revised to read "MSA-1653-B": • PA request • PA request form • request for prior authorization • the form • prior authorization request	Consistency in wording
Hearing Services	Throughout the chapter	The following terms were revised to read "MSA-1653-B": • PA request • PA request form • request for prior authorization • the form • prior authorization request	Consistency in wording

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	7.5 Disproportionate Share Hospital (DSH) Process	Under "*Step 2: Interim DSH Settlement*", 2nd paragraph, the last sentence was revised to read: For example, during 2013, data from hospital cost reports with FYs ending between January 1, 2012 and December **31**, 2012 will be used to complete the FY 2012 Interim DSH Settlement calculations.	Correction.
Nursing Facility Cost Reporting & Reimbursement Appendix	Section 3 – Definitions	For the 'Class Average of Variable Costs (AVC)', 'Class Variable Cost Limit (VCL)' and 'Cost Index' definitions, the years are revised to read: ~~2002~~ **2015** ~~2003~~ **2016** ~~2004~~ **2017**	Years updated in examples to be more current.
Nursing Facility Cost Reporting & Reimbursement Appendix	Section 5 - Plan Cost Certification	Throughout this section, the years were revised to read: ~~2002~~ **2015** ~~2003~~ **2016** ~~2004~~ **2017** ~~2005~~ **2018** ~~2006~~ **2019** ~~2007~~ **2020**	Years updated in examples to be more current.
Nursing Facility Cost Reporting & Reimbursement Appendix	8.3.B. Enforcement Actions	In the 2nd bullet, the 1st sentence was revised to read: The time period of imposition of a DPNA is reduced by 50 percent **or more** due to a change in the date that a nursing facility is determined to have been in compliance.	Clarification; policy is clear that the enforcement remedies have to be reduced by 50 percent or more, not exactly 50 percent.
Nursing Facility Cost Reporting & Reimbursement Appendix	8.13 Maintenance of Effort Contributions by County Government	The 1st sentence was revised to read:	Updated for grammatical changes and rewording.

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<table>
<tr><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th><th>COMMENT</th></tr>
<tr><td></td><td></td><td>In accordance with Public Act 408 of 1984, as amended, county governments that own and operate a nursing facility are responsible for maintenance of effort funding levels for the operation of that facility.</td><td></td></tr>
<tr><td>Nursing Facility Cost Reporting & Reimbursement Appendix</td><td>8.17.B. Compensation Limit for Owner and/or Administrator Serving Multiple Nursing Facilities</td><td>The 2nd paragraph was revised to read:

The following illustrates an example of the allowable owner/administration compensation limit application for a group of four facilities of varying sizes with a total of 400 beds, and the allowable facility compensation. The owner and/or administrator total compensation is $250,000 for full time nursing facility related activity for a cost reporting period ending December 31, 2015. The compensation is $38,795 greater than the limit ($250,000 minus $211,205 equals $38,795).
<table>
<tr><td>Total number of beds in all facilities served</td><td>400</td></tr>
<tr><td>Compensation Cost Limit for 150+ bed facility as of 12/31/2015</td><td>$211,205</td></tr>
<tr><td>Owner and/or Administrator Total Compensation</td><td>$250,000</td></tr>
<tr><td>Amount allowed for allocation to individual facilities (lesser of bed size limit or actual compensation)</td><td>$211,205</td></tr>
<tr><td>Amount of compensation not allowed</td><td>$38,795</td></tr>
</table>
<table>
<tr><th>Nursing Facility Bed Sizes</th><th>1-49 Beds</th><th>50-99 Beds</th><th>100-149 Beds</th><th>150+ Beds</th></tr>
<tr><td>Facility Compensation Limit 12/31/2015</td><td>$70,403</td><td>$117,337</td><td>$140,805</td><td>$211,205</td></tr>
</table></td><td>Years and values were updated in examples to be more current.</td></tr>
</table>

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CHAPTER	SECTION	CHANGE	COMMENT

Example Facilities	Facility 1	Facility 2	Facility 3	Facility 4
Total Facility Beds	40	70	100	190
Allocation of Owner and/or Administrator Compensation[1]	**$21,121**	**$36,961**	**$52,801**	**$100,322**
Compensation of Facility Administrator	**$40,000**	**$85,000**	**$95,000**	**$115,000**
Facility Total Compensation to be Compared to Limit[2]	**$61,121**	**$121,961**	**$147,801**	**$215,322**
Disallowed Compensation per Facility	$0	**$4,624**	**$6,996**	**$4,117**

1 The percentage of the facility's beds of the total across all four facilities is multiplied by the compensation limit, e.g., 40/400 x **$211,205**.

2 Total compensation equals the sum of the allocation amount and the individual nursing facility administrator compensation.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	9.6.C. Related or Chain Organization Cost Allocation	Throughout the subsection (except for the last paragraph), the years used were revised to read: ~~2003~~ **2016** ~~2004~~ **2017** ~~2005~~ **2018** ~~2006~~ **2019** ~~2007~~ **2020** The 4th paragraph was revised to read: Costs incurred by a nursing facility for services furnished by a related organization are allowable. The cost allocated to the nursing facility cannot exceed the price of comparable services, facilities, or supplies that could be purchased in competitive market conditions. The principles of reimbursement applied for the determination of allowable cost to the nursing facility are also applicable to the related organization. If a cost would be unallowable to the nursing facility, it would be unallowable to the related organization. Throughout the last paragraph, the years are revised to read: ~~2004~~ **2015** ~~2005~~ **2016**	Updated for grammatical changes, rewording, and to make the years more up to date.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.5 Variable Cost Component (VCC) – Class I and Class III Facilities	The years were revised to read: ~~2002~~ **2015** ~~2003~~ **2016** ~~2004~~ **2017**	Years were updated in examples to be more current.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	10.5.B. Cost Index (CI)	The years were revised to read: ~~2002~~ **2015** ~~2003~~ **2016** ~~2004~~ **2017**	Years were updated in examples to be more current.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.5.C. Class Average Variable Costs (AVC)	The years were revised to read: ~~2002~~ **2015** ~~2003~~ **2016** ~~2004~~ **2017**	Years were updated in examples to be more current.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.5.D. Class Variable Cost Limit (VCL)	The years were revised to read: ~~2002~~ **2015** ~~2003~~ **2016** ~~2004~~ **2017**	Years were updated in examples to be more current.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.6 Class V Nursing Facilities – Ventilator Dependent Care (VDC) Units	The 1st paragraph was revised to read: The reimbursement rate for special nursing facilities caring for ventilator-dependent residents (Class V) is set prospectively **by Medicaid** as an individual nursing unit rate per resident day **and is based on actual occupancy**.	Clarification added that the 85% occupancy for rate setting purposes does not apply to VDC Units.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.7.A. Class I and Class III Nursing Facilities	In the 1st paragraph, the 4th sentence was revised to read: A nursing facility that is experiencing a significant increase or decrease in its Medicaid utilization **for the current rate year resulting in** a difference of greater than five percent in the nursing facility's total QAS payments for the year must contact the SMA for consideration of adjustment to the facility's monthly QAS payment.	Updated for grammatical changes and rewording.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	10.13.D. Rate Relief Period	The 3rd paragraph was revised to read: **Example**: If rate relief takes effect January 1, **2016**, the facility would not be eligible for rate relief again until on or after January 1, **2023**.	Years were updated in examples to be more current.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.13.G.1. Rate Relief Methodology	Throughout the subsection, the years were revised to read: ~~2003~~ **2016** ~~2004~~ **2017**	Years were updated in examples to be more current.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.13.H.1. Rate Relief Methodology	Throughout the subsection, the years were revised to read: ~~2009~~ **2016** ~~2010~~ **2017**	Years were updated in examples to be more current.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.13.I.1. Rate Relief Methodology	Throughout the subsection, the years were revised to read: ~~2014~~ **2016** ~~2015~~ **2017**	Years were updated in examples to be more current.
Nursing Facility Cost Reporting & Reimbursement Appendix	Section 13 - Appraisal Guidelines	In the 2nd paragraph, under 'Appraisal Date', the 2nd sentence was revised to read: For example, if December 31, **2015** was established as the appraisal date and the actual physical inventory of fixed assets was taken on February 1, **2016**, any additions or dispositions of fixed assets between December 31, **2015** and February 1, **2016** must be taken into account in the appraisal values.	Years were updated in examples to be more current.

