MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

Bulletin Number: MSA 17-44

Distribution: All Providers

Issued: December 1, 2017

Subject: Updates to the Medicaid Provider Manual; Clarification to Bulletin MSA 17-10

Effective: January 1, 2018

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

Updates to the Medicaid Provider Manual

The Michigan Department of Health and Human Services (MDHHS) has completed the January 2018 quarterly update of the Michigan Medicaid Provider Manual. The Manual is maintained on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Medicaid Provider Manual. A compact disc (CD) version of the Manual is available to enrolled providers upon request.

The January 2018 version of the Manual does not highlight changes made in 2017. Refer to the online version of this bulletin at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms to view the attachments that describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change. Subsequent changes made for the April, July, and October 2018 versions of the manual will be highlighted within the text of the on-line manual.

Clarification to Bulletin MSA 16-37

Bulletin MSA 16-37, issued November 30, 2016, updated the billing limitation policy, also known as timely filing. Medicaid beneficiary eligibility/authorization established after the date of service is considered an exception to timely filing limits. A claim will be accepted up to 12 months after the date of service, or up to six months after the retroactive eligibility determination date, whichever date is later. Providers with claims that meet the retroactive eligibility exception must indicate ‘timely filing’, or if known, indicate an MSA-1038 is on file in the comment section of the claim.

Clarification to Bulletin MSA 17-10

MDHHS issued bulletins MSA 17-10 and MSA 17-24 requiring Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Tribal Health Centers (THCs) to submit claims using the ASC X12N 837 5010 institutional format effective August 1, 2017. Bulletin MSA 17-10 designates the use of modifier 59 to document a subsequent injury or illness that requires additional diagnosis or treatment on the same day. Per the Centers for Medicare & Medicaid Services (CMS) National Correct Coding Initiative, it is also appropriate for FQHCs, RHCs, and THCs to utilize modifier 25 to indicate significant, separately identifiable evaluation and management services by the same physician on the same day of the procedure.

MSA 17-10 and MSA 17-24 may be found on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Manual Maintenance

If utilizing the online version of the manual at www.michigan.gov/medicaidproviders >> Policy, Letters & 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

Kathy Stiffler, Acting Director
Medical Services Administration

Michigan Department of Health and Human Services

Medicaid Provider Manual
January 2018 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	12.3 Timely Filing Billing Limit	In the 5th paragraph, the 2nd bullet point was revised to read: • Medicaid beneficiary eligibility/authorization was established retroactively~~:~~ ➢ ~~Beneficiary eligibility/authorization was established~~ more than 12 months after the DOS.~~; and~~ ➢ ~~The provider submitted the initial invoice within twelve months of the establishment of beneficiary eligibility/authorization.~~ The following bullet was added after the 2nd bullet: • Medicaid beneficiary eligibility/authorization was established retroactively less than 12 months after the DOS. Claims will be accepted up to six months after the retroactive eligibility determination date. Providers with claims that meet this retroactive eligibility exception must indicate 'timely filing' in the comment section of the claim.	
Beneficiary Eligibility	2.1 Benefit Plans	Addition of new benefit plan: Benefit Plan ID: MA-FTW Benefit Plan Name: Freedom to Work Benefit Plan Description: Freedom to Work is available to a client with disabilities, age 16 through 64, who has earned income. The client must be disabled according to the disability standards of the Social Security Administration, except employment, earnings, and substantial gainful activity (SGA) cannot be considered in the disability determination. The client must be employed. There may be temporary breaks in employment up to 24 months if they are the result of involuntary layoff or are determined to be medically necessary. FTW coverage is retained when a participant is relocated due to employment. Type: Fee-For-Service Funding Source: XIX Covered Services: 1, 33, 35, 47, 48, 50, 71, 86, 88, 91, 92, 98, AL, MH, UC (35: FFS dental only if HK Dental is not assigned for DOS)	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Coordination of Benefits	2.6.B. Medicare Part A	The text box following the 1st paragraph was revised to read: For QMBs, if MDHHS is paying a beneficiary's Medicare Part B premium and the beneficiary does not have free Medicare Part A, MDHHS also pays the beneficiary's Medicare Part A premium.	Clarification.
Coordination of Benefits	2.6.K. Other Insurance Carrier ID List	The subsection title was revised to read: Other Insurance Payer ID Text was revised to read: Other Insurance Payer IDs can be accessed in CHAMPS by individual beneficiary. ~~The Other Insurance Carrier ID List on the MDHHS website provides a listing of codes assigned by MDHHS for each insurance carrier. (Refer to the Directory Appendix for website information.) The list is available by carrier code and by carrier name and is updated quarterly.~~ All third-party carriers must be used to the fullest extent possible~~,~~ prior to billing Medicaid and Children's Special Health Care Services (CSHCS) Programs, including Medicaid Health Plans (MHPs) and PIHPs/CMHSPs/CAs. ~~Major carriers (e.g., Blue Cross/Blue Shield, Aetna) are listed by the Other Insurance Code with the home offices first, usually followed by the district offices. Providers should submit the other insurance claims to the nearest office. If the provider is in doubt, claims should be sent to the home office of the carrier.~~	Removal of obsolete information.
Ambulance	2.8 Neonatal	The last paragraph was revised to read: Waiting time that exceeds 30 minutes is reimbursable and must be billed ~~as detailed in~~ consistent with the Waiting Time subsection of this section.	Clarification.

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

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CHAPTER	SECTION	CHANGE	COMMENT
		• type of ongoing treatment (required for ongoing, planned treatment); and • an explanation of why ground transportation is not appropriate (required when transported by air ambulance). A separate physician's order is required for each individual round trip transport, unless a beneficiary has a chronic medical condition that requires planned treatment. For chronic conditions, a physician may order non-emergency transportation for a maximum time period of up to 60 days in a single order. The physician's order for ongoing treatment must state the frequency of the transport and the type of ongoing treatment necessary. If the ambulance provider is unable to obtain a written order signed ~~physician certification statement from~~ by the beneficiary's attending physician, ~~a signed certification statement must be obtained from the~~ a physician's assistant, nurse practitioner, clinical nurse specialist, registered nurse, or discharge planner who is knowledgeable about the beneficiary's condition and who is employed by the attending physician or facility to which the beneficiary was admitted may sign in the physician's place. Non-emergency transport in a Medi-van or other wheelchair-equipped vehicle is not a covered service for ambulance providers. However, Medicaid beneficiaries or transportation providers may receive reimbursement for this type of transport directly from the local MDHHS office, an MDHHS contracted transportation broker or, if the beneficiary is enrolled, an MHP. Refer to the Non-Emergency Medical Transportation Chapter of this manual for additional information. (textbox language remains the same)	
Ambulance	3.3 Continuous or Round Trip Transport	The 1st paragraph was revised to read: ~~This~~ These types of transports are ~~is~~ considered to be one run. The base rate code for the highest level of service performed during transport should be billed on one claim line. Loaded mileage is also billed on one claim line, with the total number of whole (loaded) miles ~~reported~~ indicated as the quantity.	Clarification.

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Ambulance	3.4 Nursing Facilities	Text was revised to read: ~~Routine, non-emergency medical transportation provided for NF residents in a van or other nonemergency vehicle is included in the facility's per diem rate. This includes transportation for medical appointments, dialysis, therapies, or other treatments not available in the facility.~~ When ~~the~~ a resident~~'s attending~~ requires physician ~~orders~~ ordered medically necessary non-emergency ambulance transportation ~~(due to the need for a stretcher or other emergency equipment)~~, the ambulance provider may only bill MDHHS directly. This cost must not be claimed as a routine cost on Michigan's Medicaid cost report. The ambulance provider must maintain the physician's written order as documentation of medical necessity. (Refer to the Nursing Facility Coverages Chapter of this manual for additional information.) If ~~the~~ a resident's attending physician does not order non-emergency ambulance transport, arrangements for payment must be between the facility and the ambulance provider, and cannot be charged to the resident, the resident's family, or used to offset the patient-pay amount. This cost ~~may~~ must not be claimed as a routine cost on Michigan's Medicaid cost report. The cost of non-emergency ambulance transports not ordered by the resident's physician must be identified and removed on Worksheet 1-B by the NF. ~~For direct reimbursement by MDHHS to an enrolled ambulance provider for services provided to a Medicaid beneficiary who is a resident of a NF, refer to the Ambulance Quick Reference Guide Section of this chapter.~~	Clarification.
Ambulance	3.5 Multiple Arrivals	The 1st sentence was revised to read: When multiple units respond to a call for services, only the entity that actually provides services ~~for~~ to the beneficiary may bill and be paid.	Clarification.
Ambulance	3.8 Out of State/Beyond Borderland Transports	The 1st sentence was revised to read: Except ~~for emergencies~~ in situations when an emergency response is required, out of state/beyond borderland ambulance transports require PA.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	2.4 Staff Provider Qualifications	In the table in the 2nd paragraph, text for 'Dietitian' was revised to read: An individual who is a Registered Dietitian or an individual who meets the qualification of Registered Dietitian established by the ~~American Dietetic Association~~ Academy of Nutrition and Dietetics.	Update.
Behavioral Health and Intellectual and Developmental Disability Supports and Services – Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix	2.3 Family Support and Training	In the 1st paragraph, the 1st sentence was revised to read: This service is provided by a peer-parent who has completed ~~specialized~~ MDHHS endorsed training. In the 2nd paragraph, the 3rd sentence was revised to read: The trained ~~peer-~~parent support partner has had or currently has a child with special mental health needs; provides education, training, and support; and augments the assessment and mental health treatment process. The 3rd paragraph was revised to read: The ~~peer-~~parent support partner must complete the MDHHS-~~approved~~ endorsed statewide training curriculum and be provided regular supervision and team consultation by the treating professionals. Completion of the initial three-day training curriculum is documented by a Certificate of Completion which must be maintained in the parent support partner's personnel file.	Consistency with terminology; clarification.
Behavioral Health and Intellectual and Developmental Disability Supports and Services – Non-Physician Behavioral Health Appendix	Section 1 – General Information	The 3rd sentence was revised to read: This information should be used in conjunction with the Billing & Reimbursement ~~for Professionals~~ Chapters of this manual, as well as the Medicaid Code and Rate Reference tool, MDHHS Practitioner and Medical Clinic Fee Schedule, and other related procedure databases/fee schedules located on the MDHHS website.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services – Non-Physician Behavioral Health Appendix	Section 3 – Covered Services	The following text was added to the 1st paragraph (before the last sentence): Non-physician behavioral health services are only covered in a non-facility setting.	Clarification.
Dental	1.1.A. Early and Periodic Screening, Diagnosis and Treatment	Text was revised to read: The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is available to all Medicaid beneficiaries under ~~the age of~~ 21 years of age. This program was established to detect and correct or ameliorate defects and physical and mental illnesses and conditions discovered in children. Under EPSDT, dental services are to be provided at intervals which meet reasonable standards of dental practice. Primary care providers (PCPs) should provide an oral health screening and caries risk assessment for beneficiaries under 21 years of age at each well child visit as recommended by the AAP periodicity schedule. Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter for additional information. ~~Primary Care Physicians (PCPs) should provide an oral health screening and caries risk assessment for beneficiaries under 21 years of age at each well child visit. As an oral health intervention, providers should apply fluoride varnish to all children from birth to 35 months of age up to four times in a 12 month time period.~~ ~~Providers must complete the online Children's Oral Health training modules and obtain certification prior to providing oral health screenings and fluoride varnish applications. Providers who complete the certification requirements are allowed to bill Medicaid for these services. Specific certification requirements are available on the MDHHS Oral Health website. (Refer to the Directory Appendix for website information). Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter for additional information.~~	Revised language to be more consistent with State Plan. Updated language to defer to AAP guidelines rather than indicating specific ages and frequency. The 1st, 2nd, and 3rd paragraphs are being combined. Language regarding online Children's Oral Health training modules will be indicated in the EPSDT chapter.

