MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

Bulletin Number: MSA 21-05

Distribution: All Providers

Issued: March 2, 2021

Subject: Updates to the MDHHS Medicaid Provider Manual

Effective: April 1, 2021

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

The Michigan Department of Health and Human Services (MDHHS) has completed the April 2021 update of the online version of the MDHHS Medicaid Provider Manual. The manual will be available April 1, 2021 at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Medicaid Provider 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.

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 MDHHS Medicaid Provider Manual, providers should retain all bulletins issued since the version date of the CD. Providers are encouraged to use the MDHHS 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 questions, 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

Kate Massey, Director
Medical Services Administration

Michigan Department of Health and Human Services

Medicaid Provider Manual
April 2021 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	7.3 Out of State/Beyond Borderland Providers	In the 1st paragraph, the 1st bullet point was revised to read: • Emergency services as defined by the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and the federal Balanced Budget Act of 1997 and its regulations; or	Clarification.
Billing & Reimbursement for Institutional Providers	7.15 Emergency Department Services	In the table, under "Emergency Department Stabilization/Emergency Treatment Services", the 4th bullet point was revised to read: • Hospitals must apply current guidelines designated by the appropriate ED HCPCS code to reasonably relate the intensity of hospital resources to the different E&M levels represented by the codes. **Exception:** The reason the encounter was considered an emergency must be entered in the Remarks Section if the principal diagnosis or the admitting diagnosis does not reflect the definition of an emergency as stated in the federal Balanced Budget Act of 1997 and its regulations. Information in the Remarks Section should include vital signs, medical problems or conditions noted during the ED visit, if an IV was started, and medications administered during the visit. This information must be adequate to confirm the emergent condition.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	1.1 MDHHS Approval	Text was revised to read: Pursuant to Michigan's Medicaid State Plan and federally approved ~~1915(b) waiver and 1915(c) Habilitation Supports Waiver (HSW),~~ managed care waiver, community-based mental health, substance abuse and developmental disability specialty services and supports are covered by Medicaid when delivered under the auspices of an approved Prepaid Inpatient Health Plan (PIHP). To be an approved Medicaid provider, a PIHP must be certified as a Community Mental Health Services Program (CMHSP) by MDHHS in accordance with Section 232a of the Michigan Mental Health Code. A PIHP may be either a single CMHSP, or the lead agency in an affiliation of CMHSPs approved by the Specialty Services Selection Panel. Service providers may contract with the PIHP or an affiliate of the PIHP. PIHPs must be enrolled with MDHHS as Medicaid providers. (Refer to the General Information for Providers Chapter of this manual for additional information.) The PIHP must offer, either directly or under contract, a comprehensive array of services, as specified in Section 206 of the Michigan Mental Health Code, being Public Act 258 of 1974, as amended, and all of those specialty services/supports included in this manual. ~~For the Specialty Services and Supports Program, Centers for Medicare & Medicaid Services gave Michigan permission to use Section 1915(b)(3) of the Social Security Act which allows a state to use Medicaid funds to provide services that are in addition to the state plan services. Those services are described in the Additional Mental Health Services (B3s) section of this chapter. Services selected during the person-centered planning process may be a mix of state plan, HSW, and additional/B3 services, or state plan or HSW or additional/B3 services only, depending on what services best meet a beneficiary's needs and will assist in achieving his goals.~~	Medicaid Managed Care authority change.

