MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

Bulletin Number: MSA 18-45

Distribution: All Providers

Issued: November 30, 2018

Subject: Updates to the Medicaid Provider Manual

Effective: January 1, 2019

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

Updates to the Medicaid Provider Manual

The Michigan Department of Health and Human Services (MDHHS) has completed the January 2019 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 2019 version of the Manual does not highlight changes made in 2018. 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 2019 versions of the manual will be highlighted within the text of the on-line manual.

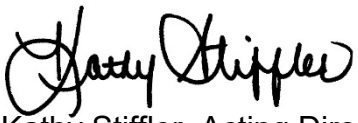
Manual Maintenance

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. Typical Providers may phone toll-free 1-800-292-2550. Atypical Providers may phone toll-free 1-800-979-4662.

Approved



Kathy Stiffler, Acting Director
Medical Services Administration

Michigan Department of Health and Human Services

Medicaid Provider Manual
January 2019 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	Section 18 – Review of Proposed Changes	In the 5th paragraph, the 3rd bullet point was revised to read: • ~~Mailing address (and~~ E-mail address~~, if requesting electronic distribution)~~;	Obsolete information. (Draft policies posted for public comment are distributed via E-mail only.)
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.29 Wraparound Services for Children and Adolescents	The 1st paragraph was revised to read: Wraparound services for children and adolescents is a highly individualized planning process facilitated by ~~specialized supports coordinators~~ Wraparound facilitators. The 3rd paragraph was revised to read: The Wraparound plan may also consist of other non-mental health services and supports that are secured from, and funded by, other agencies in the community. The Wraparound plan is the result of a collaborative team planning process that focuses on the unique strengths, values and preferences of the child/youth and family and is developed in partnership with other community agencies. This planning process tends to work most effectively with children/youth and their families who, due to safety and other risk factors, require services from multiple systems and informal supports. The Community Team, which consists of parents/guardians/legal representatives, agency representatives, and other relevant community members, oversees Wraparound from a system level. In the 4th paragraph, bullet points were revised to read: • (3rd bullet point) Children/youth who have ~~been served through~~ received other mental health services with minimal improvement in functioning. • (last bullet point) Numerous providers are ~~serving~~ working with multiple children/youth in a family and the identified outcomes are not being met.	Wraparound facilitators and supports coordinators are different roles. Clarifying language - Wraparound plans are not only coordination of services Clarifying intent of Community Team roles Clarifying language to be more family-driven and youth-guided because it is about partnering with children and families.

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

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.29.A. Organizational Structure	The 1st paragraph was revised to read: The required organizational structure of Wraparound programs must include a Wraparound facilitator, supervisor, and Community Team; define the roles and responsibilities of those staff and the Community Team; and delineate expectations regarding ~~caseload sizes~~ child and family team capacity. The 4th and 5th bullet points were revised to read: • The ~~caseload~~ child and family team ratio shall be reflective of the needs of individual children/youth and families being served and shall not exceed a ratio of one facilitator to 10 children/youth and family teams. ~~Caseloads~~ The number of child and family teams for one facilitator may increase to a maximum of 12 when two child/youth and family teams are transitioning from Wraparound. • If facilitators are assigned to other programs as well as Wraparound, the number of Wraparound child/youth and family teams they facilitate shall correlate to the percentage of their position dedicated to providing Wraparound facilitation. For example, if a worker is a .50 FTE Wraparound facilitator, the number of teams assigned to that Wraparound facilitator shall not exceed six when one team is in transition. In addition, ~~mixed caseloads~~ facilitators who have other roles shall not exceed ~~15 total cases~~ a total of 15 families across programs.	Change of language to reflect commitment to Family Driven Youth Guided Policy- cases is pejorative. Change of language to reflect commitment to Family Driven Youth Guided Policy.

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

Medicaid Provider Manual
January 2019 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.29.B. Qualified Staff	In the 1st paragraph, bullet points were revised to read: • (1st bullet point) Complete the MDHHS three-day new facilitator training within 90 days of hire. The Medicaid encounter cannot be reported until after completion of the initial training unless provisional approval has been applied for and granted by MDHHS. • (3rd bullet point) Demonstrate proficiency in facilitating the Wraparound process, as monitored by their supervisor ~~and Community Team~~. In the 2nd paragraph, bullet points were revised to read: • (2nd bullet point) Attend two MDHHS Wraparound trainings annually, one of which shall be a Wraparound supervisor-specific training. • (4th bullet point) Provide individualized ~~clinical~~ supervision and coaching to the Wraparound staff weekly based on their individual needs and experience and maintain a supervision log. Supervision logs will be available at site reviews and re-enrollment.	Incorporating Provisional approval into Medicaid Manual. Adapting the role of the community team to focus on community issues and barriers. Language clarification. Using supervision to enhance facilitator's understanding of the process.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.29.C. Plans of Service	The 1st bullet point was revised to read: • Evidence that the child/youth and family team completed each step/phase of the Wraparound process, including completion of the strengths/culture discoveries, needs assessments, crisis/safety support plans, Wraparound plans, outcomes, and the development of the ~~family~~ team mission statement.	Focus on importance of team. Family is an active part of the Wraparound team.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.29.E. Evaluation and Outcomes Measurement	The last bullet point was revised to read: • Adherence to Wraparound model fidelity may be reviewed at enrollment, re-enrollment, and at ~~site reviews~~ technical assistance visits through ~~case~~ file review, family interviews, and evaluation and fidelity tools.	Change of language to reflect commitment to Family-Driven Youth-Guided Policy and the Wraparound Statewide Coordinator will provide TA visits.

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

Medicaid Provider Manual
January 2019 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	Section 11 – Personal Care in Licensed Specialized Residential Settings	The 1st paragraph was revised to read: Personal care services are those services provided in accordance with an individual plan of service to assist a beneficiary in performing ~~his~~ their own personal daily activities. For children with serious emotional disturbance, personal care services may be provided only in a licensed foster care setting or in a Child Caring Institution (CCI) if it is licensed as a "children's therapeutic group home" as defined in Section 722.111 Sec. 1(f) under Act No. 116 of the Public Acts of 1973, as amended. For children with intellectual/developmental disabilities, services may be provided only in a licensed foster care or ~~child caring institution (~~CCI~~)~~ setting with a specialized residential program certified by the state. These personal care services are distinctly different from the state plan Home Help program administered by MDHHS.	Additional clarification for EPSDT children settings that are licensed in the State of Michigan.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	11.2 Provider Qualification	The 1st sentence was revised to read: Personal care may be rendered to a Medicaid beneficiary in ~~an Adult~~ a Foster Care or ~~a~~ CCI setting licensed and certified by the state under the 1987 Michigan Department of Health and Human Services Administrative Rule R330.1801-09 (as amended in 1995).	Additional clarification on settings covered for children under the EPSDT benefit.
Behavioral Health and Intellectual and Developmental Disability Supports and Services Non-Physician Behavioral Health Appendix	Section 5 – Claims Processing	The section title was revised to read: Claims Processing and Reimbursement Amounts The following text was added: Non-physician behavioral health payment rates are established by MDHHS as a fee screen for each procedure. Reimbursement is based on the Medicaid Practitioner fee schedule. Services performed by non-physician behavioral health providers are reimbursed at a percentage of the non-facility practitioner rate. Refer to the Medicaid Non-Physician Behavioral Health fee schedule or the Community Health Automated Medicaid Processing System (CHAMPS) Medicaid Rate and Reference tool for additional information. The fee schedule is reviewed and updated at least annually.	Update language to clarify reimbursement.

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

CHAPTER	SECTION	CHANGE	COMMENT
Early and Periodic Screening, Diagnosis and Treatment	5.2.C. Referral	Text was revised to read: A referral to a hearing center, audiologist, otologist, or Children's Special Health Care Services (CSHCS)-sponsored otology clinic at a LHD should be made if there are symptoms (e.g., parent/guardian has suspicions about poor hearing in the child), risk factors (e.g., exposure to ototoxic medications, family history of hearing deficits), or other medical justification for further objective testing or diagnosis.	Clarification of acronym.
Early and Periodic Screening, Diagnosis and Treatment	13.1 Psychiatric Services	The 1st paragraph was revised to read: ~~Limited~~ Psychiatric services are available for Medicaid FFS beneficiaries younger than 21 years of age with mild/moderate mental health conditions or suspected behavioral disorders. (Refer to the Behavioral Health and Substance Use Disorder Services subsection of the Practitioner Chapter for specific coverages.) MHP contracts include ~~limited~~ mental health benefit coverage for beneficiaries with mild/moderate mental health conditions.	Update.
Early and Periodic Screening, Diagnosis and Treatment	13.4 Pediatric Outpatient Intensive Feeding Program Services (new subsection; following subsections were re-numbered)	New subsection text reads: Pediatric outpatient intensive feeding program services are for beneficiaries with significant feeding and swallowing difficulties. Pediatric Outpatient Intensive Feeding Program services may be considered medically necessary for individuals with anatomical, physiological, congenital, or cognitive conditions and/or complications of severe illness who experience significant feeding difficulties. The child should be referred to a CSHCS-approved, Medicaid-enrolled program site that is certified by MDHHS. (Refer to the Pediatric Outpatient Intensive Feeding Program Services Section of the Special Programs Chapter for additional information.)	Groups similar services together (i.e., WIC and Pediatric Outpatient Intensive Feeding Program Services both have a nutritional component).
Early and Periodic Screening, Diagnosis and Treatment	~~13.4.B.~~ 13.5.B. Blood Lead Nursing Assessment Visits	The 1st sentence was revised to read: Blood lead nursing assessment visits for children with blood lead levels of 5 mcg/dL or greater are covered under the ~~Children's Special Health Care Services (~~CSHCS~~)~~ case management benefit.	Use of acronym.

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

CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	2.4 Medicare Severity Diagnosis Related Grouper Assignment	Subsection was deleted. Encompasses the following: 2.4.A. Inflation 2.4.B. MS-DRG Relative Weights 2.4.C. Episode File 2.4.D. DRG Price 2.4.D.1. Incentive Calculations 2.4.D.2. Updated Cost Adjustor 2.4.D.3. Budget Neutrality Factor 2.4.D.4. Cost-to-Charge Ratio 2.4.D.5. Summary of DRG Price Calculations 2.4.E. Special Circumstances Under DRG Reimbursement 2.4.E.1. High Day Outliers 2.4.E.2. Low Day Outliers 2.4.E.3. Less Than Acute Care 2.4.E.4. Cost Outliers 2.4.E.5. Transfers to an Acute Care Inpatient Hospital 2.4.E.6. Transfers from a Hospital 2.4.E.7. Readmissions 2.4.E.8. Percent of Charge Reimbursement 2.4.E.9. Hospitals Outside of Michigan 2.4.E.10. New DRG Hospitals 2.4.F. Hospitals and Units Exempt from DRG Reimbursement	Obsolete information. (The MS-DRG section of the Hospital Reimbursement Appendix was retained after the October 1, 2015 adoption of APR-DRG for provider's historical reference.)

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

CHAPTER	SECTION	CHANGE	COMMENT
		2.4.F.1. Freestanding Rehabilitation Hospitals/Distinct Part Rehabilitation Units 2.4.F.2. Hospitals Outside of Michigan 2.4.F.3. New Freestanding Hospitals and Distinct Part Units 2.4.G. Frequency of Recalibrations 2.4.H. Mergers 2.4.H.1. General Hospitals 2.4.H.2. Freestanding Rehabilitation Hospitals/Distinct Part Rehabilitation Units	
Local Health Departments	2.2.B.2. Environmental Investigations	The 5th paragraph was revised to read: Risk assessors must prepare a risk assessment report per rule ~~R325.9916~~ R325.99404 promulgated pursuant to the Lead Abatement Act that includes lead hazard control recommendations and the potential relocation of the child depending upon the severity of the lead hazards found.	Citation update.
Non-Emergency Medical Transportation	Section 3 – Transportation Authorization	The 2nd and 3rd paragraphs were revised to read: The Medicaid program contracts with Medicaid Health Plans (MHPs) and Integrated Care Organizations (ICOs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. MHPs and ICOs are responsible for providing NEMT services to their enrollees for all services covered under the managed care contract. (For additional information, refer to the Medicaid Health Plans and MI Health Link chapters of this manual.) MHPs and ICOs may have different prior authorization and documentation requirements from those described in this chapter. Providers, beneficiaries or authorizing parties should contact the specific ~~health plan~~ MHP/ICO for further information regarding NEMT. Transportation services for managed care enrollees may vary depending on the beneficiary's benefit plan. For additional information regarding benefit plans, refer to the Beneficiary Eligibility chapter of this manual.	Clarification.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Non-Emergency Medical Transportation	5.3 Fees and Tolls	Text was revised to read: Travel-related fees and tolls (e.g., parking, toll road, and bridge fare) are reimbursed at actual cost and require original, unaltered receipts. In situations when it is necessary for a Medicaid beneficiary to traverse the Mackinac Bridge and the original, unaltered receipt(s) is unavailable, the authorizing party may still approve reimbursement for the toll when supported by documentation on the MSA-4674. Documentation must include the origin and destination points, and a notation regarding the reason an original receipt is unavailable. ~~Per leg reimbursement for passenger vehicles crossing the Mackinac Bridge will be consistent with rates included on the Mackinac Bridge Authority website. Bridge fare is only reimbursable when the beneficiary is in the vehicle.~~ This exception is not intended to eliminate the requirement that necessary Mackinac Bridge tolls require original, unaltered receipts and may be subject to post-payment review. Per leg reimbursement for passenger vehicles crossing the Mackinac Bridge will be consistent with rates included on the Mackinac Bridge Authority website.	Rephrasing for better flow and clarity.
Non-Emergency Medical Transportation	5.6 Hospital Facility Meal and Lodging Reimbursement	Text was revised to read: Some hospital facilities (e.g., University of Michigan Health System [Michigan Medicine]) provide advance expenses for meals or lodging on a per diem basis to Medicaid beneficiaries securing inpatient or outpatient treatment ~~at their facility, and~~ and their medically necessary attendant (or individual with a vested interest). These facilities seek reimbursement directly from an authorizing party or local MDHHS office after the treatment's end. For these facilities to receive reimbursement of their advance expenses, they must provide to the local MDHHS office, or authorizing party, an invoice or general authorization of services documenting the name of the facility, the name of the Medicaid beneficiary, the date(s) of service, the service(s) requesting reimbursement (i.e., meals or lodging), and the cost of each service. Requests made by the facilities for reimbursement must be received by the local MDHHS office, or authorizing party, within 90 calendar days of the last date-of-service. The current maximum per-day rates for these services are indicated on the MDHHS NEMT Database.	Clarifying that medically necessary attendants and vested interest individuals can also receive per diem meals and lodging.