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Pharmacy	11.3 Refills	The following text was added: For non-controlled substances, a FFS beneficiary cannot obtain a refill of the prescription until at least 75 percent of the drug quantity limit has been consumed in compliance with the prescribed dose, amount, frequency, and time intervals established by MDHHS. (Refer to the Narcotic Analgesics subsection for additional information regarding refill thresholds for narcotic analgesics.) The pharmacy may contact the MDHHS PBM Technical Call Center to request an override for an instance where an early refill is warranted. (Refer to the Directory Appendix for contact information.)	Incorporates information in the D.0 Claims Processing Manual.
Practitioner	23.2 Enrollment of Nurse Practitioners	Text was revised to read: Nurse practitioners who render services to Medicaid beneficiaries must be enrolled providers. In order for an NP to enroll, he/she must enroll as either a Rendering/Servicing-Only Provider or an Individual/Sole Provider and: …	Clarification.
Practitioner Reimbursement Appendix	1.3 Injectables	Subsection was deleted.	Obsolete information.
Private Duty Nursing		Throughout the chapter, revisions were made to “Program Review Division” to reflect use of the acronym “PRD”. Throughout the chapter, revisions were made to “Plan of Care” to reflect use of the acronym “POC”.	Consistency in term use.
Rural Health Clinics	Section 8 – Reconciliation Reporting	In the 3rd paragraph, the 1st bullet point was revised to read: • **Rendering** Provider NPI	Consistency in wording.

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CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Provider Resources	Addition of: **Contact/Topic:** Community Health Centers/Federally Qualified Health Centers **Web Address:** www.michigan.gov/mdhhs >> Assistance Programs >> Health Care Coverage >> Help Finding Health Care >> Free or Low Cost Primary Care from a Doctor or Nurse **Information Available/Purpose:** Source for Free or Low Cost Primary Care	
Glossary Appendix	Noncovered Service	The 3rd bullet point was revised to read: • Not described in a **MHP's** Certificate of Coverage;	Correction.

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MSA 16-18	6/1/2016	Private Duty Nursing	1.3 Provision of Private Duty Nursing	The following text was added as paragraph 7: When more than one agency is authorized to provide PDN for a beneficiary, the hours rendered by each must be reported to the PRD on a monthly basis in order to permit the adjustment of authorized hours as necessary between the providers. Payment cannot be made until all utilized hours are reported. The primary agency on the case (the first agency involved) is responsible for contacting the other PDN provider(s) caring for the beneficiary to obtain the actual number of hours rendered during the preceding month, and must fax the total hours provided by each to the PRD. The authorization letter will detail all PDN providers that are caring for a beneficiary during the authorization period.
			1.4 Prior Authorization	The following text was added as paragraph 6: MDHHS will not reimburse PDN providers for services that have not been prior authorized. All forms and documentation must be completed according to the procedures provided in this chapter. If information is not provided according to policy (which includes signatures and correct information on the MSA-0732, POC and nursing assessment), requests will be returned to the provider. Authorization cannot be granted until all completed documentation is provided to MDHHS. Corrected submissions will be processed as a new request for PDN authorization and no backdating will occur. The following text was added as paragraph 10: When a parent/guardian requests a transfer of care from one PDN provider to another, a completed MSA-0732 must be submitted to the PRD along with signed and dated documentation from the parent/guardian indicating that they are requesting a change in providers. The balance of hours authorized to a previous PDN provider will not be automatically transferred to a new provider. The new PDN provider is responsible for submitting the MSA-0732 to the PRD along with documentation from the parent/guardian requesting a new provider. The following text was added as paragraph 12: Other services provided in the home by community-based programs may affect the total care needs and the amount of PDN authorized. These other services must be disclosed on the MSA-0732 and documented in the POC. Although the amount of PDN authorized considers the beneficiary's medical needs and family circumstances, community-based services provided in the home are also part of this assessment. Disclosure is necessary to prevent duplication of services to allow for an accurate calculation of authorized PDN hours. Providers are advised that failure to disclose all community resources in the home may be cause for recoupment of funds.

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			1.4.A. Documentation Requirements	In the 3rd bullet point, the 2nd sentence was revised to read: ... The POC must support the skilled nursing services requested**, and contain dates inclusive of the requested authorization period.** In the 3rd bullet point, the 6th sub-bullet point was revised to read: Other services being provided in the home by community-based entities that may affect the total care needs **MUST be documented.** The 4th bullet point was revised to read: If the beneficiary was hospitalized during the last authorization period, include documentation related to the PDN qualifying diagnosis/condition, i.e., all hospital discharge summaries, history and physical examination, social worker notes/assessment, consultation reports (pulmonary; ears, nose and throat [ENT]; ventilator clinic; sleep study; etc.), and emergency department reports (if emergency services were rendered during the last authorization period). The following text was added as bullet 5: Teaching records pertaining to the education of parents/caregivers on the child's care.
			1.7 Benefit Limitation	In the 1st paragraph, the following text was inserted after the 1st sentence: PDN is intended as a transitional benefit to support and teach family members to function as independently as possible. Authorized hours will be modified as the beneficiary's condition and living situation stabilizes or changes. A decrease in hours will occur, for example, after a child has been weaned from a ventilator or after a long term tracheostomy no longer requires frequent suctioning, etc. The following text was added at the end of the 1st paragraph: Substantial alterations to the scheduled allotment of daily PDN hours due to family choice (i.e., vacations) unrelated to medical need or emergent circumstances require advance notice to the PRD. The remaining balance of authorized hours will not be increased to cover this type of utilization. Authorized time cannot be carried over from one authorization period to another. The following text was added as paragraph 3:

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				PDN providers are encouraged to work with families to assist in developing a backup plan for care of their child in the event that a PDN shift is delayed or cancelled, and the parent/guardian is unable to provide care. The parent/guardian is expected to arrange backup caregivers that they will notify, and the parent/guardian remains responsible for contacting these backup caregivers when necessary.
			1.8 Service Log	In the 1st paragraph, the 2nd sentence was revised to read: The service log must be beneficiary specific, with the beneficiary's name and birth date in the header portion of the document **and must clearly identify the specific time worked by each PDN in the home and for each date of service**. In the 1st paragraph, the last sentence was revised to read: This log must be kept in the beneficiary's record **and may be documented in electronic or paper format. The medical record itself or nursing flow sheets containing other information are not considered a service log for the purposes of this policy. Failure to maintain a log or to submit this information to MDHHS upon request may result in recoupment of PDN reimbursement.**
			1.13 Caring for More than One Patient at a Time	The following text was added as paragraph 2: When two Medicaid beneficiaries less than 21 years of age reside in the same home and require PDN services, one nurse will be authorized to provide care for both individuals. (The PDN rate is adjusted to accommodate this ratio.) In the event of an exceptional and emergent circumstance, a ratio of 1:1 nursing will be authorized for a limited period of time when two PDN beneficiaries reside in the same home. During this time period, PDN services must be reassessed on at least a monthly basis, documented in the POC, and submitted to the PDN authorizing entity to demonstrate the need for continuation of 1:1 nursing services. The POC must document efforts being made to wean the beneficiaries from 1:1 care.
			2.3 Medical Criteria	For 'Medical Criteria 1', the 1st bullet point was revised to read: Mechanical ventilation four or more hours per day, or assisted respiration **does not automatically include ventilation through Bi-level Positive Airway Pressure (Bi-PAP) or Continuous Positive Airway Pressure (CPAP). Use of these devices to satisfy this criteria will be evaluated on a case-by-case basis;** or

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			2.4 Determining Intensity of Care and Maximum Amount of PDN	In the last paragraph, 6th bullet point, 1st paragraph, the last sentence was revised to read: Authorization of PDN hours will not automatically be increased during breaks from school (vacations) or adjusted beyond the limits of factors I and II.
			2.7 Hospice Services	The 3rd paragraph was revised to read: **PRD** staff may request additional medical record documentation for their review. **PDN authorization cannot occur unless the hospice submits the requested documentation to the PRD.** If services are approved, the hospice must work with the PDN agency to develop a coordinated **POC**. Both the hospice and PDN staff must ensure that duplication of services does not occur. While hospice maintains the lead in coordinating the services, the PDN agency must continue to obtain prior authorization from MDHHS for the PDN services. **Hospice services must be utilized to the fullest extent before PDN services will be authorized.**
MSA 16-16	6/1/2016	Billing and Reimbursement for Institutional Providers	7.3.B. Multiple Transports Per Beneficiary	The 3rd paragraph was deleted.
		Billing and Reimbursement for Professionals	7.2.B. Multiple Transports Per Beneficiary	The 3rd paragraph was deleted.