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CHAPTER	SECTION	CHANGE	COMMENT
Dental	1.1.B. Early and Periodic Screening, Diagnosis and Treatment Dental Periodicity Schedule	The 3rd paragraph was revised to read: The guidelines recommend that a child have a first dental visit when the first tooth erupts or no later than 12 months of age. ~~The examination is to be repeated every six months or as indicated by the child's risk status and susceptibility to disease.~~ The examination includes assessment of pathology and injuries, growth and development, and caries-risk assessment. Based on clinical findings and susceptibility to disease, the timing and frequency of radiographic imaging, oral prophylaxis, and topical fluoride should be provided as determined necessary. Systemic fluoride supplementation should be considered when fluoride exposure is suboptimal. The examination is to be repeated every six months or as indicated by the child's risk status and susceptibility to disease.	Clarification.
Dental	6.1.E.2. Screening of a Patient < 3 Years	The subsection title was revised to read: Oral Health Screening of a Patient ~~< 3 Years~~ Text was revised to read: An oral health ~~A~~ screening of a patient ~~<3 years~~ is an inspection of the oral cavity by a ~~medical provider~~ primary care provider (PCP) as part of the well child exam to determine the need for referral to a dentist for evaluation and diagnosis. This includes state or federally mandated screenings. Counseling with the primary caregiver and referral (as needed) is required. The oral health screening of a patient ~~<3 years~~ may be billed in conjunction with topical fluoride varnish applications, but may not be billed on the same date of service as other oral evaluation services. PCPs should provide an oral health screening and caries risk assessment for beneficiaries at each well child visit as recommended by the AAP periodicity schedule. Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter for additional information.	The AAP indicates the PCP should perform an "oral health screening." Deferring to AAP guidelines rather than indicating specific ages and frequency.
Dental	6.2.B. Topical Application of Fluoride	In the table, under "Varnish", bullet points were revised to read: • Ages 0 ~~–~~ through 2: Four times per 12 months as a therapeutic application for all children. • Ages 3 ~~–~~ through 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 ranges.

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CHAPTER	SECTION	CHANGE	COMMENT
Dental	8.1 Covered Services	In the 3rd paragraph, text was revised to read: Beneficiaries under age 21 who are dually-enrolled in Medicaid and Children's Special Health Care Services (CSHCS) ~~and reside in any county except Kent, Oakland and Wayne~~ will receive their general dental benefits through *Healthy Kids Dental* up to age 21. ~~In Kent, Oakland and Wayne counties, *Healthy Kids Dental* provides the general dental benefit to all dually-enrolled beneficiaries up to age 13. Dually-enrolled Medicaid and CSHCS beneficiaries over the age of 13 who reside in Kent, Oakland and Wayne counties receive dental benefits through Medicaid Fee-For-Service (FFS).~~ If the beneficiary's CSHCS diagnosis qualifies for CSHCS specialty dental services (e.g., orthodontics), the specialty dental services are administered through MDHHS and are not part of the *Healthy Kids Dental* benefit plan. The specialty provider must be a CSHCS approved provider listed on the beneficiary's file, and must follow the coverage requirements and claims procedures for specialty dentistry described in ~~the Dental Chapter~~ this chapter and in the Billing & Reimbursement for Dental Providers Chapter.	Update.
Early and Periodic Screening, Diagnosis and Treatment	Section 12 - Children in Foster Care	In the 6th paragraph, the 1st sentence was revised to read: The Implementation, Sustainability and Exit Plan (ISEP) requires that all children who are 3 years of age or older at the time of entry into foster care will receive a dental examination within 90 days of entry into foster care unless the child had a dental exam in the six months prior to foster care placement.	Language differentiates requirement of AAP vs. foster care ISEP requirements.
Federally Qualified Health Centers	Throughout the Chapter	Use of 'Memorandum of Agreement' was revised to read 'Memorandum of Understanding'. Use of 'MOA' was revised to read 'MOU'.	Update.
Federally Qualified Health Centers	6.4 Medicaid Appeals	The 2nd sentence was revised to read: The appeal process is outlined in the General Information for Providers Chapter of this manual and in the MDHHS Medicaid Provider Reviews and Hearings rules, Michigan Administrative Code R 400.~~3401~~ 3402 through R400.~~3424~~ 3425, amended, and filed with the Secretary of State on ~~March 7, 1978~~ May 19, 2016.	Update to reflect amended administrative rules.

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CHAPTER	SECTION	CHANGE	COMMENT
Hearing Aid Dealers	1.7 Dispensing Fee	In the 1st paragraph, the 1st bullet point was revised to read: • Hearing aid delivery (includes digital hearing aids for all ages ~~effective 2/1/09~~)	Removal of obsolete text.
Hearing Aid Dealers	2.1 Hearing Aids - General	In the 2nd paragraph, the 3rd bullet point was revised to read: • No hearing aid has been dispensed to the beneficiary within the last ~~three years. For hearing aids ordered on or after February 1, 2009, the dispensing period is~~ five years.	Removal of obsolete text.
Hearing Aid Dealers	2.3.D. Payment Rules	The 1st paragraph was revised to read: Each of the HCPCS procedure codes for CROS systems covers both the transmitter and the receiver/hearing aid. No other hearing aid device procedure code may be billed in addition to the specific CROS code used.	Consistency with terminology; clarification.
Hospital Reimbursement Appendix	8.8 GME Innovations Agreements	The subsection was reformatted to allow for subsection categories. A new subsection category, titled 8.8.A. GME Innovations Hospital Program, was established and text formerly under 8.8 GME Innovations Agreements was relocated to this new subsection category. In the 1st paragraph, the last bullet point was revised to read: • Pine Rest Christian Mental Health Services for $3,960,000 in FY17, $6,336,000 in FY 18, and $7,603,200 in FY 19 and future years. In the 2nd paragraph, the 1st sentence was revised to read: MDHHS will approve ~~two~~ three agreements statewide each fiscal year.	Clarification; corrections.
Hospital Reimbursement Appendix	13.1 Registration and Interfaces with the National Level Repository	In the 2nd paragraph, the 6th sentence was revised to read:: Providers must be an enrolled Michigan Medicaid provider and have an active Payee-Tax Identification on record within ~~the Michigan Treasury MAIN system~~ SIGMA Vendor Self Service (VSS).	SIGMA update.

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CHAPTER	SECTION	CHANGE	COMMENT
Local Health Departments	7.3 Medicaid Provider Appeals	The 2nd paragraph was revised to read: The appeals process is outlined in the MDHHS Medicaid Provider Reviews and Hearings rules, Michigan Administrative Code R 400.~~3401~~ 3402 through R 400.~~3424~~ 3425, amended. ~~in the Michigan Compiled Laws.~~ Any questions regarding the appeal process should be directed to the MAHS.	Update to reflect amended administrative rules.
Medical Supplier	1.7.J. Hospital Discharge Waiver Services	In the 2nd paragraph, 'EO165' was revised to read 'E0165'.	Correction: 'zero' rather than 'O'.
Medical Supplier	2.13.A. Enteral Nutrition (Administered Orally)	Under 'PA Requirements', code B9000 was removed.	Removal of discontinued HCPCS code.
Medical Supplier	2.13.B. Enteral Nutrition (Administered By Tube)	Under 'PA Requirements', code B9000 was removed.	Removal of discontinued HCPCS code.
MI Choice Waiver	Section 11 – Appeals	The last sentence was revised to read: Provider appeal rights conform to the requirements of the Michigan Compiled Laws, MCL 400.1 et seq., ~~law~~ and the administrative rules found at ~~MCL 400.1 et seq. and MAC~~ Michigan Administrative Code R 400.~~3401~~ 3402 ~~et seq~~ through R 400.3425, amended.	Update to reflect amended administrative rules.
Non-Emergency Medical Transportation	Section 6 – Managed Care Programs	The following text was added after the 1st paragraph: For services provided to managed care enrollees in an FQHC, the MHP covers NEMT when: • the service is covered under the MHP contract and the FQHC is in the MHP's provider network; or • the MHP has prior authorized the FQHC for the service.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Non-Emergency Medical Transportation	Section 11 – Non-Covered Services	Text after the 8th bullet point was revised to read: • Services for long-term care beneficiaries. Routine, non-emergency medical transportation provided for long-term care residents in a van or other non-emergency vehicle is included in the facility's per diem rate. This includes transportation for medical appointments, dialysis, therapies, or other treatments not available in the facility. (Refer to the Nursing Facility Coverages chapter of this manual for additional information regarding NEMT for long-term care beneficiaries); ~~and~~ • Transportation for managed care program enrollees for services covered under the program contract (refer to the Managed Care Programs section of this chapter for additional information); and • Transportation for services provided in FQHCs.	Clarification.
Nursing Facility Coverages	10.37.A. Non-emergency Non-ambulance Transportation	In the 1st paragraph, the 2nd sentence was revised to read: This transportation includes transport to medical appointments/treatment not available in the facility (e.g., dialysis treatment), as well as when the facility arranges for services to be provided at the facility (e.g., hearing aid dealer; transportation costs of portable x-ray equipment and personnel).	Additional example to provide clarification.
Nursing Facility Coverages	10.37.C. Non-emergency Ambulance	The 1st paragraph was revised to read: When a physician issues a written order for non-emergency ambulance transportation, usually due to the need for a stretcher or other emergency equipment, the ambulance provider may only bill Medicaid directly and must maintain the physician's order as documentation of medical necessity. The written order must contain, at a minimum, the following information:	Clarification.
Nursing Facility Cost Reporting & Reimbursement Appendix	8.7 Facility Vehicles and Travel	In the 1st paragraph, the 1st sentence was revised to read: The cost of operating a facility-owned or -leased vehicle must be adequately documented and differentiated between ~~types~~ resident care ~~serviced~~ -use, business use or personal use.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Rural Health Clinics	9.5 Appeals	In the 2nd paragraph, the 1st sentence was revised to read: The appeal process is outlined in the MDHHS Medicaid Provider Reviews and Hearings administrative rules, Michigan Administrative Code R 400.~~3401~~ 3402 through R400.~~3424~~ 3425.	Update to reflect amended administrative rules.
School Based Services	2.1 Individuals with Disabilities Education Act Assessment and IEP/IFSP Development, Review and Revision	Under 'Provider Qualifications', the 6th and 7th bullet points were revised to read: • A fully licensed psychologist ~~(Doctoral level)~~ • A limited-licensed psychologist ~~(Doctoral level)~~ (under the supervision of a licensed psychologist)	Update.
Tribal Health Centers	Section 1 – General Information	Text was revised to read: Under the Indian Self-Determination and Education Assistance Act (Public Law 93-638), tribal facilities, including Tribal Health Centers (THCs), are those owned and operated by American Indian/Alaska Native tribes and tribal organizations under contract or compact with the Indian Health Service (IHS). The Michigan Department of Health and Human Services (MDHHS), which administers the State Medicaid Agency (SMA), has the authority to enter into reimbursement agreements with THCs to establish a payment mechanism for Medicaid beneficiaries receiving outpatient services through a THC. ~~The reimbursement agreement is called a Memorandum of Agreement (MOA). THCs have the option of signing either the THC MOA or the Federally Qualified Health Center (FQHC) MOA. The MOA is effective when both MDHHS and a THC have signed the agreement. Outpatient benefits covered under the MOA are outlined in the Michigan Medicaid State Plan.~~ ~~Information in this chapter is to be used by THCs that have signed the THC MOA. This chapter is to be used in combination with other chapters in this manual.~~	Removal of obsolete information; update of terminology; clarification.