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

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	Section 8 – PASARR Process	In the 3rd paragraph, the 1st bullet point was removed. • ~~When an individual is admitted to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).~~	This term is no longer used.
		In the 3rd paragraph, 6th bullet point, 2nd paragraph, the 2nd sentence was revised to read: If the patient is on ~~antipsychotic~~ psychotropic or antidepressant medications for purposes of pain control/symptom relief for end of life, note that information on the DCH-3877.	******** Federal Rule word change (483.45)
		In the last paragraph, under 'Change in Condition', text was revised to read: …….. Changes to the Minimum Data Set (MDS), Section E (indicators of depression, anxiety, mood) would indicate a significant change for PASARR purposes. A change in condition would also be done if the consumer is in a facility in any state other than Michigan and transfers in to a Michigan nursing facility. This should be done as soon as the consumer arrives at the Michigan nursing facility, no later than the 14th day after arrival. The nursing facility must notify their local CMHSP via a DCH-3877 for a Level II evaluation.	********** To further clarify when CIC should be done.
		In the last paragraph, under 'Borton vs. Califono Transfer Trauma', text was revised to read: Transfer trauma protections apply to individuals with mental illness or intellectual disability who were determined during a PASARR Level II evaluation to not need nursing facility services. Transfer Trauma is defined as any adverse psychological and/or physical effects occasioned by the transfer of a nursing facility patient that would be materially detrimental to the physical or mental health of the patient.	********** To help define transfer trauma.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	8.1 Level I Screening	In the 3rd paragraph, the 2nd sentence was revised to read: Included are examples of anti-depressant and ~~anti-psychotic~~ psychotropic medications, defined as any drug that affects brain activities associated with mental processes and behavior. In the 3rd paragraph, the title of the 2nd chart was revised to read: **~~Anti-Psychotic~~ Psychotropic Medications**	Federal Rule word change (483.45)
Nursing Facility Coverages	8.3 Level II Evaluation Exemption	In the 1st paragraph, the last sentence was revised to read: The DCH-3878 may be completed by a registered nurse, licensed Bachelor's or Master's Social Worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner, or physician. ~~and~~ The DCH-3878 must be signed, along with a printed name, and dated by a physician's assistant, nurse practitioner, or a physician. In the 2nd paragraph, 3rd bullet point, 1st sub-bullet point, the last sentence was revised to read: An individual who received inpatient treatment in a psychiatric facility cannot be admitted to a nursing facility claiming this exemption, nor can an individual who comes directly from home or any other community placement (i.e., Adult Foster Care [AFC] and assisted living).	Clarification form completion requirements. ********* Further definition.
Nursing Facility Coverages	8.6 Compliance	In the 3rd paragraph, the 1st sentence was revised to read: The Level I screening is considered completed when the DCH-3877 has been filled out, signed, and distributed or, if exemption criteria are met, both the DCH-3877 and DCH-3878 have been filled out, signed and dated with appropriate credentials noted, and distributed.	Clarification form completion requirements.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Certification, Survey & Enforcement Appendix	3.1 Nurse Aide Certification and Training	In the 2nd paragraph, the bullet points were revised to read: • For information about training requirements, programs or facilities, or concerns regarding the testing program or information placed on the Nurse Aide Registry, contact the LARA Bureau of ~~Professional Licensing~~ Community and Health Systems. • For testing registration information or assistance, or test site concerns, contact the ~~Michigan Nurse Aide Customer Service~~ LARA BCHS Nurse Aide Section or refer to their website. • To inquire about a nurse aide's listing on the Registry, name and good standing, contact the ~~Michigan Nurse Aide Registry~~ LARA BCHS Nurse Aide Section or refer to their website.	Update.
Nursing Facility Cost Reporting & Reimbursement Appendix	Section 3 – Definitions	The definition for "'Net Quality Assurance Supplement (Net QAS)' was revised to read: The ~~Quality Assurance Supplement~~ QAS minus the non-Quality Measure Initiative share of the Medicaid Quality Assurance Assessment Program tax. ~~share of the assessment, based on non-Medicare nursing facility days~~.	Make section text clearer with the incorporation of bulletins MSA 17-28 and MSA 18-25.
Nursing Facility Cost Reporting & Reimbursement Appendix	4.11.B. Related Party Business Transactions	The 3rd paragraph was revised to read: These dollar limits apply to related party business transactions whether they are routine or ancillary nursing services. The dollar thresholds ~~will~~ only apply to costs allocated to a Medicaid routine care unit, either directly or through the stepdown process (i.e., if $25,000 in costs are allocated to a nursing facility from a related party, but none of the costs are allocated to the Medicaid routine care unit, then no home office cost report ~~would be~~ is required). Beginning October 1, 2018 and biennially thereafter, these amounts ~~will be~~ are updated based on the Centers for Medicare & Medicaid Services (CMS) Skilled Nursing Facility (SNF) Market Basket. ~~The updated~~ Amounts ~~will be~~ are posted ~~to~~ on the Long-Term Care Reimbursement and Rate Setting Section (RARSS) website. (Refer to the Directory Appendix for website information.)	Clarification.

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

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	5.3 Plant Cost Certification Effective Period	Text in the tables at the end of the subsection was revised as follows: The Nursing Facility Initial Period Interim Rates for Plant Cost Reimbursement example was revised to read: **Rate Year: October 2018 – September 2019** | October 2018 – June 2019: Plant cost for the cost year end December ~~2016~~ 2017 | July 2019 – September 2019: Plant cost based on plant cost certification reflecting expected cost for the cost report year end December 2019 The Nursing Facility Final Rates for Plant Cost Reimbursement example was revised to read: **Rate Year: October 2018 – September 2019** | October 2018 – December 2018: Plant cost for the cost report year end December 2017 | January 2019 – September 2019: Plant cost for the cost report year end December ~~2019~~ 2017	Corrections.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.7 Nursing Facility Quality Assurance Assessment Program (QAAP)	The 1st paragraph was revised to read: The ~~Quality Assurance Assessment Program (~~QAAP~~)~~ was implemented by Medicaid in compliance with Michigan law. The QAAP provides a ~~Quality Assurance Supplement~~ QAS to nursing facility reimbursement rates incorporating funds from the quality assurance assessment tax. When a provider	Replace words with accepted acronyms.

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

Medicaid Provider Manual
January 2019 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	10.7.A. Class I And Class III Nursing Facilities	The subsection title was revised to read: Quality Assurance Supplement (QAS) for Class I and Class III Nursing Facilities The 1st sentence was revised to read: The nursing facility will receive a ~~Quality Assurance Supplement (~~QAS~~)~~ payment as a monthly gross adjustment. In the last paragraph, the 2nd sentence was revised to read: Medicaid will reimburse hospice providers 100 percent of a nursing facility's ~~Quality Assurance Supplement (~~QAS~~)~~ rate add-on for Medicaid beneficiaries provided hospice care in Medicaid participating nursing facilities.	Make section title clearer with the incorporation of bulletins MSA 17-28 and MSA 18-25. Replace words with accepted acronym.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.7.B. Class V Nursing Facilities - Ventilator Dependent Care (VDC) Units	The subsection title was revised to read: Quality Assurance Supplement (QAS) for Class V Nursing Facilities – Ventilator Dependent Care (VDC) Units In the 1st paragraph, the 2nd sentence was revised to read: The monthly gross adjustment for an individual unit will be determined based on one-twelfth of the VDC unit's annual historical Medicaid utilization (resident days) multiplied by the unit's ~~Quality Assurance Supplement (~~QAS~~)~~ per resident day basis.	Make section title clearer with the incorporation of bulletins MSA 17-28 and MSA 18-25. Replace words with accepted acronym.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.11 Class VII Nursing Facilities – State Veterans' Homes	The 6th paragraph was revised to read: State Veterans' Homes are excluded from the NF ~~Quality Assurance Assessment Program (~~QAAP~~)~~ and all supplemental payments funded by the QAAP.	Replace words with accepted acronym.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	10.14.A. Eligibility Criteria	In the 4th bullet point, 1st sub-bullet point, the 1st sentence was revised to read: The sum of the provider's Variable Rate Base, Economic Inflation Update, and other associated rate add-ons (excluding Nurse Aide Training and Testing reimbursement), plus the Net ~~Quality Assurance Supplement~~ QAS, must be less than the provider's audited Medicaid variable cost per resident day for the provider's two fiscal cost reporting periods (not rate setting periods) of not less than seven months immediately prior to the first period of rate relief.	Replace words with accepted acronym.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.15.C. Calculation of CMCFSP Payment	Text was revised to read: An interim payment and reconciliation process will be employed to make payments to qualifying facilities. Allowable unreimbursed costs for services provided to Medicaid beneficiaries will be determined ~~based on information obtained~~ from information reported on the most recently filed cost report. Allowable unreimbursed costs are defined as total allowable Medicaid routine costs before formula limitations minus total Medicaid routine services revenue received. Medicaid routine services revenue includes all revenues received for Medicaid routine services, including all supplemental/enhanced payments (e.g., Net QAS, Net QMI Amount, etc.) from the State and all payments received from residents and other payers for the same services. Costs will be trended to the current state fiscal year using an inflation factor, without capital, taken from the Health Care Cost Review, which is published quarterly by Global Insight. Interim payments will then be made to qualifying CMCFs.	Conform language with State Plan language and clarify how the Quality Measure Initiative payments are factored into the calculation.
Practitioner	14.1 Behavioral Health Services	In the table at the end of the subsection, text for 'Office-Based Opioid Treatment (OBOT)' was relocated to 14.2 Substance Use Disorder Services.	This is a substance use disorder service rather than a behavioral health service.
Practitioner	14.2 Substance Use Disorder Services	Text for 'Office-Based Opioid Treatment (OBOT)' was relocated from 14.1 Behavioral Health Services and added to the table.	This is a substance use disorder service rather than a behavioral health service.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Practitioner		The following sections (and subsections) were re-numbered and re-titled: Section 18 ~~24~~ Anesthesiologist Assistant Section 19 ~~18~~ Certified Registered Nurse Anesthetist Section 20 ~~23~~ Certified Nurse Practitioner 20.1 ~~23.1~~ General Information 20.2 ~~23.2~~ Enrollment of Certified Nurse Practitioners 20.2.A. ~~23.2.A.~~ Rendering/Servicing-Only Certified Nurse Practitioners 20.2.B. ~~23.2.B.~~ Individual/Sole Provider Certified Nurse Practitioners 20.3 ~~23.3~~ Collaborative Practice Agreement Section 21 ~~22~~ Certified Nurse Midwife 21.1 ~~22.1~~ Enrollment 21.2 ~~22.2~~ Family Planning 21.3 ~~22.3~~ Gynecologic Care 21.4 ~~22.4~~ Laboratory Tests 21.5 ~~22.5~~ Maternity Care 21.6 ~~22.6~~ Office Visits 21.7 ~~22.7~~ Pharmacy Section 22 ~~19~~ ~~Physician's~~ Physician Assistant Section 23 ~~21~~ Physical Therapist Section 24 ~~20~~ Podiatrist 24.1 ~~20.1~~ Copayment 24.2 ~~20.2~~ Consultations 24.3 ~~20.3~~ Nursing Facility Services	Restructuring order to allow for easier location of providers. Addition of the term "certified".

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

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Provider Assistance	Under "Provider Inquiry", text was revised as follows: **Information Available/Purpose:** Provider resource for ~~policy clarification,~~ billing assistance (including out-of-state and nonenrolled provider claims).	Update.
Directory Appendix	Provider Assistance	Addition of: **Contact/Topic:** Atypical Providers M-F 8 am to 5 pm EST **Phone # Fax #:** 800-979-4662 **Mailing/Email/Web Address:** MDHHS/Provider Inquiry PO Box 30731 Lansing, MI 48909-8231 providersupport@michigan.gov **Information Available/Purpose:** Provider and client resource for Home Help/Adult Foster Care/Non-Emergency Transportation services that involve questions of approved authorizations and payment information, along with submission of claims for personal care services.	Update.
Directory Appendix	Eligibility Verification	Under "CHAMPS Eligibility Inquiry", text under 'Phone # Fax #' was revised to read: MDHHS Provider Inquiry Helpline 1-800-292-2550 for questions/issues related to the eligibility response~~, and for providers without internet access to verify eligibility~~.	Update.
Directory Appendix	Maternal Infant Health Program Resources	Under 'Maternal Infant Health Program', the following information was added: Phone #: 1-833-644-6447 Fax #: 517-763-0366	Update.

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

<table>
<tr><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th><th>COMMENT</th></tr>
<tr><td>Directory Appendix</td><td>Non-Emergency Medical Transportation

(new subsection)</td><td>New subsection text includes the following:

<table>
<tr><th colspan="4">NON-EMERGENCY MEDICAL TRANSPORTATION</th></tr>
<tr><th>CONTACT/TOPIC</th><th>PHONE # FAX #</th><th>MAILING/EMAIL / WEB ADDRESS</th><th>INFORMATION AVAILABLE/ PURPOSE</th></tr>
<tr><td>MDHHS NEMT Database</td><td></td><td>www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Non-Emergency Medical Transportation (NEMT)</td><td>This database includes current information pertaining to NEMT reimbursement rates and services.</td></tr>
<tr><td>LogistiCare Solutions</td><td>866-569-1902</td><td></td><td>Non-emergency medical transportation for qualifying beneficiaries in Wayne, Oakland and Macomb counties.</td></tr>
</table>
</td><td></td></tr>
</table>

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Nursing Facility Resources	Information for "Informal Deficiency Dispute Resolution" was revised to read: Contact/Topic: Informal ~~Deficiency~~ Dispute Resolution (IDR) and Independent Informal Dispute Resolution (IIDR) Fax #: deleted fax ~~517-241-0093~~ Mailing/Email/Web Address: Department of Licensing and Regulatory Affairs Bureau of Community and Health Systems ~~Enforcement and Compliance Section~~ Workforce Background Check PO Box 30664 Lansing, MI 48909 Addition of email address: bchs-enforcement@michigan.gov Information Available/Purpose: ~~Process for submitting informal deficiency dispute resolution requests.~~ ~~Nursing facility enforcement.~~ For questions regarding completion or timeliness of IDR/IIDR process for long term care facilities.	Updates.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Forms Appendix	DCH-3878; Mental Illness/Intellectual Disability/Related Condition Exemption Criteria Certification	On the 1st page, under 'Instructions', the 1st bullet point was revised to read: • This form must be completed, ~~by a registered nurse, licensed bachelor or master social worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or physician and~~ signed and dated by a physician's assistant, nurse practitioner or physician. On the 2nd page, the 2nd paragraph was revised to read: This form must be completed, ~~by a registered nurse, licensed bachelor or master social worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or physician, and~~ signed and dated by a physician's assistant, nurse practitioner or physician.	A physician, NP or PA must certify that the exemption is valid, so they should fill out the form. It would be out of the scope of practice for others to fill out the form.