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CHAPTER	SECTION	CHANGE	COMMENT
		~~The 1915(c) Children's Waiver services are delivered under the auspices of a CMHSP that has been enrolled as a Children's Waiver provider. Children's Waiver services are reimbursed by MDHHS through a fee-for-service (FFS) payment system. The Children's Waiver program is described in the Children's Home and Community-Based Services Waiver Section of this chapter.~~	
Behavioral Health and Intellectual and Developmental Disability Supports and Services	1.4 Provider Registry	Text was revised to read: The PIHPs must register with MDHHS any Medicaid ~~state plan, HSW, or additional/B3~~ specialty services and support they provide directly or through one of their contracted providers, or an affiliate as applicable, as specified in the MDHHS /PIHP contract. The PIHPs should contact the Division of Quality Management and Planning for more information about the provider registry, and the Bureau of Community Based Services for MDHHS approval of special programs. (Refer to the Directory Appendix for contact information.) PIHPs must update the registry whenever changes (address, scope of program, additions, deletions) occur, according to the format and schedule specified by MDHHS. ~~Children's Waiver providers must be registered by the CMHSPs.~~	
Behavioral Health and Intellectual and Developmental Disability Supports and Services	1.7 Definition of Terms	The definition for **Covered Services or Medicaid Covered Services** was revised to read: For the purposes of this manual, Medicaid State Plan Services and ~~Additional Mental Health Services (B3s)~~ specialty services and supports.	Waiver authorities change effective 10/1/2019.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	2.1 Mental Health and Developmental Disabilities Services	The 4th bullet point was revised to read: • Provided according to an individual written plan of service that has been developed using a person-centered planning process and that meets the requirements of Section 712 of the Michigan Mental Health Code. A preliminary plan must be developed within seven days of the commencement of services or, if a beneficiary is hospitalized, before discharge or release. Pursuant to state law and in conjunction with the federal Balanced Budget Act of 1997, Section 438.10 (f)(6)(v), each beneficiary must be made aware of the amount, duration, and scope of the services to which he is entitled. Therefore, each plan of service must contain the expected date any authorized service is to commence, and the specified amount, scope, and duration of each authorized service. The beneficiary must receive a copy of his plan of services within 15 business days of completion of the plan.	Clarification.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	2.3 Location of Service	The 5th paragraph was revised to read: Medicaid does not cover services delivered to beneficiaries with a Serious Mental Illness (SMI) in Institutions for Mental Diseases (IMD) for individuals between ages ~~22~~ 21 and 64, as specified in §1905(a)(B) of the Social Security Act when the length of stay in the IMD is more than 15 days during the month. However, per Michigan's 1115 Behavioral Health Demonstration, Medicaid does cover services delivered to beneficiaries with a Substance Use Disorder (SUD) in IMDs for individuals between ages 21 and 64 when the stay in the IMD is more than 15 days during the month. Medicaid does not cover services provided to children with serious emotional disturbance in Child Caring Institutions (CCI) unless it is licensed as a "children's therapeutic group home" as defined in Section 722.111 Sec.1(f) under Act No. 116 of the Public Acts of 1973, as amended, or it is for the purpose of transitioning a child out of an institutional setting (CCI). Medicaid may also be used for the purpose of transitioning a child out of Hawthorn Center. For both the CCI and Hawthorn Center, the following mental health services initiated by the PIHP (the child needs to be open to the PIHP/CMHSP) may be provided within the designated timeframes:	Under Medicaid managed care coverage, states may make monthly payments to managed care organizations for enrollees aged 21 through 64 who are patients in an IMD. In May 2016, CMS added this policy to regulations and specified that states may make payments to managed care organizations for enrollees aged 21 through 64 who are patients in an IMD as long as the length of stay in the IMD is no more than 15 days during the month of the payment.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.4 Behavior Treatment Review	The 1st paragraph was revised to read: The ~~1997~~ federal Balanced Budget Act of 1997 requires states to assure that enrollees in their PIHPs will "be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints or seclusion" [42 CFR 438.100 (b)(2)(v)].	For consistency in terminology used in Manual.

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	Section 15 – Habilitation Supports Waiver for Persons with Developmental Disabilities	The 1st paragraph was revised to read: Beneficiaries with developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid covered state plan ~~or additional/B3~~ services. A HSW beneficiary must receive at least one HSW service per month in order to retain eligibility. Medical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary's services and supports that are to be provided under the auspices of the PIHP must be specified in his individual plan of services developed through the person-centered planning process. The 3rd paragraph was revised to read: The PIHP's enrollment process also includes confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, ~~or~~ does not receive at least one HSW habilitative service per month, ~~or~~ withdraws from the program voluntarily, or dies. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDHHS Bureau of Community Based Services. (Refer to the Directory Appendix for contact information.)	Delete reference to previous coverage authority B3. Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	15.1 Waiver Supports and Services	The title for the first section in the table was revised to read: **Community Living Supports (CLS)** (This is a habilitative service.) Under **"Enhanced Medical Equipment and Supplies"**, the 7th paragraph was revised to read: Items that are considered family recreational choices are not covered (e.g., outdoor play equipment, swimming pools, pool decks and hot tubs). The purchase or lease of a vehicle, as well as any repairs or routine maintenance to the vehicle, is not covered. Educational equipment and supplies are expected to be provided by the school as specified in the Individualized Education Plan and are not covered. Eyeglasses, hearing aids, and dentures are not covered. The following text was added: Fiscal Intermediary — Refer to the Additional Mental Health Services (B3s) section, Fiscal Intermediary Services subsection, of this chapter for information.	Clarifies services that are habilitative within the HSW. Adds examples for providers. Covered HSW service effective 10/1/2019.