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		Under the Michigan Medicaid State Plan, THCs have the option of choosing from one of three reimbursement mechanisms. The THC may elect to be reimbursed under only one of the options listed below, and the selected option applies to all beneficiaries receiving services at the THC. The options are: • A THC may choose to be certified as an IHS facility~~, sign the THC MOA~~ and receive the IHS ~~encounter~~ outpatient all-inclusive rate (AIR) for eligible encounters. ~~in accordance with the terms of the MOA.~~ The AIR applies to encounters for both native and non-native Medicaid beneficiaries. THCs are reimbursed at the AIR unless the THC chooses a different payment option and informs MDHHS of this choice in writing. • If a THC chooses to be reimbursed as a FQHC, the entity would be required to adhere to the same requirements specified in the Federally Qualified Health Centers Chapter. • A THC may be reimbursed as a fee-for-service provider. THCs choosing this option receive payment for covered services. No additional reimbursement or settlement is made. Upon federal approval by the Health Resources and Services Administration, THCs may be reimbursed as a Federally Qualified Health Center (FQHC) by signing the FQHC Memorandum of ~~Agreement~~ Understanding (MOU). THCs choosing this option will receive the FQHC encounter rate set by the State in accordance with the Michigan Medicaid State Plan and federal regulations. The FQHC encounter rate applies to encounters for both native and non-native Medicaid beneficiaries. A THC electing to be reimbursed as an FQHC is not required to have a contract with the managed care entity.	

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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 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 THC MOA. These~~ Services must be billed using the appropriate evaluation and management (E/M) codes listed in the American Medical Association's Current Procedural Terminology (CPT) Book or Healthcare Common Procedure Coding System (HCPCS) codes. Providers should refer to the Non-Physician Behavioral Health provider database on the MDHHS website for the current list of covered procedure codes. The list of allowable services is reviewed annually and updated as applicable. Refer to the Additional Code/Coverage Resource Materials Section of the General Information for Providers Chapter for additional information regarding coverage parameters.	Removal of obsolete information.
Tribal Health Centers	2.2 Nonenrolled Providers	The 2nd sentence was deleted: ~~These services are reimbursed under the THC MOA.~~	Removal of obsolete information.
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, if applicable, ~~to the THC MOA rate (if the THC rate is elected) when~~ for services provided to Medicaid fee-for-service (FFS) or managed care beneficiaries. In the table in the 3rd paragraph, 'Pharmacy Services', the 1st and 2nd paragraphs were revised to read: Pharmacy services billed under the practitioner NPI number are included in the encounter rate but do not constitute a separate encounter ~~for reimbursement at the THC MOA rate~~ as they are considered part of the office visit. ~~Under the THC MOA,~~ Practitioner pharmacy services do not include drugs provided by a pharmacy. THCs with enrolled pharmacy providers may continue to bill prescription claims to the MDHHS Pharmacy Benefits Manager (PBM).	Removal of obsolete information; clarification

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CHAPTER	SECTION	CHANGE	COMMENT
Tribal Health Centers	3.4 Services Provided to Medicaid Health Plan Enrollees	The last sentence was revised to read: Approved services provided to MHP enrollees are then recognized as encounters. ~~for reimbursement purposes under the THC MOA.~~	Removal of obsolete information.
Tribal Health Centers	Section 6 – Encounters	Text was revised to read: THCs ~~signing one of the MOAs~~ are eligible to receive an encounter (per visit) rate as reimbursement for Medicaid covered services provided at the THC for native and non-native Medicaid beneficiaries. ~~not enrolled in managed care.~~ The IHS outpatient all-inclusive rate (AIR) is determined by the Centers for Medicare & Medicaid Services (CMS) and is published in the Federal Register. The FQHC encounter rate under the FQHC MOU ~~MOA~~ is an alternative methodology that was based on the prospective payment system (PPS) outlined in section 1902(bb) of the Social Security Act.	Clarification; update of terminology.
Tribal Health Centers	7.1 Other Insurance	The last sentence was revised to read: If payment received from other insurance exceeds the amount Medicaid would have paid, the THC must still submit a claim to Medicaid with the appropriate procedure code in order for the visit to be counted as an encounter. ~~under the MOA~~.	Removal of obsolete information.
Tribal Health Centers	7.6 Place of Service	In the 1st paragraph, the 1st sentence was revised to read: THC services provided to beneficiaries at the THC are reconciled annually, if applicable. ~~to the THC outpatient facility all-inclusive encounter rate or according to the signed MOA.~~	Clarification; removal of obsolete information.
Tribal Health Centers	8.1 Quarterly Payments	The 1st sentence was revised to read: ~~Under the MOA,~~ Quarterly payments are made to the THC at the beginning of each quarter.	Removal of obsolete information.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Tribal Health Centers	8.2 Initial Reconciliation and Settlement	The 1st sentence was revised to read: An annual reconciliation, if applicable, ensures that reimbursement is made according to the payment option selected by the THC ~~at the rates agreed to in the THC MOA.~~	Clarification; removal of obsolete information.
Tribal Health Centers	8.4 Appeals	The 2nd sentence was revised to read: The appeals process is outlined in MDHHS Medicaid Provider Reviews and Hearings rules, Michigan Administrative Code R 400.~~3401~~ 3402 through R 400.~~3424~~ 3425, amended, and filed with the Secretary of State on ~~March 7, 1978~~ May 19, 2016.	Update to reflect amended administrative rules.
Acronym Appendix		Addition of: AIR – All-Inclusive Rate ISEP - Implementation, Sustainability and Exit Plan MOU – Memorandum of Understanding SGA - substantial gainful activity	Update.
Directory Appendix	Eligibility Verification - Web-DENIS	The website address was revised to read: www.michigan.gov/medicaidproviders >> Beneficiary Eligibility Verification	Update.
Directory Appendix	Eligibility Verification - Medicare DSH Audits - Eligibility Verification for Dates Of Service Over 12 Months for Hospital Providers	The CHAMPS website was revised to read: www.michigan.gov/tradingpartners >> HIPAA –Companion Guides	Update.
Directory Appendix	Prior Authorization - Prior Authorization (MHP)	The website address was revised to read: www.michigan.gov/medicaid >> Program Resources >> Medicaid Health Plans	Update.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Billing Resources - Other Insurance Carrier List	Information for 'Other Insurance Carrier List' was removed.	Removal of obsolete information.
Directory Appendix	Claim Submission/Payment - Document Management Portal	The website address was revised to read: www.michigan.gov/medicaidproviders >> Document Management Portal	Update.
Directory Appendix	Policy/Forms/ Publications - ListServ Communications	The website address was revised to read: www.michigan.gov/medicaidproviders >> Listserv Instructions (under Resources)	Update.
Directory Appendix	Policy/Forms/ Publications Numbered Letters	The website address was revised to read: www.michigan.gov/medicaidproviders >> Policy, Letters & Forms	Update.
Directory Appendix	Appeals - Appeals (Provider)	The website address was revised to read: www.michigan.gov/medicaidproviders >> Michigan Administrative Hearing System for the Department of Health and Human Services (under Resources)	Update.
Directory Appendix	Health Plan Information - Medicaid Health Plans	The website address was revised to read: www.michigan.gov/medicaid >> Program Resources >> Medicaid Health Plans	Update.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Health Plan Information - ~~MHP &~~ PIHP Contact Information, Services Areas	The Contact/Topic was revised to read: ~~MHP &~~ PIHP Contact Information, Services Areas The website address was revised to read: www.michigan.gov/mdhhs >> Keeping Michigan Healthy >> Behavioral Health and Developmental Disability >> Mental Health >> Community Mental Health Services	Update.
Directory Appendix	Provider Resources - MDHHS Bureau of Epidemiology and Population Health; Division of Communicable Diseases	The website address was revised to read: www.michigan.gov/mdhhs >> Keeping Michigan Healthy >> Communicable & Chronic Diseases >> Communicable Disease Information and Resources	Update.
Directory Appendix	Provider Resources - Medicaid State Plan	The website address was revised to read: www.michigan.gov/medicaid >> Program Resources	Update.
Directory Appendix	MI Choice Waiver Resources - MI Choice Intake Guidelines	The website address to view documents was revised to read: www.michigan.gov/medicaidproviders >> MI Choice	Update.
Directory Appendix	MI Choice Waiver Resources - MI Choice Waiver – Provider Information	The website address was revised to read: www.michigan.gov/medicaidproviders >> MI Choice	Update.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	MI Choice Waiver Resources - Waiting List Removal – Adequate Action Notice	The website address was revised to read: www.michigan.gov/medicaidproviders >> MI Choice	Update.
Directory Appendix	MI Health Link Medicaid State Plan Personal Care Services Payment Schedule	The website address was revised to read: www.michigan.gov/homehelp	Update.
Directory Appendix	MI Health Link - MI Health Link	The website address was revised to read: www.michigan.gov/mihealthlink >> Providers	Update.
Directory Appendix	Nursing Facility Resources - Michigan Medicaid Nursing Facility Level of Care Determination	The website address was revised to read: www.michigan.gov/medicaidproviders >> Michigan Medicaid Nursing Facility Level of Care Determination	Update.
Directory Appendix	Other Health Care Resources/Programs - MIChild	Mailing/Email/Web Address information was revised to read: ~~Local Health Department~~ www.michigan.gov/michild Application at: www.michigan.gov/mibridges Information Available/Purpose was revised to read: Apply at local MDHHS office or online though MI Bridges	Update.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Claim Submission/Payment Vendor Registration and Electronic Funds Transfer	'Mailing/Email/Web Address' text was revised to read: ~~Department of Technology, Management & Budget~~ State Budget Office The website was revised to read: www.michigan.gov/SIGMAVSS	SIGMA update.
Directory Appendix	Nursing Facility Resources Payee Registration Helpline	Under 'Mailing/Email/Web Address', the website was revised to read: www.michigan.gov/SIGMAVSS 'Information Available/Purpose' was revised to read: Enroll with ~~Contracts & Payment Express~~ SIGMA Vendor Self Service (VSS) for payment issued outside claims processing	SIGMA update.
Forms Appendix	Sample 4 – Paper Remittance Advice	The sample for the 'Paper Remittance Advice' was revised.	SIGMA update.