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

Medicaid Provider Manual
January 2019 Updates

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 18-12	5/25/2018	Home Health	8.1 Home Health Aide Prior Authorization (new subsection; following subsection re-numbered)	New subsection text reads: Home health aide services for Medicaid beneficiaries must be authorized by the MDHHS Program Review Division after the initial 90 days, and every 90 days thereafter if continued services are deemed medically necessary. Prior authorization is required each time services are requested for: ▪ continuation of services beyond the initial 90 days; ▪ continuation of services beyond the end date of the current authorization period (renewal); ▪ an increase in services; or ▪ a decrease in services. After the initial 90 days, home health aide services may be provided up to a maximum of 36 visits within 90 consecutive calendar days. If the beneficiary's attending physician orders home health aide services, the HHA must assess the availability of the family or another entity (e.g., Home Help Program or MI Choice Waiver) to perform the services. Physicians ordering home health aide services must determine that medical services are medically necessary and appropriate for continuation of services beyond the initial 90 days, and for each PA request thereafter. In some cases, the beneficiary's attending physician may order home health aide services that extend beyond the maximum of 36 visits within 90 consecutive calendar days. For requests that extend beyond 36 or more visits within 90 consecutive calendar days, the PA request will be reviewed for medical appropriateness, the availability of the family or another entity (e.g., Home Help Program or MI Choice Waiver), and the cost effectiveness of other programs available for the beneficiary.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				Following receipt and review of the Home Health Aide Prior Approval Request/ Authorization form (MSA-181) and the required documentation by the Program Review Division, a determination notification is sent to the HHA and beneficiary or primary caregiver indicating the outcome of the review. (Refer to the Forms Appendix for a copy of MSA-181.) If approved, the notification letter will contain the PA number and approved authorization dates. It is important to include this PA number on every claim and in all other communications to the MDHHS Program Review Division. If a beneficiary receiving home health aide services continues to require the services after the initial authorization period, a new MSA-181 must be submitted by the HHA along with the required documentation to support medical necessity for continuation of services beyond the approved authorization dates. This request must be received by the Program Review Division no less than 15 business days before the end of the current authorization period. Failure to do so may result in a delay of authorization for continued services which, in turn, may result in delayed services or no payment for services rendered without authorization. The length of each subsequent authorization period will be determined upon review by the Program Review Division and will be specific to each beneficiary based on several factors, including the beneficiary's medical and functional needs, personal care services through another entity (e.g., Home Help Program, waiver services, or other community services), and family or caregiver support.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			8.1.A. Documentation Requirements (new subsection)	New subsection text reads: The following documentation is required for all initial PA requests for home health aide services and must accompany the MSA-181: ▪ documentation of the face-to-face encounter; ▪ all components of the POC as identified in 42 CFR §484 and MDHHS policy; ▪ OASIS; and ▪ other documentation as requested by MDHHS. The documentation listed above is also required at subsequent 12-month intervals. The anniversary date is the date 12 months from the date services were first provided. ▪ For services beyond the initial authorized 90 days and for subsequent requests, the MSA-181, an updated POC complete with all components, and other documentation as requested by MDHHS must be submitted to the Program Review Division for review. ▪ If a beneficiary's condition changes during an authorization period warranting an increase or decrease in the number of approved hours or discontinuation of services, the HHA must report the change to the Program Review Division. It is important that the HHA report all changes as soon as they occur, as well as properly update the POC and written instructions for the home health aide. ▪ To request an increase in hours, the following are required: ➢ an updated MSA-181 indicating the increase in hours; ➢ an updated and signed POC; and ➢ documentation from the attending physician. ▪ To request a decrease in hours, the following are required: ➢ an updated MSA-181 indicating the decrease in hours; and ➢ an updated and signed POC. PA and documentation requirements apply to all Medicaid beneficiaries.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			8.1.B. Medical Necessity (new subsection)	New subsection text reads: Home health aide services must be reasonable to support the beneficiary's medical and functional needs based on the beneficiary's medical condition and associated symptoms. Documentation to support medical necessity must include the beneficiary's progress or lack of progress, medical condition, functional losses, and treatment goals (e.g., the POC). MDHHS identifies criteria for medical necessity as one or more of the following that directly impact the beneficiary's medical and functional needs: ▪ New onset or acute exacerbation of diagnosis (supportive documentation must include the date of the new onset or acute exacerbation); ▪ New or changed prescription medications (e.g., newly prescribed medications within the last 30 days or changed dosage, frequency, or route of administration within the last 60 days, including but not limited to diagnosis such as diabetes or hypertension); ▪ Recent hospitalizations (must include the date and reason for the hospitalization); ▪ Recent discharge from an acute or post-acute setting (e.g., skilled nursing facility); ▪ Change in caregiver status, absence of a caregiver, or unstable caregiving situation; or ▪ Complicating factors (e.g., presence of Stage III or IV decubiti). The beneficiary's medical necessity must be clearly identified by the physician and documented in the POC. All PA requests will be considered on an individualized basis to determine medical necessity, reasonableness for home health aide services, and consistency with MDHHS policy.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			8.1.C. Beneficiary Eligibility (new subsection)	New subsection text reads: Approval of the MSA-181 confirms that the service is authorized for the beneficiary. The approval does not guarantee that the beneficiary is eligible for Medicaid. If the beneficiary is not eligible on the date of service, MDHHS will not reimburse the provider for services provided and billed. To ensure payment, the HHA must verify beneficiary eligibility monthly at a minimum.
			8.1.D. Retroactive Prior Authorization (new subsection)	New subsection text reads: Services provided before PA is approved will not be covered unless the beneficiary was not Medicaid eligible on the date of service but became eligible retroactively. If MDHHS eligibility information does not demonstrate retroactive eligibility, then the request for retroactive PA will be denied.
			Forms Appendix	Addition of: MSA 181; Home Health Aide Prior Approval Request/Authorization
MSA 18-13	5/25/2018	Home Health	Section 1 – General Information	The 2nd paragraph was revised to read: Home health is a covered Medicaid benefit for beneficiaries whose conditions do not require continuous medical/nursing and related care~~,~~ but do require health services on an intermittent basis ~~in the home setting~~ for the treatment of an injury, illness, or disability. Medicaid covered services may be provided in ~~the home only if circumstances, conditions, or situations exist which prevent the beneficiary from being served in a physician's office or other outpatient setting~~ any setting in which normal life activities take place. 'Normal life activities' refers to activities that could occur in or out of an individual's home. Except as detailed in this chapter, the beneficiary's primary need must be for nursing care, ~~and/or~~ physical therapy and/or home health aide services rather than personal care or physician's care.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			1.1 Face-to-Face Encounter	The 7th, 8th and 9th paragraphs were revised to read: ~~The face-to-face beneficiary encounter must be a separate and distinct section of, or an addendum to, the certification and must be clearly titled, dated and signed by the certifying physician. Use of a specific form for the certification or the plan of care is not required.~~ Documentation of the face-to-face encounter must reflect the certifying practitioner's assessment of the beneficiary and include: • Date of the encounter, • Primary reason for the encounter (medical condition), • Clinical findings that support the need for skilled nursing, ~~or~~ therapy or home health aide services, and • Clinical findings that support home health eligibility. An addendum may consist of clinical documents from a hospital or post-acute facility (e.g., emergency visit record or discharge summary). It is allowable for the certifying physician to use such a document as an addendum for the face-to-face encounter if: • The addendum contains all ~~of~~ the documentation requirements for face-to-face documentation; and • ~~The addendum document, which is serving as the face-to-face documentation, is clearly titled and dated as such; and~~ • The certifying physician signs and dates the addendum, demonstrating that the certifying physician received that information from the allowed NPP or physician who performed the face-to-face encounter, and that the certifying physician is using that addendum document as his/her documentation of the face-to-face encounter.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			Section 2 – Home Setting	The section title was revised to read: ~~Home~~ Service Setting Section text was revised to read: Home health services are intended for beneficiaries who are unable to access services (nursing, OT, PT, speech and language pathology therapy [ST]) in an outpatient setting. However, it is not required that beneficiaries be totally restricted to their home but may be provided, as appropriate, in any setting in which normal life activities take place. A determination and documentation is required by the HHA to validate the beneficiary's eligibility and need for home health services ~~that the home is the most appropriate setting in which to provide the service(s).~~ Home health services are **not** provided solely on the basis of convenience. All covered home health services ~~must~~ may be rendered in a beneficiary's home or any setting in which normal life activities take place, except for those services listed below. Home may be the beneficiary's owned/rented home, an apartment, Assisted Living Facility, Adult Foster Care (AFC) facility, or home of another family member (secondary residence of the beneficiary, i.e., joint custody situation for a minor child). • Home Health aide services are not a covered benefit for beneficiaries who reside in a Home for the Aged (HFA) or ~~Adult Foster Care (~~AFC~~)~~ facility as this would be duplication of personal care services already provided by staff of these facilities. • Michigan Department of Health and Human Services (MDHHS) does not cover any Home Health services rendered to a beneficiary in a hospital, nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Intermediate Care Facility for the Mentally Ill (ICF/MI), school, ~~or~~ adult day care, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				To determine if ~~services in the~~ home health services, rather than ~~in an~~ outpatient ~~setting~~ services, are most appropriate, consider the following: • ~~Is in-home care~~ Are home health services necessary for the adaptation, training or teaching of nursing or treatment procedures, plans, equipment, appliances or prosthetics ~~in the home setting~~? • ~~Is in-home care~~ Are home health services necessary to prevent undue exposure to infection and/or stress for the beneficiary as identified and documented by a health care professional? • Is leaving the home medically contraindicated, as identified and documented by a health care professional? • ~~Is in-home care~~ Are home health services necessary to prevent a documented problem with access to services, continuity of care or provider, or coordination of services, as documented by a health care professional? • ~~Is in-home care~~ Are home health services the most cost-effective method to provide care? Services must be appropriate and medically necessary for the treatment of an identified illness, injury or disability. The services provided must be consistent with the nature and severity of the beneficiary's illness, injury or disability, ~~his~~ particular medical needs and accepted standards of medical practice. Beneficiaries with established frail conditions may need assessments by skilled nurses to prevent further decline of the frail condition.
			Section 3 – Plan of Care	The 3rd paragraph was revised to read: Ordering physicians must determine that medical/health services are medically necessary and/or appropriate. The authorization and subsequent provision of home health services will continue to be based on medical necessity, not the setting. Any increase in the frequency of services, addition of new services, or modifications of treatment during a certification period must be authorized by the attending physician and documented in the beneficiary's medical record by way of a verbal order or written order prior to the provision of the increased, additional, or modified treatment.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			Section 6 – Nursing Services	The following text was added as the last paragraph: Nursing services must be provided through the State Plan Medicaid program in accordance with established policy. MI Choice nursing services shall not duplicate services available through the Medicaid State Plan home health benefit, and under no circumstance shall the beneficiary receive both MI Choice and State Plan services concurrently. Waiver agencies cannot authorize payment for services that are (already) offered under the State Plan.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			Section 8 – Home Health Aides	Section text was revised to read: Home health aide services may be rendered independently, and not contingent upon the need of skilled nursing or therapy services. Home health aide services are covered only when ordered by the attending physician and ~~performed in conjunction with direct, ongoing skilled nursing care and/or PT~~ authorized according to Medicaid policy. The services provided by the home health aide must be medically necessary. Medicaid would not cover home health aide services solely for personal care needs, or for the convenience of the beneficiary. The POC must clearly outline the duties to be performed by the home health aide. ~~For example, if a beneficiary with a diagnosis of quadriplegia requires a monthly urinary catheter change, and this is not in conjunction with other skilled nursing needs, home health aide services would not be covered. Another example would be that of an elderly and frail beneficiary with a diagnosis of osteoarthrosis requiring a monthly observation/evaluation visit. If their need is assistance with personal care needs (such as eating/feeding, bathing, toileting, dressing, transferring, laundry, housework, shopping/errands) at specified intervals (e.g., daily, weekly) not in conjunction with direct, ongoing nursing and/or PT services, Medicaid would not cover the aide services.~~ ~~If the beneficiary's attending physician orders home health aide services to be performed in conjunction with the nursing and/or PT services, the HHA must assess the ability of the family or another entity (e.g., Home Help Program or MI Choice Waiver) to perform the services.~~ The HHA must identify the availability of other caregiver(s) (e.g., family member or another caregiver). The availability of the caregiver(s) must be identified in the POC. When a caregiver is providing services that adequately meet the member's needs, it is not medically necessary for the HHA to provide services. If the family or other entity is unable to perform the service, the reason must be fully documented in the POC. (Refer to the Personal Care Section in this chapter for additional information.)

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			Section 9 – Personal Care	The following text was added: It is the responsibility of the HHA to identify other services the beneficiary may be receiving to ensure the services of the home health aide and personal care services through another entity (e.g., Home Help, MI Choice Waiver) and to assess the ability of the family or caregiver to perform personal care services. For beneficiaries enrolled with another entity (e.g., Home Help Program or MI Choice Waiver), the HHA must contact the adult services specialist or the waiver agent to ensure coordination and verify services are not duplicative in nature, nor occur simultaneously.
			9.2 Home and Community Based Services Waiver for the Elderly and Disabled	The 2nd paragraph was revised to read: MI Choice beneficiaries are identified in the eligibility response with the Benefit Plan ID of MI Choice-MC. (Refer to the Beneficiary Eligibility chapter for additional information.) ~~When the physician orders home health services, and the beneficiary is enrolled in the waiver program, the HHA should contact the waiver agent in order to assure coordination and verify there is no duplication of care provided.~~

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			Section 10 – Durable Medical Equipment (DME)/Supplies	The 1st paragraph was revised to read: Durable Medical Equipment (DME), certain medical supplies, orthotic and prosthetic appliances, shoe supplies, and oxygen (gas and equipment) are covered services for HHA beneficiaries when providing medically necessary skilled nursing or aide services. HHAs are required to provide medically necessary equipment and supplies either directly or through arrangement with DME providers. These items must be supplied and billed by a Medicaid enrolled medical supplier, orthotist, prosthetist, shoe supplier, or oxygen supplier, except as noted below. The beneficiary's attending physician (MD, DO, DPM) must order these items in writing. These providers may have to obtain PA for certain services, and the services provided must be in accordance with Medicaid policies. The 3rd and 4th paragraphs were revised to read: If the treatment regimen requires quantities beyond those listed above for gloves, simple dressings, or sterile solutions, the HHA or the medical supplier may bill separately for the additional quantities. The need for additional supplies must be documented in the medical record. These are items that may be left in the beneficiary's home between visits where repeated applications are required, and the applications will be performed by the beneficiary, family member, nurse, etc. Supplies billed to Medicaid must be dispensed to a specific beneficiary and must be ordered by the attending physician as part of a written POC.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				The MDHHS Home Health Database, available on the MDHHS website, contains a list of medical supply items that may be billed separately from the nurse or aide visit. If the quantity needed is beyond what is listed on the Home Health Database, the supplies must be billed by a DME/Medical Supplier. (Refer to the Directory Appendix for website information.) HHAs choosing to provide routine medical supplies beyond what is listed on the MDHHS Home Health Database and other medically necessary equipment and medical supplies directly to beneficiaries receiving home health services must enroll with Medicaid as DME providers. (Refer to the General Information for Providers chapter and the Medical Supplier chapter for additional information). ~~These are items that may be left in the beneficiary's home between visits where repeated applications are required, and the applications will be performed by the beneficiary, family member, nurse, etc. Supplies billed to Medicaid must be dispensed to a specific beneficiary and must be ordered by the attending physician as part of a written POC.~~
MSA 18-23	8/1/2018	Billing & Reimbursement for Institutional Providers	8.2.C.1. Claim Documentation Requirements When Offsetting the Patient-Pay Amount (new subsection)	New subsection text reads: Documentation must accompany the claim when offsetting the patient-pay amount with Value Codes 25, 26, 27, 28, 29, 33, or 34. Refer to the NUBC website for additional information. (Refer to the Directory Appendix for website information.)

