MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

Bulletin Number: MSA 19-15

Distribution: All Providers

Issued: May 31, 2019

Subject: Updates to the Medicaid Provider Manual; Medicaid Health Plan Carve-out

Effective: As Indicated

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 July 2019 update of the online version of the Medicaid Provider Manual. The manual will be available July 1, 2019 at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Medicaid Policy Manual.

If changes were made in a chapter, a note will appear in the affected section/subsection title of that chapter's table of contents. If both technical and bulletin incorporation changes apply to the section/subsection, color coding will be limited to reflect a bulletin-related change.

Please refer to the online version of this bulletin at www.michigan.gov/medicaidproviders >> Policy, 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.

Medicaid Health Plan Carve-out

Effective for dates of service on and after April 1, 2019, MDHHS will be adding J1322 (Vimizim) to the Medicaid Health Plan Carve-out list. Coverage of this medication will require prior authorization.

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, NPI number, 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
July 2019 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Throughout the Manual		"Michigan Administrative Hearing System" was revised to read "Michigan Office of Administrative Hearings and Rules". "MAHS" was revised to read "MOAHR".	Update per Executive Order.
Medicaid Provider Manual Overview	1.1 Organization	In the table, under 'Provider/Service Specific Chapters': Under 'Nursing Facility', 'Chapter Content' was revised to read: Coverage policy; certification, survey and enforcement policy; cost reporting and reimbursement methodology~~; and appeals related to nursing facilities~~.	Technical change to reflect revised composition of chapter.
Medicaid Provider Manual Overview	1.1 Organization	In the table, under 'Provider/Service Specific Chapters': Addition of: Chapter Title: Nursing Facility Level of Care Determination Affected Providers: Nursing Facilities, MI Choice Waiver Program, Program of All-Inclusive Care for the Elderly (PACE), and the MI Health Link HCBS Waiver Program Chapter Content: Policies, processes, and criteria for Nursing Facility Level of Care Determination, Informed Choice, and Appeals	Update to reflect new chapter.
Ambulance	2.9 Non-Emergency	The 5th paragraph was revised to read: If the ambulance provider is unable to obtain a written order signed by the beneficiary's attending physician, a physician's assistant, advanced practice registered nurse (including nurse practitioner, clinical nurse specialist, and certified nurse midwife), registered nurse, or discharge planner who is knowledgeable about the beneficiary's condition and who is employed by the attending physician or facility to which the beneficiary was admitted may sign in the physician's place.	Adding clarification to advanced practice registered nurses.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	1.7 Definition of Terms	The definition for 'Health Care Professional' was revised to read: A physician, registered nurse, physician~~'s~~ assistant, nurse practitioner, clinical nurse specialist, or dietitian. Services provided must be relevant to the health care professional's scope of practice. Refer to the Staff Provider Qualifications in the Program Requirements Section of this chapter.	We are adding the Clinical Nurse Specialist to any area within the chapter that allows for the Nurse Practitioner.

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Medicaid Provider Manual
July 2019 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	1.7 Definition of Terms	Under 'Substance Abuse Treatment Specialist', the following was added to the 1st bullet point: • Clinical Nurse Specialist (CNS) Under 'Substance Abuse Treatment Specialist', the last paragraph was revised to read: A physician (MD, DO), physician assistant, nurse practitioner, registered nurse, clinical nurse specialist, or licensed practical nurse who provides substance use disorder treatment services within the scope of their practice is considered to be specifically-focused treatment staff and is not required to obtain MCBAP credentials. If one of these professionals provides substance use disorder treatment services outside their scope of practice, the appropriate MCBAP/IC & RC credential applies.	We are adding the Clinical Nurse Specialist to any area within the chapter that allows for the Nurse Practitioner.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	2.4 Staff Provider Qualifications	The following text was added to the chart in the 2nd paragraph: Clinical Nurse Specialist: An individual licensed as a registered professional nurse who has been granted a specialty certification as a clinical nurse specialist by the Michigan Board of Nursing under section 17210.	We are adding the Clinical Nurse Specialist to any area within the chapter that allows for the Nurse Practitioner.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.3 Assessments	Text for 'Health Assessment' was revised to read: Health assessment includes activities provided by a registered nurse, physician assistant, nurse practitioner, clinical nurse specialist, or dietitian to determine the beneficiary's need for medical services and to recommend a course of treatment within the scope of practice of the nurse or dietician.	We are adding the Clinical Nurse Specialist to any area within the chapter that allows for the Nurse Practitioner.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.3 Assessments	Under 'Psychiatric Evaluation', the 1st paragraph was revised to read: A comprehensive evaluation performed face-to-face by a psychiatrist, ~~or~~ psychiatric mental health nurse practitioner, or appropriately trained clinical nurse specialist that investigates a beneficiary's clinical status, including the presenting problem; the history of the present illness; previous psychiatric, physical, and medication history; relevant personal and family history; personal strengths and assets; and a mental status examination.	We are adding the Clinical Nurse Specialist to any area within the chapter that allows for the Nurse Practitioner.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.10 Health Services	Text was revised to read: Health Services are provided for purposes of improving the beneficiary's overall health and ability to care for health-related needs. This includes nursing services (on a per-visit basis, not on-going hourly care), dietary/nutritional services, maintenance of health and hygiene, teaching self-administration of medication, care of minor injuries or first aid, recognizing early symptoms of illness and teaching the beneficiary to seek assistance in case of emergencies. Health assessments are covered under Assessments subsection above. A registered nurse, nurse practitioner, clinical nurse specialist, physician~~'s~~ assistant, or dietician must provide these services, according to their scope of practice. Health services must be carefully coordinated with the beneficiary's health care plan so that the PIHP does not provide services that are the responsibility of the MHP.	We are adding the Clinical Nurse Specialist to any area within the chapter that allows for the Nurse Practitioner.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.16 Medication Administration	The 1st paragraph was revised to read: Medication Administration is the process of giving a physician-prescribed oral medication, injection, intravenous (IV) or topical medication treatment to a beneficiary. This should not be used as a separate coverage when other health services are utilized, such as Private Duty Nursing or Health Services, which already include these activities. A physician, physician~~'s~~ assistant, nurse practitioner, clinical nurse specialist, or registered nurse may perform medication administration under the direction of the physician. A licensed practical nurse who is assisting a physician may perform medication administration as long as the physician is on-site.	We are adding the Clinical Nurse Specialist to any area within the chapter that allows for the Nurse Practitioner.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.17 Medication Review	Text was revised to read: Medication Review is evaluating and monitoring medications, their effects, and the need for continuing or changing the medication regimen. A physician, physician assistant, nurse practitioner, clinical nurse specialist, registered nurse, licensed pharmacist, or a licensed practical nurse assisting the physician may perform medication reviews. Medication review includes the administration of screening tools for the presence of extra pyramidal symptoms and tardive dyskinesia secondary to untoward effects of neuroactive medications.	We are adding the Clinical Nurse Specialist to any area within the chapter that allows for the Nurse Practitioner.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.18 Nursing Facility Mental Health Monitoring	Text was revised to read: This service is the review of the beneficiary's response to mental health treatment, including direct beneficiary contact and, as appropriate, consultation with nursing facility staff to determine whether recommendations from mental health assessments are carried out by the nursing facility. Nursing facility mental health monitoring is intended to allow follow-up for treatment furnished in response to emerging problems or needs of a nursing facility resident. It is not intended to provide ongoing case management, nor is it for monitoring of services unrelated to the mental health needs of the beneficiary. Nursing facility mental health monitoring can be provided by a physician, physician assistant, clinical nurse specialist, or nurse practitioner. If nursing facility mental health monitoring is provided by a limited licensed master's social worker or limited licensed bachelor's social worker, they must be supervised by a licensed master's social worker. If monitoring is provided by a licensed bachelor's social worker or a registered nurse, they need to be supervised by a professional. A "professional" is a physician, physician assistant, clinical nurse specialist, nurse practitioner, licensed master's social worker, professional counselor, QIDP or QMHP.	We are adding the Clinical Nurse Specialist to any area within the chapter that allows for the Nurse Practitioner.

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Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.19 Occupational Therapy	Under 'Evaluation', text was revised to read: Physician/licensed physician assistant/family nurse practitioner/clinical nurse specialist - prescribed activities provided by an occupational therapist licensed by the State of Michigan to determine the beneficiary's need for services and to recommend a course of treatment. An occupational therapy assistant may not complete evaluations. Under 'Therapy', the last paragraph was revised to read: Services must be prescribed by a physician/licensed physician~~'s~~ assistant/family nurse practitioner/clinical nurse specialist and may be provided on an individual or group basis by an occupational therapist or occupational therapy assistant, licensed by the State of Michigan or by an occupational therapy aide who has received on-the-job training. The occupational therapist must supervise and monitor the assistant's performance with continuous assessment of the beneficiary's progress, but on-site supervision of an assistant is not required. An aide performing an occupational therapy service must be directly supervised by a qualified occupational therapist who is on site. All documentation by an occupational therapy assistant or aide must be reviewed and signed by the appropriately credentialed supervising occupational therapist.	We are adding the Clinical Nurse Specialist to any area within the chapter that allows for the Nurse Practitioner.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	4.3 Essential Elements	Under 'Team-Based Service Delivery', 2nd paragraph, the last sentence was revised to read: Physicians/Nurse Practitioners/Clinical Nurse Specialists must participate in the MDHHS-approved Physicians/Nurse Practitioners/Clinical Nurse Specialists training one time, with additional ACT training/participation for Physicians/Nurse Practitioners/Clinical Nurse Specialists encouraged, but not mandatory. In the 3rd paragraph, the 2nd sentence was revised to read: Physicians, ~~and/or~~ Nurse Practitioners and/or Clinical Nurse Specialists are expected to participate in ACT team meetings at least weekly.	We are adding the Clinical Nurse Specialist to any area within the chapter that allows for the Nurse Practitioner

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TECHNICAL CHANGES*

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Behavioral Health and Intellectual and Developmental Disability Supports and Services	4.3 Essential Elements	Under 'Team Composition and Size', in the 1st column, the 4th comment was revised to read: *All telepractice interactions shall occur through real-time interactions between the ACT consumer and the physician/nurse practitioner/clinical nurse specialist from their respective physical location. Psychiatric services are the only ACT services that are approved to be provided in this manner.* Under 'Team Composition and Size', in the 2nd column, the 3rd bullet point was revised to read: • A physician who provides psychiatric coverage for all beneficiaries served by the ACT team is required. The physician is considered a part of the ACT team, but is not counted in the staff-to-beneficiary ratio. The physician participates in the team meeting at least weekly and is assigned to the ACT team at least 15 minutes per beneficiary per week in a capacity that allows for immediate access to the physician so that emergency, urgent or emergent situations may be addressed. The expectation is that some beneficiaries will need more physician time and some beneficiaries will need less time during any given week. The physician may delegate psychiatric activities to a nurse practitioner or clinical nurse specialist, but the nurse practitioner/clinical nurse specialist must be supervised by that physician. Typically, although not exclusively, physician activities may include team meetings, beneficiary appointments during regular office hours, psychiatric evaluations, psychiatric meetings/consultations, medication reviews, home visits, telephone consultations and telepractice. The physician (MD or DO) must possess a valid license to practice medicine in Michigan, a Michigan Controlled Substance License, and a Drug Enforcement Administration (DEA) registration.	We are adding the Clinical Nurse Specialist to any area within the chapter that allows for the Nurse Practitioner.