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		Ambulance	1.8 Prior Authorization (new subsection)	New subsection text reads: For services requiring PA, the ambulance provider must request authorization from the MDHHS Program Review Division (PRD). (Refer to the Directory Appendix for contact information.) The request must include the following information: • Beneficiary's name and Medicaid ID number • Diagnosis • Point of pick-up and destination • Services(s) to be provided • Explanation as to why the ambulance transportation is medically necessary • Explanation as to why the beneficiary cannot be transported by other means • Name, address, and National Provider Identifier (NPI) of the ambulance provider • PA requestor's name Based on the documentation provided, PRD approves or denies the PA request. The ambulance provider may not bill MDHHS for prior authorized services until PRD approves the PA request. The PA requestor must notify PRD of any changes made to the approved authorization. Except as otherwise specified, the PA number must be entered on the claim before the ambulance provider is reimbursed for services.
			2.1 Air Ambulance	The 1st paragraph was revised to read: **Air ambulance providers who are licensed by MDHHS to provide emergency medical services and are properly enrolled in the Medicaid program may be reimbursed for medically necessary air ambulance services. To become Medicaid-enrolled, Michigan-licensed air ambulance providers must submit a copy of their state-issued aircraft operations license number with their provider enrollment application. For prospective air ambulance providers who are not Michigan-licensed, a copy of their respective state-issued aircraft operations license must be submitted with their provider enrollment application, along with a copy of their Commission on Accreditation of Medical Transport Systems (CAMTS) accreditation or an affidavit of substantial CAMTS accreditation compliance.** Providers must indicate on the enrollment application that they are requesting either fixed-wing air ambulance or helicopter air ambulance status. Coverage of the air ambulance services includes the base rate, loaded mileage, and waiting time.

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			2.1.A. Fixed Wing Air Ambulance	Text was revised to read: The Medicaid Provider Enrollment file reflects enrollment as a fixed wing air ambulance provider.
			2.1.B. Helicopter Air Ambulance	Text was revised to read: The Medicaid Provider Enrollment file reflects enrollment as a helicopter air ambulance provider.
			2.9 Non-Emergency	In the 1st paragraph, the 3rd bullet point was revised to read: • the transport is provided in a licensed BLS, ALS or air ambulance vehicle. **Prior authorization (PA) is required for non-emergency air ambulance transports. (Refer to the Prior Authorization subsection of this chapter for additional information.)**
			3.7 Multiple Transports Per Beneficiary	Text was revised to read: **If more than two ambulance transports are needed for the same beneficiary on the same date of service, the third transport will require PA. When additional transports of an emergent nature are necessary, ambulance providers can secure PA after the transport has been rendered. (Refer to the Prior Authorization subsection of this chapter for additional information.) Additional information regarding billing is contained in the Billing & Reimbursement for Institutional Providers and the Billing & Reimbursement for Professionals Chapters of this manual.**
			3.8 Out of State**/Beyond Borderland** Transports	The subsection title was revised. Text was revised to read: Except for emergencies, out of state**/beyond borderland** transports require PA. (Refer to the General Information for Providers chapter of this manual for additional information **on out of state/beyond borderland policy**.) **(Refer to the Prior Authorization subsection of this chapter for additional information.)**

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MSA 16-15	6/1/2016	Hospital	Section 2 - Prior Authorization	Revisions to the table: Under "Cosmetic Surgery": • 'Obtained Via' was revised to read: **Practitioner Special Services Prior Approval – Request/Authorization Form (MSA-6544-B)** • 'Documentation for Claim' was revised to read: **Prior Authorization (PA) Number** Under "Services for Weight Reduction (e.g., Surgery)": • 'Obtained Via' was revised to read: **Practitioner Special Services Prior Approval – Request/Authorization Form (MSA-6544-B)** • 'Documentation for Claim' was revised to read: **PA Number** Under "Organ Transplants": • 'Documentation for Claim' was revised to read: **PA Number** Under "Pediatric Multi-Channel Recording (if more than two per year considered medically necessary)": • 'Obtained Via' was revised to read:

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				Practitioner Special Services Prior Approval – Request/Authorization Form (MSA-6544-B) • 'Documentation for Claim' was revised to read: **PA Number**
		Practitioner	1.9.A. To Obtain Prior Authorization	The 1st paragraph was revised to read: Requests for PA for surgeries, procedures, office-administered pharmaceuticals, biologicals, and out-of-state-care must be submitted utilizing the Practitioner Special Services Prior Approval – Request/Authorization form (MSA-6544-B). (Refer to the Forms Appendix for a copy of the form or download the form from the MDHHS website.) The form must be completed in its entirety. Supportive medical documentation must accompany the form.
		Forms Appendix		Addition of: MSA-6544-B; Practitioner Special Services Prior Approval – Request/Authorization
MSA 16-14	6/1/2016	Medicaid Provider Manual Overview	1.1 Organization	Under 'Behavioral Health and Intellectual and Developmental Disability Supports and Services', text for 'Affected Providers' was revised to read: Mental Health and Substance Abuse providers**,** Fee for Service – Psychologists, Social Workers, Counselors, **and Marriage and Family Therapists**

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		Behavioral Health and Intellectual and Developmental Disability Supports and Services Non-Physician Behavioral Health Appendix	Section 1 - General Information	The 1st sentence was revised to read: This appendix applies to non-physician behavioral health providers, psychologists, social workers, counselors, **and marriage and family therapists**.
			Section 2 - Provider Qualifications	In the 1st paragraph, the 2nd and 3rd sentences were revised to read: ... Licensed psychologists (Master's Limited or Doctoral level), social workers (Master's level), professional counselors (Master's or Doctoral level**) and marriage and family therapists** who serve Medicaid beneficiaries are required to enroll as Medicaid providers. The NPI of the psychologist, social worker, professional counselor, **or marriage and family therapist** must be uniquely identified on all claims. ... The 2nd paragraph was revised to read: Services performed by limited licensed psychologists (except as noted in Section 333.18223 of the Public Health Code), social workers, professional counselors, **marriage and family therapists**, or student interns must be performed under the supervision of an enrolled, fully-licensed provider of the same profession. Supervision is defined by Section 333.16109 of the Public Health Code (Act 368 of 1978). Services are billed to Medicaid under the National Provider Identifier (NPI) of the supervising psychologist, social worker, professional counselor, or **marriage and family therapist**. In the 3rd paragraph, the 1st sentence was revised to read: A student intern is an individual who is currently enrolled in a health profession training program for, **psychology, social work, counseling, or marriage and family therapy** that has been approved by

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				the appropriate board, is performing the duties assigned in the course of training, and is appropriately supervised according to the standards set by the appropriate board and the training program. ...
		Federally Qualified Health Centers	1.1.A. Non-Physician Behavioral Health Services	The 1st paragraph was revised to read: Licensed psychologists (Master's Limited or Doctoral level), social workers (Master's level), professional counselors (Master's or Doctoral level**), and marriage and family therapists who serve Medicaid beneficiaries are required** to enroll as Medicaid providers. **The NPI of the** psychologist, social worker, **professional** counselor**, or marriage and family therapist is** reimbursed under the FQHC PPS or MOA. These services ...
			1.4 Nonenrolled Provider Services	In the 1st paragraph the 1st sentence was revised to read: Professional services performed by limited licensed psychologists (except as noted in Section 333.18223 of the Public Health Code), social workers, professional counselors, **marriage and family therapists,** or student interns must be performed under the supervision of an enrolled, fully-licensed provider of the same profession. These services ...
		Practitioner	14.1 Behavioral Health Services	In the 1st paragraph, the 6th sentence was revised to read: Under FFS, behavioral health services may be provided by a physician (MD or DO), psychologist, social worker, **professional** counselor**, or marriage and family therapist** (as defined in the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, Non-Physician Behavioral Health Appendix).
		Rural Health Clinics	2.1.A. Non-Physician Behavioral Health Service	In the 1st paragraph, the 1st and 2nd sentences were revised to read: Licensed psychologists (Master's Limited or Doctoral level), social workers (Master's level), professional counselors (Master's or Doctoral level**), and marriage and family therapists who serve Medicaid beneficiaries are required** to enroll as Medicaid providers. **The NPI of the** psychologist, social worker, **professional** counselor**, or marriage and family therapist is** reimbursed under the RHC PPS. ...