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE	
				Documentation Requirements	The documentation that must accompany the claim includes the specific reason that the patient-pay amount is being offset, a detailed description of the specific item or service that is offset, and receipt showing that the beneficiary paid for the Medicaid non-covered service. The nursing facility must upload the documentation to the Document Management Portal (DMP). The nursing facility is responsible for a successful upload of the documentation. This tool enables providers to electronically submit supporting documentation for Medicaid claims. A review guide for the DMP is available on the MDHHS website. (Refer to the Directory Appendix for website information.) **Note:** The nursing facility must report in the Note section of the claim that documents have been uploaded to the DMP.
				Claims Processing	There will be a change in the processing of claims when the above Value Codes are reported. Claims will suspend for review of the submitted documentation. Claims submitted with no documentation will be rejected.
				MI Health Link	For beneficiaries enrolled in the MI Health Link program, nursing facilities must still collect and maintain patient-pay amount offset information according to policy. Nursing facilities will not be required to submit this information to MDHHS for the months in which a beneficiary is enrolled in MI Health Link. Nursing facilities should continue to abide by their individual contracts with the Integrated Care Organizations (ICOs) as it relates to reporting patient-pay amount offsets when a beneficiary is enrolled in MI Health Link.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Billing & Reimbursement for Institutional Providers	11.3.A. Claim Documentation Requirements When Offsetting the Patient-Pay Amount (new subsection)	New subsection text reads: Documentation must accompany the claim when offsetting the patient-pay amount with Value Codes 25, 26, 27, 28, 29, 33, or 34. Refer to the NUBC website for additional information. (Refer to the Directory Appendix for website information.)

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE	
				Documentation Requirements	The documentation that must accompany the claim includes the specific reason that the patient-pay amount is being offset, a detailed description of the specific item or service that is offset, and receipt showing that the beneficiary paid for the Medicaid non-covered service. The hospice provider must upload the documentation to the Document Management Portal (DMP). The hospice provider is responsible for a successful upload of the documentation. This tool enables providers to electronically submit supporting documentation for Medicaid claims. A review guide for the DMP is available on the MDHHS website. (Refer to the Directory Appendix for website information.) **Note:** The hospice provider must report in the Note section of the claim that documents have been uploaded to the DMP.
				Claims Processing	There will be a change in the processing of claims when the above Value Codes are reported. Claims will suspend for review of the submitted documentation. Claims submitted with no documentation will be rejected.
				MI Health Link	For beneficiaries enrolled in the MI Health Link program, the hospice provider must still collect and maintain patient-pay amount offset information according to policy. Hospice providers will not be required to submit this information to MDHHS for the months in which a beneficiary is enrolled in MI Health Link. Hospice providers should continue to abide by their individual contracts with the Integrated Care Organizations (ICOs) as it relates to reporting patient-pay amount offsets when a beneficiary is enrolled in MI Health Link.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 18-24	8/1/2018	Healthy Michigan Plan	5.3 Hearing Aids	Text was revised to read: The Healthy Michigan Plan covers hearing aid services for all beneficiaries when provided by a licensed hearing aid dealer, hearing center, or ~~licensed~~ audiologist ~~affiliated with a hearing center~~. Providers should refer to the Hearing Aid Dealers Chapter for additional guidance regarding hearing aid coverage.
		Hearing Aid Dealers	Table of Contents page	The texbox was removed. ~~**As required by Executive Order 2009-22, effective for dates of service on and after 07/01/2009, hearing aids are no longer payable for beneficiaries age 21 and older.**~~
			Section 1 – Coverage Overview	The 1st paragraph was revised to read: This chapter applies to licensed hearing aid dealers, hearing centers, and ~~licensed~~ audiologists ~~affiliated with Hearing Centers~~. The 5th paragraph was revised to read: Providers must purchase hearing aids directly from the manufacturers that are part of the volume purchase contract. The Hearing Aid Contract Vendor listing is maintained on the MDHHS website. (Refer to the Directory Appendix for website information.) Licensed hearing aid dealers, hearing centers, and ~~licensed~~ audiologists ~~affiliated with a hearing center~~ must bill and are reimbursed the contract price for the hearing aid. The contract price for a hearing aid cannot be further reduced or altered.
			1.1 Provider Licensure Requirement	The 2nd bullet point was revised to read: • a licensed audiologist ~~affiliated with a~~ or hearing center.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			1.3 Covered Services	The 1st sentence was revised to read: Medicaid covers the following services when provided by a licensed hearing aid dealer, hearing center, or ~~licensed~~ audiologist ~~affiliated with a hearing center~~.
			1.7 Dispensing Fee	In the 1st paragraph, the last bullet point was revised to read: • A 90-day trial/adjustment period with exchange/return privilege. Hearing aids that do not prove satisfactory to a user are to be returned to the manufacturer within 90 days from the date the hearing aid is provided to the beneficiary at no cost to MDHHS~~,~~ or the licensed hearing aid dealer, hearing center, or ~~the licensed~~ audiologist ~~affiliated with a hearing center~~.
			2.7.A. Standards of Coverage	In the 1st paragraph, the 1st sentence was revised to read: Medicaid covers replacement of disposable hearing aid batteries, as appropriate, up to a quantity of ~~25~~ 36 batteries per hearing aid per six months.
			2.8.A. Standards of Coverage	Text was revised to read: **13 years and over** — Beneficiaries who use hearing aids that require custom earmolds are eligible for replacement earmolds every 12 months without prior approval. **3 to 12 years** — Beneficiaries are eligible for replacement earmolds ~~every six months~~ two times per 12 months without prior approval. **Under age 3 years** — Beneficiaries are eligible for replacement earmolds ~~every three months~~ four times per 12 months without prior approval.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Hearing Services	1.1.A.1. Licensed Audiologists/Hearing Centers	The subsection title was revised to read: Licensed Audiologists~~/Hearing Centers~~ Text was revised to read: Licensed audiologists ~~practicing in freestanding hearing centers~~ may enroll with Medicaid for reimbursement of audiology services. ~~The freestanding hearing center must not be part of, or owned by, a hospital, Comprehensive Outpatient Rehabilitation Facility, Rehabilitation Agency or university graduate education program.~~ Services must be provided at the service/practice address identified on the provider enrollment application or may be provided to nursing ~~home~~ facility residents at a Medicaid-enrolled nursing facility. When enrolling in Medicaid, audiologists must provide proof of their current licensure. Out of state providers must be licensed in the state where services are rendered if that state requires audiologists to be licensed. Proof of licensure must be presented when enrolling in Medicaid.
			1.1.A.4. Hearing Centers (new subsection)	New subsection text reads: Freestanding hearing centers may enroll with Medicaid for reimbursement of audiology services. The freestanding hearing center must not be part of, or owned by, a hospital, Comprehensive Outpatient Rehabilitation Facility, Rehabilitation Agency, or university graduate education program. Services must be provided at the service/practice address identified on the provider enrollment application or may be provided to nursing facility residents at a Medicaid-enrolled nursing facility.
		MI Health Link	Section 5 – Covered Services	In the 1st paragraph, the 2nd bullet point was revised to read: • Medicaid State Plan services, including personal care services and hearing aid coverage

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 18-25 (includes MSA 17-28)	8/30/2018	Nursing Facility Cost Reporting & Reimbursement Appendix	Section 3 - Definitions	Addition of the following definitions: **Net Quality Measure Initiative Amount (Net QMI Amount)**: The Quality Measure Initiative payment amount minus the Quality Measure Initiative share of the Medicaid Quality Assurance Assessment Program tax. **Quality Measure Initiative (QMI)**: Quality Assurance Assessment Program funded payments to nursing facilities based on their average quality measure domain rating on the Nursing Home Compare (NHC) website, along with a resident satisfaction survey factor.
			8.29.B. Quality Assurance Assessment Tax	The subsection title was revised to read: Quality Assurance Assessment Program (QAAP) Tax Text was revised to read: A nursing facility's ~~Quality Assurance Assessment~~ QAAP ~~T~~ tax, including the Quality Measure Initiative (QMI) share of the tax, is an allowable cost and must be reported in the nursing facility Medicaid annual cost report. The tax must be reported on the provider's cost report as assessed and accounted for on the accrual basis. The ~~Quality Assurance Assessment~~ QAAP ~~T~~ tax cost is adjusted through the cost reporting process to be segregated from use in rate setting. The QMI share of the QAAP tax must be reported on a separate account on the provider's cost report than the rest of the QAAP tax.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			9.15 Quality Measure Initiative (QMI) Special Cost Reporting Requirements (new subsection)	New subsection text reads: The nursing facility QMI provides payments to facilities based on their average quality measure domain rating on the Nursing Home Compare (NHC) website. For additional information about the QMI, refer to the Nursing Facility Quality Measure Initiative (QMI) subsection of the Rate Determination section of this Appendix. The Quality Assurance Assessment Program (QAAP) tax levied for the QMI and the payment amount of the QMI are to be reported on the cost report the year they are applicable and in the following manner: ▪ The QAAP tax assessed during the cost reporting period is to be reported on the "Quality Measure Initiative Assessment" line of the cost report under the Administrative & General cost center. ▪ The amount of QMI payments in a cost reporting period are to be reported on the "Quality Measure Initiative Payment" line of the cost report under Routine Services Revenue. The QAAP tax assessed is adjusted from the cost report in accordance with the Quality Assurance Assessment Tax subsection of the Allowable and Non-Allowable Costs section of this Appendix. An adjustment is also made to the cost report to remove the Net QMI Amount. The QMI adjustment may not exceed zero (i.e., the adjustment is either a negative amount or zero), and the adjustment amount is made to "Miscellaneous – Base" in the Medicaid Routine Care Unit #1 cost center of the cost report. **Example:** Facility A had $150,000 in QMI QAAP tax assessed and $250,000 in QMI payments during their 2019 cost reporting period, so Facility A would apply a -$100,000 adjustment to the "Miscellaneous – Base" line in the Medicaid Routine Care Unit #1 cost of their 2019 cost report.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				Example: Facility B had $150,000 in QMI QAAP tax assessed and $100,000 in QMI payments during their 2019 cost reporting period, so Facility A would not apply an adjustment to the "Miscellaneous – Base" line in the Medicaid Routine Care Unit #1 cost of their 2019 cost report.
			10.7 Nursing Facility Quality Assurance Assessment Program (QAAP)	Text was revised to read: The ~~Quality Assurance Assessment Program (~~QAAP~~)~~ was implemented by Medicaid in compliance with Michigan and Federal law. The QAAP provides a Quality Assurance Supplement payment and Quality Measure Initiative payment to nursing facilities ~~facility reimbursement rates~~ by incorporating funds from the quality assurance assessment tax. When a provider sells a nursing facility, the provider is responsible for all QAAP assessments billed and incurred prior to the date of the sale. The purchaser(s) must assure escrow of any outstanding QAAP amounts owed, or the purchaser(s) becomes responsible for payment of the QAAP and penalty amounts owed before Medicaid participation is granted. If the provider quits the business, the provider is responsible for all QAAP assessments billed and prorated as of the date MDHHS determines the facility closed. The QAAP applies to Class I, Class III and Class V nursing facilities.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			10.7.D. Nursing Facility Quality Measure Initiative (QMI) (new subsection)	New subsection text reads: Eligible nursing facilities may receive a supplemental QMI payment. Payments to individual nursing facilities will be determined by their average 5-star quality measure rating on the CMS Nursing Home Compare (NHC) website, Medicaid utilization rate, number of licensed beds, and resident satisfaction survey data as described in this section. In cases of a change of ownership, the new owner's QMI payment will continue to be calculated based off the prior owner's average quality measure rating, Medicaid utilization rate, number of licensed beds, and resident satisfaction survey data. The average 5-star quality measure rating will be based upon the average rating from July of the prior calendar year to June of the current calendar year (e.g., for the rate year beginning October 1, 2018, the average 5-star quality measure rating would be based on the average rating between July 1, 2017 to June 30, 2018). For special cost reporting requirements related to the QMI, refer to the Quality Measure Initiative (QMI) Special Cost Reporting Requirements subsection of the Cost Classifications and Cost Finding section of this Appendix. Refer to the Nursing Facility Resources section of the Directory Appendix for additional resources and contact information.

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			10.7.D.1. Eligibility for QMI Payment (new subsection)	New subsection text reads: To be eligible to receive a QMI payment, a provider must meet the following conditions: ▪ The provider must be a Class I or III nursing facility. ▪ The provider must have a 1, 2, 3, 4 or 5-star quality measure rating on the NHC website. ▪ The provider must be a Medicaid-certified nursing facility. ▪ The provider must not be closed for business. That includes a voluntary closure, or an action by MDHHS, CMS or LARA to decertify or delicense a provider. ▪ The provider must not be designated as a Special Focus Facility (SFF) by CMS. ▪ If the provider has an average quality measure rating below 2.5 stars, they must submit an action plan to the Long Term Care Policy Section as described in the QMI Action Plan subsection. ▪ The provider must deliver at least one day of Medicaid nursing facility services at the room and board level during the state fiscal year in which they receive QMI payments and in their immediate prior year-end cost reporting period. QMI payments made to a provider found to have no days of Medicaid nursing facility services during the state fiscal year shall be recouped by the Michigan Department of Health and Human Services (MDHHS).