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		The 5th bullet point was revised to read: • A nurse practitioner or clinical nurse specialist may perform clinical tasks delegated by and under the supervision of the physician. The nurse practitioner/clinical nurse specialist must hold a specialty certification as a nurse practitioner/clinical nurse specialist in Michigan, a current license to practice nursing in Michigan, and a master's degree in psychiatric mental health nursing. If the ACT team includes a nurse practitioner/clinical nurse specialist, he/she may substitute for a portion of the physician time, but may not substitute for the ACT RN. The nurse practitioner/clinical nurse specialist is not counted in the staff-to-beneficiary ratio. Typically, although not exclusively, nurse practitioner/clinical nurse specialist activities may include team meetings, beneficiary appointments during regular office hours, evaluations, psychiatric meetings/consultations, medication reviews, home visits, telephone consultations and telepractice.	
Behavioral Health and Intellectual and Developmental Disability Supports and Services	4.3 Essential Elements	Under 'Staff-to-Beneficiary Ratio', text was revised to read: The staff-to-beneficiary ratio shall be no less than 1:10, i.e., a maximum of 10 beneficiaries to each ACT staff. With the exceptions of the limitations on paraprofessionals and peer support specialists described above, the ratio includes all ACT team members, excluding the clerical support staff and physicians, ~~or~~ nurse practitioners, and clinical nurse specialists.	We are adding the Clinical Nurse Specialist to any area within the chapter that allows for the Nurse Practitioner.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	6.1 Population	The last sentence was revised to read: The goal of crisis residential services is to facilitate reduction in the intensity of those factors that lead to crisis residential admission through a person-centered/Family Driven, Youth-Guided, and recovery/resiliency-oriented approach.	Family Driven, Youth Guided (FD/YG) was added to recognize the difference in planning between adults and families. FD/YG is a current policy attached to the Prepaid Inpatient Health Plan (PIHP) contract with MDHHS.

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Behavioral Health and Intellectual and Developmental Disability Supports and Services	7.1 Program Approval	In the table, under 'Organizational Structure' the 5th and 6th bullet points were revised to read: • If providers wish to utilize clinicians who ~~serve mixed caseloads~~ have more than one role in the agency (home-based services plus other services, e.g., outpatient, case management, etc.), the percentage of each position dedicated to home-based services must be specified. The number of home-based services ~~cases~~ families assigned to each partial position cannot exceed the same percentage of the maximum active home-based services ~~caseload~~ families. For example, a 50% home-based position could serve no more than 6 home-based ~~cases~~ families. The total maximum ~~caseload~~ number of families, including home-based and other services ~~cases~~ families, for a full-time clinician ~~serving a mixed caseload~~ with multiple roles is 20 ~~cases~~ families. • To determine the appropriate ~~caseload size~~ number of families for any home-based services worker, the intensity of service need presented by each family should be considered. The worker-to-family ratio can always be lower than the maximum to accommodate families with very high service needs. In the table, under 'Amount and Scope of Service' the first sentence in the 4th paragraph was revised to read: The amount and scope of home-based services to families as they transition out of home-based services into a less intensive service or to ~~case~~ closure can be determined by family-driven and youth-guided decision making to maintain continuity of treatment and ensure stability. In the table, under 'Location of Service', the 2nd sentence was revised to read: Any contacts that occur other than in the home or community must be clearly explained in ~~case~~ record documentation as to the reason, the expected duration, and the plan to address issues that are preventing the services from being provided in the home or community.	FD/YG is a current policy attached to the PIHP contract with MDHHS. Trying to use more family-driven, youth-guided language in the Medicaid Provider Manual. Children and families are not "cases."

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	8.5.C. Inpatient Admission Criteria: Children Through Age 21	In the 1st paragraph, the 2nd sentence was revised to read: The SI/IS criteria for admission are based on the assumption that the ~~beneficiary~~ child, youth or young adult is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments and manifesting a level of clinical instability (risk) that are, either individually or collectively, of such severity that treatment in an alternative setting would be unsafe or ineffective.	FD/YG is a current policy attached to the PIHP contract with MDHHS. Children and youth language is more family friendly rather than "beneficiary."
Behavioral Health and Intellectual and Developmental Disability Supports and Services	12.2.A. Provision of Services	The last bullet point was revised to read: • Methadone must be administered by an appropriately-licensed MD/DO, physician~~'s~~ assistant, nurse practitioner, clinical nurse specialist, registered nurse, licensed practical nurse, or pharmacist.	We are adding the Clinical Nurse Specialist to any area within the chapter that allows for the Nurse Practitioner.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	17.3.B. Community Living Supports	In the last paragraph, the 1st sentence was revised to read: Community Living Supports (CLS) provides support to ~~a beneficiary~~ children and youth younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community.	FD/YG is a current policy attached to the PIHP contract with MDHHS. Children and youth language is more family friendly rather than "beneficiary."
Hospital Reimbursement Appendix	2.3.E. Hospital Change of Ownership (new subsection)	New subsection text reads: In accordance with 42 CFR 455.104 and the Provider Ownership and Control Disclosures subsection of the General Information for Providers Chapter of the Medicaid Provider Manual, hospitals are required to disclose ownership information to MDHHS within 35 days of a change of ownership. Failure to notify MDHHS of any change in identification information may result in the loss of Medicaid enrollment, lapse of provider eligibility, or nonpayment of services.	Repeating information contained elsewhere in the manual for emphasis.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	Section 6 – Medicaid Interim Payments and Capital Interim Payments	The section title was revised to read: Medicaid Interim Payments ~~and Capital Interim Payments~~ Text was revised to read: Medicaid Interim Payments (MIPs) ~~and Capital Interim Payments (CIPs)~~ are available on a voluntary basis to all inpatient hospitals. MIPs ~~and CIPs~~ are paid on a monthly schedule (12 payments per year). ~~Only hospitals that elect to receive MIPs are eligible to receive CIPs.~~ For hospitals electing MIP, at the beginning of each hospital's fiscal year, annual program liabilities are set for Title XIX and Title V. Separate amounts are computed for each of a hospital's inpatient units (e.g., acute care and rehabilitation). ~~CIP amounts are set using the most recent available cost data and an estimated impact of any applicable limits on capital. CIP amounts are set annually at the beginning of the hospital's fiscal year. CIPs may be adjusted due to significant changes of at least 10% in capital costs that are not reflected in the most recent cost report. Hospitals wishing to request a CIP adjustment must submit a written request to the MDHHS Hospital and Clinic Reimbursement Division (HCRD). (Refer to the Directory Appendix for contact information.)~~ ~~Medicare's Principles of Reimbursement are used to determine Medicaid's share of allowable capital costs. MDHHS policy is used to determine capital reimbursement.~~	Capital interim payments (CIPs) are covered in Section 5 – Capital.
Hospital Reimbursement Appendix	6.1 DRG	The subsection was divided into additional subsections: 6.1.A. Title XIX Gross Program Liability 6.1.B. Title V Gross Program Liability	

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	6.1.A. Title XIX Gross Program Liability (new subsection)	New subsection text reads: If DRG-reimbursed, Title XIX calculation of gross program liability is as follows: • Gross Liability = (Discharge Count x Case Mix Value x DRG) + (Calculated Outlier Amount) + (Capital Rate Per Discharge x Discharge Count). ▪ Discharges are from the four most recently filed Quarterly Cost Reports, less Outlier Count from MDHHS paid claims files. ▪ Case mix is a hospital specific value and is drawn from MDHHS paid claims files. ▪ Gross Liability is reduced by estimated other insurance and patient pay amounts.	Clarification/adding detail.
Hospital Reimbursement Appendix	6.1.B. Title V Gross Program Liability (new subsection)	New subsection text reads: If DRG-reimbursed, Title V calculation of gross program liability is as follows: ▪ Gross Liability = (Discharge Count x Case Mix Value x DRG) + (Capital Rate Per Discharge x Discharge Count). ▪ Discharges are from the four most recently filed Quarterly Cost Reports. ▪ Case mix is a hospital specific value and is drawn from MDHHS paid claims files. ▪ Gross liability is reduced by estimated other insurance and patient pay amounts.	Clarification/adding detail.
Hospital Reimbursement Appendix	6.2 Per Diem	Text was revised to read: If per-diem reimbursed, calculation of gross program liability is as follows: ▪ ~~(Per Diem x Days) - (Other Insurance + Patient Pay)~~ Gross Liability = (Days Count x Per Diem) + (Days Count x Capital Rate Per Diem). ▪ Days are from the four most recently filed Quarterly Cost Reports. ▪ Gross liability is reduced by estimated other insurance and patient pay amounts.	Clarification/adding detail.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	6.4 Reconciliation	Text was revised to read: An initial MIP reconciliation is done for operating costs only~~, and an initial CIP reconciliation is done for capital costs only~~. Fifteen months after a hospital's fiscal year ends, reconciliation is done to compare the amount paid by MDHHS to the claims approved amount for the fiscal year reviewed. For capital cost settlements for hospitals with fiscal years ending on and after January 1, 2002, filed Medicaid Cost Reports, instead of audited Medicaid Cost Reports, are used to complete a hospital desk review and settlement prior to issuing a Notice of Program Reimbursement. ~~Medicaid~~ MDHHS does not wait for Medicare to complete its audit of a hospital's cost report before ~~Medicaid~~ MDHHS does its cost settlement. In order to capture the maximum paid claims data, Medicaid final settlements and corresponding final reconciliations are not calculated earlier than 27 months after the end of a hospital's fiscal year end.	Capital interim payments (CIPs) are covered in Section 5 – Capital.
Hospital Reimbursement Appendix	6.5 Data Corrections	Text was revised to read: MIP is an estimate of the amount due a provider in the interim. There is no appeal process. If there is a calculation mistake, the hospital must ~~contact~~ notify the MDHHS HCRD in writing ~~explaining the situation~~. (Refer to the Directory Appendix for contact information.)	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	6.6 Monitoring	Text was revised to read: Hospitals that wish to receive MIPs must file Quarterly Cost ~~utilization~~ Reports. MDHHS specifies the format and time frames for the filing of these reports. MIP is monitored based on the quarterly reports submitted by the provider. These reports are due 30 calendar days after the end of the quarter. Hospitals may elect to be removed from MIP and receive payments for claims processed weekly. Hospitals removed from MIP are not allowed to reenter the MIP process. If the MIP payment significantly exceeds the amount approved for two consecutive years, the hospital may be removed from MIP. Hospitals under bankruptcy are automatically removed from MIP and are reimbursed for claims processed through CHAMPS. ~~CIPs are monitored based on quarterly reports submitted by the provider. These reports are due 30 days after the end of the quarter. Adjustments to CIPs are made quarterly where significant changes in utilization are shown.~~	Capital interim payments (CIPs) are covered in Section 5 – Capital. Formatted to one paragraph.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	7.1 Disproportionate Share Hospital Payments	Text was revised to read: Indigent volume data is taken from each hospital's Medicaid Cost Report and from supplemental forms that each hospital must file with its Medicaid Cost Report. Data from the most recently available filed Medicaid Cost Report are used to calculate a disproportionate share adjustor. New adjustors are calculated and become effective concurrently with annual inflation updates. Separate indigent volume data is collected for, and separate adjustors are applied to, distinct part psychiatric units and distinct part rehabilitation units. Indigent volume is measured as the percentage of inpatient indigent charges to a hospital's net hospital charges as reported on the Medicaid Cost Report. Indigent charges are the annual charges for services rendered to patients eligible for payments under Medicaid, CSHCS, MIChild, MOMS, and Healthy Michigan Plan, plus uncompensated care charges. Uncompensated care is limited by Medicare standards and is offset by any recoveries. No Medicare charges and no Medicaid obligation to cover premiums, copayments, coinsurance and/or deductibles for beneficiaries who are dually eligible for both Medicaid and Medicare are to be included as a Medicaid charge for the purpose of calculating the amount of indigent volume to be reported on any line of a hospital's Indigent Volume ~~Report~~ worksheet. Also excluded are charges for Medicaid patients who have other insurance coverage and for whom the full payment, except for copayment, coinsurance and/or deductible, comes from the insurance payer. Uncompensated care, bad debt recovery, and/or Hill-Burton offset may be apportioned using the ratio of total inpatient medical-surgical charges to total charges, the ratio of total distinct part rehabilitation unit charges to total charges, the ratio of total distinct part psychiatric unit charges to total charges, and the total of outpatient charges to total charges.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	7.1.A. Indigent Volume Report and Disproportionate Share Hospital Eligibility Form	The subsection title was revised to read: Indigent Volume ~~Report~~ Data and Disproportionate Share Hospital Eligibility Form Text was revised to read: Each hospital must complete the Indigent Volume (IV) ~~Report~~ worksheet and the Disproportionate Share Hospital (DSH) Eligibility Status Verification form to be eligible for Disproportionate Share Hospital (DSH) funds. The Indigent Volume (IV) ~~Report~~ worksheet is to be completed as part of the hospital's annual Medicaid Cost Report ~~package~~ and returned to MDHHS. The Medicaid Cost Report will not be accepted without the IV ~~Report~~ worksheet. In order to receive a disproportionate share adjustor other than 1.00, hospitals must also meet at least one of the four criteria on the Disproportionate Share Hospital (DSH) Eligibility Status Verification form. The Disproportionate Share Hospital (DSH) Eligibility Status Verification form is to be completed annually and is reported separately from the Medicaid Cost Report ~~package~~. *[NOTE: There are no revisions to the form example.]*	Clarification
Hospital Reimbursement Appendix	7.1.B Medicaid Utilization Rate	In the 2nd paragraph, the 1st sentence was revised to read: Days are taken from filed hospital Medicaid Cost Reports for fiscal years ending during the second previous state fiscal year.	Clarification
Hospital Reimbursement Appendix	7.2.A. $45 Million Pool	In the 3rd paragraph, the 1st sentence was revised to read: Title XIX charges used for computing DSH payments are the sum of Title XIX charges and Title XIX MCO charges from hospital IV ~~Reports~~ worksheets for cost periods ending during the second previous state fiscal year.	Clarification