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CHAPTER	SECTION	CHANGE	COMMENT
		Under **"Goods and Services"**, text was revised to read: The purpose of Goods and Services is to promote individual control over, and flexible use of, the individual budget by the HSW beneficiary using ~~arrangements that support self-determination~~ self-directed services and facilitate creative use of funds to accomplish the goals identified in the individual plan of services (IPOS) through achieving better value or an improved outcome. Goods and services must increase independence, facilitate productivity, or promote community inclusion and substitute for human assistance (such as personal care in the Medicaid State Plan and community living supports and other one-to-one support as described in the HSW or ~~§1915(b)(3) Additional Service definitions~~ covered State Plan definitions) to the extent that individual budget expenditures would otherwise be made for the human assistance. A Goods and Services item must be identified using a person-centered planning process, meet medical necessity criteria, and be documented in the IPOS. Purchase of a warranty may be included when it is available for the item and is financially reasonable. Goods and Services are available only to individuals ~~participating in arrangements of self-determination~~ who self direct their services whose individual budget is lodged with a fiscal intermediary. This coverage may not be used to acquire goods or services that are prohibited by federal or state laws or regulations, e.g., purchase or lease or routine maintenance of a vehicle.	

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CHAPTER	SECTION	CHANGE	COMMENT
		The following text was added: Non-Family Training — Refer to the Children's Home and Community-Based Services Waiver (CWP) section, Covered Waiver Services subsection, of this chapter for information. For **"Out-of-Home Nonvocational Habilitation"**, the title was revised to read: **Out-of-Home Nonvocational Habilitation** (This is a habilitative service.) The 3rd paragraph was revised to read: Services must be furnished ~~four or more hours per day~~ on a regularly scheduled basis for one or more days per week unless provided as an adjunct to other day activities included in the beneficiary's plan of service.	Covered HSW service effective 10/1/2019. Clarifies services that are habilitative within the HSW.

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CHAPTER	SECTION	CHANGE	COMMENT
		For **"Prevocational Services"**, the title was revised to read: **Prevocational Services** (This is a habilitative service.) The 1st paragraph was revised to read: Prevocational services involve the provision of learning and work experiences where a beneficiary can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated, community settings. Services are expected to occur over a defined period of time and provided in sufficient amount and scope to achieve the outcome, as determined by the beneficiary and his/her care planning team in the ongoing person-centered planning process. Services are expected to specifically involve strategies that enhance a beneficiary's employability in integrated, community settings. Competitive employment and supported employment are considered successful outcomes of prevocational services. However, participation in prevocational services is not a required prerequisite for individual competitive integrated employment or receiving supported employment services. The following text was added after the 6th paragraph: Prevocational services needed for each individual are documented, coordinated, and non-duplicative of other services otherwise available under a program funded under section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401(16 and 17)).	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
		Under **"Private Duty Nursing"**, the 12ht paragraph was revised to read: These services should be provided to a beneficiary at home or in the community. A physician's prescription is required as defined in the General Information section of this chapter.	
Early and Periodic Screening, Diagnosis and Treatment	Section 3 – History and Well Child Visits	The 2nd paragraph was revised to read: Well child visits are the health check-ups, newborn, well baby, and well child exams represented by appropriate Current Procedural Terminology (CPT) preventive medicine services procedure codes. ~~and are used in conjunction with the following International Classification of Diseases (ICD) diagnosis codes:~~ • ~~ICD-9: V20.0 - V20.2, V20.31, V20.32, and/or V70.0, and/or V70.3 - V70.9~~ • ~~ICD-10: Z76.2, Z00.110, Z00.111, Z00.121, Z00.129, and/or Z00.00-01, and/or Z02.0-Z02.6, Z02.81-Z02.83, Z02.89, Z00.5, Z00.6, Z00.70, Z00.71, Z00.8~~	General update.