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				MDHHS will generally check in August prior to the beginning of a rate year and approximately every three months thereafter to see which facilities are designated as SFFs or have closed. A provider designated as a SFF will not be eligible to receive any QMI payments until they graduate from the SFF list. A SFF that graduates after the rate year begins will only be eligible for prorated QMI payments for the balance of the remaining months of the rate year (e.g., a provider that graduates from the SFF list would not receive reimbursement equal to what they would have received had they been eligible for the entire rate year). If a provider has closed or graduated from the SFF list, MDHHS may recalculate some or all QMI payments depending on the amount of available funds.
			10.7.D.2. QMI Action Plan (new subsection)	New subsection text reads: A provider with an average quality measure rating below 2.5 stars must file an acceptable QMI action plan with the Long Term Care Policy Section to be eligible for a QMI payment. The action plan will need to provide specific details reflecting how a provider intends to use QMI funds to increase quality outcomes. The Long Term Care Policy Section will electronically provide written notice to providers with a rating below 2.5 stars and will provide the expectations for the action plan. A plan that does not provide the specific details required in the notice will not be accepted by the Long Term Care Policy Section. The Long Term Care Policy Section will set a due date in the notice for a provider to submit the action plan. A provider that fails to submit an action plan by the due date cannot receive payment until an action plan is sent to and accepted by the Long Term Care Policy Section. If a provider fails to submit an acceptable action plan within 30 days of the due date, they will be unable to receive a QMI payment for the remainder of the fiscal year. Unless directed otherwise by the Long Term Care Policy Section, the action plan must be sent electronically as specified in the notice.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			10.7.D.3. QMI Payment Methodology (new subsection)	New subsection text reads: The Medicaid utilization rate will be determined from the immediate prior year-end cost report covering a period of at least seven months (e.g., 2016 year-end cost reports will set the utilization rate for the fiscal year beginning October 1, 2017). For the purposes of this section, a cost report refers to the uniform Medicaid nursing facility cost report or a less than complete cost report. The sum of the total Title XIX patient days in the Medicaid Routine Care Unit #1 and the Medicaid Special Care Unit #1 over the sum of the total inpatient days in all nursing facility units on the cost report will set the utilization rate (e.g., if the sum of the Title XIX inpatient days in the Medicaid Routine Care Unit #1 and the Medicaid Special Care Unit #1 is 1,000, while the sum of total inpatient days in all units is 1,500, the Medicaid utilization rate would be 66.7%). If the immediate prior year-end cost report does not cover a period of at least seven months, then the Medicaid utilization rate will be determined as follows: ▪ If the prior year-end cost report covers a period of less than seven months, and if multiple cost reports were filed by the current or prior facility owner, then all cost reports submitted for the prior year-end will be used in calculating the Medicaid utilization rate (i.e., if the current owner and the prior owner each submitted a 2016 year-end cost report, then both cost reports would be used to determine the Medicaid utilization rate). ▪ If no cost report was filed for the prior year-end because the current or prior owner submitted an extended period cost report, then the most recent cost report filed prior to the previous calendar year that covers a period of at least seven months will be used in calculating the Medicaid utilization rate. ▪ If the immediate prior year-end cost report is the only cost report the provider has ever filed, then that cost report will be used in calculating the Medicaid utilization rate even if it covers a cost reporting period of less than seven months. ▪ A provider that has not filed an immediate prior year-end cost report will be assumed to have no Medicaid utilization.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				Per-bed QMI payment amounts are multiplied by a Medicaid utilization scale. The Medicaid utilization scale will be applied as follows: ▪ For nursing facilities with a Medicaid utilization rate of above 63%, the facility shall receive 100% of the QMI payment. ▪ For nursing facilities with a Medicaid utilization rate between 50% and 63%, the facility shall receive 75% of the QMI payment. ▪ For nursing facilities with a Medicaid utilization rate of less than 50%, the facility shall receive a payment proportionate to their Medicaid utilization rate. **Example:** Facility A has a Medicaid utilization rate of 64% while Facility B has a Medicaid utilization rate of 35%, so Facility A would receive 100% of their QMI payment while Facility B would receive 35% of their payment. Effective for rate years beginning on or after October 1, 2018, an adjustment is made for the submission of resident satisfaction survey data from recently performed surveys. The Long Term Care Policy Section will provide notice to facilities prior to the fiscal year on how to submit the data, what documentation is necessary, and where to submit resident satisfaction survey data by a due date specified in the notice. Per-bed QMI payments will be multiplied by 100% for facilities that submit acceptable resident satisfaction survey data and documentation, but payments will be multiplied by a percentage set by MDHHS for facilities that do not submit the data and documentation. The resident satisfaction survey must have been conducted no more than 12 months before the submission of the notice, and survey data submitted for prior year QMI payments will not be accepted.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				The following formula demonstrates the monthly adjusted QMI payment (for rate years prior to October 1, 2018, the resident satisfaction survey factor is not included in the formula): ▪ QMI Gross Adjustment = (([NHC Per-Bed Amount] x [Medicaid Utilization Scale] x [Resident Satisfaction Survey Factor]) x [Number of Licensed Nursing Facility Beds])/[Number of Eligible Payment Months] **Examples:** ▪ For rate year October 1, 2017, Nursing Facility A has an average NHC rating of 5 stars, a Medicaid utilization rate of 55%, 100 licensed nursing facility beds, and meets all the payment eligibility requirements. The NHC per-bed amount for a 5-star rating is $2,000, so the QMI Gross Adjustment = (($2,000) x (75%) x (100))/12 = $12,500/month. ▪ For rate year October 1, 2017, Nursing Facility B has an average NHC rating of 2 stars, a Medicaid utilization rate of 32%, 45 licensed nursing facility beds, and meets all the payment eligibility requirements. The NHC per-bed amount for a 2-star rating is $1,250, so the QMI Gross Adjustment = (($1,250) x (50%) x (45))/12 = $2,343.75/month. ▪ For rate year October 1, 2018, Nursing Facility C has an average NHC rating of 3 stars, a Medicaid utilization rate of 78%, 200 licensed nursing facility beds, has not submitted resident satisfaction survey data, and meets all the payment eligibility requirements. The NHC per-bed amount for a 4-star rating is $1,750 and the resident satisfaction survey factor for facilities with no survey is 85%, so the QMI Gross Adjustment = (($1,750) x (100%) x (85%) x (200))/12 = $24,791.67/month. All values in the examples above are for example purposes only and do not reflect actual rates.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			14.4 Administrative & General	The following text is added after "Quality Assurance Assessment – Hospital (non-Long Term Care)": Quality Measure Initiative Assessment…. Support
		Acronym Appendix		Addition of: NHC – Nursing Home Compare QMI – Quality Measure Initiative SFF - Special Focus Facility
		Directory Appendix	Nursing Facility Resources	Addition of: Contact/Topic: Quality Measure Initiative (QMI) Phone # Fax #: Mailing/Email/Web Address: Email: MDHHS-NFQMI@michigan.gov Website: www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Nursing Facilities >> Nursing Facility Quality Measure Initiative Information Available/Purpose: Additional resources and contact information related to the nursing facility QMI.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 18-22	8/31/2018	Hospital Reimbursement Appendix	2.3.A.6. Special Circumstances	The following text was added: **Long-Acting Reversible Contraception**: Long Acting Reversible Contraceptives (LARCs) provided in the inpatient hospital setting immediately postpartum are excluded from the DRG payment. An additional payment for the LARC device will be made to a hospital when a LARC is provided immediately postpartum. Practitioners will receive payment for their professional services related to the immediate postpartum LARC insertion procedure when billed separately from the professional global obstetric procedure codes and the hospital facility. Costs associated with a LARC device are to be billed separately from the inpatient visit using the Medicaid fee schedule (insertion and device).
		Acronym Appendix		Addition of: LARC - Long Acting Reversible Contraceptive

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

BULLETINS INCORPORATED*

<table>
<tr><th>BULLETIN NUMBER</th><th>DATE ISSUED</th><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th></tr>
<tr><td>MSA 18-29</td><td>8/31/2018</td><td>Medicaid Provider Manual Overview</td><td>1.1 Organization</td><td>Table text was revised to read:
<table>
<tr><th>Chapter Title</th><th>Affected Providers</th><th>Chapter Content</th></tr>
<tr><td>Hearing Services</td><td>Hearing Centers, ~~Outpatient~~ Therapy Providers</td><td>Coverage policy related to hearing evaluations and speech/language services</td></tr>
<tr><td>~~Outpatient~~ Therapy Services</td><td>~~Outpatient~~ Therapy Providers, Medical Suppliers</td><td>~~Outpatient~~ Therapy provider participation requirements and coverage policy.</td></tr>
</table></td></tr>
</table>

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Billing & Reimbursement for Institutional Providers	7.28 Therapies (Occupational, Physical and Speech-Language)	The 1st and 2nd paragraphs were revised to read: ~~Dual-use therapy codes may be billed by both a physical therapist and an occupational therapist on the same date of service when both professionals provided covered therapy services on the same day under their corresponding treatment plans. The appropriate OPPS modifier must be reported if applicable.~~ ~~Refer to the CMS website for a list of HCPCS therapy codes and their respective designations used for therapy services (i.e., "always therapy" and "sometimes therapy"). HCPCS codes assigned as "sometimes therapy" services may be reimbursed as non-therapy services if billed appropriately. (Refer to the Directory Appendix for website information.)~~ Therapy services must be reported using the appropriate procedure code and therapy modifier to distinguish the discipline under which the service is delivered. Services should also be billed with the appropriate modifier that represents the nature of the therapy (habilitative vs. rehabilitative) performed. For MHP enrollees, the provider should check with the MHP for PA requirements. Refer to the Therapy Services chapter for additional information related to therapies. In the table, the 1st bullet point under "Occupational Therapy" was revised to read: ▪ OT does not require PA for a maximum of 144 units within ~~the first 12 consecutive calendar months of therapy~~ a calendar year. ~~For MHP enrollees, the provider should check with the MHP for PA requirements~~. In the table, the 1st bullet point under "Physical Therapy" was revised to read: ▪ PT does not require PA for maximum of 144 units within ~~the first 12 consecutive calendar months of therapy~~ a calendar year.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			8.11 Ancillary Physical and Occupational Therapy, Speech Pathology	Text after the 1st paragraph was revised to read: When billing on the NUBC claim form, facilities must use the revenue codes and HCPCS codes identified on the MDHHS Therapy Services Database available on the MDHHS website. (Refer to the Directory Appendix for website information.) ▪ Each ancillary service must be billed on a separate claim line. Series billing is not allowed. ▪ Each claim line requires a: ➢ Date of service ➢ Revenue code and a HCPCS code ~~➢ PA number on the claim~~ ➢ Therapy discipline and nature modifier. ▪ PA number must be on the claim. *(text box remains the same)* ~~Dual-use therapy codes may be billed by a physical therapist and an occupational therapist on the same date of service when both professionals provide covered therapy services on the same day under their corresponding treatment plans. The codes are identified on the MDHHS Therapy Services Database with required modifiers GO and GP. The appropriate modifier must always be used on the claim line to avoid a claim rejection when billing a dual-use code.~~ Therapy services must be reported using the appropriate therapy modifier to distinguish the discipline under which the service is delivered. In addition, services must be reported with the appropriate modifier that represents either the habilitative or rehabilitative nature of the therapy. Maintenance therapy visits should also include the MDHHS designated maintenance modifier. Refer to the Therapy Services chapter for additional information related to therapies.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				▪ Occupational therapy modifier: GO ▪ Physical therapy modifier: GP ▪ Speech therapy modifier: GN ▪ Rehabilitative therapy modifier: 97 ▪ Habilitative therapy modifier: 96 ▪ Maintenance visit modifier: TS (Follow-up Service)

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

<table>
<tr><th>BULLETIN NUMBER</th><th>DATE ISSUED</th><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th></tr>
<tr><td></td><td></td><td>Billing & Reimbursement for Professionals</td><td>7.16 Therapy Services

(new subsection; following subsection was re-numbered)</td><td>New subsection text reads:

Therapy claims must be submitted using the appropriate procedure code and therapy modifier to distinguish the discipline under which the service is delivered. In addition, services must be reported with the appropriate modifier that represents the nature of therapy being performed (habilitative vs. rehabilitative). Maintenance therapy visit claims should also include the MDHHS designated maintenance modifier. Therapy services submitted without these modifiers may be denied.

<table>
<tr><th>Modifier</th><th>Description</th><th>Special Instructions</th></tr>
<tr><td>96</td><td>Habilitative Service</td><td>Used to identify therapy services habilitative in nature.</td></tr>
<tr><td>97</td><td>Rehabilitative Service</td><td>Used to identify therapy services rehabilitative in nature.</td></tr>
<tr><td>GP</td><td>Service delivered under an outpatient physical therapy plan of care.</td><td>Identifies services provided under a physical therapy treatment plan.</td></tr>
<tr><td>GO</td><td>Service delivered under an outpatient occupational therapy plan of care.</td><td>Identifies services provided under an occupational therapy treatment plan.</td></tr>
<tr><td>GN</td><td>Service delivered under an outpatient speech-language pathology plan of care.</td><td>Identifies services provided under a speech therapy treatment plan.</td></tr>
<tr><td>TS</td><td>Follow-up Service</td><td>Used to identify therapy services as maintenance related.</td></tr>
</table>
</td></tr>
</table>