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	7.3.A. Government Provider DSH Pool	The 3rd, 4th, and 5th paragraphs were revised to read: Medicare 2552 cost reports, supplemented by ~~Michigan Medicaid Forms (MMFs)~~ the Medicaid Cost Reports, will be used to determine each hospital's allowable DSH costs eligible for federal financial participation. An interim payment and reconciliation process will be employed when making allocations from this pool. Allowable DSH costs will be determined based on information obtained from the cost report periods ending during the second previous state fiscal year. Costs will be obtained from the most recently filed Medicare 2552 cost report and ~~Michigan Medicaid Forms~~ Medicaid Cost Report for that period. These costs will be trended to the current state fiscal year using an inflation factor taken from Health-Care Cost Review published quarterly by Global Insight. Interim payments will then be made. Interim payments will be reconciled twice. First, an interim reconciliation of the original payments will be conducted based on updated allowable DSH costs. Information needed to reconcile initial payments will be obtained from hospital Medicare 2552 cost reports filed with the fiscal intermediary and ~~Michigan Medicaid Forms~~ Medicaid Cost Report for the applicable reporting period. Second, payments will be adjusted for a final time based on Medicare 2552 cost reports finalized with the fiscal intermediary and ~~Michigan Medicaid Forms~~ Medicaid Cost Report for the applicable reporting period.	Michigan Medicaid Forms (MMFs) have been incorporated into the MDHHS Facility Settlement system.

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Hospital Reimbursement Appendix	7.3.C. Outpatient Uncompensated Care DSH Pool	In the 2nd paragraph, the 2nd sentence was revised to read: DSH eligibility criteria are specified in the Disproportionate Share Hospital Payments, the Indigent Volume ~~Report~~ worksheet and Disproportionate Share Hospital Eligibility Form, and the Medicaid Utilization Rate subsections of this chapter. The 5th paragraph was revised to read: The determination of the number of acute care beds for a hospital will be based on data reported on hospital Medicaid Cost Reports for hospital fiscal years ending during the second previous state fiscal year. Specifically, data reported on Worksheet S-3, Part 1, Column 2, Line 14 (or comparable lines from succeeding Medicaid Cost Reports) will be assessed to determine the number of total hospital beds. The determination will apply to all components of the Outpatient Uncompensated Care DSH Pool regardless of the state fiscal year from which the DSH funds are drawn.	Clarification.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	7.5 Disproportionate Share Hospital (DSH) Process	Under *Step 1: Initial DSH Calculation*, the last sentence of the 1st paragraph was revised to read: For example, data from hospital Medicaid Cost Reports with FYs ending between October 1, 2009 and September 30, 2010 will be used to complete the FY 2012 Initial DSH Calculation. Under *Step 2: Interim DSH Settlement*, the 1st and 2nd paragraphs were revised to read: DSH ceilings, DSH payments and Medicaid utilization rates are recalculated using new Medicaid Cost Report data during the Interim DSH Settlement step to mitigate final DSH audit-related DSH recoveries. This may result in DSH recoveries for some hospitals during this step. DSH funds will be reallocated in a manner that maintains the pool order outlined in the Initial DSH Calculation step. As part of the Interim DSH Settlement, MDHHS will recalculate hospital-specific DSH ceilings, DSH payment allocations and Medicaid utilization rates during the year following the applicable DSH year. Inpatient and outpatient data from Medicaid Cost Reports with hospital FYs ending during the previous calendar year will be utilized for ceiling, payment, and Medicaid utilization rate recalculations. The data will not be trended. For example, during 2013, data from hospital cost reports with FYs ending between January 1, 2012 and December 31, 2012 will be used to complete the FY 2012 Interim DSH Settlement calculations.	Clarification.
Hospital Reimbursement Appendix	7.5.A. Distribution of DSH Payments for Merged Hospitals	Text was revised to read: When two or more hospitals merge, eligibility for DSH payments after the merger is based on the combined Medicaid Cost Report data of the merged hospitals.	Clarification.
Hospital Reimbursement Appendix	7.6.E. Allocation of Pools	The 2nd sentence was revised to read: Eligible hospitals will share proportionately from each pool based upon a hospital's total paid claims (inpatient)/~~MMF~~ Medicaid Cost Report payments (outpatient), divided by the total Medicaid paid claims/MMS payments for all eligible hospitals, times the dollar amount of the individual pool.	Clarification.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	7.8 Rural Access Pool	The 1st and 2nd paragraphs were revised to read: The Rural Access Pool (RAP) is a pool for hospitals that provide Medicaid services to low-income rural residents and will be created and renewed annually. To be eligible for this pool, hospitals must be categorized by CMS as a sole community hospital, or meet both of the following criteria: ▪ A hospital must have 50 or fewer staffed beds. MDHHS will calculate staffed beds by dividing the total hospital days reported by the hospital on its Medicaid Cost Report with a FY ending between October 1, 2010 and September 30, 2011 by the number of days covered in the Medicaid Cost Report; and ▪ A hospital must be located in a county with a population of not more than 165,000 and within a city, village, or township with a population of not more than 12,000. The population threshold will be measured against population counts from the 2000 federal decennial census. Each hospital's allocation from this pool will be calculated as the unreimbursed cost the hospital incurred providing inpatient and outpatient services to Michigan Medicaid beneficiaries during its cost period that ended during the second previous FY. (Example: To calculate the FY 2014 pool, hospital Medicaid Cost Reports with FYs ending between 10/1/2011 and 9/30/2012 will be used.) The following gross Medicaid payments from this Medicaid Cost Report period will be applied against cost to determine unreimbursed costs: operating, capital, graduate medical education (GME), executive order reductions, and Medicaid Access to Care Initiative (MACI). Payments from this pool will be issued quarterly in four equal installments based on the total amount the hospital is eligible to receive.	Clarification.
Hospital Reimbursement Appendix	8.2 Formula Payments to Hospitals for Health Professions Education	Subsection was deleted. Following subsections were re-numbered.	Information is already present in the applicable sections.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	8.3 Distribution of GME Funds	The 1st paragraph was revised to read: Distribution of graduate medical education funds is calculated annually for three formula pools: the Dental and Podiatry, the GME Funds and the Primary Care. In order to receive funds for GME, a hospital must have operated a nationally accredited medical education program(s) in the fiscal year that data is drawn from the hospital cost reports used to calculate the GME payments. ~~Payments are fixed, prospective payments, made in full and are not subject to future cost settlement or appeal.~~ Payments are made only to hospitals that provide requested information by the dates required. The 3rd paragraph was revised to read: To distribute funds from the GME Funds and the Primary Care Pools, data is drawn from accepted hospital cost reports for the most recent fiscal year that data is available. For the GME Funds Pool, the unweighted FTE count is used (Worksheet E-4, Title XVIII, Line 6) + (Worksheet E-4, Title XVIII, Line 15.01). For the Primary Care Pool, the weighted FTE count for primary care physicians is used (Worksheet E-4, Title XVIII, Line 8, Column ~~3~~1) + (Worksheet E-4, Title XVIII, Line 15.00). If the cost report is changed, equivalent data is used.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	Section 9 - Cost Reporting Requirements	Text was revised to read: Each hospital, unless specifically exempt, is required to submit a MDHHS Facility Settlement Medicaid Cost Report ~~package~~ to the MDHHS HCRD on or before the last day of the fifth month following the close of its cost reporting period. The HCRD grants extensions only when a hospital's operation is adversely affected due to circumstances beyond its control (e.g., staffing turnovers are considered within the control of the hospital, whereas fires and floods would be considered beyond its control). If a hospital fails to submit a completed Medicaid Cost Report ~~package~~ via the MDHHS Facility Settlement system on time and has not been granted an extension of the time limit, a notice of delinquency is issued. If the Medicaid Cost Report ~~package~~ is not submitted within 30 calendar days from the date of the notice of delinquency, the hospital's payments are terminated until the Medicaid Cost Report ~~package~~ is received and accepted by MDHHS in the Facility Settlement system. Payments withheld due to late submission are paid upon acceptance of the Medicaid Cost Report ~~package~~. The cost report ~~package~~ covers a 12-month cost reporting period unless the Medicare and Medicaid Programs have granted prior approval. Approval for filing a cost ~~package~~ report for a period ~~less~~ other than 12 months may be granted when a hospital changes the end date of its cost reporting period. In such case, the hospital is required to file a Medicaid Cost Report ~~package~~ for the period between the end of the original cost reporting period and the beginning of the new cost reporting period. Hospitals with subacute ventilator dependent care units must obtain MDHHS approval to file Medicaid Cost Reports ~~packages~~ treating the unit as a subprovider in accordance with the HIM-15 2336, 2336.1, 2336.2, and 2336.3. MDHHS approval must be requested in writing from the HCRD and must be obtained prior to the start of the first hospital fiscal year during which the exemption applies.	MDHHS cost report integration in Facility Settlement system.