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			2.2 Nonenrolled Providers	The 1st sentence was revised to read: Professional services performed by limited licensed psychologists (except as noted in Section 333.18223 of the Public Health Code), social workers, professional counselors**, marriage and family therapists**, or student interns must be performed under the supervision of an enrolled, fully-licensed provider of the same profession.
		Tribal Health Centers	2.1.A. Non-Physician Behavioral Health Services	Text was revised to read: Licensed psychologists (Master's Limited or Doctoral level), social workers (Master's level), professional counselors (Master's or Doctoral levels)**, and marriage and family therapists who serve Medicaid beneficiaries are required** to enroll as Medicaid providers**. The NPI of the** psychologist, social worker, **professional** counselor**, or marriage and family therapist is** reimbursed under the THC MOA. These services …
			2.2 Nonenrolled Providers	Text was revised to read: Professional services performed by limited licensed psychologists (except as noted in Section 333.18223 of the Public Health Code), social workers, professional counselors**, marriage and family therapists**, or student interns must be performed under the supervision of an enrolled, fully-licensed provider of the same profession. These services …
			5.1 Nonenrolled Providers	Text was revised to read: Professional services performed by limited licensed psychologists (except as noted in Section 333.18223 of the Public Health Code), social workers, professional counselors**, marriage and family therapists**, or student interns are covered but must be performed under the supervision of an enrolled, fully-licensed provider of the same profession. Individuals who …

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MSA 16-12	6/1/2016	Children's Special Health Care Services	12.6 Medicare	The following text was added as paragraph 2: CSHCS may cover the out-of-pocket pharmacy costs related to the CSHCS covered diagnoses for CSHCS beneficiaries enrolled with a Medicare Part D Pharmacy Drug Plan. These out-of-pocket costs include copays, co-insurance and deductibles specific to the Medicare Part D pharmacy benefit. Providers and beneficiaries should contact CSHCS for additional information regarding the reimbursement of out-of-pocket pharmacy costs. (Refer to the Directory Appendix for contact information.)
MSA 16-13	5/19/2016	Federally Qualified Health Centers	Section 7 – MI Care Team (Primary Care Health Home Benefit)	Addition of new section.
			7.1 General Information (new subsection)	New subsection text reads: Effective July 1, 2016, MDHHS implemented a new care management and care coordination primary care Health Home benefit called the MI Care Team. The goals of the program are to ensure seamless transitions of care and to connect eligible beneficiaries with needed clinical and social services. MDHHS expects the benefit will enhance patient outcomes and quality of care, while simultaneously shifting people from emergency departments and hospitals to a primary care setting. The MI Care Team has an operations guide for providers called the MI Care Team Handbook. In addition, the MI Care Team has a website with provider resources. (Refer to the Directory Appendix for website information.) **Note: Continuation of the MI Care Team policy/benefit after eight (8) quarters of the effective date is subject to MDHHS review and approval.**

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			7.2. Beneficiary Eligibility (new subsection)	New subsection text reads: Eligible beneficiaries meeting geographic area requirements cited in the Provider Eligibility Requirements subsection of this policy include those enrolled in Medicaid, the Healthy Michigan Plan, or MIChild who have a diagnosis of depression and/or anxiety in addition to a diagnosis of one of the following: • Asthma • Diabetes • Hypertension • Heart Disease • Chronic Obstructive Pulmonary Disease
			7.3 Beneficiary Enrollment (new subsection)	
			7.3.A. Enrollment Processes (new subsection)	New subsection text reads: The MI Care Team uses a two-pronged enrollment approach where both MDHHS and Health Home providers participate. The process is as follows: • MDHHS will identify potential eligible beneficiaries using claims data and send each beneficiary a letter notifying them of their eligibility. MDHHS will also provide a list of potential eligible beneficiaries to designated MI Care Team providers with whom they have an established relationship. The list of eligible beneficiaries will be updated and maintained on a monthly basis. Enrollment is contingent on beneficiary consent (refer to the Beneficiary Consent subsection), and beneficiary assignment will occur only after a beneficiary visits a MI Care Team provider, fills out the enrollment and consent forms, and establishes a Health Action Plan (an individualized care plan). These steps must be documented.

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				• MI Care Team providers are permitted to recommend potential eligible beneficiaries for enrollment to MDHHS. MI Care Team providers must provide documentation that indicates that a prospective MI Care Team beneficiary meets all eligibility for the benefit, including presence of qualifying conditions, consent, and establishment of an individualized care plan. MDHHS shall authorize all beneficiary eligibility and process approved enrollments.
			7.3.B. Beneficiary Consent (new subsection)	New subsection text reads: Beneficiaries must provide a signed MI Care Team Beneficiary Enrollment/Disenrollment form (MSA-1030) and a signed Consent to Share Behavioral Health Information for Care Coordination Purposes form (DCH-3927) to enroll in and receive the MI Care Team benefit. Signed enrollment and consent forms must be collected and retained in the beneficiary's health record. Providers are responsible for verifying receipt of signed enrollment and consent forms and providing proper documentation to MDHHS. All documents must be maintained in compliance with MDHHS record-keeping requirements.
			7.3.C. MI Care Team Benefit Plan Assignment (new subsection)	New subsection text reads: Once the steps outlined above are completed, the beneficiary will be assigned a benefit plan of HHMICARE associated to their Medicaid member ID in CHAMPS. It is incumbent upon MI Care Team providers to verify a beneficiary's HHMICARE assignment prior to rendering services. Beneficiaries without the benefit plan assignment of HHMICARE are not eligible for MI Care Team payment.

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			7.3.D. Beneficiary Disenrollment (new subsection)	New subsection text reads: Beneficiaries may disenroll from the MI Care Team benefit at any time. Beneficiaries who decline enrollment initially may elect to enroll at a later date contingent on meeting eligibility requirements. Beneficiaries who decline services or disenroll may do so without jeopardizing their access to other medically necessary services. Other than beneficiary-initiated disenrollment, disengaged beneficiaries will be categorized into the following two groups which have unique disenrollment processes: • Beneficiaries who have moved out of an eligible geographic area, died, or are otherwise no longer eligible for Medicaid program benefits will have their eligibility files updated per the standard MI Bridges protocol. Providers will receive updated files accordingly. • Beneficiaries who are unresponsive for reasons other than moving or death. Providers must make three unsuccessful beneficiary contact attempts within three consecutive months for MDHHS to deem a beneficiary as unresponsive. Providers will not receive payment for unsuccessful contacts. Providers must provide documentation for each unsuccessful contact attempt. After the final unsuccessful attempt, providers will recommend disenrollment to MDHHS with proper documentation. Providers should process disenrollments by completing the disenrollment section of the MI Care Team Beneficiary Enrollment/Disenrollment form (MSA-1030). Moreover, providers must document disenrollments in the Waiver Support Application. MDHHS requires that providers try to re-establish contact with disenrolled beneficiaries at least bi-annually, as applicable.