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Medicaid Provider Manual
January 2018 Updates

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 17-09	2/24/2017	General Information for Providers	4.2 Provider Profiles	In the table in the 3rd paragraph, the following profiles were added for Pharmacy providers: • CHAMPS Full Access • CHAMPS Limited Access • Claims Access
		Pharmacy	1.2 Definitions	Text for 'Average Wholesale Price (AWP)' was removed. The following text was added: National Average Drug Acquisition Cost (NADAC): Pricing benchmark based on a nationwide survey of retail community pharmacy covered outpatient drug prices.
			13.4 Product Cost Payment Limits	Text was revised to read: Product Cost Payment Limits are based on the NDC the pharmacy identifies as the product that was dispensed. Reimbursement is the lower of the ~~Average Wholesale Price (AWP) minus a discount,~~ National Average Drug Acquisition Cost (NADAC), the Wholesale Acquisition Cost (WAC) ~~markup~~, the MAC, or the provider's charge. Misrepresentation of the product's NDC results in denied payment and fraud/abuse sanctions subject to applicable Federal and State laws. Entities that participate in the Federal 340B program must bill the 340B price. ~~Medicaid's AWP discount or equivalent WAC markup is posted on the MDHHS website.~~ NADAC rates are posted on the CMS website. (Refer to the Pharmacy Resources portion of the Directory Appendix for website information.)

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			13.5 Dispensing Fees	The subsection title was revised to read: Professional Dispensing Fees The 1st sentence was revised to read: The professional dispensing fee is defined as the fee charged for filling a prescription and all related services performed by a pharmacy.
			13.10 Coordination of Benefits	In the 1st paragraph, the 5th sentence was revised to read: Providers must submit the charge as the amount allowed by the other insurance, indicating the other insurance payment (including the professional dispensing fee) and the other insurance copayment.
			14.4.B. Dispensing Fees	The subsection title was revised to read: Professional Dispensing Fees In the 1st paragraph, the 1st sentence was revised to read: Professional dispensing fees for compounded drugs are available on the MDHHS website.
			14.6 Clozapine	The 2nd sentence was revised to read: A professional dispensing fee may be reimbursed each week when billed in accordance with other MDHHS and FDA product licensure guidelines.
			Section 16 – Public Health Service and Disproportionate Share Hospitals	In the 2nd paragraph, the 1st sentence was revised to read: In addition to these product cost discounts, entities participating in this contract drug program are required by Federal policies to bill drugs covered in the PHS program using the actual acquisition cost for a drug plus a professional dispensing fee.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			19.1 Documentation Requirements	In the table in the 2nd paragraph, topics were placed in alphabetical order. Information for 'Dispensing Fees' was revised to read: Professional Dispensing Fees Pharmacies may not bill in a pattern that would lead to more than 13 professional dispensing fees in a 365-day billing period for the same drug entity. Splitting prescriptions to increase the number of fees paid is considered fraud and will be reported to the appropriate unit for investigation.

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			19.3 Medication Therapy Management Documentation Requirements (new subsection)	New subsection text reads as follows: Pharmacists must document each Medication Therapy Management (MTM) service provided. Documentation must include, but is not limited to, the following: • Beneficiary information ➢ Name ➢ Address and telephone number ➢ Medicaid identification number ➢ Gender ➢ Date of birth • Beneficiary's consent for the MTM service, indicated by the beneficiary's signature and date ➢ If the beneficiary is a child who is younger than the age of consent per state law, or has physical or cognitive impairments that preclude the beneficiary from managing his or her own medications, a caregiver (e.g., caretaker relative, legal guardian, power of attorney, licensed health professional) may provide written consent on the beneficiary's behalf. • Pharmacist information ➢ Name ➢ Pharmacist National Provider Identifier (NPI) ➢ Pharmacy Name and NPI • Date of Service • Place of Service • Indication of how the beneficiary meets the criteria to receive an MTM service (e.g., meets the chronic condition requirement) • Indication if this is an initial assessment or follow-up assessment • Current medical conditions • Allergies • Primary physician and contact information Other information may include the following (items are required if relevant):

				• Date of documentation • Location of beneficiary if service is provided through telepractice • Time spent with beneficiary • Resolved medical conditions • List of all prescription drugs, along with prescriber information and name of dispensing pharmacy • List of nonprescription drugs with their indications • List of drug doses, directions and intended use • List of all relevant medical devices • List of all dietary supplements and herbal products • Alcohol and tobacco use history • List of environmental factors that impact the beneficiary • Assessment of drug problems identified, including but not limited to: ➢ Determining that the medications are appropriately indicated ➢ Determining if the beneficiary needs additional medications ➢ Determining if the medications are the most effective products available for the conditions ➢ Determining if the medications are dosed appropriately to meet goals of therapy ➢ Identifying adverse effects caused by medications ➢ Determining if the medications are dosed excessively and causing toxicities ➢ Determining if the beneficiary is taking the medications appropriately to meet goals of therapy ➢ Evaluating effectiveness and safety of current drug therapy ➢ Written plan, including goals and actions needed to resolve issues of current drug therapy ➢ Evaluation of success in meeting goals of medication treatment plan ➢ Information, instructions and resources delivered to the beneficiary ➢ Content of pharmacist's communications to beneficiary's other health care providers