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CHAPTER	SECTION	CHANGE	COMMENT
		Each hospital's Medicaid Cost Report data must include an itemized list of all expenses recorded from the formal and permanent accounting records of the facility. The accrual method of accounting is mandated for all facilities not owned by government. Generally accepted accounting principles must be followed. All of the hospital's accounting and related records, including the general ledger, books of original entry, and statistical data, must be maintained for at least three years after receipt of final settlement (42 CFR §413.20 and Provider Reimbursement Manual §2304; 42 CFR §405.1885). These records must be made available for verification during onsite visits by state or federal audit staff. All Medicaid Cost Reports ~~packages~~ are retained by MDHHS for at least three years following the date of settlement. ~~MDHHS electronically notifies all providers of the specific information needed to file an acceptable MDHHS cost report package.~~ The Medicaid Cost Report ~~package~~ must be sent to MDHHS HCRD via the Facility Settlement system. The Medicaid Cost Report ~~package~~ must include: ▪ The CMS 2552 Medicare standardized electronic cost report (ECR) filed in the manner required by MDHHS for MDHHS programs reporting. ▪ MDHHS specific filed Medicaid Cost Report. ~~with worksheets including, but not limited to: General Hospital Information, Settlement Summary Page, Capital Cost, GME, Rehab Unit Settlement, Outpatient Education Settlement, the Indigent Volume Report form for Title V and Title XIX, Healthy Michigan Plan, and Managed Care Organization (MCO).~~ ~~▪ A signed Provider Certification page produced by the MDHHS filed Cost Report Application for Title V, Title XIX and Healthy Michigan Plan.~~ ▪ The hospital's audited Financial Statements. ▪ Hospitals that participate in the Medicaid FFS 340B program must provide sufficient documentation to confirm the reasonableness of reported charges.	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
		The Medicaid Cost Report ~~package~~ is accepted only if all of the following conditions are met: ▪ All submitted documents are in a usable format. ▪ MDHHS can generate a full CMS 2552 cost report from the electronic cost report file. MDHHS uses the KPMG/CompuMax system to generate viewable cost reports. ~~▪ The signed, error-free Provider Certification page.~~ ▪ Data is provided for all authorized MDHHS units and programs (Medical/Surgical, Rehabilitation, Outpatient, Psychiatric, Clinic, Title V, Title XIX and Healthy Michigan Plan). ▪ Data meet a set of reasonableness checks, or variances are explained. ▪ Hospitals that participate in the Medicaid FFS 340B program must provide sufficient documentation to confirm the reasonableness of reported charges. ▪ Hospitals must maintain an active NPI and accurate specialty enrollment information as described in the General Information for Providers chapter of the Medicaid Provider Manual.	
Hospital Reimbursement Appendix	10.1 Desk Audit	The 1st sentence was revised to read: The audit process includes desk audit procedures and audit scope determinations for both MDHHS program(s) audit verification purposes and~~, under the Common Audit Agreement with the Medicare fiscal intermediary,~~ determination of allowable costs.	Clarification.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	11.1 Initial Settlement(s)	The subsection title was revised to read: Initial ~~Settlement(s)~~ Upper Payment Limit Text was revised to read: In aggregate, MDHHS limits hospital reimbursement to the maximum allowable under the Federal upper payment limits (UPL) for services provided to Medicaid beneficiaries. MDHHS calculates inpatient and outpatient UPLs by benefit plan using CMS 2552 and Medicaid Cost Reports. The UPL calculation is completed at the time MDHHS accepts a hospital's Medicaid Cost Report and recovers amounts in excess of calculated limits. ~~Settlement is based upon processed non-zero dollar MDHHS programs liability invoices for services rendered to MDHHS beneficiaries during the cost report period and remitted prior to the paid claim report run date.~~ ~~Initial settlements may be calculated using the cost information determined from the cost report and from charges for services to MDHHS beneficiaries as accumulated by MDHHS.~~ ~~Inpatient MDHHS applicable programs upper payments limit is allowable inpatient charges. Outpatient MDHHS applicable programs upper payments limit is allowable outpatient costs.~~ ~~Total payments for inpatient services are limited to the lesser of operating amount approved (DRG, per diem, and the operating portion of any percent of charge payments), plus capital less any limits that apply, or full charges. This limitation is applied separately by program against the aggregate operating payment amounts approved and capital payments.~~ ~~Final reimbursement is limited to the lesser of outpatient payment amounts approved, allowable outpatient charges, or allowable outpatient costs.~~	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	11.3 Final Settlement(s)	Text was revised to read: Settlement is based upon processed non-zero dollar MDHHS liability claims for services rendered to MDHHS beneficiaries during the Medicaid Cost Report period and remitted prior to the paid claim report run date. MDHHS calculates the final settlement amount to be reimbursed no earlier than 27 months after the period covered by the Medicaid Cost Report ~~and sends the hospital MDHHS programs audit adjustment reports~~. MDHHS may approve requests for final settlement calculations prior to 27 months in the event of hospital bankruptcy or closure. ~~Once~~ Upon completion, the final settlement results ~~MDHHS audit adjustment reports~~ are transmitted to the hospital via the Facility Settlement system, the Medicare/Medicaid CMS 2552 report and/or the ~~Michigan Medicaid Forms (MMF)~~ Medicaid Cost Report and will not be amended unless specific cost report changes are approved by MDHHS. Facilities can appeal or request changes to the final settlement up to 30 calendar days from the final settlement completion date noted in the Facility Settlement system. The total amount paid for inpatient capital is eligible to be settled 27 months after the hospital's fiscal year ends. For testing against the ~~Medicare~~ Medicaid upper payment limits, inpatient payments are limited by allowable inpatient charges and outpatient payments are limited by allowable outpatient costs. Total payments for inpatient services are limited to the lesser of operating amount approved (DRG, per diem, and the operating portion of any percent of charge payments), ~~plus~~ including capital less any limits that apply, or full charges. This limitation is applied separately by program against the aggregate operating payment amounts approved and capital payments. Final reimbursement is limited to the lesser of outpatient payment amounts approved, allowable outpatient charges, or allowable outpatient costs. ~~Separate settlements are made for each program and each unique outpatient NPI.~~	MDHHS settlement integration in Facility Settlement system. Adding clarifying language that exists in other parts of the chapter. Formatting to consolidate paragraphs.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
		For the purpose of the hospital final settlement process only, hospitals that participate in the Medicaid FFS 340B program will have the option to have their 340B drug costs adjusted from actual acquisition cost to a hospital's normal and customary charge. Participation in the 340B final settlement adjustment process is contingent on the provision of sufficient documentation to confirm the reasonableness of reported charges. This adjustment will not apply to drug reimbursement, and participating providers are required to continue to bill 340B actual acquisition cost and all applicable modifiers. This policy does not impact or require any additional action for providers that do not participate in the Medicaid FFS 340B program. This policy is effective for final settlements with fiscal year ends on and after October 1, 2015, and does not apply to prior settlements or settlements reopened prior to this effective date.	
Hospital Reimbursement Appendix	11.4 Responses to the Audit Adjustment Reports(s)	The subsection title was revised to read: Responses to the ~~Audit Adjustment Reports(s)~~ Final Settlement Text was revised to read: The ~~Audit Adjustment Report~~ Facility Settlement system contains a descriptive list of all program data adjustments made to a Medicaid Cost Report by the MDHHS HCRD audit staff. The Notice of Amount of Program Reimbursement is the notice of final determination and is considered the offer of settlement for all reimbursement issues for the cost reporting period under consideration. The process is initiated by the hospital after the receipt of the ~~Audit Adjustment Report~~ Facility Settlement system notification. The MDHHS HCRD concludes the process on the day the Notice of Amount of Program Reimbursement is electronically transmitted to the hospital. The ~~Audit Adjustment Report~~ final settlement result must be accepted or rejected by the hospital within 30 calendar days of the Notice of Amount of Program Reimbursement ~~is~~ being electronically transmitted to the hospital.	MDHHS settlement integration in Facility Settlement system and clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
		The hospital may take the following actions: ▪ **Hospital Accepts the Notice of Amount of Program Reimbursement ~~Report~~** If the hospital accepts the findings contained in the ~~Audit Adjustment Report~~ final settlement, an appropriate officer of the hospital must electronically sign the ~~Audit Adjustment Report~~ final settlement within the Facility Settlement system. ~~and transmit it to the MDHHS HCRD. (Refer to the Directory Appendix for contact information.)~~ The MDHHS ~~programs~~ Notice of Amount of Program Reimbursement will be electronically transmitted to the hospital. No further administrative appeal rights will be available for the adjustments contained in the ~~Audit Adjustment Report~~ final settlement. ▪ **Hospital Does Not Respond to the Notice of Amount of Program Reimbursement ~~Report~~** If the hospital does not respond within ~~this~~ the 30 calendar day time period, MDHHS shall electronically transmit a Notice of Amount of Program Reimbursement, which is the final determination of an adverse action. No further administrative appeal rights are available. ▪ **Hospital Rejects the Notice of Amount of Program Reimbursement ~~Report~~** If the hospital rejects any or all of the findings contained in the ~~Audit Adjustment Report~~ final settlement within 30 calendar days of the transmit date of the Notice of Amount of Program Reimbursement, then an informal appeal can be requested. An informal appeal process involves the audit staff and the hospital working to resolve differences prior to a formal appeal. The hospital may request a formal appeal hearing through the administrative appeal process. ~~which must be filed within 180 calendar days after the Notice of Amount of Program Reimbursement is electronically transmitted by MDHHS to the hospital. Upon the timely receipt by MDHHS of an Application to Appeal Amount of Program Reimbursement, rules R400.3408 through R400.3424 shall be invoked.~~	

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	11.5 Reopening of Settlements	Text was revised to read: For all MDHHS final settlement reopenings, MDHHS has adopted and follows all applicable provisions of the Medicare Provider Reimbursement Manual (HIM-15), Part 1, Sections 2931 and 2932, as well as all applicable provisions of 42 CFR Section 405.1885 et. seq. For all reopenings, there is a three-year statute of limitations that begins on the date of the original MDHHS Notice of Amount of Program Reimbursement. The three-year time period ends on the third anniversary of that date. A separate ~~Notice of Reopening~~ Facility Settlement system notification regarding settlement recalculation will be required for each provider and each cost year. If MDHHS electronically notifies a provider of its ~~Notice of Reopening~~ settlement recalculation before the expiration of the three-year period, the three-year requirement will be considered met. After this point, the reopened settlement ~~should~~ will be completed in a timely fashion. ~~Neither the existence of a Common Audit Agreement between MDHHS and the Medicare Intermediary nor whether the Medicare Intermediary provides timely notice of a~~ A Medicare settlement reopening will not affect the application of the three-year time limit on MDHHS settlement reopenings. Once the final settlement has been calculated and ~~the MDHHS audit adjustment report has been~~ sent to the hospital, the Medicare/Medicaid CMS 2552 report will not be amended without specific CMS 2552 changes being approved by MDHHS. New laws, regulations, policy directives, or the interpretation of such issued subsequent to a settlement will not serve as basis to reopen a settlement. ~~Nor can any of~~ Additionally, the above cannot be introduced as part of a reopened settlement. The sole exception is when MDHHS is directed to do so by court order.	MDHHS settlement integration in Facility Settlement system.
Hospital Reimbursement Appendix	13.2 Requirements for Participation	In the 1st paragraph, the 1st sentence was revised to read: In order to participate in the Michigan Medicaid EHR Incentive Program, hospitals must be a Medicaid enrolled provider and have a completed Medicaid Quarterly Report, Medicaid Cost Report ~~(MMF)~~ and CMS 2552 Cost Report on file with MDHHS that correlates with the specified timeframe from which data are pulled.	Medicaid Cost Report no longer referred to as the Michigan Medicaid Form (MMF).