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CHAPTER	SECTION	CHANGE	COMMENT
Early and Periodic Screening, Diagnosis and Treatment	Section 12 – Children in Foster Care	The 6th paragraph was revised to read: ~~The Implementation, Sustainability and Exit Plan (ISEP) requires that all children who are 3 years of age or older at the time of entry into foster care will receive a dental examination within 90 days of entry into foster care unless the child had a dental exam in the six months prior to foster care placement. It is the responsibility of the foster care parent to take the child to the dentist.~~ The dental examination must follow the American Academy of Pediatric Dentistry (AAPD) Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling schedule. (Refer to the Directory Appendix for AAPD website information.) The guidelines recommend that a child have a first dental visit when the first tooth erupts or no later than 12 months of age. The examination is to be repeated every six months or as indicated by the child's risk status and susceptibility to disease. Refer to the Dental chapter of the Medicaid Provider Manual for additional information.	More appropriate to refer to the AAPD guidelines rather than ISEP, and to align with Dental chapter policy.
Early and Periodic Screening, Diagnosis and Treatment	12.1 Psychotropic Medication Treatment	In the 1st paragraph, the first sentence was revised to read: A psychiatric diagnosis using the Diagnostic and Statistical Manual (~~DSM~~) of Mental Disorders (DSM-5) ~~(published by the American Psychiatric Association)~~ must be made before prescribing psychotropic medications to any child in foster care.	Clarification.
Family Planning Clinics	1.3 Diagnosis Codes	Text was revised to read: The appropriate ICD diagnosis code(s) must be indicated on the claim form when billing for family planning services. ~~For dates of service (DOS) before 10/1/15, family planning services are limited to the V25 (ICD-9) diagnosis code range. For DOS on and after 10/1/15,~~ Family planning services are limited to the Z30 (ICD-10) code range. Providers must enter the appropriate code on the claim form.	General update.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital	3.14.B. Treatment of Emergency Medical Condition	The 2nd paragraph was revised to read: An emergency medical condition is defined by the federal Balanced Budget Act of 1997 and its regulations.	Clarification.
Hospital Reimbursement Appendix	14.1 Diagnoses	Text was revised to read: In order to qualify for a SHS rate, a claim must include one of the primary diagnosis codes listed on the SHS rate diagnosis code table. ~~This list~~ The SHS rate diagnosis code table is maintained on the MDHHS website. (Refer to MDHHS Institutional Billing Resource in the Directory Appendix for website information.) The list of eligible codes will be evaluated annually and updated as necessary. ~~For outpatient dates of service and inpatient dates of discharge on or after July 1, 2015 and before October 1, 2015, ICD-9 diagnosis codes will be used. For outpatient dates of service and inpatient dates of discharge on or after October 1, 2015, ICD-10 diagnosis codes will be used.~~	General update.