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				• Description of what was discussed with the beneficiary during the assessment, and whether that information was communicated to the beneficiary's primary care providers This documentation must be made available to MDHHS upon request. In addition, this documentation and any other relevant documentation may be collected by MDHHS or its designee on an annual basis for the purposes of program evaluation.
			Section 21 - Medication Therapy Management (new section)	Addition of new section title.
			21.1 Overview of Medication Therapy Management (MTM) (new subsection)	New subsection text reads as follows: Medication Therapy Management (MTM) services are face-to-face consultations provided by pharmacists to optimize drug therapy and improve therapeutic outcomes for beneficiaries. Beneficiaries may elect MTM as an optional service provided by participating pharmacists. (Refer to the Eligible Providers subsection for information on enrolling as an MTM provider.) These services are paid through the Fee-for-Service program for beneficiaries enrolled either in FFS or in a Medicaid Health Plan. There is no cost-sharing responsibility to the beneficiary for the MTM service. The requirements outlined in the Counseling Requirements section may not be billed as an MTM service.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			21.2 Covered Services (new subsection)	New subsection text reads as follows: MTM services include the following: • Obtaining necessary assessments of the beneficiary's health status • Formulating a medication treatment plan • Monitoring and evaluating the beneficiary's response to therapy, including safety and effectiveness • Performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events • Documenting the care delivered and communicating essential information to the beneficiary's other primary care providers • Referring the beneficiary to his/her primary care provider or specialist, if necessary • Providing verbal education and training designed to enhance the beneficiary's understanding and appropriate use of medications • Providing information, support services, and resources designed to enhance adherence with the beneficiary's therapeutic regimens • Providing an updated personal medication record and medication action plan for the beneficiary • Coordinating and integrating MTM services within the broader health care management services being provided to the beneficiary Any recommended changes to the beneficiary's drug therapy must be approved by the original prescriber(s) of the affected drugs. Refer to the Medication Therapy Management Documentation Requirements subsection for requirements on documenting MTM services.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			21.3 Non-covered Services (new subsection)	New subsection text reads as follows: The following are not eligible to be covered as MTM services: • Services provided by telephone, email or US Postal Service mail • Services provided in skilled nursing facilities • Services provided to more than one beneficiary at a time (i.e., group services) • Services provided in an inpatient, institutional, or incarceration setting
			21.4 Eligible Recipients (new subsection)	New subsection text reads as follows: Beneficiaries are eligible for MTM services if they are not eligible for Medicare Part D and are taking a medication to treat or prevent one or more chronic conditions as identified in the List of Chronic Conditions for MTM Eligibility. (Refer to the Directory Appendix for website information.) MTM services must be provided face-to-face with the beneficiary whenever possible. If the beneficiary is a child who is younger than the age of consent per state law, or has physical or cognitive impairments that preclude the beneficiary from managing his or her own medications, MTM services may be provided face-to-face to a caregiver (e.g., caretaker relative, legal guardian, power of attorney, licensed health professional) on the beneficiary's behalf.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			21.5 Eligible Providers (new subsection)	New subsection text reads as follows: To provide MTM services, a pharmacist must be licensed and have successfully completed either the American Pharmacists Association's "Delivering Medication Therapy Management Services" certificate training program or other MTM program(s) approved by the Accreditation Council of Pharmacy Education. Pharmacists who meet these requirements must enroll in the Community Health Automated Medicaid Processing System (CHAMPS) with an Individual (Type 1) National Provider Identifier (NPI) Number as a Rendering/Servicing-Only provider. Under this type of enrollment, pharmacists are required to affiliate themselves with the billing NPI of a pharmacy, Federally Qualified Health Center (FQHC), Tribal Health Center (THC), or Rural Health Clinic (RHC). The pharmacist must enroll as a Non-Physician, with a Pharmacist specialty and the subspecialty of Medication Therapy Management. Individual pharmacists are not eligible for direct Medicaid reimbursement; payment for MTM services will be issued to the affiliated pharmacy, FQHC, THC and/or RHC NPI. Refer to the Provider Enrollment section of the General Information for Providers chapter for more information on this process. These services may not be delegated by pharmacists to pharmacy technicians or other healthcare professionals.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			21.6 Location Requirements (new subsection)	New subsection text reads as follows: MTM services may be provided in the following settings: • Ambulatory care outpatient setting • Clinic • Pharmacy • Beneficiary's home if the beneficiary does not reside in a non-covered services setting These services must be provided face-to-face in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings.
			21.7 Telepractice for MTM Services (new subsection)	New subsection text reads as follows: In the event that the beneficiary is unable to physically access a face-to-face care setting, an eligible pharmacist may provide MTM services via telepractice. Telepractice is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of services. Telepractice must be obtained through real-time interactions between the beneficiary's physical location (origin site) and the pharmacist provider's physical location (distant site). Telepractice services are provided to beneficiaries through hardwire or internet connection. It is the expectation that providers and facilitators involved in telepractice are trained in the use of equipment and software prior to servicing beneficiaries. The arrangements for telepractice will be made by the pharmacist. The administration of telepractice services are subject to the same provision of services that are provided to a beneficiary in person. Providers must ensure the privacy of the beneficiary and secure any information shared via telepractice. Refer to the Billing Instructions subsection (of this section) for instructions on indicating the MTM service was provided through telepractice.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			21.8 Billing Instructions (new subsection)	Addition of new subsection title.
			21.8.A Professional Claims (new subsection)	New subsection text reads as follows: Pharmacy-based MTM claims must be submitted on the professional claim format (HIPAA 837P). The Billing Provider reported on the claim must be the Pharmacy's (Type 2) NPI and be actively enrolled in CHAMPS to be paid. The Rendering Provider reported on the claim must be the Pharmacist's (Type 1) NPI and be actively enrolled in CHAMPS. For services provided through telepractice, each procedure code must include the modifier GT. Providers can submit HIPAA 837P electronic claims to CHAMPS through a billing agent, through a batch upload process, or through Direct Data Entry (DDE). Providers can also view claims online and complete claim replacements or voids within CHAMPS.
			21.8.B. Institutional Claims (new subsection)	New subsection text reads: The Billing Provider NPI reported on the claim must be the FQHC, RHC, or THC and be actively enrolled in CHAMPS. The Pharmacist (Type 1) NPI must be reported on the Institutional MTM claim as the Rendering Provider and must be actively enrolled in CHAMPS and associated to the Billing FQHC, RHC, or THC for the date of service. The NPI (Type 1 – Individual) number of the physician (MD or DO) overseeing the patient's care must be entered as the attending provider. The attending provider field is mandatory to complete.
		Tribal Health Centers	3.1 Covered Services	In the table in the 3rd paragraph, 'Pharmacy Services', the following text was inserted after the 2nd paragraph: Medication Therapy Management (MTM) services are face-to-face consultations provided by pharmacists to optimize drug therapy and improve therapeutic outcomes for beneficiaries. MTM services provided according to Medicaid policy may be eligible to receive the encounter rate. (Refer to the Pharmacy Chapter of this manual for additional information.)

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Acronym Appendix		Removal of: AWP - Average Wholesale Price Addition of: NADAC - National Average Drug Acquisition Cost
		Directory Appendix	Pharmacy Resources	Addition of: Contact/Topic: List of Chronic Conditions for Medication Therapy Management Eligibility Website: www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider-Specific Information >> Pharmacy
		Directory Appendix	Pharmacy Resources	Addition of: Contact/Topic: National Average Drug Acquisition Cost Website: https://data.medicaid.gov

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 17-10 and MSA 17-24	3/31/2017 and 6/30/2017	Federally Qualified Health Centers	Section 4 - Billing	The 1st paragraph was revised to read: FQHC providers are expected to practice in accordance with the accepted standards of care and professional guidelines applicable to medical, dental, and behavioral health services, and comply with all applicable policies published in the Michigan Medicaid Provider Manual. FQHC services must be billed according to instructions published in the Billing & Reimbursement for ~~Professionals~~ Institutional Providers Chapter of this manual. FQHCs must refer to this chapter for information needed to submit ~~professional~~ claims for Medicaid services, as well as information about how MDHHS processes claims and notifies the FQHC of its action. Policies for specific services are found in the provider-specific chapters of this manual. The 4th paragraph was revised to read: ~~The Provider (Type 1 – Individual) NPI number of the provider who performed the service, or the supervising physician, should be entered as the rendering provider. Do not enter the Group NPI number as the rendering provider.~~ The NPI (Type 1 – Individual) number of the physician (MD or DO) overseeing the beneficiary's care must be entered as the attending provider. The attending provider field is mandatory to complete. Additionally, the NPI (Type 1 – Individual) number of the practitioner who performed the service should be entered as the rendering provider. Do not enter a Group (Type 2) NPI number as the attending or rendering provider. The 5th paragraph was deleted. ~~NOTE: If the rendering provider field is left blank, the information in the billing provider field is used as the rendering provider which may result in improper edits, rejection of the claim, or inaccurate settlements.~~

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Federally Qualified Health Centers	4.1 Place of Service	The 1st paragraph was revised to read: Place of service codes are not applicable to institutional billing. However, if the FQHC performs a service that must be billed on the professional claim form ~~When billing services provided~~ within the FQHC, the appropriate place of service code is 50. For services not provided in the FQHC, bill the appropriate place of service (POS) code listed in the Billing & Reimbursement for Professionals Chapter of this manual.
		Federally Qualified Health Centers	4.2 Billing for Maternity Care	The last two sentences were revised to read: The claim for prenatal care ~~should be billed with a FQHC place of service (50) using the appropriate prenatal codes. These prenatal services~~ will be reimbursed under the PPS methodology.
		Federally Qualified Health Centers	4.3 Other Insurance	The last sentence was deleted. ~~(Refer to the Billing & Reimbursement for Professionals Chapter of this manual for specific billing guidelines.)~~
		Federally Qualified Health Centers	4.4 Medicare and Medicaid Crossover Claim	The 1st sentence was revised to read: Refer to the Billing & Reimbursement ~~for Professionals~~ Chapters of this manual for specific instructions regarding Medicare and Medicaid claims.
		Federally Qualified Health Centers	5.1 Reconciliation of Fee-for-Service	In the 1st paragraph, the last sentence was revised to read: (Refer to the Billing & Reimbursement ~~for Professionals~~ Chapters of this manual for additional billing information.)

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Rural Health Clinics	6.1 Billing Rural Health Clinic Services	The 1st paragraph was revised to read: RHC services must be billed according to instructions contained in the Billing & Reimbursement for ~~Professionals~~ Institutional Providers Chapter of this manual. RHCs must refer to that chapter for information needed to submit ~~professional~~ claims for Medicaid services, as well as information about how MDHHS processes claims and notifies the RHC of its action. If the RHC performs a service that must be billed on the professional claim form, refer to the Billing & Reimbursement for Professionals Chapter of this manual. Policies for specific services are found in the provider-specific chapters of this manual. The following text was inserted after the 3rd paragraph: The NPI (Type 1 – Individual) number of the physician (MD or DO) overseeing the beneficiary's care must be entered as the attending provider. The attending provider field is mandatory to complete. Additionally, the NPI (Type 1 – Individual) number of the practitioner who performed the service should be entered as the rendering provider. Do not enter a Group (Type 2) NPI number as the attending or rendering provider. The 4th and 5th paragraphs were deleted. ~~The Provider (Type 1 – Individual) NPI number of the provider who performed the service should be entered as the rendering provider. Do not enter the Group NPI number as the rendering provider.~~ ~~**NOTE:** If the rendering provider field is left blank, the information in the billing provider field is used as the rendering provider which may result in improper edits, rejection of the claim, or inaccurate settlements.~~
		Rural Health Clinics	6.2 Place of Service Requirements	The 1st paragraph was revised to read: Place of service codes are not applicable to institutional billing. However, if the RHC performs a service that must be billed on the professional claim form within the clinic, RHCs must use place of service (POS) code 72. ~~when billing services provided in the clinic.~~ For services provided outside the RHC, bill with the appropriate POS code noted in the Billing & Reimbursement for Professionals Chapter of this manual.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Rural Health Clinics	6.3 Billing for Maternity Care	In the 1st paragraph, the last two sentences were revised to read: The claim for prenatal care ~~should be billed with a RHC place of service (72) using the appropriate prenatal codes. These prenatal services~~ will be reimbursed under the PPS methodology.
		Rural Health Clinics	6.4 Other Insurance	The last sentence was revised to read: (Refer to the Billing & Reimbursement ~~for Professionals~~ Chapters of this manual for specific billing guidelines).
		Rural Health Clinics	6.5 Medicare and Medicaid Crossover Claims	The 1st sentence was revised to read: Refer to the Billing & Reimbursement ~~for Professionals~~ Chapters of this manual for specific instructions regarding Medicare and Medicaid claims.
		Tribal Health Centers	3.1 Covered Services	In the 3rd paragraph, text for 'Maternal Infant Health Program (MIHP)' was revised to read: THCs providing Maternal Infant Health Program (MIHP) services must be certified through MDHHS. Information specific to the coverages and limitations for MIHP services are detailed in the Maternal Infant Health Program Chapter of this manual. MIHP related services rendered to fee-for-service beneficiaries must be billed on the ASC X12N 837 5010 professional format. Refer to the Billing & Reimbursement for Professionals Chapter of this manual for specific billing guidelines. If the THC subcontracts any MIHP services, no duplicate billing is permitted.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Tribal Health Centers	Section 7 – Billing	The 2nd paragraph was revised to read: ~~The Provider (Type 1 – Individual) NPI number of the provider who performed the service should be entered as the rendering provider. Do not enter the Group NPI number as the rendering provider. NOTE: If the rendering provider field is left blank, the information in the billing provider field is used as the rendering provider which may result in improper edits and rejection of the claim.~~ The NPI (Type 1 – Individual) number of the physician (MD or DO) overseeing the beneficiary's care must be entered as the attending provider. The attending provider field is mandatory to complete. Additionally, the NPI (Type 1 – Individual) number of the practitioner who performed the service should be entered as the rendering provider. Do not enter a Group (Type 2) NPI number as the attending or rendering provider.
		Tribal Health Centers	7.2 Medicare and Medicaid Claims	The 1st sentence was revised to read: Refer to the Billing & Reimbursement ~~for Professionals~~ Chapters of this manual for specific instructions regarding Medicare and Medicaid claims.