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	13.4.A. Average Length of Stay (LOS)	The 1st sentence was revised to read: Average LOS is calculated by reviewing the current CMS 2552 Cost Report and ~~MMF~~ Medicaid Cost Report on file with MDHHS.	Medicaid Cost Report no longer referred to as the Michigan Medicaid Form (MMF).
Hospital Reimbursement Appendix	13.5.A. Timing	The 2nd and 3rd paragraphs were revised to read: EHs are paid up to 100% of the calculated aggregate EHR hospital incentive payment amount over a three-year period. Data utilized to calculate the aggregate EHR hospital incentive amount is derived from filed hospital cost reports (CMS 2552 and ~~MMF~~ Medicaid Cost Report) from the hospital CY that ends during the CY prior to the hospital CY that serves as the first payment year. All revisions, amendments, and modifications to data sources must be completed prior to a hospital's registration for the EHR Incentive Program. This includes revisions to the filed cost reports (CMS 2552 and ~~MMF~~ Medicaid Cost Report) used to calculate the aggregate EHR incentive amount. Incomplete hospital data sources will result in delays in eligibility determinations and payment calculations.	Medicaid Cost Report no longer referred to as the Michigan Medicaid Form (MMF).
Hospital Reimbursement Appendix	13.5.B. Payment Formula	Under "Medicaid Share", the 4th paragraph was revised to read: For the purposes of the EHR incentive payment calculation, charity care is calculated using data from the ~~MMF~~ Medicaid Cost Report Indigent Volume ~~Form~~ worksheet as follows:	Medicaid Cost Report no longer referred to as the Michigan Medicaid Form (MMF).
Laboratory	2.2.A. Physician's Office Laboratory	In the 2nd paragraph, the 2nd bullet point was removed: The laboratory is subject to the following policies: • Laboratory claims must be billed using the physician's provider NPI number. • ~~Laboratory claims are subject to the practitioner laboratory daily reimbursement limit.~~ • The laboratory must not accept referrals from physicians outside of the physician's practice or group practice.	Text not applicable to current policy.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Laboratory	2.2.B. Dual Physician's Office/Independent Laboratory	The 2nd paragraph was revised to read: Dual physician's office/independent laboratories are subject to the following policies: • Laboratory claims generated by the physician owner must be billed using the physician's provider NPI number. ~~These claims are subject to the practitioner laboratory daily reimbursement limit.~~ • Laboratory claims generated by physicians outside of the physician's practice or group practice must be billed using the independent laboratory NPI number. ~~These claims are subject to the independent laboratory daily reimbursement limit.~~ • The laboratory must not accept referrals from immediate family members.	Text not applicable to current policy.
Maternal Infant Health Program	2.17 Communications with the Medical Care Provider	The 1st paragraph was revised to read: When an MIHP case is opened ~~without the medical care provider's involvement~~, the MIHP provider must notify the medical care provider within 14 calendar days. When an MIHP case is opened for a pregnant woman with no medical care provider, the MIHP must assist the woman in finding a medical care provider.	Clarification.
Medical Supplier	2.13.A. Enteral Nutrition (Administered Orally)	Under 'PA Requirements', the following HCPCS codes were added: B4100, B4105, E0776	Update.
Medical Supplier	2.13.B. Enteral Nutrition (Administered by Tube)	Under 'PA Requirements', the following HCPCS codes were added: B4100, B4105, E0776	Update.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Non Emergency Medical Transportation	Section 6 - Managed Care Programs	The following text was added at the end of the section: MDHHS contracts with dental health plans (DHPs) for the administration of dental services for Healthy Kids Dental (HKD) beneficiaries. The DHP is responsible for providing, arranging, and reimbursing covered dental services to enrolled Medicaid beneficiaries. Providers must contact the DHP for specific information about covered HKD benefits. (For additional information about HKD, refer to the Dental chapter of this manual.) Local MDHHS offices, except in Wayne, Oakland, and Macomb counties, are responsible for providing NEMT services to and from DHP covered dental services. A contracted transportation broker is responsible for providing NEMT services to and from DHP covered dental services in Wayne, Oakland, and Macomb counties.	Policy clarification.
Nursing Facility Coverages	5.1 Nursing Facility Eligibility	The 4th and 5th bullet points were revised to read: • A determination of medical/functional eligibility based upon a web-based version of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) ~~that was~~ conducted ~~online at the time the resident was either Medicaid eligible or Medicaid pending and conducted within the timeframes specified in the Michigan Medicaid Nursing Facility Level of Care Determination subsection of this chapter~~ prior to or the day of admission to a nursing facility. (Refer to the Nursing Facility Level of Care Determination Chapter for additional information.) • Computer-generated Freedom of Choice (FOC) form signed and dated by the beneficiary or the beneficiary's representative as described in the Nursing Facility Level of Care Determination Chapter.	Technical changes to adhere to revisions within LOCD policy as outlined in the Nursing Facility Level of Care Determination Chapter of the Medicaid Provider Manual.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	5.1.A Verification of Medicaid Financial Eligibility	The 2nd paragraph was removed: ~~The online Michigan Medicaid Nursing Facility Level of Care Determination must be conducted within the required timeframe for Medicaid or Medicaid-pending beneficiaries.~~ The last (boxed) paragraph was reformatted to remove box effect; text was revised to read: In order for Medicaid to reimburse for nursing facility services from the date of admission of a Medicaid-eligible beneficiary, the Medicaid beneficiary must be in a Medicaid-certified bed, and the LOCD must be conducted ~~online ONLY for Medicaid eligible or Medicaid pending beneficiaries and within the timeframes outlined in the Michigan Medicaid Nursing Facility Level of Care Determination subsection of this chapter~~ as indicated in the Nursing Facility Level of Care Determination Chapter.	Technical changes to eliminate redundancy and to adhere to revised LOCD policy as outlined in the Nursing Facility Level of Care Determination Chapter.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	5.1.D.1. Michigan Medicaid Nursing Facility Level of Care Determination	The 1st paragraph was revised to read: Financially eligible Medicaid residents must meet medical/functional eligibility for Medicaid reimbursed nursing facility services. To verify medical/functional eligibility, the nursing facility (i.e., hospital long term care unit, county medical care facility, ventilator dependent unit, hospital swing bed, State Veterans' Home) must complete the online LOCD ~~under the provider's NPI prior to the start of Medicaid reimbursable services. The nursing facility must submit the information from any hard-copy LOCD into the LOCD's web-based version only for Medicaid eligible and Medicaid pending beneficiaries, and within the timeframes specified in the Michigan Medicaid Nursing Facility Level of Care Determination subsection of this chapter under ONLINE LOCD.~~ as described in the Nursing Facility Level of Care Determination Chapter. The 2nd paragraph (boxed) was removed: ~~Ventilator Dependent Care Units (VDCUs) and Medicare/Medicaid Crossover Claims: Medicaid-enrolled VDCUs have a distinct National Provider Identifier (NPI) number for Medicaid billing. The number is separate from the "regular" facility NPI number. An LOCD must be completed under the "regular" NPI number for days 1 to 100. For days 101 and forward, the facility must complete an LOCD under the VDCU's distinct NPI number.~~	Technical changes to eliminate redundancy and to adhere to revised LOCD policy as outlined in the Nursing Facility Level of Care Determination Chapter.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
		The third (boxed) paragraph was reformatted to remove box effect; text was revised to read: **Change of Ownership (CHOW)** If a new National Provider Identification (NPI) will be issued to a provider who is going through a ~~change of ownership~~ CHOW, the provider must conduct the hard copy version of the LOCD and Freedom of Choice (FOC). ~~The hard copy LOCD must be conducted according to policy outlined in this chapter. The FOC must be signed and dated, and completed according to policy outlined in this chapter.~~ Hard copies of the LOCD and FOC must be conducted in accordance with the policies in the Nursing Facility Level of Care Determination Chapter. Once the provider is given full access to CHAMPS under their new NPI, the provider must enter all of the information ~~on~~ from the hard copy LOCD into the online version of the LOCD in CHAMPS under their new NPI. ~~The provider must then submit to Provider Support all hard copy FOCs. The online LOCD will be backdated to the date on a signed and dated FOC that corresponds to the beneficiary's online LOCD.~~ To ensure proper payments, CHAMPS will then check if the conducted date of the LOCD and enrollment date of the new NPI are within the last six months. Both conditions must be met during a CHOW for CHAMPS to process payments. If the new owner will not be issued a new NPI, the new owner must continue to conduct online LOCDs according to the ~~policy outlined in this chapter~~ policies within the Nursing Facility Level of Care Determination Chapter. ***Text beginning with the 4th paragraph and though the end of the subsection was deleted.***	
Nursing Facility Coverages	5.1.D.2. Nursing Facility Level of Care Exception Process	Subsection was deleted.	Technical changes to eliminate redundancy and to adhere to revised LOCD policy as outlined in the Nursing Facility Level of Care Determination Chapter.
Nursing Facility Coverages	5.1.D.3. Telephone Intake Guidelines	Subsection was deleted.	Information now contained within the Nursing Facility Level of Care Determination Chapter.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	5.1.D.4. Ongoing Assessments	Subsection was deleted; following subsection was re-numbered.	Information now contained within the Nursing Facility Level of Care Determination Chapter.
Nursing Facility Coverages	5.1.D.5. Retrospective Review and Medicaid Recovery	The 1st paragraph revised to read: At random and whenever indicated, the MDHHS designee will perform retrospective reviews of a sample of residents. The purpose is to validate the medical/functional eligibility of the beneficiary. ~~to validate the Michigan Medicaid Nursing Facility LOC Determination and the quality of Medicaid MDS data overall.~~ The provider must submit all medical documentation requested by the MDHHS designee. If the resident is found to be ineligible for nursing facility services, MDHHS will recover all Medicaid payments made for nursing facility services rendered during the period of ineligibility. The 2nd paragraph removed: ~~If a provider, upon receipt of an adverse LOCD retrospective review notice from the MDHHS designee, conducts a subsequent LOCD to redetermine the beneficiary's LOCD eligibility for the purpose of re-establishing Medicaid reimbursement, the provider may request the subsequent LOCD be audited through the MDHHS retrospective review process. This additional audit applies only to an LOCD conducted subsequent to receipt of an adverse retrospective review notice of LOCD ineligibility from a given date forward (in continuance) for the same beneficiary, during the same stay, with the same provider.~~	Technical changes to eliminate redundancy and to adhere to revised LOCD policy as outlined in the Nursing Facility Level of Care Determination Chapter.
Nursing Facility Coverages	5.1.D.6. Adverse Action Notice	Subsection was deleted.	Information now contained within the Nursing Facility Level of Care Determination Chapter.
Nursing Facility Coverages	5.1.E. Freedom of Choice	Subsection was deleted.	Information now contained within the Nursing Facility Level of Care Determination Chapter.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	5.2 Appeals	Subsection was deleted, including: 5.2.A. Individual Appeals 5.2.A.1. Financial Eligibility 5.2.A.2. Medical/Functional Eligibility 5.2.B. Provider Appeals The following subsections were re-numbered.	Information now contained within the Nursing Facility Level of Care Determination Chapter.
Nursing Facility Coverages	10.4 Beauty and Barber Services	The 1st sentence was revised to read: Any ~~s~~ervices of a professional beautician or barber are not included in the per diem rate and are not covered by the Medicaid Program.	Clarifying that personal services to residents are not allowable if provided by a professional beautician or barber.
Nursing Facility Cost Reporting & Reimbursement Appendix	6.1.D. Reopening Audit Determinations	In the 1st paragraph, the 4th sentence was revised to read: If it is determined that the audited cost report contains incorrect data, MDHHS will use corrected data to compute future rates.	Technical change to correct grammar.
Nursing Facility Cost Reporting & Reimbursement Appendix	8.1 Advertising	Text was revised to read: Allowable advertising costs are considered those costs incurred by the nursing facility for an informational objective to inform the public about its services. Costs incurred for a promotional objective ~~in an attempt~~ to increase patient utilization are not properly related to patient care and are not allowable. Examples of advertising costs incurred for a promotional objective include, but are not limited to, television ads, radio ads, restaurant placemats, billboards, and placing a facility's name on items without contact information. Advertising in the Yellow Pages is an allowable cost, except that Medicaid limits the cost to that associated with a black ink Yellow Pages ad listing not to exceed 2" x 2" in size.	Clarification to provide examples of non-allowable advertising costs.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	8.3.C. General Administration of the Facility	Addition of the following text: • Legal and attorney fees associated with a legal settlement negotiated by the provider or court-ordered damages are allowable, provided the fees are not covered by any of the provider's liability insurance (examples of liability insurance include, but are not limited to, auto liability insurance, general liability insurance, professional liability insurance, etc.). The fees must also meet all other Medicaid and federal allowable cost principles and policies.	Clarification to let providers know what the policy requirements are for allowable legal and attorney fees associated with a legal settlement or court-ordered damages.
Nursing Facility Cost Reporting & Reimbursement Appendix	8.8 Interest	The 6th bullet point was revised to read: • Working capital borrowings are considered funds borrowed for a relatively short period of 12 months or less to meet current normal operating expenses. For lines of credit, the borrowing shall be compliant with the 12 month requirement if the provider repays the entire amount withdrawn within 12 months of the date of the first draw. If the entire amount of the working capital borrowing is not repaid within 12 months, then all the interest expense associated with the borrowing is unallowable.	Clarifying that the policy requires the full amount of the working capital loan or line of credit to be paid back within 12 months for any of the interest expense to be allowable.
Nursing Facility Cost Reporting & Reimbursement Appendix	9.4 Capital Asset Expenditure	The 4th paragraph was revised to read: The nursing facility must have written policies and procedures that establish dollar level thresholds beyond which an asset acquisition is considered a capital asset. Medicaid sets the thresholds at having an estimated useful life of at least two years and a historical cost of at least $5,000. The nursing facility capital asset policy may have lower dollar level threshold than the Medicaid limit, but may not have a higher limit. ~~The provider must follow its established policy for cost reporting when its capitalization policy sets lower thresholds than Medicaid.~~ If the provider's capitalization policy sets lower thresholds than Medicaid, then the provider's established policy must be followed for cost reporting. A provider may not have separate capitalization policies for Medicaid cost reporting and for other financial statements and reports.	Clarification to spell out the last sentence of this paragraph so there is no confusion that a provider cannot have more than one capitalization policy.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	9.10 Beauty and Barber Service Cost Center	The 1st paragraph was revised to read: Personal services for residents, such as simple barber and beautician services (e.g., shaves, haircuts, shampoos, and simple hair sets), that residents need are considered routine patient care. The provision of such services is reimbursed in the routine per diem rate when provided routinely without charge to the resident in the nursing facility. Personal services provided by a professional beautician or barber are unallowable costs.	Clarifying that personal services to residents are not allowable if provided by a professional beautician or barber.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.13.F.4. Class III Nursing Facility Reimbursement for FIDS	The last bullet point was reformatted to reflect two sub-bullet points: • To determine the amount of the FIDS supplement, MDHHS will apply the following to qualifying project costs: ➢ For FIDS renovation projects, the supplement is determined using qualifying costs to calculate the plant cost per resident day above the facility's PCL per resident day. ➢ For a newly constructed facility, the calculation will be based on plant cost per resident day above the Class PCL per resident day effective the quarter the new construction is placed into service.	Formatting.
Practitioner	3.14.D. Children's Special Health Care Services Coverage	The 1st sentence was revised to read: The coverages defined in this section ~~and the daily reimbursement limits~~ do not apply to beneficiaries with only Children's Special Health Care Services (CSHCS) eligibility.	Text not applicable to current policy.
Special Programs	5.1 Eligible Beneficiaries	The textbox was removed. ~~Effective January 1, 2016, the Michigan Department of Health and Human Services (MDHHS) converted the MIChild program to a Medicaid expansion program. Although individuals are enrolled in a Medicaid expansion program, the program will continue to be referred to as the MIChild program. All Medicaid coverages and conditions will apply in accordance with current Medicaid policy.~~	Dated material.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Appeals Nursing Facility Level of Care Determination	Miscellaneous updates relative to Michigan Administrative Hearing System (MAHS) and Michigan Office of Administrative Hearings and Rules (MOAHR).	