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MI Health Link	7.6.C. Level I Assessments	In the 1st paragraph, the last bullet point was revised to read: • The ICO will use the ~~DSM-V~~ DSM-5 screening tool as part of or in addition to its Level I Assessment tool to identify Individuals with BH, SUD, and/or I/DD needs. Under **"Level I Results and Referral"**, the 1st paragraph was revised to read: The ICO will use the results of the Level I Assessment to confirm the appropriate acuity or risk stratification level for individual Care Coordinator assignments. The Level I Assessment and the ~~DSM-V~~ DSM-5 screening tool for BH, SUD, I/DD, will be used to determine need for a Level II Assessment, referral for PIHP services, or development of the IICSP.	Clarification
Pharmacy	14.15 Vaccines	The 3rd paragraph was revised to read: Pharmacists must be in compliance with State of Michigan rules and regulations~~,~~ and have received the appropriate training for vaccine administration~~, and have a letter of delegation from a physician~~ in order to be eligible to administer vaccines. Standing orders are required from a Michigan-licensed physician who is responsible for the clinical practice of the vaccine operations. This documentation must be readily available onsite in the event of an audit.	The "letter of delegation" is no longer required.
Practitioner	6.2 Treatment of Emergency Medical Condition in the Emergency Department	The 2nd paragraph was revised to read: An emergency medical condition is defined by the federal Balanced Budget Act of 1997 and its regulations.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Program of All-Inclusive Care for the Elderly	Section 1 – General Information	The 3rd paragraph was revised to read: The PACE capitated benefit was authorized by the federal Balanced Budget Act of 1997 and features a comprehensive service delivery system with integrated Medicare and Medicaid financing.	Clarification.
Therapy Services	4.1 Occupational Therapy	In the table following the 7th paragraph, under "Occupational therapy is not covered for the following:", the 9th ullet point was removed. • ~~Feeding for a beneficiary whose status is nothing per oral cavity (NPO), with physician orders to continue NPO, and who does not demonstrate the potential to improve oral and/or pharyngeal phases of swallowing (i.e., pleasure eating).~~ The following bullet points were added: • Feeding for a beneficiary whose status is nothing per oral cavity (NPO), with physician orders to continue NPO. • Feeding for a beneficiary who does not demonstrate the potential to improve oral and/or pharyngeal phases of swallowing (i.e., pleasure eating).	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Therapy Services	4.3 Speech-Language Therapy	In the table following the 8th paragraph, under "Speech-Language therapy is not covered for the following:", the 6th bullet point was removed. • ~~Feeding for a beneficiary whose status is NPO, with physician orders to continue NPO, and who does not demonstrate the potential to improve oral and/or pharyngeal phases of swallowing (i.e., pleasure eating).~~ The following bullet points were added: • Feeding for a beneficiary whose status is NPO, with physician orders to continue NPO. • Feeding for a beneficiary who does not demonstrate the potential to improve oral and/or pharyngeal phases of swallowing (i.e., pleasure eating).	Clarification.
Acronym Appendix		Removal of: ~~ISEP – Implementation, Sustainability and Exit Plan~~ Addition of: AAPD - American Academy of Pediatric Dentistry MSA – Medical Services Administration	Obsolete information. General update.
Directory Appendix	Maternal Infant Health Program Resources	Under "Contact/Topic" for LogistiCare Solutions, text was revised to read: ModivCare Solutions (formerly known as LogistiCare Solutions)	LogistiCare changed its name effective 1/6/21.

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CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Non-Emergency Medical Transportation	Under "Contact/Topic" for LogistiCare Solutions, text was revised to read: ModivCare Solutions (formerly known as LogistiCare Solutions)	LogistiCare changed its name effective 1/6/21.

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Michigan Department of Health and Human Services

Medicaid Provider Manual
April 2021 Updates

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 20-55	12/1/2020	Medicaid Provider Manual Overview	1.1 Organization	Addition of: Chapter Title: Brain Injury Services Affected Providers: Brain Injury Services providers, Hospitals, Practitioners, Nursing Facilities Chapter Content: Coverage policy related to services provided by Brain Injury Services.
		Beneficiary Eligibility	9.1 Enrollment	In the table, under "Excluded Enrollment", the 4th bullet point was revised to read: • People in the MDHHS ~~Traumatic Brain Injured~~ Brain Injury Services transitional residential ~~rehabilitation~~ program.
		Brain Injury Services		Addition of new chapter.
		Nursing Facility Certification, Survey & Enforcement Appendix	2.1 Dual Certification	The 7th paragraph was revised to read: Facilities granted a Certificate of Need (CON) for special population beds, as defined in the Certificate of Need Review Standards for Nursing Home and Hospital Long-Term Care Unit (HLTCU) beds, are also required to dually certify these special population beds (e.g., ventilator dependent care beds, behavioral, acquired or traumatic brain injury/spinal cord injury [ABI/TBI/SCI]). ICF/IID or MI beds need not be dually certified.
		Special Programs	2.2 Traumatic Brain Injury Rehabilitation Program	Subsection was deleted as information is now included in the Brain Injury Services chapter. (Includes subsections 2.2.A. Eligible Beneficiaries and 2.2.B. Covered Services.)