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Healthy Michigan Plan	5.2.A. Covered Services and Limits	Text after the 1st paragraph was revised to read: Physical and occupational therapy services provided in ~~an~~ a private practice or outpatient ~~hospital~~ setting will be limited to 144 units (15-minute increments) in a ~~consecutive 12-month~~ calendar year period without PA. Evaluations and re-evaluations will be limited to two per year without PA. Speech therapy services provided in ~~an~~ a private practice or outpatient ~~hospital~~ setting will be limited to 36 visits in a ~~consecutive 12-month~~ calendar year period without PA. Evaluations and re-evaluations will be limited to two per year without PA. ~~Modifier SZ~~ The habilitative services modifier must be reported in addition to the procedure code for all habilitative services submitted either on PA requests or for claim adjudication to ensure proper payment. Refer to the Billing & Reimbursement chapters for additional therapy modifier information.
		Hearing Services	2.2 Speech Services	Text was revised to read: Refer to the ~~Outpatient~~ Therapy Services Chapter of this manual for information related to speech services.
		Home Health	Section 7 – Therapies (Occupational, Physical and Speech)	The following text was added: Medicaid covers home occupational therapy (OT) and physical therapy (PT) when medically necessary, reasonable, and necessary to help the beneficiary return to a previous functional level or to a functional level that is appropriate to a stable medical status. Under certain circumstances, home speech therapy (ST) is covered for children enrolled in Children's Special Health Care Services (CSHCS). Refer to the Therapy Services Chapter of this manual for additional information.
			7.1 Occupational Therapy	Subsection was deleted.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			7.2 Physical Therapy	Subsection was deleted. Includes: 7.2.A. Active Therapy 7.2.B. Maintenance/ Monitoring Services
			7.3 Speech-Language Therapy	Subsection was deleted.
			7.4 Resuming Therapies	Subsection was deleted.
		Hospital	Section 2 – Prior Authorization	In the table, under "Service", text was revised as follows: * Outpatient Occupational Therapy (OT) (after the initial 12 months of treatment or 144 ~~visits~~ units) * Physical Therapy (PT) (after the initial 12 months of treatment or 144 ~~visits~~ units) * Outpatient Speech-Language Pathology (after the initial 12 months of treatment or ~~144~~ 36 visits)
			3.30 Occupational Therapy	In the 1st paragraph, the last sentence was revised to read: Refer to the Standards of Coverage and Service Limitations Section of the ~~Outpatient~~ Therapy Services Chapter for criteria. In the 2nd paragraph, the 1st sentence was revised to read: Refer to the Standards of Coverage and Service Limitations Section of the ~~Outpatient~~ Therapy Services Chapter for therapy provided in the outpatient hospital setting.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			3.31 Physical Therapy	In the 1st paragraph, the last sentence was revised to read: Refer to the ~~Outpatient~~ Therapy Services Chapter of this manual for standards of coverage and service limitations for therapy provided in the outpatient hospital setting.
			3.32 Therapy, Speech-Language Pathology	In the 2nd paragraph, the 1st sentence was revised to read: Refer to the ~~Outpatient~~ Therapy Services Chapter of this manual for standards of coverage and service limitations for therapy provided in the outpatient hospital setting.
		Medical Supplier	2.39 Speech Generating Devices	Under "Documentation", 1st paragraph, bullet points were revised as follows: • (2nd bullet point) the date of onset, progress made and a comprehensive summary of the beneficiary's communication goals. (Refer to criteria outlined in the ~~Outpatient~~ Therapy Services Chapter, Speech-Language Therapy subsection.) • (7th bullet point) specifications for the SGD. (Refer to the ~~Outpatient~~ Therapy Services Chapter.) The 2nd paragraph was revised to read: All SGD evaluation documentation must be submitted following the established criteria stated within the Evaluations and Follow-up for Speech Generating Devices/Voice Prostheses subsection of the ~~Outpatient~~ Therapy Services Chapter. Under "Follow-Up Services", the 2nd sentence was revised to read: (Refer to the ~~Outpatient~~ Therapy Services Chapter and the Medicaid Code and Rate Reference tool for PA and coverage parameters.)

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Nursing Facility Coverages	10.36 Therapies	Text was revised in its entirety to read: Routine maintenance therapy consists of the repetitive services required to maintain function. The development of the therapy and treatment are included in the per diem rate. Such therapy does not require the therapist to perform the service, nor does it require complex and sophisticated procedures. Nursing facilities must provide or obtain specialized rehabilitative services if required by the beneficiary's plan of care. Non-routine occupational therapy (OT), physical therapy (PT) and speech therapy (ST) are ancillary services that are covered separately from the per diem rate if prior authorization is obtained and the following conditions are met: • The therapy must be billed by the facility; • There must be a written order by the attending physician/licensed physician's assistant for each calendar month of therapy; and • The written orders must be signed by the attending physician/licensed physician's assistant and retained in the beneficiary's medical record. Refer to the Therapy Services Chapter of this manual for additional information. Non-routine OT, PT and ST services are included in the Resource Utilization Group (RUG) rates paid to State Veterans' Homes. State Veterans' Home providers are to bill for non-routine therapies on the same claims as daily care. All therapy services require prior authorization.
			10.36.A. Occupational Therapy (OT)	Subsection was deleted.
			10.36.B. Physical Therapy (PT)	Subsection was deleted.
			10.36.C. Speech Pathology/Therapy (ST)	Subsection was deleted.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			10.36.D. Prior Approval for Therapies	Subsection was deleted. Includes: 10.36.D.1. Initial Request 10.36.D.2. Continued Request 10.36.D.3. Process 10.36.D.4. Billing 10.36.D.5. Progress Notes
		Outpatient Therapy		Chapter was replaced by new chapter: Therapy Services
		Practitioner	Section 16 – Outpatient Therapy	Text was revised to read: Refer to the ~~Outpatient~~ Therapy Services Chapter of this manual for additional information.
			Section 23 – Physical Therapist	Text was revised to read: ~~Medicaid only covers Medicare coinsurance and deductible amounts for services provided by enrolled physical therapists. A physician/physician assistant/nurse practitioner must prescribe physical therapy services.~~ ~~To qualify for coverage, services must be provided in the physical therapist's office. Services provided in the physician's office are covered under the physician, and services provided in a nursing facility setting are covered under the long-term care provider. A licensed physical therapist (PT) or a physical therapy assistant under the direct supervision of the physical therapist must provide services.~~ Refer to the ~~Outpatient~~ Therapy Services Chapter for additional therapy information.
		Therapy Services (new chapter)		New chapter replaces Outpatient Therapy chapter.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Forms Appendix	MSA-115; Occupational Therapy - Physical Therapy - Speech Therapy Prior Approval Request/ Authorization	Form was updated.
MSA 18-30	8/31/2018	Medical Supplier	1.8.C. Repairs and Replacement Parts	The 5th paragraph was revised to read: Repair of DME involving the replacement of a component part includes the cost of the part and the labor associated with its removal, replacement and finishing. For repairs to wheelchairs, refer to the Wheelchair Repair/Labor Guide posted on the MDHHS website, and to the Prior Authorization for Purchase, Rentals, Repairs, and/or Replacement of Mobility Devices subsection of this chapter. The RB modifier is required.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			2.48.C. Prior Authorization for Purchase, Rentals, Repairs, and/or Replacement of Mobility Devices	Under "Rentals, Repairs and Replacement", the 2nd paragraph was revised to read: **Repairs** ~~for beneficiary-owned mobility devices are covered only after the manufacturer's warranty has been exhausted. It is the responsibility of the provider to supply loaner equipment while the original item is being serviced. If repair of a wheelchair not purchased by MDHHS is requested, the item must be medically necessary and meet the basic standards of coverage. The repair of a second (older) manual or power wheelchair used as a back-up wheelchair is not covered. Repair of a wheelchair involving the replacement of a component part includes the cost of the part and the labor associated with its removal, replacement, and finishing.~~ Labor (K0739): MDHHS developed a Wheelchair Repair/Labor Guide for providers to use to determine the maximum allowed number of units of labor for repairs to wheelchairs using replacement parts/accessories with identified HCPCS codes. The guide is posted on the Provider Specific (Medical Supplier) page of the MDHHS website. (Refer to the Directory Appendix for website information.) To request labor, report HCPCS code K0739 and the total number of units on the prior authorization request. Providers may request no more than the allowable number of labor units listed in the Wheelchair Repair/Labor Guide for each replacement part regardless of actual repair time. All repairs include screws, nuts and bolts unless otherwise stipulated in the Guide. Labor associated with the removal of the original component part, replacement with a new component, and finishing is included in the total number of labor units indicated in the Wheelchair Repair/Labor Guide. All costs to repair the wheelchair must be included on the PA request, including cost for parts and labor. The estimated cost to repair versus replace the wheelchair must be included on the PA request when requesting repairs using multiple component parts/accessories.

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				Beneficiary-owned and purchased by MDHHS: • Covered only after the manufacturer's warranty has been exhausted. • If the DME provider is the same provider that originally supplied the wheelchair, a new certificate of medical necessity (CMN) and/or physician's order is not necessary. • The treating physician or the DME provider must document the repair is reasonable and necessary. Generalized statements (e.g. "item worn out") are not specific enough to confirm the need for the repair(s). • The DME provider must document the reason for the repair(s), submit this information with the PA request, and keep a copy of the documentation in the beneficiary file. MDHHS did not purchase the original wheelchair: • Covered only after the manufacturer's warranty has expired. • Requires a new physician order, CMN, and required documentation indicated in the wheelchair and repair policies must be completed and submitted with the PA request. • The DME provider must document the repair is reasonable and necessary. Generalized statements (e.g. "item worn out") are not specific enough to confirm the need for the repair(s). • The DME provider must document the reason for the repair(s), submit this information with the PA request, and keep a copy of the documentation in the beneficiary file. It is the responsibility of the provider to supply loaner equipment while the original item is being serviced. MDHHS will not pay for repairs to parts/accessories that are not typically covered by Medicaid or that were not approved for the initial purchase of the wheelchair/accessory.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				The repair of a second (older) manual or power wheelchair used as a back-up wheelchair is not covered. Routine cleaning of wheelchairs or parts is not covered. MDHHS does not reimburse for labor and repairs: • For initial purchases; • During rental periods; or • For items under warranty. Refer to the Repairs and Replacement Parts subsection of this chapter for further repair policy.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Glossary		The definition for "Durable Medical Equipment (DME)" was revised to read: ~~Items that can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and can be used in the beneficiary's home.~~ Equipment that can withstand repeated use, is reusable or removable, is suitable for use in any non-institutional setting in which normal life activities take place, is primarily and customarily used to serve a medical purpose and is generally not useful to an individual in the absence of illness, injury or disability. The definition for "Medical Supplies" was revised to read: ~~Items that are required for medical management of a beneficiary, are disposable, or have a limited life expectancy and can be used in the beneficiary's home.~~ Health care related items that are required to address an individual's illness, injury or disability; are consumable, disposable or have a limited life expectancy, cannot withstand repeated use, and are suitable for use in any non-institutional setting in which normal life activities take place. Examples are: hypodermic syringes/needles, ostomy supplies, and dressings necessary for the medical management of the beneficiary.
MSA 18-31	8/31/2018	General Information for Providers	Section 3 – Maintenance of Provider Information	In the 2nd paragraph, the following bullet point was added: • Addition/change of information related to the participating or collaborating physician and/or agreements.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Billing & Reimbursement for Professionals	2.3.D. Supervising Provider	Text was revised to read: The supervising physician NPI is a claim editing requirement which must be included on claims when physician services are rendered by an enrolled non-physician practitioner, such as a physician's assistant or ~~nurse practitioner~~ advanced practice registered nurse. Physician supervision and oversight must be consistent with Michigan Public Act 368 of 1978, as amended. The supervising physician must be enrolled with the program.
		Practitioner	1.5 Hospital-Based Provider	The 2nd paragraph was revised to read: For purposes of Medicaid, a HBP includes physicians (MD, DO, DPM). Some nonphysician practitioners, such as physician assistants (PAs), certified registered nurse anesthetists (CRNAs), nurse practitioners (NPs), clinical nurse specialists, and certified nurse midwives (CNMs), ~~and physician assistants (PAs)~~ can also be considered HBPs under certain circumstances.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			1.7 Physician Delegation and Supervision	Text was revised to read: ~~All P~~hysician services covered by Medicaid must be performed by the physician personally, the physician's employee, or an employee of the same legal entity that employs the physician, under the physician's delegation and supervision in accordance with State law, professional scope of practice, and program and organizational policy. Only persons currently licensed/certified in an appropriate health occupation/profession (e.g., advanced practice registered nurse or physician~~'s~~ assistant~~, NP, CNM~~) as authorized by Public Act 368 of 1978, as amended, may provide direct patient care under the delegation and supervision of a physician when the physician is not physically present on the premises. The delegating/supervising physician must be continuously available through direct communication such as telephone, radio, or telecommunication when not on the premises. Delegated and supervised services rendered by non-physician practitioners (e.g., advanced practice registered nurses, physician assistants ~~and nurse practitioners~~) must be billed under the non-physician practitioner's NPI and include the NPI of the supervising physician as applicable. In the physician's absence, licensed persons who are under the physician's delegation and supervision at the medical care site where the physician regularly sees beneficiaries may provide medical services. Records must demonstrate that the licensed physician is regularly available and provides medical care to beneficiaries at the site on a routine basis. This does not preclude licensed persons under the physician's delegation and supervision from making calls or going on rounds to private homes, public institutions, hospitals, or other health care facilities, as long as the care is a supplement to and does not replace the physician's personal services. ~~Care and treatment of Medicaid beneficiaries may only be~~ Medicaid covers services delegated to unlicensed/certified persons only when the delegating physician or licensed non-physician practitioner is physically present and providing direct supervision.

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				For information related to services provided by an advanced practice registered nurse or physician assistant under the terms of a valid collaborative, practice or alliance agreement, refer to the provider-specific section of this chapter.
			Section ~~19~~ 22 – Physician~~'s~~ Assistant	Text was revised to read: ~~Medicaid covers services provided by a physician's assistant provided under the delegation and supervision of a physician licensed under part 170, part 175, or part 180 of Michigan Public Act 368 of 1978, as amended. The supervising physician must comply with the physician delegation and supervision requirements for utilizing physician's assistants specified in Public Act 368 of 1978, as amended, and any related rules promulgated by the State of Michigan or its Departments.~~ ~~To enroll as a Medicaid provider, physician assistants must complete an on-line application through CHAMPS and are to be enrolled as Rendering/Servicing-Only providers. Physician assistants are not eligible for direct Medicaid reimbursement. Payment for services rendered by a physician's assistant will be made to the delegating/supervising physician, group or billing provider NPI. The supervising physician is responsible for the services performed by the physician's assistant.~~ ~~The physician's assistant may provide direct patient care under the delegation and supervision of a physician at the medical care site where the physician regularly sees patients. Records must demonstrate that the physician's assistant provided the services, and that the licensed physician is regularly available and provides medical care to beneficiaries at the site on a routine basis. When the supervising physician is not physically present on the premises, he must be continuously available to the physician's assistant through direct communication such as telephone, radio, or telecommunication. This does not preclude licensed persons under the physician's delegation and supervision from making calls or going on rounds to private homes, public institutions, hospitals, or other health care facilities as long as the care is a supplement to, and does not replace, the physician's personal services.~~ ~~(Refer to the Surgery – General Section of this chapter for information on a physician's assistant functioning as an assistant at surgery.)~~

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				Medicaid covers physician assistant (PA) services provided by qualified, Medicaid enrolled practitioners in conjunction with covered surgeries and other procedures. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter or the Medicaid Code and Rate Reference tool available through CHAMPS for more information regarding coverage parameters. (Refer to the Directory Appendix for CHAMPS access information.)
			22.1 Covered Services (new subsection)	New subsection text reads: Medicaid covers medically necessary services provided by a PA, as defined in Public Act 368 of 1978 as amended, when all the following requirements are met: • the services are the type that are considered physician's services if furnished by a Doctor of Medicine or Osteopathy (MD/DO); • the services are performed by a person who is licensed as a PA under state law; • the PA is legally authorized to perform the service in compliance with state law; • the services are performed under the terms of a valid practice agreement with a Medicaid-enrolled MD/DO; and • the services are not restricted to physicians or otherwise excluded by Medicaid program policy or federal and state statutes.
			22.2 Enrollment of Physician Assistants (new subsection)	New subsection text reads: PAs who provide professional services to Medicaid beneficiaries are required to be enrolled providers in the Medicaid program and uniquely identified on claims for their services to be considered eligible for reimbursement. To enroll, the PA must complete an online application in the Community Health Automated Medicaid Processing System (CHAMPS) with an Individual (Type 1) National Provider Identifier (NPI) as a Rendering/Servicing-Only provider. Additional provider enrollment information can be found on the MDHHS website and in the General Information for Providers Chapter of this manual. (Refer to the Directory Appendix for website information.)