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Medicaid Provider Manual
July 2019 Updates

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 18-35	8/31/2018	Pharmacy	13.6.A. Medicaid Copayments	In the Copayment Exemptions table, under 'Other Exclusions', the following text was added: Claims for the following drugs related to the treatment of Mental Health Conditions and Substance Use Disorders are exempt from copayments. • Central Nervous System Drugs • Psychotherapeutic Drugs • Sedative/Hypnotics • Anti-Alcoholic Preparations • Selective Serotonin Reuptake Inhibitors • Narcotic Withdrawal Therapies • Neuropathic Agents

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 18-53	3/1/2019	General Information for Providers	13.1 Estate Recovery Program (new subsection)	New subsection text reads: Pursuant to 42 USC §1396p, the federal government requires state Medicaid programs to seek recovery from the estates of certain deceased beneficiaries who received benefits from a state Medicaid program. This is referred to as the Estate Recovery Program. Under some circumstances, the state may choose not to seek or may defer recovery from the estate. Estate recovery applies only to Medicaid beneficiaries who: ▪ are 55 years of age or older; and ▪ received long-term care services any time on or after September 30, 2007. The Estate Recovery Program can only recover from assets flowing through the probate process. When a provider has a balance in a patient trust account after the death of a beneficiary, any balance in the account should be refunded to the family to open a probate estate with those funds. Once an estate is opened in probate court, MDHHS will file a claim.
		Beneficiary Eligibility	12.1.D. Excess Patient Pay Amounts (new subsection)	New subsection text reads: If the provider has an excess patient pay amount and has been billing Medicaid, the provider must return any overpayments made by MDHHS. This must be done using a replacement claim or void/cancel claim. The provider may then use the remaining funds for beneficiary private pay.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 19-02	2/1/2019	Nursing Facility Cost Reporting & Reimbursement Appendix	8.23 Provider Donations for Outstationed State Staff	Text was revised to read: For cost reporting periods beginning prior to April 1, 2019, provider donations and administrative costs and incidental costs (workspace and telephone) incurred by the provider for outstationed staff are allowable costs. Costs are allowable to the amount contractually determined with the State. For cost reporting periods beginning on or after April 1, 2019, provider donations for outstationed state staff and any associated costs paid to the State of Michigan for outstationed state staff are non-allowable costs. These costs must be reported on the provider's cost report and then adjusted from the cost report to be excluded from the rate setting process. A provider that utilizes an outstationed state worker(s) must submit a copy of their contract(s) for the use of that worker with their cost report.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 19-03	2/8/2019	General Information for Providers	Section 2 - Provider Enrollment	Text was revised to read: Consistent with 42 CFR 431.51(c)(2), 42 CFR 455.452, and pursuant to Michigan's Social Welfare Act (Public Act 280 of 1939 [MCL 400.111e]), the Medicaid single state agency is required , and has the authority, to set reasonable standards and screening related to the qualifications of providers, and may define exclusions that the Medicaid Director determines necessary to protect the best interests of the program and its beneficiaries. An eligible provider who complies with all licensing laws and regulations applicable to the provider's practice or business in Michigan, who is not currently excluded from participating in Medicaid by state or federal sanction or exclusion, is a valid provider type in CHAMPS, and whose services are directly reimbursable per MDHHS policy may enroll as a Medicaid provider. Out-of-state providers must be licensed and/or certified by the appropriate standard-setting authority in the state they are practicing. (Refer to the Beyond-Borderland Area subsection of this chapter for more information.) In addition, some providers must also be certified as meeting Medicare or other standards as specified by MDHHS. MDHHS is prohibited by federal law from issuing Medicaid payment to any financial institution or entity whose address is outside of the United States. Any individual or entity that provides services to, or orders, prescribes, refers or certifies eligibility for services for, individuals who are eligible for medical assistance under the Medicaid State Plan is required to be screened and enrolled in Medicaid. The following disclosing individuals are also required to be screened as part of the provider's enrollment: • An individual with a 5% or greater direct or indirect ownership interest in the provider. This requirement pertains to individuals as well as groups of individuals;

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				• An agent. An agent is any person who has been delegated the authority to obligate or act on behalf of a provider such as a fiduciary agent or contractor; • An individual who is on the Board of Directors of a provider entity. A Board of Directors is a group of individuals who are selected or elected to establish corporate management-related policies and to make decisions on major company issues; or • An individual who is a managing employee. A managing employee would be a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of the institution, organization, or agency, either under contract or through some other arrangement, whether or not the individual is a W-2 employee. Providers must have their enrollment approved through the on-line MDHHS CHAMPS Provider Enrollment (PE) subsystem to be reimbursed for covered services rendered to eligible Medicaid beneficiaries. Enrollment in CHAMPS neither requires nor mandates those providers who are part of a managed care network to accept Medicaid Fee-for-Service beneficiaries. Refer to the Directory Appendix for contact information related to the online application process, including a CHAMPS Preparation Checklist of required information.

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				A provider's participation in Medicaid will be effective on the date the provider's on-line application is submitted, or a provider may request that enrollment be retroactive to a specific date when completing the on-line application. Retroactive enrollment is not considered prior to the effective date of licensure/certification. Enrollment may be retroactive one year from the date the request is received if the provider's licensure/certification is effective for that entire period. Retroactive enrollment eligibility is not a waiver for claims/services that do not meet established Medicaid billing criteria. All providers are required to revalidate their Medicaid enrollment information a minimum of once every five years, or more often if requested by MDHHS. MDHHS will notify providers when revalidation is required. Providers must notify MDHHS within 35 days of any change to their enrollment information. Providers must have their social security number (SSN), employer identification, or tax identification number (EIN/TIN) registered with the Michigan Department of Technology, Management & Budget Vendor Registration prior to enrolling with MDHHS. ~~MDHHS is prohibited by federal law from issuing Medicaid payment to any financial institution or entity whose address is outside of the United States.~~

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				Providers electing to appoint another person to enter their MDHHS enrollment information in the CHAMPS PE subsystem on their behalf must complete and retain a copy of the MDHHS Provider Electronic Signature Agreement Cover Sheet (MDHHS-5405) and the MDHHS Electronic Signature Agreement (DCH-1401). Both forms must be submitted to the Provider Enrollment Section per instructions provided on the cover sheet. (Refer to the Forms Appendix for a copy of the MDHHS-5405 and the DCH-1401.) Providers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) must be enrolled as a Medicare provider. Each DMEPOS provider must enter their Medicare Provider Transaction Access Number (PTAN) in the CHAMPS Provider Enrollment subsystem. ~~A provider's participation in Medicaid will be effective on the date the provider's on-line application is submitted, or a provider may request that enrollment be retroactive to a specific date when completing the on-line application. Retroactive enrollment is not considered prior to the effective date of licensure/certification. Enrollment may be retroactive one year from the date the request is received if the provider's licensure/certification is effective for that entire period. Retroactive enrollment eligibility is not a waiver for claims/services that do not meet established Medicaid billing criteria.~~ ~~All providers are required to revalidate their Medicaid enrollment information a minimum of once every five years, or more often if requested by MDHHS. MDHHS will notify providers when revalidation is required. Providers must notify MDHHS within 35 days of any change to their enrollment information.~~

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				For information regarding substitute physician or a locum tenens arrangement, refer to the Practitioner Chapter of this manual. A Medicaid Health Plan (MHP) is responsible for reimbursing a contracted provider or subcontractor for its services according to the conditions stated in the subcontract. The MHP must also reimburse noncontracted providers for properly authorized, medically necessary covered services.
			2.3 Enrollment Screening	Text was revised to read: MDHHS conducts Medicaid provider enrollment screening per federal and state rules and regulations.
			2.3.A.2. Screening Activities Based on Risk Category and Provider Type	In the table, the following bullet point was added to 'Screening Activities' for both 'Moderate' and 'Limited' categories: • Criminal background check
			2.3.E. Home Help – Personal Choice and Acknowledgement of Provider Selection (new subsection)	New subsection text reads: A beneficiary receiving personal care services through the Medicaid Home Help program may select any family member or other individual who has been convicted of certain crimes by signing a personal acknowledgement form. The beneficiary must submit their request on the Personal Choice and Acknowledgement of Provider Selection form (MSA-119) that indicates receipt of notification of the criminal offense(s) which prompted the exclusion and must indicate their selection of that provider to deliver services. The selection shall not be considered effective and eligible for payment until the signed acknowledgement has been received, processed, and recorded by MDHHS.