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			7.3.E. Beneficiary Changing MI Care Team Providers (new subsection)	New subsection text reads: To maximize continuity of care and the patient-provider relationship, MDHHS expects beneficiaries to establish a lasting relationship with their chosen MI Care Team provider. However, beneficiaries may change MI Care Team providers, and should notify their current MI Care Team provider immediately if they intend to do so. The current and future MI Care Team providers must discuss the timing of the transfer and communicate transition options to the beneficiary. Additionally, the beneficiary must complete new enrollment and consent forms (MI Care Team Beneficiary Enrollment/Disenrollment form [MSA-1030] and a signed Consent to Share Behavioral Health Information for Care Coordination Purposes form [DCH-3927]). The MI Care Team provider change should occur on the first day of the next month with respect to the new provider's appointment availability. Only one MI Care Team provider may be paid per beneficiary per month. The new MI Care Team provider will also not be eligible for the initial "Access and Health Action Plan" payment if that one-time payment was already made to another MI Care Team provider. (Refer to the MI Care Team Payment subsection of this policy for additional information.)
			7.4 Covered Services (new subsection)	New subsection text reads: MI Care Team services provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of comorbid physical and behavioral health conditions. These services include the following: • **Comprehensive Care Management**, including but not limited to: ➢ Assessment of each beneficiary, including behavioral and physical health care needs; ➢ Assessment of beneficiary readiness to change; ➢ Development of a Health Action Plan; ➢ Documentation of assessment and Health Action Plan in the Electronic Health Record; and ➢ Periodic reassessment of each beneficiary's treatment, outcomes, goals, self-management, health status, and service utilization.

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				• **Care Coordination and Health Promotion**, including but not limited to: ➢ Organization of all aspects of a beneficiary's care; ➢ Management of all integrated primary and specialty medical services, behavioral health services, physical health services, and social, educational, vocational, housing, and community services; ➢ Information sharing between providers, patient, authorized representative(s), and family; ➢ Resource management and advocacy; ➢ Maintaining beneficiary contact, with an emphasis on in-person contact (although telephonic contact may be used for lower-risk beneficiaries who require less frequent face-to-face contact); ➢ Appointment-making assistance, including coordinating transportation; ➢ Development and implementation of a Health Action Plan; ➢ Medication adherence and monitoring; ➢ Referral tracking; ➢ Use of facility liaisons; ➢ Use of patient care team huddles; ➢ Use of case conferences; ➢ Tracking of test results; ➢ Requiring discharge summaries; ➢ Providing patient and family activation and education; ➢ Providing patient-centered training (i.e., diabetes education, nutrition education, etc.); and ➢ Connection of beneficiary to resources (i.e., smoking cessation, substance use disorder treatment, nutritional counseling, obesity reduction and prevention, disease-specific education, etc.).

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				• **Comprehensive Transitional Care**, including but not limited to: ➢ Connecting the patient to health services; ➢ Coordinating and tracking the patient's use of health services; ➢ Providing and receiving notification of admissions and discharges; ➢ Receiving and reviewing care records, continuity of care documents, and discharge summaries; ➢ Post-discharge outreach to assure appropriate follow-up services; ➢ Medication reconciliation; ➢ Pharmacy coordination; ➢ Proactive care (versus reactive care); ➢ Specialized transitions when necessary (i.e., age, corrections); and ➢ Home visits. • **Patient and Family Support**, including but not limited to: ➢ Reducing barriers to the beneficiary's care coordination; ➢ Increasing patient and family skills and engagement; ➢ Use of community supports (i.e., community health workers, peer supports, support groups, self-care programs, etc.); ➢ Facilitating improved adherence to treatment; ➢ Advocating for individual and family needs; ➢ Assessing and increasing individual and family health literacy; ➢ Use of advance directives; ➢ Providing assistance with maximizing beneficiary's level of functioning; and ➢ Providing assistance with development of social networks.

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				• **Referral to Community and Social Support Services,** including but not limited to: ➢ Providing beneficiaries with referrals to support services; ➢ Collaborating/coordinating with community-based organizations and key community stakeholders; ➢ Emphasizing resources closest to the beneficiary's home ➢ Emphasizing resources which present the fewest barriers; ➢ Identifying community-based resources; ➢ Providing resource materials pertinent to patient needs; ➢ Assisting in attaining other resources, including benefit acquisition; ➢ Providing referral to housing resources; and ➢ Providing referral tracking and follow up. • **Use of Health Information Technology to link services**, including but not limited to: ➢ Use of an Electronic Health Record with meaningful use attainment; ➢ Use of CareConnect360 for care coordination, transition and planning; and ➢ Use of telemedicine as needed.
			7.5 Provider Eligibility Requirements (new subsection)	New subsection text reads: Eligible providers are selected by MDHHS through its Invitation-to-Bid (ITB) process. Applicants are selected on the basis of meeting the requirements outlined in the ITB. Selected MI Care Team providers will assure that all requirements are met and maintained. Failure to meet and maintain these requirements can result in loss of MI Care Team eligibility.
			7.5.A. Geographic Area (new subsection)	New subsection text reads: Eligible providers must implement the MI Care Team in geographic areas determined by the ITB process.

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			7.5.B. Provider Types (new subsection)	New subsection text reads: Eligible provider types for the MI Care Team are Federally Qualified Health Centers (FQHCs), including Section 330 grantees and FQHC Look-Alikes, and Tribal Health Centers (THCs).
			7.5.C. Provider Requirements (new subsection)	New subsection text reads: Providers must meet the requirements indicated in the ITB, Memorandum of Agreement (MOA), and the MI Care Team Handbook. (Refer to the Directory Appendix for website information.)
			7.5.D. Provider Infrastructure Requirements (new subsection)	New subsection text reads: MI Care Team providers will assure beneficiary access to an interdisciplinary care team that addresses the beneficiary's behavioral and physical health needs. The on-site care team must consist of, at a minimum, the following: • Primary Care Provider ➢ Must be a primary care physician, physician's assistant, or nurse practitioner with appropriate credentials to practice in Michigan (i.e., full licensure and certification, as applicable) • Behavioral Health Consultant ➢ Must be a licensed master's level social worker in Michigan • Nurse Care Manager ➢ Must be a licensed registered nurse in Michigan • Community Health Worker (CHW) ➢ Must be at least 18 years of age ➢ Must possess a high school diploma or equivalent

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				➢ Must be supervised by licensed professional members of the care team ➢ MDHHS strongly encourages the completion of a CHW Certificate Program • Health Home Coordinator ➢ Must be an administrative staff person employed by the eligible provider • Access to a Psychiatrist/Psychologist for consultation purposes (can be off-site) ➢ Must be a doctoral level licensed psychiatrist or psychologist in Michigan In addition to the above required provider infrastructure, eligible providers should coordinate care with the following professions: • Dentist • Dietician/Nutritionist • Pharmacist • Peer support specialist • Diabetes educator • School personnel • Others as appropriate
			7.6 Provider Enrollment and MI Care Team Designation (new subsection)	New subsection text reads: All providers selected through the ITB process and meeting the requirements in the Provider Eligibility Requirements subsection of this policy may enroll as a designated MI Care Team provider contingent upon adherence to this policy and the MI Care Team MOA. MDHHS will provide, in writing, the MOA and any other contingencies needed to obtain or preserve MI Care Team designation. Providers must sign and attest to adhere to this policy and the MOA and return to MDHHS. Only after MDHHS receives this signed attestation will a provider become a designated MI Care Team provider.