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		Tribal Health Centers	7.6 Place of Service	Text was revised to read: Place of service codes are not applicable to institutional billing. However, if the THC performs a service that must be billed on the professional claim form within the clinic, THCs must use place of service (POS) code 07. For services provided outside the THC, bill with the appropriate POS code noted in the Billing & Reimbursement for Professionals Chapter of this manual. THC services provided to beneficiaries at the THC are reconciled annually, if applicable. ~~to the THC outpatient facility all-inclusive encounter rate or according to the signed MOA. The appropriate place of service (POS) code must be used on the claim form when billing. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for a list of POS codes.)~~ The THC may bill for covered services that are not provided at the THC. These services must be billed with the appropriate Place of Service (POS) code in compliance with the coverages and limitations specified in the Practitioner Chapter of this manual. A complete list of POS codes can be found in the Billing & Reimbursement for Professionals Chapter of this manual. ~~Covered services provided off-site to beneficiaries temporarily homebound because of a medical condition that prevents the beneficiary from traveling to the THC are eligible to receive the all-inclusive rate. The services must be provided by a practitioner employed by the THC, and the appropriate POS code must be used on the claim form when billing. A complete list of POS codes can be found in the Billing & Reimbursement for Professionals Chapter of this manual.~~ Services billed to Medicaid are subject to audit and verifications.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 17-16	6/1/2017	Hospital Reimbursement Appendix	8.8.B. GME Innovations Sponsoring Institution Program (new subsection)	New subsection text reads as follows: The GME Innovations Sponsoring Institution Program supports limited non-hospital affiliated GME Programs that emphasize the importance of coordinated care, health promotions and psychiatric care in integrated systems. The purpose of this training is to develop the skills and experience necessary to provide psychiatric services utilized by Michigan Medicaid patient groups. The GME Innovations Sponsoring Institution Program supports limited non-hospital affiliated GME programs that meet the requirements below. This includes sponsoring institutions whose primary purpose is to provide educational programs and/or health care services. A sponsoring institution assumes the financial and academic responsibility for a GME program. The single state agency will approve one (1) agreement statewide each Fiscal Year (FY). This agreement will be with Authority Health for $2.8 million for FY 2017 and $3.1 million for FY 2018 and subsequent years. If GME distributions exceed the expenses incurred by the sponsoring institution in residency training, the size of the agreement will be reduced to bring these elements into alignment. To be eligible for the GME Innovations Program without a hospital partner, an organization must meet the following criteria: • The organization must possess appropriate accreditation credentials. • The organization must meet the requirements associated with receiving Medicaid payments. • The organization must have an approved agreement with a sponsoring institution, a university psychiatric residency training program, and one or more community mental health services programs to provide accredited psychiatric residency training. • The organization must provide assurances that all training will take place in Michigan and prepare health care professionals to provide care to populations with the special characteristics of Michigan Medicaid patient groups.

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MSA 17-18	6/1/2017	Medical Supplier	1.5 Medical Necessity	The 1st paragraph was revised to read: ~~Medical devices are covered if they are the most cost-effective treatment available and meet the Standards of Coverage stated in the Coverage Conditions and Requirements Section of this chapter.~~ Medicaid covers medically necessary durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) for beneficiaries of all ages. DMEPOS are covered if they are the least costly alternative that meets the beneficiary's medical/functional need and meet the Standards of Coverage stated in the Coverage Conditions and Requirements Section of this chapter. The following text was added after the last paragraph: Refer to the Prior Authorization subsection of this chapter for medical need of an item beyond the MDHHS Standards of Coverage. NOTE: Federal EPSDT regulations require coverage of medically necessary treatment for children under 21 years of age, including medically necessary habilitative services. Refer to the Early and Periodic Screening, Diagnosis and Treatment Chapter for additional information. The Healthy Michigan Plan (HMP) covers habilitative services for all ages. Refer to the Healthy Michigan Plan Chapter for additional information.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			2.39 Speech Generating Devices	Text for 'Definition' was revised to read: ~~A Speech Generating Device (SGD) is defined as any electric or nonelectric aid or device that replaces or enhances lost communication skills. The device must be an integral part of a treatment plan for a person with a severe communication disability who is otherwise unable to communicate basic functional needs.~~ Speech generating devices (SGD) are defined as durable medical equipment (electric or nonelectric) that provide an individual with a severe speech impairment, who is unable to communicate using natural means (e.g., spoken, written, gestures, sign language), the ability to meet his or her daily communication needs. Other terms used interchangeably with SGD include augmentative and alternative communication (AAC) device or augmentative communication device (ACD).

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				Text for 'Standards of Coverage' was revised to read: ~~SGDs may be covered under the following conditions for beneficiaries who demonstrate the comprehension and physical skills necessary to communicate using the requested device.~~ ~~• Prosthetic Function - To replace a missing body part, to prevent or correct physical deformity or malfunction, or to support a weak or deformed portion of the body.~~ ~~• Rehabilitative Function - To restore communication skills to the previous functional level by providing a tool to the beneficiary.~~ ~~A speech-language pathologist, in conjunction with other disciplines such as occupational therapists, physical therapists, psychologists, and seating specialists as needed, must provide a thorough and systematic evaluation of the beneficiary's receptive and expressive communication abilities.~~ ~~Ancillary professionals must possess proper credentials (certification, license and registration, etc., as appropriate).~~ ~~SGD vendors (manufacturers, distributors) may not submit assessment information or justification for any requested SGD.~~ To be considered for coverage, documentation must substantiate medical need for beneficiaries whose needs cannot be met using natural communication methods and demonstrate the comprehension and physical skills necessary to communicate using the requested device. An SGD will be considered medically necessary when supporting documentation demonstrates all of the following: • The prognosis for developing and using oral speech as a primary method of communication is considered guarded; • The requested SGD is an integral part of the communication plan of care; and • The beneficiary will be able to use the device in all environments he/she frequents (e.g., home, school, job, etc.).

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				Software intended for augmentative communication purposes may be considered upon review of documentation supporting medical necessity. If the beneficiary intends to download augmentative communication software onto his/her personal laptop, computer, or iPad, it is the responsibility of the beneficiary and/or his/her legal guardian to check with the vendor of the personal device for licensing, compatibility, repair, warranty and proprietary information. Frequency – The program will purchase … The category 'Standards of Coverage - Eye Control' was added after 'Standards of Coverage': Standards of Coverage – Eye Control An eye control is a type of mechanism that helps the beneficiary access the SGD. The eye control may or may not be integrated within the speech generating device. Eye control mechanisms will be covered when all of the following apply: • All other methods to operate the SGD have been evaluated and ruled out and the eye control is the most appropriate method that provides a functional level of communication (speed, accuracy, etc.); • Documentation specifies medical, functional and physical necessity that supports the need for the eye control; and • The evaluation(s) has documented evidence of the beneficiary's ability to physically activate the system and demonstrate meaningful use of the device with minimal assistance from others.

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				The category 'Non-covered' was added after 'Standards of Coverage – Eye Control': Non-covered The following are non-covered: • Items that do not meet the definition of durable medical equipment and are not dedicated speech devices. • Software to play games, create spreadsheets or documents or is not specific to augmentative communication. • Environmental control units. • More than one SGD per beneficiary. • Registering the device. • Extended warranties. • SGDs used solely for education, vocational or recreational purposes. It is expected that the beneficiary will be able to use the device in all environments he/she frequents (e.g., home, school, job, etc.). • Replacements based on manufacturer recommended replacement schedules. • SGD requests for devices that do not match the beneficiary's current and reasonably foreseeable communication abilities and needs. • Separate billing for interfaces, cables, adapters or interconnects and switches (with the exception of accessing switches) necessary to interface with the SGD. • Requests for replacement due to new technology when the beneficiary's current SGD continues to meet his/her medical and functional needs. • Items that are not defined by the American Medical Association, the Food and Drug Administration, and the Pricing, Data Analysis, and Coding (PDAC) contractor as medical devices or dedicated durable medical equipment (e.g., personal tablets, computers, iPads, iPhones, etc.).

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				The category 'Evaluation Components' was added after 'Non-covered': Evaluation Components A speech-language pathologist, in conjunction with other disciplines such as occupational therapists, physical therapists, psychologists, and seating specialists as needed, must provide a thorough and systematic evaluation of the beneficiary's receptive and expressive communication abilities. Ancillary professionals must possess proper credentials (certification, license and registration, etc.) as appropriate. SGD vendors (manufacturers, distributors) may not submit assessment information or justification for any requested SGD. An objective evaluation (using objective functional baseline measures and/or standardized testing) of the beneficiary's receptive and expressive communication abilities by a speech-language pathologist (SLP), in conjunction with other applicable disciplines (e.g., occupational therapist, physical therapist, psychologists, and seating specialists, etc.) as needed, has been performed and the SLP has documented the following: • The beneficiary's functional ability to use the device throughout their daily activities. • The consideration of alternative access and positioning devices, as appropriate. • The device is appropriate to the beneficiary's current comprehension, abilities and skills. • The beneficiary demonstrates the cognitive, physical, visual and hearing skills necessary to communicate using the requested device. • The SGD is the least costly device that meets the beneficiary's basic communication needs (in the home and in their community). Include in the evaluation supporting documentation substantiating the requested device as the least costly alternative that meets the beneficiary's current functional needs.

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				• Assessment of the beneficiary on more than one device, by more than one manufacturer, and documenting why the requested device is more appropriate than the other device(s). Include the following in the evaluation: ➢ Device(s) evaluated; ➢ The beneficiary's performance on each device evaluated; ➢ The device requested (brand, make/model and type); and ➢ Reasons why other evaluated devices did not meet the beneficiary's needs. • A trial period using the requested device must be provided for initial device authorization requests. The trial period must be a least one month in length (the SLP may submit a prior authorization request for up to three months). The SLP must document a description of the trial period with the requested device, including length of trial, settings, outcome, and additional training needs identified.