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			22.2.A. Participating Physician (new subsection)	New subsection text reads: Professional services rendered by a PA will be covered when provided under the terms of a valid practice agreement established with a participating physician as defined in state law. A group of physicians practicing other than as sole practitioners may designate one or more physicians in the group to enter into a practice agreement. During enrollment and enrollment revalidation, the PA must report the NPI of their Medicaid-enrolled participating physician by including the participating physician's NPI on the checklist and associating to the participating physician in the "Associate to Billing Provider/Other Association" step in CHAMPS. Disenrollment of the participating physician from the program may prompt disenrollment of the PA. To avoid interruption in enrollment, the PA must ensure his/her CHAMPS enrollment information reflects current/accurate participating physician information. Practitioners who wish to provide services to Medicaid Health Plan (MHP) enrollees are encouraged to contact the individual MHP for additional enrollment, credentialing, and contract requirements.
			22.2.B. Practice Agreement (new subsection)	New subsection text reads: As part of the enrollment process, the PA must attest to having a valid practice agreement with a participating physician that complies with applicable state law requirements. Determination of medical necessity and appropriateness of services is the responsibility of the PA and participating physician based on the terms of the practice agreement. The participating physician does not have to be physically on the premises where the services are provided. The PA shall maintain the practice agreement at his/her primary place of practice and provide the agreement to MDHHS upon request.
			22.3 Billing & Reimbursement (new subsection)	Heading only – see accompanying subsections for content.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			22.3.A. Claims (new subsection)	New subsection text reads: Professional claims must include the NPI of the PA in the Rendering Provider field and the participating or supervising physician in the Supervising Provider field as applicable. Refer to the Billing & Reimbursement for Professionals and the Billing & Reimbursement for Institutional Providers Chapters for additional Information.
			22.3.B. Reimbursement (new subsection)	New subsection text reads: As a Rendering/Servicing-Only provider, PAs are not eligible to receive direct reimbursement. Payment for PA services will be issued to the participating physician, physician group or billing provider. Professional services are only covered when the PA has personally performed the service and no other provider or entity has been paid for the service. Services provided jointly by the PA and physician are covered for a single practitioner only. Fee-for-Service reimbursement for PA services is based upon the limits and rates associated to physician professional services and are published on the Practitioner fee schedule located on the MDHHS website. Provider specific information may be located utilizing the Medicaid Code and Rate Reference tool within CHAMPS. Refer to the Billing & Reimbursement Chapter for additional information. MHPs are responsible for reimbursing contracted providers or subcontractors for their services according to the conditions stated in the subcontract established between the practitioner and the MHP. Noncontracted providers must comply with all applicable authorization requirements of the MHP and uniform billing requirements. (Refer to the Surgery - General section of this chapter for information on a PA functioning as an assistant at surgery.)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 18-33	8/31/2018	Beneficiary Eligibility	2.1 Benefit Plans	In the table, the Benefit Plan Description for 'HK-Dental' was revised to read: ~~The Healthy Kids Dental program is a selective contract between the Michigan Department of Health and Human Services (MDHHS) and the Delta Dental Plan of Michigan to administer the Medicaid dental benefit in selected counties to beneficiaries under the age of 21.~~ MDHHS contracts with dental health plans (DHPs) for the administration of dental services for ***Healthy Kids Dental*** (HKD) beneficiaries. The DHPs are paid a monthly capitation rate to provide covered services to enrolled Medicaid beneficiaries. The DHP is responsible for providing, arranging, and reimbursing covered dental services. DHPs may cover additional dental services not included on the MDHHS Dental Fee Schedule. Providers must contact the DHP for specific information about covered HKD benefits.
			9.9 Copayments	Text was revised to read: Health plan beneficiaries may be charged a copayment for physician, dental and outpatient hospital evaluation and management visits, non-emergency visits to the emergency department, the first day of an inpatient hospital stay (~~with the exception of~~ except for emergent admissions), and pharmacy, podiatric, chiropractic, vision, or hearing services as described in this manual. Preventive medicine evaluation and management services are not subject to beneficiary cost sharing. ~~For beneficiaries enrolled in an MHP, the copayment requirements and amounts may not exceed the Medicaid FFS copayments. Beneficiaries excluded from Medicaid FFS copayments are also excluded from MHP copayment requirements. A list of current copayments is available on the MDHHS website. (Refer to the Directory Appendix for website information.)~~ ~~Dental services are not provided by health plans. They are provided on a FFS basis or through the ***Healthy Kids Dental*** Program. Dental providers should charge the beneficiary 21 years of age or older a copayment, even if the beneficiary is enrolled in a health plan.~~ (Refer to the Dental Chapter of this manual for additional information.)

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Dental	9.1 Coverage and Service Area Information	Text was revised to read: ~~MDHHS contracts for the administration of the Medicaid dental benefit called ***Healthy Kids Dental*** to all Medicaid beneficiaries under age 21. The dental services provided through the contractor are the same services provided through the Medicaid FFS program. (Refer to the Directory Appendix for contact information.)~~ ~~Medicaid beneficiaries have access to dentists through the contractor's participating dental networks. Beneficiaries must see a dentist who participates with the ***Healthy Kids Dental*** contract.~~ MDHHS contracts with dental health plans (DHPs) for the administration of dental services for ***Healthy Kids Dental*** (HKD) beneficiaries. The DHPs are paid a monthly capitation rate to provide covered services to enrolled Medicaid beneficiaries. The DHP is responsible for providing, arranging, and reimbursing covered dental services. The HKD benefit plan covers, at a minimum, all Codes on Dental Procedures and Nomenclature listed on the MDHHS Dental Fee Schedule, including:

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				• Emergency dental services • Diagnostic services • Preventive services • Restorative services • Limited adjunctive services • Endodontic services • Limited crown coverage • Prosthodontics • Removable prosthodontics • Oral surgery services • Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services • All medically necessary services DHPs may cover additional dental services not included on the MDHHS Dental Fee Schedule. Providers must contact the DHP for specific information about covered HKD benefits. HKD beneficiaries must access dental services through a DHP network dentist. DHP networks provide services throughout the entire state.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			9.2 Enrollment Information	Text was revised to read: ~~Beneficiaries enrolled in ***Healthy Kids Dental*** are identified with the Benefit Plan ID of HK-Dental. Enrollment occurs monthly, and the contractor receives the enrollment file at the beginning of each month. A beneficiary must have active Medicaid status by the end of the month to appear on the following month's enrollment file. Enrollment in ***Healthy Kids Dental*** is always prospective, never retroactive. Beneficiaries have the Medicaid FFS dental benefit until enrolled in the Benefit Plan ID of HK-Dental. Foster care children whose service living arrangement places them out of the state or into a facility do not have the Benefit Plan ID of HK-Dental.~~ All newly eligible HKD beneficiaries are automatically enrolled in a DHP using the following methodology: The effective date of enrollment in the DHP will be the first day of the month that CHAMPS receives information that the beneficiary has been determined eligible for Medicaid. For example, if CHAMPS is notified that a beneficiary was determined eligible on October 24, the beneficiary will have a DHP enrollment effective date of October 1. MDHHS mails confirmation letters to all beneficiaries who have been automatically enrolled in a DHP. The letter includes the beneficiary's assigned DHP and information on their right to choose a different DHP. Before providing services, dentists and dental staff should verify enrollment and covered dental benefits with the beneficiary's DHP.

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			9.2.A. Verification of Enrollment	Subsection was deleted. ~~Verification of beneficiary enrollment in Medicaid, MIChild or Healthy Kids Expansion may be obtained through CHAMPS Eligibility Inquiry. The CHAMPS Eligibility Inquiry and 270/271 response will report "FFS Dental" for beneficiaries who have Fee for Service Dental.~~ ~~Verification of beneficiary enrollment in the ***Healthy Kids Dental*** program may be obtained through the dental benefits administrator.~~ ~~(Refer to the Directory Appendix for contact information.)~~
			9.2.A. Change in Enrollment (new subsection)	New subsection text reads: A beneficiary may change DHPs within 90 days of the DHP enrollment effective date. Beneficiaries may contact the MDHHS contracted enrollment broker, MI Enrolls, for help with their DHP selection. MI Enrolls is independent from the DHPs and provides beneficiaries with choice counseling information, including dental provider participation in each DHP's network. Beneficiaries may call or send a form to MI Enrolls to change their DHP. Any change of DHP made by a beneficiary is made on a prospective basis. If the beneficiary contacts MI Enrolls prior to the last business day of the month, the new DHP enrollment is effective on the first day of the following month. For example, a beneficiary who calls MI Enrolls on October 5 and selects a different DHP is changed to the new DHP effective November 1. MDHHS gives beneficiaries the opportunity to change DHPs without cause during each beneficiary's annual open enrollment period. (Refer to the Directory Appendix for MI Enrolls contact information.)

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			9.2.B. Voluntary Enrollment (new subsection)	New subsection text reads: American Indian/Alaska Native HKD beneficiaries are a voluntary enrollment population. American Indian/Alaska Native beneficiaries are automatically assigned to a DHP but are given the option to opt-out of dental managed care and be placed in the Medicaid FFS program. MDHHS mails all new automatically assigned American Indian/Alaska Native beneficiaries confirmation letters disclosing their assignment and the option to choose a different DHP or opt-out of dental managed care. American Indian/Alaska Native beneficiaries can opt-out of managed care at any time during the beneficiary's enrollment in the HKD program.
			9.2.C. Special Disenrollment (new subsection)	New subsection text reads: Beneficiaries are required to remain in their DHP if they do not make a change during their allotted open enrollment period or within 90 days of their assigned DHP's effective enrollment date. Any request to change DHP outside these time frames requires a good cause justification. Beneficiaries who believe they can show good cause may complete and submit the special disenrollment form for a MDHHS Special Disenrollment review. Beneficiaries are required to explain their reason for the requested change and may need to include a statement of support from their dental provider. Providers should refer beneficiaries to MI Enrolls for additional information and for instructions on how to obtain the special disenrollment form.
			9.2.D. Loss of Enrollment (new subsection)	New subsection text reads: Beneficiaries who lose Medicaid or Children's Health Insurance Program (CHIP) eligibility while enrolled in a DHP during active treatment that requires appointments beyond the last day of eligibility are covered for services that are completed within 60 days from the date of eligibility loss.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			9.3 Loss of Enrollment	Subsection was deleted. ~~Beneficiaries are enrolled in ***Healthy Kids Dental*** until the last day of the month in which they turn age 21. If the beneficiary loses enrollment and is in active treatment that requires multiple appointments, the provider may bill the contractor for the treatment as long as it is completed within 60 days of the loss of eligibility.~~ ~~When a beneficiary loses ***Healthy Kids Dental*** enrollment eligibility, the dental benefit is no longer administered by the contractor. Eligible Medicaid beneficiaries will have dental services provided through the Medicaid FFS program.~~

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			9.3 Transition to HKD (new subsection)	New subsection text reads: If a beneficiary enrolled in HKD starts dental treatment prior to being enrolled in a DHP and requires multiple visits, and the dentist has incurred costs related to that care, the dentist must bill Medicaid FFS for the procedure using the begin date as the date of service. For example, a beneficiary is enrolled in a DHP on October 1. If the provider started a root canal treatment on September 26, but does not complete the treatment until October 3, the provider has already incurred the costs of the beneficiary's care and must bill Medicaid FFS for the entire root canal treatment using September 26 as the date of service on the dental claim. Providers who submit a Dental Prior Approval Authorization Request (MSA-1680-B) to the MDHHS Program Review Division for beneficiaries receiving the FFS dental benefit but have not begun treatment or incurred treatment costs for a procedure must follow the policies and procedures of the beneficiary's assigned DHP to deliver dental treatment. Covered services rendered during the beneficiary's DHP effective enrollment period must be billed to the beneficiary's DHP. Beneficiaries who are automatically enrolled in a DHP and receive services prior to CHAMPS notification but after the DHP effective enrollment date are eligible to receive services through their assigned DHP for the entire first month of enrollment. Providers must accept payment from the DHP as payment in full. Beneficiaries must not be billed for HKD covered services during their DHP enrollment period.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			9.4 Beneficiary Identification	Text was revised to read: ~~Beneficiaries enrolled in ***Healthy Kids Dental*** receive an ID card from the contractor. This card is issued only once at the initial enrollment. Beneficiaries are identified with their 10-digit Medicaid ID number; this number is on the ***Healthy Kids Dental*** ID card. Providers must use this identification number when verifying enrollment and for submission of claims.~~ Beneficiaries receive a ***Healthy Kids Dental*** DHP identification card upon enrollment in a DHP. Providers must use the DHP identification card when verifying beneficiary enrollment with the DHP.