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			7.6.A. Training and Technical Assistance (new subsection)	New subsection text reads: MDHHS requires provider participation in state-sponsored training and technical assistance as a standard condition for continued MI Care Team designation. A readiness assessment will be completed for each designated MI Care Team site which will provide a basis for training and technical assistance needs.
			7.6.B. Use of Applicable Health Information Technology (HIT) (new subsection)	New subsection text reads: MDHHS requires MI Care Team providers to utilize appropriate HIT for enrollment, health service documentation, and care coordination purposes. Training on specific HIT resources will be provided by MDHHS.
			7.7 Provider Disenrollment (new subsection)	New subsection text reads: To maximize continuity of care and the patient-provider relationship, MDHHS expects MI Care Team providers to establish a lasting relationship with enrolled beneficiaries. However, designated MI Care Team providers wishing to discontinue MI Care Team services must notify MDHHS at least six months in advance of ceasing MI Care Team operations. MI Care Team services may not be discontinued without MDHHS approval of a provider-created cessation plan and protocols for beneficiary transition.
			7.8 MI Care Team Payment (new subsection)	New subsection text reads: Payment for MI Care Team services is contingent on designated MI Care Team providers meeting the requirements laid out in this policy and in the MOA, and as determined by MDHHS. Failure to meet these requirements may result in loss of MI Care Team provider designation.
			7.8.A. General Provisions for MI Care Team Payment (new subsection)	New subsection text reads: To provide MI Care Team services and bill Medicaid, a provider must be enrolled in the Community Health Automated Medicaid Processing System (CHAMPS), including enrollment as a billing agent or utilization of an existing billing agent to bill for and receive the MI Care Team payments. Designated MI Care Team

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				providers have their own CHAMPS identifier which must be used to submit encounters for MI Care Team Services. This identifier is only used for documenting MI Care Team services. The Group (Type 2 - Organization) National Provider Identifier (NPI) number must be used as the billing provider on all MI Care Team service encounters submitted. The billing provider loop or field is mandatory to complete. The Provider (Type 1 - Individual) NPI number of the provider who performed the service encounter, or the supervising physician, should be entered as the rendering provider. If the provider who performed the service is not enrolled in CHAMPS (e.g., CHW), then a supervising primary care provider must be entered as the rendering provider (i.e., primary care physician, nurse practitioner, physician's assistant). Designated MI Care Team providers should use their standard NPI for payment of regular (non-MI Care Team) clinical services. Designated MI Care Team providers are paid one of two monthly case rates, which are as follows: • **Health Action Plan Rate** The MI Care Team uses a once-in-a-lifetime-per-beneficiary Health Action Plan rate to be paid only for the first month that a beneficiary participates in the MI Care Team program. This once-in-a-lifetime-per-beneficiary rate represents reimbursement for certain actions and services including, but not limited to, initial care plan development. This service must be delivered in person. • **Ongoing Care Coordination Rate** For all subsequent months following the Health Action Plan payment, the Ongoing Care Coordination rate will be paid for eligible MI Care Team beneficiaries. Details and guidance regarding applicable service encounter and diagnosis codes can be found in the MI Care Team Handbook. (Refer to the Directory Appendix for website information.) Payment for MI Care Team services is in addition to the existing fee-for-service payments, encounters, or daily rate payments for direct clinical services. MDHHS payment methodology is designed to only reimburse for the cost of MI Care Team staff for the delivery of Health Home services that are not covered by any other currently available Medicaid reimbursement mechanism.

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<table>
<tr><th>BULLETIN NUMBER</th><th>DATE ISSUED</th><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th></tr>
<tr><td rowspan="3"></td><td rowspan="3"></td><td rowspan="2"></td><td>7.8.B. Recoupment of Payment
(new subsection)</td><td>New subsection text reads:

The monthly payment is contingent on a MI Care Team beneficiary receiving a MI Care Team service during the month. The payment is subject to recoupment if the beneficiary does not receive a MI Care Team service during the calendar month. The recoupment lookback will occur four months after the monthly payment is made. Thus, four months after the month a payment is made (for example, in November, MDHHS would look back at July's payment), CHAMPS will conduct an automatic recoupment process that will look for an appropriate code. If a core MI Care Team service is not provided during a calendar month, that month's payment is subject to recoupment by MDHHS. Once a recoupment has occurred, there is no further opportunity to submit a valid MI Care Team encounter code and/or claim.</td></tr>
<tr><td>7.9. MI Care Team and Managed Care Beneficiaries
(new subsection)</td><td>New subsection text reads:

MI Care Team providers and Medicaid Health Plans are expected to work together to coordinate services for eligible members who wish to enroll in the MI Care Team benefit. Both the providers and the health plans will be given a list of their members deemed eligible for the MI Care Team program. MDHHS requires providers and health plans confer to optimize communication to beneficiaries. MI Care Team providers are primarily responsible for conducting outreach to eligible beneficiaries.</td></tr>
<tr><td>Directory Appendix</td><td>Provider Assistance</td><td>Addition of:

<table>
<tr><th>CONTACT/TOPIC</th><th>PHONE #
FAX #</th><th>MAILING/EMAIL/WEB ADDRESS</th><th>INFORMATION AVAILABLE/PURPOSE</th></tr>
<tr><td>MI Care Team</td><td></td><td>email address:
MDHHS-MICareTeam@michigan.gov

website:
www.michigan.gov/micareteam</td><td>General information.

Provider Resources, including:
• MI Care Team Handbook
• MSA-1030
• DCH-3927</td></tr>
</table>
</td></tr>
</table>

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							• sample of Beneficiary Enrollment letter Consumer Resources • MI Care team sites • Map of participating counties
						e-mail address: MDHHS-BHConsent@michigan.gov website: www.michigan.gov/bhconsent	form DCH-3927 and supporting resources, including FAQ
						e-mail address: automatedbilling@michigan.gov website: www.michigan.gov/medicaidproviders >> Provider Enrollment >> Billing Agent -User Guide	Billing agent information
						email address: MDHHSEncounterData@michigan.gov	questions related to encounter file submission and FTS issues for MI Care Team organizations
						website: www.michigan.gov/tradingpartners >> HIPAA - Companion Guides >> Electronic Submissions Manual	information and instructions relating to submitting data electronically and the File Transfer Service (FTS)

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MSA 16-10	5/4/2016	Early and Periodic Screening, Diagnosis and Training	12.4 Blood Lead Poisoning Follow-Up Services	The following text was added as paragraph 2: The PCP may refer pregnant women and children who were served by the Flint water system to the Genesee Health System, the local community mental health (CMH) serving Genesee County that serves as the Designated Provider Organization (DPO), for any needed Family Supports Coordination services. (Refer to the Special Programs Chapter, Flint Family Supports Coordination Services Section, for additional information.)
		Special Programs	Section 7 - Flint Family Supports Coordination Services (new section)	New section text reads: Family Supports Coordination services are part of a comprehensive health benefit available to pregnant women and children who were served by the Flint water system who meet the Medicaid eligibility requirements. Family Supports Coordination services assist individuals in gaining access to appropriate medical, educational, social, and/or other services. Family Supports Coordination services include assessments, planning, linkage, advocacy, care coordination, referral, monitoring, and follow-up activities. In addition to Family Supports Coordination services, eligible beneficiaries will receive the full array of Medicaid-covered benefits. This includes the provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children up to age 21, Non-Emergency Medical Transportation (NEMT), and Maternal Infant Health Program (MIHP) services.
			7.1 Eligibility (new subsection)	New subsection text reads: Providers may verify beneficiary eligibility for Family Supports Coordination services through a Community Health Automated Medicaid Processing System (CHAMPS) online eligibility inquiry or via a Health Insurance Portability and Accountability Act (HIPAA) 270 transaction. The CHAMPS or 271 eligibility response for beneficiaries eligible for Family Supports Coordination services will show: • a current MAGI category beginning with "F"; and • a current benefit plan of "TCMF" in addition to their assigned Medicaid or Children's Health Insurance Program (CHIP)-related benefit plans.

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			7.2 Core Elements of Family Supports Coordination (new subsection)	New subsection text reads: The purpose of Family Supports Coordination services is to provide a comprehensive array of services that are appropriate to the conditions of the individual. At a minimum, Family Supports Coordination services must include: • a face-to-face comprehensive assessment, history, re-assessments, and identification of a course of action to determine the specific needs of the beneficiary and to develop an individual Plan of Care; • planning, linking, coordinating, follow-up, and monitoring to assist the beneficiary in gaining access to services; • coordination with the beneficiary's primary care provider (PCP), other providers, and Medicaid Health Plan (MHP), as applicable; and • any other service approved by MDHHS.
			7.2.A. Initial/ Annual Comprehensive Assessment Visit (new subsection)	New subsection text reads: All comprehensive assessment visits, including the initial face-to-face comprehensive assessment visit, must be conducted by a qualified licensed nurse or social worker with the beneficiary in the beneficiary's home or primary place of residence. The purpose of the comprehensive assessment visit is to gather sufficient information to develop an individualized Plan of Care for the beneficiary and to ensure that all other eligible individuals in the household are identified for further screening. It is expected that face-to-face assessments are performed annually; however, the frequency should be based on the needs and circumstances of the beneficiary and/or family. Active participation by the beneficiary and/or parent(s)/legal guardian(s) is necessary. Comprehensive assessment activities include: • obtaining client history; • identifying the beneficiary's needs and completing related documentation; and • gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the beneficiary.