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				The category 'Documentation' was revised to read: Documentation must be within ~~90~~ 180 days and include: • ~~Medical diagnosis. (The medical diagnosis must directly relate to the beneficiary's communication deficit.)~~ • the physician's order with the diagnosis directly related to the beneficiary's communication deficit. The order must be based on the SLP's evaluation of the beneficiary's communication abilities and medical needs. • the date of onset, progress made and a comprehensive summary of the beneficiary's communication goals. (Refer to criteria outlined in the Outpatient Therapy Chapter, Speech Therapy section.) • the assessment by a physical therapist (PT) or occupational therapist (OT) to address functional mobility and postural control. • the SLP's documentation of hearing and vision status. • a copy, if available, of the hearing (audiologist) or vision (ophthalmologist or optometrist) test if the beneficiary has had a hearing or vision test within the past 12 months. • a plan of care (POC) identifying other disciplines involved in the care and goals for therapy and training. For beneficiaries under the age of 21 attending school, the POC must include other disciplines and parents/legal guardian as appropriate (i.e., OT, PT, psychologist, school therapist, etc.). • specifications for the SGD. (Refer to the Outpatient Therapy Chapter.) • necessary therapy and training to allow the beneficiary to meet functional needs. • the speech and language evaluation results. All SGD evaluation documentation must be submitted following the established criteria stated within the Evaluations and Follow-up for Speech Generating Devices subsection of the Outpatient Therapy Chapter.

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				~~Documentation for modifications must indicate the changes in the beneficiary's functional or medical status that necessitate the need for modifications in the system or parts.~~ Documentation for modifications/upgrades must describe the changes in the beneficiary's physical, medical, cognitive, vision or hearing status that necessitates the need for the requested modifications/upgrades for the system or parts. A video of the beneficiary using the SGD and/or eye control is a useful tool in establishing the beneficiary's ability to use either item, but is not required. The SLP may submit a video with the prior authorization request if all of the following are met: • The beneficiary or beneficiary's legal guardian has dated and signed an authorization for the video documentation as additional documentation of the beneficiary's ability to use the device; • The video is current (within the past 12 months); and • The provider encrypts the video prior to sending it in with the prior authorization request (following HIPAA compliance regulations). ~~When a current SGD needs replacement and the replacement is identical to the SGD previously purchased by MDHHS, the documentation required is:~~ ~~• Clinical confirmation of continued suitability by a speech-language pathologist.~~ ~~• Clinical confirmation by a speech-language pathologist and occupational or physical therapist of the beneficiary's functional ability to use the SGD.~~ ~~• Cost of the repair and the cost of replacement.~~ ~~When a current SGD needs replacement and the replacement is different than the SGD previously purchased by the program, a new SGD evaluation must be conducted. Additional documentation required is a statement that indicates how the current system no longer meets the beneficiary's functional communication needs. A current reevaluation is required for any device that is not identical to the device being replaced.~~ ~~For replacements due to loss or damage, indicate the following additional documentation:~~ ~~• The cause of the loss or damage; and~~ • ~~The plan to prevent recurrence of the loss or damage.~~

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				The 'PA Requirements' category was revised to read: The speech-language pathologist performs the functional communication assessment and SGD evaluation and initiates the ~~PA~~ prior authorization request with a medical supplier that has a specialty enrollment with MDHHS to provide SGDs. To improve beneficiary access to low-end devices, a medical supplier without a SGD specialty enrollment with MDHHS may provide SGDs with eight minutes or less of speech capability, basic SGD accessories such as switches, buttons, etc., or SGD wheelchair mounting systems. A SGD vendor must enroll through the MDHHS CHAMPS PE on-line system as a medical supplier with a subspecialty of Speech Generating Devices in order to provide the full range of SGDs. (Refer to the Directory Appendix for contact information.) PA is required for all ~~SGD systems.~~ SGDs, eye control mechanisms, upgrades, modifications, accessories, repairs, replacements and device trials. Required documentation must accompany the Special Services Prior Approval—Request/Authorization (MSA-1653-B) when requesting authorization for all original and replacement/upgrade SGD requests. A copy of the physician prescription must be submitted with the request for an SGD. The prescription must be based on the evaluation of an individual's communication abilities and medical needs made by a speech-language pathologist and other evaluation team members (as appropriate). Modifications/Upgrades - ~~All modifications and upgrades for SGDs require PA.~~ Indicate the procedure code that defines the modification(s)~~, requesting PA for modifications and~~ or upgrade(s). Providers have six months from the prior authorization approval date to provide all approved items, including the SGD, mount and accessories. After six months, a new prior authorization request must be submitted. Repairs – For a repair, report HCPCS code ...

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				The category 'Follow-Up Services' was added after 'PA Requirements': Follow-Up Services The provision of speech therapy services for training following the purchase of an SGD is expected to occur within the 12 months following the beneficiary's receipt of the device. (Refer to the Outpatient Therapy Chapter and the Medicaid Code Rate and Reference tool for PA and coverage parameters.) During this time, the SLP and SGD provider are required to ensure that a support team is in place to assist the beneficiary and/or their family with all follow-up SGD needs and therapy. The category 'Frequency' was added after 'Follow-Up Services': Frequency The program will purchase new equipment only. Only one SGD will be purchased within a three-year period for beneficiaries under age 21. Only one SGD will be purchased within five years for beneficiaries age 21 and older. Exceptions may be considered in situations where there has been a recent and significant change in the beneficiary's medical or functional status relative to the beneficiary's communication skills. The category 'Warranty' was added after 'Frequency': Warranty The warranty period begins at the point when the device is in the beneficiary's home and the beneficiary has received adequate training to use the system for functional communication.

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				The category 'Repairs' was added after 'Warranty': Repairs Repairs for speech generating devices (SGD) are covered after the warranty expires for no more than one SGD per beneficiary. Additionally, repair of an SGD not purchased by MDHHS is covered only if the SGD is determined to be necessary to meet basic functional communication needs in accordance with the criteria for SGD coverage. For a repair, report HCPCS code K0739 (for the labor charge) and HCPCS code E1399 (for the replacement part). PA is required for all repairs. If repair charges exceed $150, a speech-language pathologist, occupational therapist, or physical therapist must conduct an evaluation. A statement must be included in the evaluation indicating whether the current SGD continues to meet the beneficiary's functional needs. If the beneficiary's needs are being met with the current system, PA may be granted. Each repair must consist of a thorough assessment of the general working condition of the entire system so that frequent repairs may be avoided. If additional repairs to the system are needed, PA for those additional services must be obtained. In some cases, it may be more costly to repair the SGD than to replace it. When requesting PA for a repair, provide the cost of the repair and the cost of the replacement so that determination can be made by MDHHS whether to repair or replace the device.

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				Technological improvements and upgrades are not considered repairs and must not be requested as such. The prior authorization request for repair must include: • Documentation from the SLP (or if not currently receiving speech services, a physician, a PT or OT, or teacher) confirming the current device is used by the beneficiary on a regular basis and continues to meet the beneficiary's needs; • Part number(s), description(s), manufacturer name, Healthcare Common Procedure Coding System (HCPCS) codes; and • Warranty information and catalog number(s) for the part number(s) to be used for the repair. Repairs must extend the useful lifetime of the SGD by at least one year from the date of the repair request.

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				The category 'Replacements' was added after ''Repairs': Replacements All replacements (identical, different, upgrades, downgrades) of an SGD require PA. Replacements may be covered when there has been a significant medical/functional change in the beneficiary's ability to use the SGD, the device is no longer repairable, or the cost of repairs exceeds the cost of replacement. Limits for replacement are based on medical/functional need and the operating condition of the beneficiary's current device. Manufacturer suggested replacement schedules are not considered a reason for replacement. When a current SGD needs replacement and the replacement is **identical** to the SGD previously purchased by MDHHS, the documentation required to be submitted with the prior authorization request is: • Clinical confirmation by the speech-language pathologist the device continues to be suitable for the beneficiary's needs; • The SLP, OT or PT confirmation of the beneficiary's functional ability to use the SGD; and • Cost to repair and cost to replace. If an identical SGD is no longer available, a new unit that is equivalent to the original in function, utility and user adaptability will be furnished.

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				When a current SGD needs replacement with an SGD that is **different** than the SGD previously purchased by the program, the documentation to be submitted with the prior authorization is: • A new speech and language evaluation; and • A statement (to be included with the evaluation) indicating why and how the current SGD no longer meets the beneficiary's functional communication needs. All other standards of coverage requirements must be met for coverage consideration. Replacement requests due to loss, damage or theft must include the policy or fire marshal report, as applicable, and a plan to prevent recurrence. MDHHS does not cover replacement of SGDs due to misuse or abuse. Under the category 'Payment Rules', text for 'Rental' was revised to read: Rental - ~~MDHHS will rent equipment or devices when the purchase price of the device, including the component parts, exceeds $9,000.~~ Equipment will not be rented for a period of less than 30 days and may be rented for a maximum period of 90 days. The monthly rental reimbursement rate will be 1/10 of the maximum purchase reimbursement. The amount reimbursed for rental will be deducted from the total purchase price. MDHHS will apply the trial period rental to the purchase of the SGD. For an SGD device(s) approved for a trial period and ruled out (by the SLP, the beneficiary and/or legal guardian, DME provider, etc.) at some point during the trial period (first, second or third month), MDHHS will reimburse the SGD provider for the period of time the device was trialed. (Refer to the Medical Supplier Database and the Medicaid Code Rate and Reference tool for specific HCPCS codes and rates.)