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			9.5 Benefit Administration	Text was revised to read: ~~The contractor administers the Medicaid dental benefit according to their standard policy and procedures, claim submission and reimbursement mechanisms. There is no copayment for beneficiaries under age 21, and there is no yearly maximum. Dental providers must accept the contractor's reimbursement as payment in full and cannot balance bill the beneficiary for services rendered. As an agent of Medicaid, the contractor must use the same regulations and guidelines that Medicaid follows.~~ Dental providers must be enrolled in the Michigan Medicaid program via CHAMPS and be a network provider of the DHP to provide dental services to HKD beneficiaries. Providers may choose to participate in either one or both DHP networks. DHPs will administer covered dental services according to Medicaid policy, contract requirements, and the DHP's standard policies, procedures, prior authorization, and claim submission process. It is the responsibility of the provider to be familiar with and follow the DHP's policies and procedures when providing services to HKD beneficiaries. There is no beneficiary copayment for HKD services. Reimbursement for covered services rendered to HKD beneficiaries is based on the individual DHP's fee schedule. The DHP provides its fee schedule directly to its network providers. Providers must accept the DHP's reimbursement as payment in full and cannot balance bill the beneficiary for services rendered. For specific information on a DHP's HKD network participation requirements, reimbursement schedule, or other DHP-specific policies and procedures, providers may contact the DHPs. (Refer to the Directory Appendix for DHP contact information.)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Federally Qualified Health Centers	5.3 Reconciliation of Quarterly Advances	The last paragraph was revised to read: Quarterly advances are an estimate of the difference between the payments that an MHP, PIHP, ~~and the ***Healthy Kids Dental*** contractor~~ or Dental Health Plan (DHP) make to the FQHC, and the payments the FQHC would have received under the PPS. This quarterly amount may be adjusted periodically by MDHHS to account for changes in the payment limits, cost, utilization, and other factors that affect Medicaid reimbursement to FQHCs. The FQHC may request a change in the quarterly payment through the MDHHS HCRD.
		Local Health Departments	5.3 Payment Methodology	The 4th paragraph was revised to read: Settlements do not apply to services for which primary reimbursement is the responsibility of the ~~Delta~~ Dental Health Plan (DHP) through the ***Healthy Kids Dental*** contract or any other third party payer.
		Tribal Health Centers	3.2 Dental Coverages and Limitations	The last paragraph was revised to read: ~~The ***Healthy Kids Dental*** Program is administered by a contractor in selected Michigan counties. (Refer to the Directory Appendix for contact information.)~~ MDHHS contracts with Dental Health Plans (DHPs) for the administration of dental services for ***Healthy Kids Dental*** (HKD) beneficiaries. Claims for services provided to beneficiaries enrolled in the ~~***Healthy Kids Dental***~~ HKD program should be submitted to the ~~contractor~~ beneficiary's DHP. Payment is made based on the ~~contractor's~~ DHP fee schedule. No additional reimbursement is made by MDHHS. (Refer to the Directory Appendix for DHP contact information.)
		Acronym Appendix		Addition of: DHP – Dental Health Plan
		Directory Appendix	Beneficiary Assistance	Information for ***'Healthy Kids Dental'*** was removed.
		Directory Appendix	Eligibility Verification	Information for ***'Healthy Kids Dental'*** was removed.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Directory Appendix	Health Plan Information	The following information was added: Contact/Topic: Dental Health Plans Mailing/Email/Web Address: www.michigan.gov/healthykidsdental Information Available/Purpose: Information related to ***Healthy Kids Dental*** enrollees, services, claims, and Dental Health Plans.
MSA 18-34	10/1/2018	Laboratory	5.5 Genetic and Molecular Testing	The following text was added as the 1st paragraph: A genetic or molecular test is a specialized diagnostic laboratory test performed to detect changes or variants in genes, chromosomes, proteins, or certain metabolites which may identify increased risks of health problems, help choose treatments, or assess patient responses to treatments.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			5.5.A. Standards of Coverage	The following text was added after the 1st paragraph: Medicaid reimburses medically necessary genetic testing when one of the following apply: • The test is necessary to establish a molecular diagnosis when a definitive diagnosis remains uncertain and a genetic diagnosis is suspected, and the results will directly impact the treatment or management of the disease. • A definitive diagnosis has been made through conventional diagnostic testing and the test is necessary to guide treatment or management of the disease, including selection of specific medication and/or medication dose to ensure efficacy and safety. In the 2nd paragraph, bullet points were revised as follows: • (1st bullet point) The testing must be ordered by a licensed physician (MD or DO), physician assistant, or advanced practice registered nurse (i.e., nurse practitioner, certified nurse midwife) who is an enrolled provider. • (3rd bullet point) ~~Following history,~~ A physical examination, history, pedigree analysis, and completion of conventional diagnostic testing~~, a definitive diagnosis remains uncertain and a genetic diagnosis is suspected.~~ must be completed prior to testing. • (4th bullet point was deleted) ~~The test results will be used to significantly alter the management or treatment of the disease.~~ The following text was added after the 2nd paragraph: The clinical utility of all requested genes and gene variants must be established and documented in the beneficiary's medical record regardless of where the test(s) is performed.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			5.5.A. Standards of Coverage	The following bullet point was added to the last paragraph: • Testing attributable to standing laboratory orders. Testing must be ordered for a specific beneficiary and the medical record and/or order must clearly document the medical necessity of the specific diagnostic test to be performed.
MSA 18-36 (includes bulletin MSA 18-17)	10/1/2018	Billing & Reimbursement for Professionals	7.6.I. Miscellaneous Supplies	"Special Instructions" for modifier KX were revised to read: Append to each HCPCS code A4253/A4259 when submitting claims for over quantity for adults (age 21 and older) with medical need to test their blood glucose more frequently than established quantities. Append to specified HCPCS codes that require a face-to-face visit. Refer to the Medical Supplier Chapter and the Medicaid Code and Rate Reference tool ~~on the MDHHS website~~ in CHAMPS for all coverage requirements.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Medical Supplier	Section 1 – Program Overview	In the last paragraph, text for "Medical Supplies" was revised to read: ~~Medical supplies are those items that are required for medical management of the beneficiary, are disposable or have a limited life expectancy, and can be used in the beneficiary's home.~~ Health care related items that are required to address an individual's illness, injury or disability; are consumable, disposable or have a limited life expectancy, cannot withstand repeated use, and are suitable for use in any **non-institutional*** setting in which normal life activities take place. Examples are: hypodermic syringes/needles, ostomy supplies, and dressings necessary for the medical management of the beneficiary. Medical supplies are items covered that: • Treat a medical condition. • Prevent unnecessary hospitalization or institutionalization. • Support Durable Medical Equipment (DME) used by the beneficiary ~~in the home~~. "Durable Medical Equipment (DME)" was revised to read: ~~DME are those items that are registered with the Food and Drug Administration (FDA), can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and can be used in the beneficiary's home.~~ Equipment that can withstand repeated use, is reusable or removable, is suitable for use in any **non-institutional*** setting in which normal life activities take place, is primarily and customarily used to serve a medical purpose, and is generally not useful to an individual in the absence of illness, injury or disability. Examples are: hospital beds, wheelchairs, and ventilators. DME is a benefit for beneficiaries when: • It is medically and functionally necessary to meet the needs of the beneficiary. • It may prevent frequent hospitalization or institutionalization. • It is life sustaining.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				The following text was added as a footnote to the table: *MDHHS considers an institution to be a nursing facility, hospital or intermediate care facility for individuals with intellectual disabilities. The following paragraph was added at the end of the subsection: Durable medical equipment, medical supplies and orthotics must be registered with the Food and Drug Administration, except for custom-fabricated items. (Refer to the Standard Equipment and Custom-Fabricated Seating and the Noncustom versus Custom-Fabricated subsections for additional information.)
			1.3 Face-to-Face (F2F) Visit Requirements (new subsection; following subsections were re-numbered)	New subsection text reads: Section 6407 of the Patient Protection and Affordable Care Act (ACA) of 2010 and Section 504 of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) of 2015 require a face-to-face (F2F) visit with a physician or non-physician practitioner (NPP) prior to the initial written order for specific durable medical equipment and medical supplies. The Centers for Medicare & Medicaid Services maintains the list of specified items that require a face-to-face visit. The Durable Medical Equipment Face-to-Face List is posted on the MDHHS website. (Refer to the Directory Appendix for provider-specific webpage information.)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			1.3.A. F2F Visit (new subsection)	New subsection text reads: Prior to the initial written order and delivery of selected durable medical equipment and medical supplies (some accessories), the beneficiary must have a face-to-face visit with a physician or NPP within six months prior to the initial written order. The visit must be related to the primary condition that supports the medical need for the equipment or supply. Telemedicine visits (refer to the Practitioner Chapter) qualify as face-to-face visits. A new face-to-face visit is required for the following: • Initial order for rental/purchase; • New prescription/order, • Replacement of the base equipment; • When there is a change in the prescription/order of the item; • When there is a change in the supplier of the item and the new supplier is unable to obtain a copy of the original order and documentation from the original supplier; and • When there is change in state or federal law, policies or regulations.
			1.3.B. Practitioners Who May Perform the Face-to-Face Visit (new subsection)	New subsection text reads: The face-to-face evaluation may be provided by a physician (MD or DO) or any of the following NPPs: • Physician Assistant (PA) • Certified Nurse Practitioner (NP) • Certified Clinical Nurse Specialist (CNS) Although the PA, NP or CNS may conduct the face-to-face visit, they may not write prescriptions/orders for the specified equipment or medical supplies, and the physician must certify that the face-to-face occurred.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			1.3.C. Physician Certification of the Face-to-Face Visit (new subsection)	New subsection text reads: The ordering physician must certify that a face-to-face visit occurred within six months prior to the written order whether he/she performed the visit or another treating or attending physician or NPP performed the visit. The physician must document the date of the face-to-face visit and specify the name of the practitioner who performed the evaluation, document the clinical findings that support the need for the item(s), and confirm the primary reason for the visit that relates to the need for the item(s). A treating or attending physician (e.g., inpatient hospital physician) may conduct the face-to-face visit and order the item(s) if all criteria of the face-to-face rules are met. If the treating or attending physician performs the face-to-face evaluation but does not write the initial order; he/she must communicate the details of the visit to the ordering physician. Documentation of the face-to-face visit may be indicated on the prescription/order, the certificate of medical necessity (CMN), or other medical record. A copy of the face-to-face visit must be kept in the beneficiary's file and the original sent to the durable medical equipment (DME) supplier. Upon receipt, the DME supplier must date stamp the face-to-face documentation and maintain the documentation in the beneficiary file. The face-to-face documentation must be available upon MDHHS request. For items requiring a prior authorization, the documentation of the face-to-face visit must accompany other required documentation with the prior authorization request.

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			1.3.D. Face-to-Face Prescriptions/Orders (new subsection)	New subsection text reads: DME and medical supplies that require a face-to-face visit may only be ordered by a physician regardless of State licensing rules that may allow NPPs to write orders. MDHHS recommends the ordering physician include the face-to-face visit information on the written order or CMN; however, it is acceptable for this information to be indicated on other medical documentation (e.g. discharge summary). If the ordering physician chooses to document the face-to-face visit on the order, he/she must include the date of the visit, the name of the physician or NPP that performed the evaluation, and document the visit was related to the primary condition that supports the need for the item(s). The face-to-face visit requirement applies to initial orders and not to supply refills, equipment repairs, the servicing of equipment, or to accessories (except for those accessories indicated on the CMS list). The ordering physician must assess the continued need for the medical supply or equipment on an annual basis. For refills of supplies, the ordering physician must indicate "renewal" on the order.
			1.3.E. Billing Face-to-Face Items (new subsection)	New subsection text reads: For items requiring a face-to-face visit, the KX modifier must be appended to the HCPCS code on the claim. The KX modifier indicates that policy requirements have been met and that documentation is on file and available upon request. Adding the KX modifier on the claim if the face-to-face documentation has not been received and/or is not in the beneficiary file is incorrect billing and could result in post-payment recovery of funds or provider audit.

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

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			1.3.F. Home Health Agencies Providing Durable Medical Equipment, Prosthetics, Orthotics and Supplies (new subsection)	New subsection text reads: The ACA requires home health agencies (HHAs) to provide medically necessary durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) either directly or through arrangement with DME providers when providing home health nursing or aide services. Except for items identified in the Home Health chapter as routine medical supplies, and those items listed on the Home Health database as separately reimbursed to HHAs, HHAs choosing to provide DMEPOS must enroll with Medicaid as DME providers. HHAs must comply with all federal and state DMEPOS provider rules, policies, and regulations. (Refer to the General Information for Providers chapter and the Home Health chapter for additional information.)
			~~1.3~~ 1.4 Place of Service	The 1st paragraph was revised to read: Medicaid covers medical supplies, durable medical equipment (DME), orthotics, and prosthetics for use in ~~the beneficiary's place of residence~~ any non-institutional setting in which normal life activities take place except for skilled nursing facilities, ~~or~~ nursing facilities, or intermediate care facilities for individuals with intellectual disabilities.
			~~1.5.A.~~ 1.6.A. Prescription Requirements	The following text was added at the end of the subsection: **Note:** Refer to the Face-to-Face (F2F) Visit Requirements subsection for timelines, additional documentation requirements, and ordering/prescribing/evaluation requirements.
			~~1.5.D.~~ 1.6.D. Certificate of Medical Necessity Requirements	The 2nd paragraph was revised to read: For specifics, refer to the Coverage Conditions and Requirements section and the Face-to-Face (F2F) Visit Requirements subsection of this chapter.
			~~1.6~~ 1.7 Documentation in Beneficiary File	The following bullet point was added: • Documentation of the face-to-face visit (if applicable).

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Practitioner	3.16 Oxygen	The last paragraph was revised to read: (Refer to the Medical Supplier Chapter of this manual for additional information related to face-to-face and ~~specific~~ PA requirements.)
			4.4.B. Medical Supplies and Equipment	The following text was added at the end of the paragraph: Face-to-face visits and prior authorization may apply.
MSA 18-38	10/1/2018	Billing & Reimbursement for Dental Providers	Section 2 – General Information/Prior Authorization	In the 2nd paragraph, the 1st bullet point was revised to read: • Radiographs must be sent along with the PA form and are returned only upon provider request.
		Dental	2.4 Approved Prior Authorization Requests	The 6th paragraph was revised to read: If a change in the treatment plan is necessary, dentists should submit a new MSA-1680-B with appropriate radiographs and information to the Dental Prior Authorization Unit. Radiographs submitted are returned only upon provider request. Providers must complete the checkbox in field 17 to request the return of submitted radiographs.
			6.1.G.4. Full Mouth or Complete Series	The last paragraph was deleted. ~~Radiographs submitted for prior authorization and audit purposes will be returned to the provider.~~
			6.1.G.6. Radiograph Submission for Prior Authorization	The 1st paragraph was revised to read: When requesting prior authorization (PA) for procedures, the dentist may be required to ~~send~~ submit radiographs along with the request. Radiographs submitted are returned only upon provider request. Providers must complete the checkbox in field 17 to request the return of submitted radiographs. ~~(Information regarding the completion of the PA request and the submission of radiographs is contained in~~ (Refer to the Billing & Reimbursement for Dental Providers Chapter of this manual for additional information.)

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			6.6.A. General Instructions	The 1st paragraph was revised to read: Complete and partial dentures are benefits for all beneficiaries. All dentures require ~~prior authorization (~~PA~~)~~. Remaining maxillary teeth must be structurally and periodontally sound, with good distribution to support a maxillary partial denture for five years. Providers must assess the beneficiary's general oral health and provide a five-year prognosis for the prosthesis requested. The provider is responsible for discussing the treatment plan with the beneficiary, including any applicable frequency limits and other pertinent information related to the proposed services. Documentation of the beneficiary's agreement with the proposed treatment plan must be retained in the beneficiary's dental record. ~~An upper partial denture PA request must also include the prognosis of six sound maxillary teeth.~~
		Forms Appendix	MSA-1680-B; Dental Prior Approval Authorization Request	Form was updated.