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				At a minimum, the comprehensive assessment visit shall assess: • the growth and development of beneficiaries up to age 21; • the behavioral profile of beneficiaries up to the age of 21, including the notation of aggressive or hyperactive behavior; • the beneficiary's access to a PCP and other health care providers; • whether the beneficiary's PCP has conducted a developmental and social-emotional screen(s) utilizing a standardized and validated tool, such as the Ages & Stages Questionnaire: Social-Emotional (ASQ:SE) or the Pediatric Symptom Checklist (PSC) as indicated by the American Academy of Pediatrics (AAP) Periodicity Schedule, and documenting the results of any screenings performed; • whether the beneficiary's PCP has assessed the beneficiary for sources of toxic stress and for sources of strength using nationally recognized tools, such as the Adverse Childhood Experiences (ACEs) and Resiliency questionnaires, and documenting the results of any screenings performed; • the beneficiary's access to prenatal care, potential for pregnancy complications, pica activities, and intent to breastfeed (pregnant beneficiaries); • the beneficiary's educational and nutritional needs, including participation in the Women, Infants and Children (WIC) program and/or the Food Assistance Program (FAP); • the beneficiary's environment and typical family practices that may pose a lead risk; • lead hazards within the family's dwelling; and • access to NEMT.

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			7.2.B. Development of the Plan of Care and Documentation (new subsection)	New subsection text reads: During or immediately following the face-to-face initial comprehensive assessment visit, a Plan of Care must be developed for beneficiaries who agree to participate in Family Supports Coordination services, with the active participation of the parent(s)/legal guardian(s) when applicable. The development (and periodic revision) of a specific Plan of Care that is based on the information collected through the comprehensive assessment must specify the goals and actions to address the medical, educational, social, and/or other services needed by the beneficiary. The supports coordinator must ensure the active participation of the beneficiary, and work with the beneficiary (or the beneficiary's parent[s]/legal guardian[s]) and others to develop those goals, and to identify a course of action to respond to the assessed needs of the beneficiary. The Plan of Care is to be shared with the beneficiary's MHP and PCP, if applicable. Beneficiaries must consent to share the Plan of Care with the MHP and other providers identified in the Plan of Care. At a minimum, the Plan of Care must: • identify a course of action to respond to the assessed needs of the beneficiary (e.g., plan for the testing of family members at risk for lead hazard exposure); • provide education and information regarding lead hazards, including the impact of lead exposure on the developing fetus of pregnant beneficiaries; and • facilitate blood lead testing and follow-up testing and treatment as recommended by the PCP. Family Supports Coordination providers are required to document the following information for all beneficiaries receiving Family Supports Coordination services: • the name of the beneficiary; • the dates of the supports coordination services; • the name of the Family Supports Coordination provider and the qualified professional (i.e., licensed nurse or social worker) providing the supports coordination services; • the nature and content of the supports coordination visits received, and whether goals specified in the Plan of Care have been achieved; • whether the beneficiary has declined services within the Plan of Care; • the need for, and occurrences of, coordination with other providers;

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				• a timeline for obtaining needed services; • a timeline for re-evaluation of the Plan of Care; and • the beneficiary's consent to share information.
			7.2.C. Referrals and Related Activities (new subsection)	New subsection text reads: In collaboration with the PCP and the MHP, it is expected that the supports coordinator will facilitate and coordinate referral and related activities to assist the beneficiary in obtaining needed services. Activities such as scheduling appointments or linking the beneficiary with medical, educational, social, and/or other programs and services to address identified needs and achieve goals specified in the Plan of Care are primary components of Family Supports Coordination services. Referral activities include, but are not limited to, the coordination of age-appropriate services such as: • health care related services, including physical and specialty behavioral health services; • nutritional services, such as coordinating referrals to the Special Supplemental Nutrition Program, WIC program, or FAP; • educational services, such as age-appropriate referrals to Early On, Great Start Readiness Programs, Head Start, and school-based services; • additional social supports (including home visiting programs) to assist the beneficiary in obtaining other assistance, such as financial, housing, and transportation assistance, and lead assessment and abatement resources; and • blood lead testing and re-testing for family members at risk for lead exposure, and education regarding lead hazards including the impact of lead exposure on young children and the developing fetus.
			7.2.D. Monitoring and Follow-Up Activities (new subsection)	New subsection text reads: Monitoring and follow-up activities include activities and contacts that are necessary to ensure the Plan of Care is implemented and adequately addresses the eligible beneficiary's needs, and which may be conducted with the beneficiary, family members, service providers, or other entities or individuals. Monitoring and follow-up activities are conducted as frequently as necessary by the supports coordinator.

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				A maximum of five (5) face-to-face monitoring visits are billable per year for each eligible beneficiary. To be reimbursed, the visit must be face-to-face. Additional monitoring and follow-up activities are likely between face-to-face visits but are not reimbursable. At least one annual face-to-face monitoring visit should be conducted to determine whether the following conditions are met: • services are being furnished in accordance with the beneficiary's Plan of Care; • services in the Plan of Care are adequate; and • changes in the needs or status of the beneficiary are reflected in the Plan of Care. Monitoring and follow-up activities include making necessary adjustments in the Plan of Care and service arrangements with providers.
			7.3 Accessing Services (new subsection)	New subsection text reads: Accessing Family Supports Coordination services may occur a number of ways. If the beneficiary is an MHP member, the MHP may initiate the initial contact with the beneficiary and identify those beneficiaries that may benefit from Family Supports Coordination services. Fee-for-Service (FFS) and MHP beneficiaries may also access Family Supports Coordination services either through a referral from their PCP or through a self-referral.
			7.4 Covered Supports and Services (new subsection)	New subsection text reads: A maximum of six (6) face-to-face visits per year will be reimbursed for each eligible beneficiary as follows: • one (1) visit for the initial/annual comprehensive assessment. • a maximum of five (5) visits for monitoring and follow-up.

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				For additional visits, MDHHS requires the provider to obtain prior authorization before the service is rendered. (Refer to the Directory Appendix for contact information regarding prior authorizations.) Reimbursement for assessment and monitoring visits is inclusive of all related care coordination and monitoring activities. MDHHS does not reimburse for missed appointments/visits. A beneficiary may not be billed for a missed appointment/visit. Medicaid reimbursement for Family Supports Coordination services may not duplicate payments made to public agencies or private entities under other program authorities for the same purpose. Supports coordination includes contacts with non-eligible beneficiaries when the contact is: • directly related to identifying the eligible beneficiary's needs and care for the purpose of assisting the beneficiary in accessing services; • identifying needs and supports to assist the beneficiary in obtaining services; • providing supports coordinators with useful feedback; and • alerting supports coordinators to changes in the beneficiary's needs. Family supports coordination does not include activities that constitute the direct delivery of underlying medical, educational, social, and/or other services to which an eligible beneficiary has been referred, including foster care programs and services such as, but not limited to, the following: • research gathering and completion of documentation required by the foster care program; • assessing adoption placements; • recruiting or interviewing potential foster care parents; • serving legal papers; • home investigations; • providing transportation; • administering foster care subsidies; and • making placement arrangements.