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				Personal choice selections are subject to the following restrictions: • The provider does not have a disqualifying conviction that is one of the four exclusions under 42 USC 1320a-7. • The provider is 18 years or older. • The provider is not legally responsible for the beneficiary. • The provider must be capable of providing the required services and must be otherwise qualified to do so. • The provider has complied with the criminal history screening conducted by MDHHS. • The provider is not an agency or associated with an agency. A personal choice selection may be applied for the limited purpose of providing Home Help services to the specific beneficiary identified in form MSA-119. A personal choice selection shall not be construed as approval, authorization or permission to provide services to other beneficiaries. Providers selected through the personal choice provisions of this section must be registered in CHAMPS and other systems (if applicable) for the purposes of monitoring, contacting, and generating payments; however, such individuals shall be prohibited from either being placed in the provider referral database or receiving referrals for additional beneficiaries through that process.

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			6.1 Termination or Denial of Enrollment	Text was revised to read: MDHHS may terminate or deny enrollment in the Michigan Medicaid program. Termination of enrollment means a provider's billing privileges have been revoked and all appeal rights have been exhausted or the timeline for appeal has expired. Denial of enrollment means the provider's application will not be approved for participation in the Medicaid program. MDHHS must terminate or deny a provider's enrollment in Michigan's Medicaid program for the following reasons: ▪ Termination on or after January 1, 2011 under Medicare or the Medicaid program, or the Children's Health Insurance Program (CHIP) of any other state. ▪ Convicted of a relevant crime described under 42 USC 1320a-7(a): ➢ Conviction of program-related crimes Any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under subchapter XVIII or under any State health care program. ➢ Conviction relating to patient abuse Any individual or entity that has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service.

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				➢ Felony conviction relating to health care fraud Any individual or entity that has been convicted for an offense which occurred after August 21, 1996, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph [1]) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct. ➢ Felony conviction relating to controlled substance Any individual or entity that has been convicted for an offense which occurred after August 21, 1996, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance. Providers who have been excluded due to one of the federal mandatory exclusions listed above will remain on the MDHHS Sanctioned Provider List until the minimum period for their exclusion has been completed and the provider has requested a lifting of their sanction from the sanctioning body.

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				▪ Failure to comply with the enrollment requirements of the Social Welfare Act, Public Act 280 of 1939 (MCL 400.111b -111e) and the provider screening and enrollment requirements pursuant to 42 CFR 455.416. The basis for termination or denial of enrollment under this section includes, but is not limited to, the provider's: ➢ failure to submit timely and accurate information; ➢ failure to cooperate with MDHHS screening methods; ➢ failure to submit sets of fingerprints as required within 30 days of a CMS or MDHHS request; ➢ failure to permit access to provider locations for site visits; ➢ falsification of information provided on the enrollment application or subsequent information requests; ➢ inability to verify their identity; or ➢ failure to comply with Medicaid policies regarding submission of claims and billing Medicaid beneficiaries.

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				▪ The provider is excluded from participating in a provider capacity in Medicare, Medicaid or any other Federal health care programs. ▪ The provider is convicted of violating the Medicaid False Claims Act, the Health Care False Claims Act, a substantially similar statute, or a similar statute by another state or the federal government. ▪ The provider has a federal or state felony conviction within the preceding 10 years of their provider enrollment application, including but not limited to, any criminal offense related to: ➢ murder, rape, abuse or neglect, assault, or other similar crimes against persons; ➢ extortion, embezzlement, income tax evasion, insurance fraud, and other similar financial crimes; ➢ the use of firearms or dangerous weapons; or ➢ any felony that placed the Medicaid program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.

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				▪ The provider has a federal or state misdemeanor conviction within the preceding five years of their provider enrollment application, including but not limited to, any criminal offense related to: ➢ any misdemeanor crime listed as a permissive exclusion in 42 USC 1320a-7(b); ➢ rape, abuse or neglect, assault, or other similar crimes against persons; ➢ extortion, embezzlement, income tax evasion, insurance fraud, or other similar financial crimes; or ➢ any misdemeanor that placed the Medicaid program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct. For the purposes of the excluded offenses mentioned above, an individual or entity is considered to have been convicted of a criminal offense when: • a judgment of conviction has been entered against the individual or entity by a federal, state, tribal or local court regardless of whether there is an appeal pending; • there has been a finding of guilt against the individual or entity by a federal, state, tribal or local court; or • a plea of guilty or nolo contendere by the individual or entity has been accepted by a federal, state, tribal, or local court.

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				The criminal history screening will be conducted by MDHHS through reputable and reliable data sources. Screenings for providers will be done as required by law and as deemed necessary by MDHHS for the protection of the Medicaid program and beneficiaries. For criminal offenses that fall under the mandatory exclusions of 42 USC 1320a-7(a), the definition of conviction will conform with 42 USC 1320a-7(i), which may include, but is not limited to, a record relating to criminal conduct that has been expunged. Any entity that offers, in writing or verbally, discounts on co-pay amounts, fax machines, computers, gift cards, store discounts and other free items, or discounts/waives the cost of medication orders if an entity uses their services: • may violate the Medicaid False Claim Act and Medicaid/MDHHS policy, which may result in disenrollment from Medicaid/MDHHS programs. • may violate the Michigan Public Health Code's prohibition against unethical business practices by a licensed health professional, which may subject a licensee to investigation and possible disciplinary action. Pursuant to MCL 400.111e, the Medicaid Director may terminate or deny enrollment if that action is necessary to protect the health of medically indigent individuals, the welfare of the public, and/or the funds appropriated for the Medicaid program. Additionally, the Medicaid Director may reduce or extend a provider's exclusion from the Medicaid program if, in the Medicaid Director's judgment, the continuation or reduction of the exclusion period is necessary to protect beneficiaries or the Medicaid program. Providers who are already enrolled at the time of a finding by MDHHS will have their enrollment ended as of the date MDHHS was notified of the excluded offense. Claims with dates of service on and after the provider's enrollment termination date will be denied.

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				~~The basis for termination or denial of enrollment includes, but is not limited to:~~ ~~• Failure to submit timely and accurate information;~~ ~~• Failure to cooperate with MDHHS screening methods;~~ ~~• Conviction of a criminal offense related to Medicare, Medicaid, or the Title XXI program in the last 10 years;~~ ~~• Termination on or after January 1, 2011 under Medicare or the Medicaid program, or the Children's Health Insurance Program (CHIP) of any other state;~~ ~~• Failure to submit sets of fingerprints as required within 30 days of a CMS or MDHHS request;~~ ~~• Failure to permit access to provider locations for site visits;~~ ~~• Falsification of information provided on the enrollment application; or~~ ~~• Inability to verify a provider applicant's identity.~~ ~~• Failure to comply with Medicaid policies regarding billing Medicaid beneficiaries.~~ ~~Providers may appeal the decision to terminate or deny enrollment. Denial of enrollment due to a temporary enrollment moratorium is appealable, but the scope of review is limited to whether the temporary moratorium applies to the provider appealing the denial. The basis for imposing a temporary moratorium is not subject to review. After termination from the Medicaid program, the provider must contact MDHHS to request re-enrollment as a Medicaid provider and reinstatement of billing privileges. Providers whose enrollment has been denied are not prohibited from submitting a subsequent re-enrollment application.~~

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				~~Summary suspension prevents further payment after a specified date, regardless of the date of service (DOS).~~ ~~If an indication of fraud or Medicaid misuse/abuse is discovered during any of the following, MDHHS considers it as a basis for summary suspension:~~ • ~~An evaluation of billing practices.~~ • ~~The prior authorization (PA) process.~~ • ~~An on-site review of financial and medical records and a written report of this review is filed.~~ • ~~The construction of a profile to evaluate patterns of utilization of Medicaid beneficiaries served by the provider.~~ • ~~A peer review of services or practices.~~ • ~~A hearing or conference between MDHHS and the provider (and counsel, if so requested).~~ • ~~Indictment or bindover on charges under the Medicaid or Health Care False Claim Act or similar state/federal statute.~~ ~~Any entity that offers, in writing or verbally, discounts on co-pay amounts, fax machines, computers, gift cards, store discounts and other free items, or discounts/waives the cost of medication orders if an entity uses their services:~~ • ~~May violate the Medicaid False Claim Act and Medicaid/MDHHS policy, which may result in disenrollment from Medicaid/MDHHS programs.~~ • ~~May violate the Michigan Public Health Code's prohibition against unethical business practices by a licensed health professional, which may subject a licensee to investigation and possible disciplinary action.~~

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			6.2 Enrollment and Reinstatement After Termination or Denial (new subsection)	New subsection text reads: Providers who are excluded from participation in the Medicaid program due to conviction of a crime listed in the previous subsection may request enrollment or reinstatement upon a showing that the provider's participation is in the best interest of the Medicaid program and of Medicaid beneficiaries. Factors that may be considered when determining whether enrollment or reinstatement in the Medicaid program is in the best interest of the Medicaid program and beneficiaries includes, but is not limited to: • whether the exclusion poses an undue hardship to beneficiaries; • whether the provider is the sole community physician or sole source of specialized services in the community; • subsequent offenses of the provider; • amount of time that has lapsed since the excluded offense; • whether all conditions, terms of probation or parole, penalties, fines, etc. of the felony or misdemeanor offenses that resulted in exclusion have been fully completed; • provider's participation in Medicare or other state Medicaid programs; or • other factors that demonstrate the provider does not otherwise pose a risk to the Medicaid program or beneficiaries. Requests for reinstatement must be sent in writing to the Medicaid Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.) MDHHS will address requests for enrollment and reinstatement within 30 days after all requested information has been provided.

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			6.3 Suspension (new subsection)	New subsection text reads: Summary suspension prevents further payment after a specified date, regardless of the date of service (DOS). If an indication of fraud or Medicaid misuse/abuse is discovered during any of the following, MDHHS considers it as a basis for summary suspension: • An evaluation of billing practices. • The prior authorization (PA) process. • An on-site review of financial and medical records and a written report of this review is filed. • The construction of a profile to evaluate patterns of utilization of Medicaid beneficiaries served by the provider. • A peer review of services or practices. • A hearing or conference between MDHHS and the provider (and counsel, if so requested). • Indictment or bindover on charges under the Medicaid or Health Care False Claims Act or similar state/federal statute.
			6.4 Loss of Licensure/ Limited Licenses	Subsection was previously titled as 6.2 Loss of Licensure. The following text was added after the 2nd paragraph: Limited or suspended licenses may result in disenrollment or denial of enrollment if MDHHS determines the basis of the action to be detrimental to the health or safety of medically indigent individuals, the welfare of the public, and/or the funds appropriated for the Medicaid program
			6.5 Payment Suspension	Subsection re-numbered from 6.3.