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 17-25	9/1/2017	Behavioral Health and Intellectual and Developmental Disability Supports and Services	Section 9 – Intensive Crisis Stabilization Services	Section 9 was reformatted to reflect two subsections: • 9.1 Adult Services (with subsections 9.1.A. to 9.1.F. – previously numbered as 9.1 to 9.6) • 9.2 Children's Services (new subsection, with subsections numbered as 9.2.A. to 9.2.F.)
			Section 9 – Intensive Crisis Stabilization Services	Text was relocated/reformatted as 9.1 Adult Services. The 2nd paragraph was revised to read: A crisis situation means a situation in which an individual is experiencing a serious mental illness or a developmental disability, ~~or a child is experiencing a serious emotional disturbance,~~ and one of the following applies:
			9.6 Individual Plan of Services	Text was relocated/reformatted as 9.1.F. Individual Plan of Services The last paragraph was deleted. ~~For children's intensive/crisis stabilization services, the treatment plan must address the child's needs in context with the family needs. Educational services must also be considered and the treatment plan must be developed in consultation with the child's school district staff.~~

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			9.2 Children's Services (new subsection)	New subsection text reads: Intensive crisis stabilization services are structured treatment and support activities provided by a mobile intensive crisis stabilization team that are designed to promptly address a crisis situation in order to avert a psychiatric admission or other out of home placement or to maintain a child or youth in their home or present living arrangement who has recently returned from a psychiatric hospitalization or other out of home placement. These services must be available to children or youth with serious emotional disturbance (SED) and/or intellectual/developmental disabilities (I/DD), including autism, or co-occurring SED and substance use disorder (SUD). A crisis situation means a situation in which at least one of the following applies: • The parent/caregiver has identified a crisis and reports that their capacity to manage the crisis is limited at this time and they are requesting assistance. • The child or youth can reasonably be expected within the near future to physically injure self or another individual, either intentionally or unintentionally. • The child or youth exhibits risk behaviors and/or behavioral/emotional symptoms which are impacting their overall functioning; and/or the current functional impairment is a clearly observable change compared with previous functioning. • The child or youth requires immediate intervention in order to be maintained in their home or present living arrangement or to avoid psychiatric hospitalization or other out of home placement. The goals of intensive crisis stabilization services are as follows: • To rapidly respond to any non-imminently life threatening emotional symptoms and/or behaviors that are disrupting the child's or youth's functioning; • To provide immediate intervention to assist children and youth and their parents/caregivers in de-escalating behaviors, emotional symptoms and/or dynamics impacting the child's or youth 's functioning ability; • To prevent/reduce the need for care in a more restrictive setting (e.g., inpatient psychiatric hospitalization, detention, etc.) by providing community-based intervention and resource development;

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				• To effectively engage, assess, deliver and plan for appropriate interventions to minimize risk, aid in stabilization of behaviors, and improve functioning; and • To enhance the child's or youth's and parent's/caregiver's ability to access any identified community-based supports, resources and services.
			9.2.A. Approval	New subsection text reads: The PIHP must seek and receive MDHHS approval, initially and every three years thereafter, for the intensive crisis stabilization services in order to use Medicaid funds for program services.
			9.2.B. Population	New subsection text reads: These services are for children or youth ages 0 to 21 with SED and/or I/DD, including autism or co-occurring SED and SUD, and their parents/caregivers who are currently residing in the catchment area of the approved program, and are in need of intensive crisis stabilization services in the home or community as defined in this section. Mobile intensive crisis stabilization teams must be able to travel to the child or youth in crisis for a face to face contact in one hour or less in urban counties, and in two hours or less in rural counties, from the time of the request for intensive crisis stabilization services.

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			9.2.C. Services	New subsection text reads: Component services include: • Assessments (rendered by the treatment team) • De-escalation of the crisis • Family-driven and youth-guided planning • Crisis and safety plan development • Intensive individual counseling/psychotherapy • Family therapy • Skill building • Psychoeducation • Referrals and connections to additional community resources • Collaboration and problem solving with other child- or youth-serving systems, as applicable • Psychiatric consult, as needed
			9.2.D. Qualified Staff	New subsection text reads: Intensive crisis stabilization services must be provided by a mobile intensive crisis stabilization team consisting of at least two staff who travel to the child or youth in crisis. One team member must be a Master's prepared Child Mental Health Professional (or Master's prepared Qualified Intellectual Disabilities Professional [QIDP], if applicable) and the second team member may be another professional or paraprofessional under appropriate supervision. Team members must have access to an on-call psychiatrist by telephone, as needed. At minimum, all team members must be trained in crisis intervention and de-escalation techniques.

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			9.2.E. Location of Services	New subsection text reads: Intensive crisis stabilization services must be provided where necessary to alleviate the crisis situation, and to permit the child or youth to remain in their usual home and community environment. Exceptions: Intensive crisis stabilization services may not be provided in: • Inpatient settings; • Jails or detention centers; or • Residential settings (e.g., Child Caring Institutions, Crisis Residential).

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			9.2.F. Individual Plan of Service	New subsection text reads: Intensive crisis stabilization services may be provided initially to alleviate an immediate crisis. However, following resolution of the immediate situation, an existing individual plan of service and crisis and safety plan must be updated or, for children or youth who are not yet recipients of CMHSP services but are eligible for such services, a family-driven and youth-guided follow-up plan must be developed. If the child or youth is a current recipient of CMHSP services, mobile intensive crisis stabilization team members are responsible for notifying the primary therapist, case manager, or wraparound facilitator, as applicable, of the contact with the mobile intensive crisis stabilization team the next business day. It is the responsibility of the primary therapist, case manager, or wraparound facilitator to follow-up with the child or youth and parent/caregiver. The child or youth, parent/caregiver and the relevant treatment team members must revisit the current individual plan of service and crisis and safety plan and make adjustments where necessary to address current treatment needs. If the child or youth is not yet a recipient of CMHSP services but is eligible for such services, the follow-up plan must include appropriate referrals to mental health assessment and treatment resources and any other resources the child or youth and parent/caregiver may require. The mobile intensive crisis stabilization team is responsible for providing necessary information and referrals. The follow-up plan must also include the next steps for obtaining needed services, timelines for those activities, and identify the responsible parties. Mobile intensive crisis stabilization team members must contact the parent/caregiver by phone or face-to-face within seven business days to determine the status of the stated goals in the follow-up plan.
		Healthy Michigan Plan	5.6.B.4. Crisis Services	Under “Intensive Crisis Stabilization Services”, the following text was added: Individuals between 19-21 years of age could be served under EPSDT utilizing the intensive crisis stabilization team for children. (Refer to the Intensive Crisis Stabilization Services section in the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter for additional information.)

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MSA 17-26	9/1/2017	Federally Qualified Health Centers	5.2 Documenting Encounters	Text was revised to read: Encounter data for FQHC ~~must document encounters when~~ services ~~have been~~ provided to beneficiaries through Medicaid Health Plans, ***Healthy Kids Dental***, and/or regional Prepaid Inpatient Health Plans (PIHP) is accessible through the Community Health Automated Medicaid Processing System (CHAMPS). ~~The FQHC must submit the details of the encounters and payments received for services provided to Medicaid patients who are not in Medicaid fee-for-service. The information must be in electronic format (database or spreadsheet) and show the following for each service provided:~~ • ~~Rendering Provider NPI~~ • ~~Date of service~~ • ~~Beneficiary Medicaid ID number~~ • ~~HCPCS or CPT procedure code~~ • ~~Payment received for the procedure~~ No individual payment information is needed if health plan payments are made on a capitated basis; however, a separate summary of the monthly payments must be provided. Upon review and audit, MDHHS will reimburse the difference between the FQHC PPS rate and the amount received from the Medicaid Health Plans, ***Healthy Kids Dental***, and/or the regional PIHP.

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		Rural Health Clinics	Section 8 – Reconciliation Reporting	Text was revised to read: Medicaid Reconciliation Reports must be completed by each RHC in order to receive reimbursement under the PPS. The RHC must file the following documents at the end of its fiscal year for ~~full cost~~ PPS reimbursement: • A copy of its filed Medicare Cost Report and Trial Balance • A completed copy of the Medicaid Reconciliation Report • ~~Detailed information on managed care encounters~~ Encounter data for RHC services provided to beneficiaries through Medicaid Health Plans, ***Healthy Kids Dental***, and/or regional Prepaid Inpatient Health Plans (PIHP) is accessible through the Community Health Automated Medicaid Processing System (CHAMPS). ~~The RHC must submit the details of the encounters and payments received for services provided to Medicaid patients who are not in Medicaid fee-for-service. The information must be in electronic format (database or spreadsheet) and show the following for each service provided:~~ • ~~Rendering Provider NPI~~ • ~~Date of service~~ • ~~Beneficiary Medicaid ID number~~ • ~~HCPCS or CPT procedure code~~ • ~~Payment received for the procedure~~ No individual payment information is needed if payments are made on a capitated basis; however, a separate summary of the monthly payments must be provided. Upon review and audit, MDHHS will reimburse the difference between the RHC PPS rate and the amount received from the Medicaid Health Plans, ***Healthy Kids Dental***, and/or the regional Prepaid Inpatient Health Plan (PIHP).

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MSA 17-27	9/1/2017	Behavioral Health and Intellectual Developmental Disability Supports and Services	1.6 Beneficiary Eligibility	In the table following the 2nd paragraph, the 3rd bullet point under PIHP/CMHSP responsibilities was deleted. • ~~The beneficiary has been treated by the MHP for mild/moderate symptomatology and temporary or limited functional impairments and has exhausted the 20-visit maximum for the calendar year. (Exhausting the 20-visit maximum is not necessary prior to referring complex cases to PIHP/CMHSP.) The MHP's mental health consultant and the PIHP/CMHSP medical director concur that additional treatment through the PIHP/CMHSP is medically necessary and can reasonably be expected to achieve the intended purpose (i.e., improvement in the beneficiary's condition) of the additional treatment.~~
		Behavioral Health and Intellectual Developmental Disability Supports and Services – Non-Physician Behavioral Health Appendix	Section 3 – Covered Services	In the 1st paragraph, the 1st sentence was deleted. ~~The Medicaid FFS benefit allows 20 combined outpatient behavioral health visits in a 12-month period by all FFS providers.~~
		Early and Periodic Screening, Diagnosis and Treatment	7.1 Referrals for Behavioral Health Services/ Therapy	In the 3rd paragraph, the 3rd sentence was deleted. ~~Under the MHP or through FFS, 20 combined outpatient behavioral health visits in a 12-month period are allowed.~~ In the 4th paragraph, the 3rd sentence was deleted. ~~In addition, the PIHPs/CMHSPs may be responsible for outpatient mental health treatment when the child has been treated by the MHP or through FFS for mild/moderate symptomatology, the child has exhausted the 20-visit maximum for the calendar year, and additional treatment is deemed to be medically necessary.~~

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		Healthy Michigan Plan	5.6.A. Mental Health Services	In the 1st paragraph, the 2nd sentence was revised to read: For mental health needs that do not meet established criteria ~~or are beyond the 20 visit limitation~~, health plans must coordinate with the appropriate PIHP to ensure that medically necessary mental health services are provided.
		Medicaid Health Plans	2.7 Mental Health	Text was revised to read: MHPs are required to provide ~~up to 20 visits per calendar year~~ behavioral health services under the Mental Health Outpatient benefit, consistent with the policies and procedures established by Medicaid. Services may be provided through contracts with Prepaid Inpatient Health Plans (PIHP) and/or Community Mental Health Services Programs (CMHSP) or through contracts with other appropriate providers within the service area. For mental health needs that do not meet Medicaid's established criteria ~~or are beyond the 20 visit limitation~~, MHPs must coordinate with the appropriate PIHP/CMHSP to ensure that medically necessary mental health services are provided. The Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter provides coverage policies for PIHPs/CMHSPs.

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

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