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			7.5 Transfer of Care/ Records (new subsection)	New subsection text reads: During the course of care, the beneficiary may require services from a different supports coordinator due to relocation of the beneficiary's primary residence or due to a request of the beneficiary to change supports coordinators. When there is a planned change of the supports coordinator, information about the new supports coordinator (e.g., contact information) should be provided to the beneficiary. The referring supports coordinator must consult with the new supports coordinator about the case and transfer all applicable information and records, including all completed assessment visits and the updated Plan of Care, to the new supports coordinator in compliance with the privacy and security requirements of federal and state laws and regulations including, but not limited to, the HIPAA and the Michigan Mental Health Code.
			7.6 Family Supports Coordination Closure (new subsection)	New subsection text reads: Family Supports Coordination services are available to all eligible beneficiaries up to age 21, or for pregnant women up to and through 60 days post-delivery. Family Supports Coordination services will be discontinued: • if the beneficiary is no longer eligible; • when the beneficiary parent(s) or guardian(s) refuses the service; or • if CMS does not extend the Flint, Michigan Section 1115 Demonstration Waiver. When services are refused, Family Supports Coordination services may be resumed at any point during the defined period of eligibility. A discharge summary, including the services provided, outcomes, current status, and ongoing needs of the beneficiary, must be completed and provided to the PCP when the Family Supports Coordination case is closed.
			7.7 Provider Qualifications (new subsection)	New subsection text reads: Genesee Health System, the local community mental health (CMH) serving Genesee County, serves as the Designated Provider Organization (DPO) for Family Supports Coordination services. The DPO: • has a sufficient number of qualified staff to meet the service needs of the target population and has the administrative capacity to ensure the provision of quality services in accordance with state and federal requirements; • has experience in the coordination and linkage of community services;

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				• has the willingness and capabilities to coordinate with the beneficiary's PCP and MHP as applicable; and • must seek approval by MDHHS of all subcontractors for the provision of Family Supports Coordination services. The DPO will provide Family Supports Coordination services primarily through the use of a supports coordinator. The supports coordinator must meet one of the following professional qualifications: • licensure as a registered nurse by the Michigan Department of Licensing and Regulatory Affairs (LARA), and at least one year of experience providing community health, pediatric or maternal infant health nursing services; or • licensure as a social worker by LARA, and at least one year of experience providing social work services to families.
			7.8 Claims Submission and Payment (new subsection)	New subsection text reads: All claims submitted and accepted are processed through CHAMPS. Claims must be submitted on the ASC X12N 837 5010 professional format when submitting electronic claims or on the CMS 1500 claim form for paper claims. (Refer to the Billing & Reimbursement for Professionals Chapter for additional billing information.)
			7.8.A. Initial/Annual Assessments (new subsection)	New subsection text reads: Face-to-face assessment visits are to be billed using HCPCS code T2024 for an individual or family. This includes reimbursement for the development of a Plan of Care for one individual. HCPCS code T2024 with modifier TT (additional patient) should be billed for each additional individual Plan of Care that is developed from the assessment visit. For informational/reporting purposes, use modifier UN (two patients served), UP (three patients served), UQ (four patients served), UR (five patients served), or US (six or more patients served). Assessment visits must be in the home or "home-like" environment. One face-to face initial/annual assessment visit per year per family/household is allowed. Additional assessment visits beyond one per year per family/household require prior authorization.

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			7.8.B. Follow-up/Monitoring (new subsection)	New subsection text reads: Face-to-face follow-up/monitoring visits are to be billed using HCPCS code T1017 for an individual or family. For informational/reporting purposes, use modifier UN (two patients served), UP (three patients served), UQ (four patients served), UR (five patients served), or US (six or more patients served), and enter the Medicaid beneficiary ID numbers of the family members served during the follow-up visit in the claim notes. Follow-up visits must last at least 30 minutes and ideally take place in the home or "home-like" environment but may be performed in the office. A maximum of five face-to face follow-up/monitoring visits per year per family/household is allowed. Additional follow-up visits beyond five per year per beneficiary require prior authorization.
		Acronym Appendix		Addition of: ACEs - Adverse Childhood Experiences DPO - Designated Provider Organization FAP – Food Assistance Program
MSA 15-63	12/30/2015	Hospital Reimbursement Appendix	7.5 Disproportionate Share Hospital (DSH) Process	Under "Step 3: Final DSH Audit-Related DSH Redistribution", the following text was added as the last paragraph: In addition, any unspent federal DSH allotment will be distributed using the formula outlined in Step 3: Final DSH Audit-Related DSH Redistribution through a new pool. Funds from this pool will first be allocated to state government-owned or –operated hospitals up to applicable federal DSH limits. Any remaining unspent DSH allotment will be allocated proportionally to all other hospitals based on remaining DSH limit capacity.
MSA 15-57	12/1/2015	Tribal Health Centers	3.1 Covered Services	In the 1st paragraph, the 1st sentence was revised to read: THC services are reimbursed at the current Medicaid fee screens and reconciled annually to the THC MOA rate (if the THC rate is elected) when provided to **Medicaid** fee-for-service (FFS) **or managed care** beneficiaries.

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			7.2 Medicare and Medicaid Claims	The 2nd sentence was revised to read: If the Medicare payment exceeds the Medicaid fee screen, the **appropriate procedure** code should still be billed to Medicaid for encounter and reconciliation purposes.
			8.1 Quarterly Payments	The 2nd sentence was revised to read: The payment is based on an estimate of the difference between the amount the THC receives for Medicaid services from FFS claims**, managed care encounters,** and other third party payments (including Medicare) during the year and the amount due the Center based on the THC encounter rate.
			8.2 Initial Reconciliation and Settlement	Text after the 2nd sentence was revised to read: The number of encounters is determined from Medicaid fee-for-service (FFS) and managed care approved claims. Any difference between the THC rate and the amount paid to the THC from FFS **and managed care** payments, other insurance and quarterly payments is paid to or recovered from the THC. Future quarterly ...
MSA 15-55	12/1/2015	Pharmacy	1.7 Medicaid Health Plans	In the 3rd paragraph, the 1st sentence was revised to read: Each health plan enrolls its own providers **and** structures its own billing system. In the 4th paragraph (Pharmacy Aspects of MHP: Quick Reference), the following text was added for 'Pharmaceutical Coverage': The MHP Common Formulary establishes the minimum coverage requirements for drugs covered by health plans, as well as drug utilization management tools such as quantity limits, age and gender edits, prior authorization criteria, and step therapies. MHPs may be less restrictive, but not more restrictive, than the coverage parameters of the Common Formulary. Additional information is available on the MDHHS website. (Refer to the Directory Appendix for website information.) With the exception of products that are carved out, MHPs must have a process to approve provider requests for any prescribed medically appropriate product identified on the Michigan Pharmaceutical Product List (MPPL). (Refer to the Directory Appendix for website information.)

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		Directory Appendix	Pharmacy Resources	Addition of: **Contact/Topic:** Medicaid Health Plan Pharmacy Benefit **Web Address:** www.Michigan.gov/MCOpharmacy **Information Available/Purpose:** Medicaid Health Plan Common Formulary
MSA 14-36	12/1/2014	General Information for Providers	Section 9 – Inpatient Hospital Authorization Requirements	In the 3rd paragraph, the 2nd sentence was revised to read: **For claims with dates of discharge on or after October 1, 2014,** when an inpatient claim is deemed medically inappropriate or unnecessary through a pre-payment predictive modeling review or a post-payment audit, hospitals are allowed to submit a hospital outpatient Type of Bill (TOB) 013X for all outpatient services and any inpatient ancillary services performed during the inpatient stay.
		Hospital	4.1 Noncovered Admissions	The 2nd paragraph was revised to read: **Inpatient claims with discharge date prior to October 1, 2014** where that stay has been denied as inappropriate or unnecessary may not be resubmitted to MDHHS as outpatient charges. Charges resubmitted as outpatient charges are monitored, and any payment made may be recovered during a post-payment audit. **Any accommodations or ancillary services provided during nonallowable admissions or parts of stays will not be reimbursed.** The following text was added as paragraph 3: **Medically inappropriate or unnecessary admissions claims with dates of discharge on or after October 1, 2014 may be resubmitted as outpatient claims (Type of Bill 013x) for all outpatient services and any inpatient ancillary services performed during the inpatient stay.** The last paragraph was deleted.

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