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			6.6 Appeals (new subsection)	New subsection text reads: Providers may appeal the decision to terminate or deny enrollment. Denial of enrollment due to a temporary enrollment moratorium is appealable, but the scope of review is limited to whether the temporary moratorium applies to the provider appealing the denial. The basis for imposing a temporary moratorium is not subject to review. Refer to the Provider Appeal Process section of this chapter for additional information.
			Section 17 – Provider Appeal Process	The 1st paragraph was revised to read: Any provider participating in, or applicant wishing to participate in, Medicaid has the right to appeal any adverse action taken by MDHHS unless the adverse action resulted from an action over which MDHHS had no control (e.g., Medicare termination, license revocation, court's findings in a criminal case). The method of appeal depends upon the provider type and is subject to the Social Welfare Act, Public Act 280 of 1939 (MCL 400.01 et seq.); Chapters 4 and 6 of the Administrative Procedures Act of 1969 (MCL 24.271 to 24.287, MCL 24.301 to 24.306); and the Public Health Code, Public Act 368 of 1978 (MCL 333.20173b). Most providers are informed of the steps to be taken to appeal the action via the notice of adverse action. (Hospital providers may appeal at the time of adverse action, prior to the notice.) Institutional providers should refer to their respective chapters of this manual for the appropriate steps and time frames for appeal.
MSA 19-06	3/1/2019	General Information for Providers	1.7 Beneficiary Medical Assistance Line	The 2nd paragraph was removed: ~~Within the limits of Medicaid, MDHHS does not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap, political beliefs, or source of payment.~~

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BULLETINS INCORPORATED*

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		General Information for Providers	Section 5 - Nondiscrimination	Text was revised to read: ~~Federal regulations require that all programs receiving federal assistance through the U.S. Department of Health & Human Services (HHS) comply fully with Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. Providers are prohibited from denying services or otherwise discriminating against any medical assistance recipient on the grounds of race, color, national origin or handicap. For complaints of noncompliance, contact the Michigan Department of Civil Rights or the Office for Civil Rights within the U.S. Department of Justice. (Refer to the Directory Appendix for contact information.)~~ In accordance with federal regulations, including Section 1557 of the Patient Protection and Affordable Care Act, an individual shall not be excluded from participation in, be denied the benefits of, or be subjected to discrimination on the grounds prohibited under Title VI of the Civil Rights Act of 1964, 42 USC 2000d et seq. (race, color, national origin), Title IX of the Education Amendments of 1972, 20 USC 1681 et seq. (sex, gender identification, sexual orientation), the Age Discrimination Act of 1975, 42 USC 6101 et seq. (age), or Section 504 of the Rehabilitation Act of 1973, 29 USC 794 (disability), under any health program or activity, any part of which is receiving federal financial assistance, or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the Affordable Care Act or its amendments. All Michigan Medicaid program participants and providers are to ensure compliance with all relevant Federal and State nondiscrimination provisions. Failure to comply may result in the provider's disenrollment from the Michigan Medicaid program. To report noncompliance, contact the Michigan Department of Civil Rights or the U.S. Office for Civil Rights, Department of Health and Human Services. (Refer to the Directory Appendix for contact information.)

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BULLETINS INCORPORATED*

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		General Information for Providers	8.4 Nondiscrimination	The subsection title was revised to read: Nondiscrimination in Delivery of Services Text was revised to read: Providers must render covered services to a beneficiary in the same scope, quality, and manner as provided to the general public. Within the limits of Medicaid, providers must take the necessary steps to ensure compliance with all relevant nondiscrimination provisions. Failure to comply may result in the provider's disenrollment from the program. Refer to the Nondiscrimination section of this chapter for additional information. ~~shall not discriminate on the basis of age, race, religion, color, sex, handicap, national origin, marital status, political beliefs, or source of payment.~~
		Pharmacy	Section 6 – General Noncovered Services	In the 2nd paragraph, the 20th bullet point was removed: • ~~Drugs used to treat gender identity conditions, such as hormone replacement~~
		Practitioner	Section 1 – General Information	The 2nd paragraph was revised to read: Generally, medically necessary services provided to a Medicaid beneficiary by an enrolled practitioner are covered. This includes, but is not limited to, medically necessary health care services that are evidence-based and provided within generally accepted standards of medical practice to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms. The services addressed in this chapter include services that require explanation or clarification, have special coverage requirements, require prior authorization (PA), or must be ordered by a physician (MD or DO).

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MSA 19-08	4/1/19	Medical Supplier	2.29 Osteogenesis Stimulator	Text was revised to read:

PA Requirements	PA is required and ~~evaluated on a case-by-case basis~~ approved for three months at a time for up to a maximum of ten months. For consideration of rental beyond the initial three months, a new MSA-1653-B must be submitted, along with physician documentation establishing medical reason(s) for continued need.
Payment Rules	Osteogenesis stimulators are ~~**rental only** items (up to three months)~~ considered a capped rental item and are inclusive of the following: • All accessories needed to use the unit (e.g., electrodes, wires, cables, coupling gel, etc.). • Education on the proper use and care of the equipment. • Routine servicing and all necessary repairs or replacements to make the unit functional based on manufacturer warranty. ~~For consideration of rental beyond the initial three months, a new MSA-1653-B must be submitted, along with physician documentation establishing medical reason(s) for continued need.~~ After purchase: Accessories needed to use the device, or the replacement of the stimulator, require prior authorization. The manufacturer's warranty must be exhausted prior to requesting a replacement osteogenesis stimulator.

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BULLETINS INCORPORATED*

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MSA 19-09	4/1/2019	Billing and Reimbursement for Professionals	7.14 Surgical Assistance	The Description for Modifier AS was revised to read: PA, NP, ~~or~~ CNS, or CNM services for assistant at surgery
		Practitioner	11.9 Assistant at Surgery/ Assistant Surgeon	The last paragraph was revised to read: Medicaid covers assistant at surgery services performed by a second physician, a physician's assistant (PA), ~~or~~ a nurse practitioner (NP) and, in limited instances, a certified nurse midwife (CNM). ~~Physician's assistant and~~ PA, NP, and CNM services as assistant at surgery must be under the delegation and supervision of the physician employing the ~~physician's assistant or~~ PA, NP, or CNM, or a physician employed by the same group practice that employs the ~~physician's assistant or~~ PA, NP, or CNM. If the ~~physician's assistant and/or~~ PA, NP and/or CNM are employees of the hospital, their services are covered as a part of the hospital charges.
		Practitioner	Section 21 – Certified Nurse Midwife	Text was revised to read: Medicaid covers services provided by qualified Medicaid enrolled certified nurse midwives (CNMs). (Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter or the Medicaid Code and Rate Reference tool for additional information regarding coverage parameters.) ~~CNM coverage includes the management of low-risk and uncomplicated pregnancies and services to essentially normal women and newborns. Medically complicated pregnancies and services to beneficiaries with high-risk conditions MUST be referred to a physician. Services provided to high-risk women and women with medical complications are only covered under the delegation and supervision of a physician.~~
			21.1 Enrollment	Subsection was deleted.

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BULLETINS INCORPORATED*

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			21.1 Covered Services (new subsection)	New subsection text reads: Medicaid covers medically necessary professional services provided by a CNM, 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 an advanced practice registered nurse (APRN) under state law, with the CNM specialty certification granted by the Michigan Board of Nursing; • the CNM is legally authorized to perform the service in compliance with state law; and • the services are not restricted to physicians or otherwise excluded by Medicaid program policy or federal and state statutes. Covered services include those within the CNM's scope of practice as defined in state law. Services focus on inpatient and outpatient obstetric, gynecologic and women's primary health care. Services must be administered within the framework of an alliance agreement that provides for physician consultation and referral as indicated by the health of the beneficiary. Covered CNM services include the following:

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				• Maternity care, including antepartum care, hospital delivery and postpartum care; • Newborn care; • Primary care services for women throughout their lifespan, including physical exams; • Diagnosis and treatment of common health problems; • Gynecological services; • Reproductive health services; • Contraceptive services; • Treatment of male partners for sexually transmitted infection and reproductive health; and • The prescribing of pharmacological and nonpharmacological interventions and treatments that are within the CNM's specialty role, scope of practice, and state law.
			21.2 Family Planning	Subsection was deleted.
			21.3 Gynecologic Care	Subsection was deleted.
			21.4 Laboratory Tests	Subsection was deleted. Following subsections were re-numbered.

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			~~21.5~~ 21.2 Maternity Care	Text was revised to read: Medicaid covers antepartum care, delivery, and postpartum care rendered by a CNM when provided in compliance with ~~the specific coverage policies of this chapter~~ Medicaid policy. **Antepartum Care** Coverage for antepartum care includes all usual and customary antepartum services provided prior to delivery and referral to MIHP ~~given the presence of~~ when there are psychosocial or nutritional factors that could adversely affect the pregnancy or the health and well-being of the mother or infant. If the provider initiated prenatal care within the first six months of pregnancy through the month of delivery, the appropriate antepartum care CPT code is covered. If the beneficiary is seen by ~~several~~ multiple CNMs or physicians within a group ~~or multiple CNMs supervised by the same physician or physician group~~ practice, the antepartum care package ~~is~~ may be covered. (Refer to the Maternity Care and Delivery Services Section of this chapter for details on coverage of antepartum care and when individual E/M services are covered.) ~~CNMs may perform and bill Medicaid for non-stress tests when this service is determined medically necessary and is part of routine care provided for uncomplicated pregnancies. CNMs may receive direct reimbursement for this service when completed within the CNM scope of practice guidelines.~~

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				Delivery — Deliveries performed by a CNM are covered in a licensed hospital setting only. Home deliveries and services associated with these deliveries are not covered. Coverage of the delivery includes the usual and customary services associated with the hospital admission, management of labor, monitoring, vaginal delivery, and resuscitation of the newborn infant when necessary. **Post-partum Care** — Medicaid covers usual and customary inpatient and outpatient post-partum ~~office visits following~~ services provided after the delivery. Routine post-partum hospital care for the mother is covered as a part of the delivery. Routine care of the newborn in the hospital is covered for the provider who examines and provides the total hospital care of the newborn regardless of whether he or she performed the delivery. (Refer to the Services to Newborns subsection in this chapter for additional coverage information.)
			~~21.6~~ 21.3 Office Visits	No changes other than re-numbering.
			21.7 Pharmacy	Subsection was deleted.

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BULLETINS INCORPORATED*

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			21.4 Enrollment of Certified Nurse Midwives (new subsection)	New subsection text reads: The CNM who provides professional services to Medicaid beneficiaries is required to be an enrolled provider and uniquely identified on claims for services to be considered eligible for reimbursement. To enroll, the CNM must complete an on-line application in the Community Health Automated Medicaid Processing System (CHAMPS) and enroll with an Individual (Type 1) National Provider Identifier (NPI). Additional provider enrollment information can be found on the MDHHS website (refer to the Directory Appendix for website information) and in the General Information for Providers Chapter of this manual. 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.

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BULLETINS INCORPORATED*

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			21.5 Billing & Reimbursement (new subsection)	New subsection text reads: Professional claims must include the NPI of the CNM in the Rendering Provider field and the supervising or collaborating 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. Professional services are only covered when the CNM has personally performed the service and no other provider or entity has been paid for the service. Services provided jointly by the CNM and physician are covered for a single practitioner only. Fee-for-Service reimbursement for CNM services is based upon the limits and rates associated to physician professional services and are published on the CNM 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 Chapters for additional information. MHPs are responsible for reimbursing contracted providers or subcontractors for its 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 Medicaid Health Plans Chapter for additional information. (Refer to the Surgery-General section of this chapter for information on a CNM functioning as an assistant at surgery.)