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BULLETINS INCORPORATED*

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		Therapy Services	1.1 Service Provision	In the 2nd paragraph, the 3rd bullet point was revised to read: • Speech-Language Pathology (SLP) to improve articulation and fluency following an acquired or traumatic brain injury or develop communication skills utilizing an augmentative communication strategy.
		Acronym Appendix		Addition of: AAAASF – American Association for Accreditation of Ambulatory Surgery Facilities ABI – Acquired Brain Injury ACBIS – Academy of Certified Brain Injury Specialists BIS – Brain Injury Services BPS – Behavioral and Psychological Services CBIS – Certified Brain Injury Specialist CRT – Cognitive Rehabilitation Therapy HCBS – Home and Community Based Services LTSS – Long Term Services and Supports NPE - Neuropsychological Evaluation PMR – Physical Medicine and Rehabilitation

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		Directory Appendix	Other Health Care Resources/Programs	Revisions to: **Contact/Topic:** ~~Traumatic~~ Brain Injury Services Program **Phone #:** ~~800-642-3195~~ 517-241-1685 and 517-241-1680 **E-mail:** MDHHS-MSA-BIS@michigan.gov
MSA 20-60	9/1/2020	Tribal Health Centers	Section 1 – General Information	The 3rd paragraph was revised to read: Under the Michigan Medicaid State Plan, THCs have the option of choosing from one of ~~three~~ four reimbursement mechanisms. The THC may elect to be reimbursed under only one of the options listed below, and the selected option applies to all beneficiaries receiving services at the THC. The options are: … The following bullet point was added: • A Tribal facility may choose to enroll as a Tribal FQHC and be reimbursed for outpatient face-to-face visits within the FQHC scope of services provided to Medicaid beneficiaries, including telemedicine and services provided by contracted employees. Tribal FQHCs are eligible to receive the IHS outpatient AIR for eligible encounters.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 20-68	10/30/2020	Non-Emergency Medical Transportation	Section 3 – Transportation Authorization	The 4th paragraph was reformatted and revised to read: Reimbursement for special transportation requires a completed~~, original~~ Medical Verification for Transportation (DHS-5330) to serve as documentation of medical need and must be retained in the beneficiary's file. Special transportation includes medically needing a wheelchair lift-equipped vehicle, Medi-Van vehicle, attendant, prior authorization, and other special circumstances supported by medical documentation. (For prior authorization requirements, refer to the Prior Authorization (PA) section of this chapter.) Medicaid FFS authorizing parties may accept the submission of a complete DHS-5330 form via fax and secure email. Transportation providers and beneficiaries may submit original forms if they choose, but sending original forms is not required for authorization. Providers and beneficiaries are encouraged to keep an original or copy of forms submitted to MDHHS for reimbursement. The DHS-5330 must be completed annually. A local MDHHS office can authorize NEMT without a DHS-5330 for beneficiaries who do not require special transportation. Additionally, verification of medical need is not required when the transportation is to obtain medical evidence (i.e., employability, incapacity, or disability) or to meet the needs of children for protective services.

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				The 5th paragraph was reformatted as the 6th paragraph and revised to read: An initial verification of medical need for special transportation is required by the beneficiary's primary care physician (PCP). A~~n original,~~ completed DHS-5330 signed by the beneficiary's PCP, or a physician's assistant or nurse practitioner working under the supervision of the PCP, serves as documentation of medical need and must be retained in the beneficiary's file. In situations when a beneficiary's PCP, or a physician's assistant or nurse practitioner working under the supervision of the PCP, is unavailable and unable to complete a~~n original~~ DHS-5330 in a timely manner, another licensed provider may complete the form. Example providers include, but are not limited to, a physician specialist, clinical nurse specialist, certified nurse midwife, registered nurse, social worker, dentist, and other licensed providers. The licensed provider must be knowledgeable about the beneficiary's medical needs, capable of accurately completing the form, and providing direct medical, behavioral or dental services to the beneficiary. In the 7th paragraph, the 1st sentence was revised to read: In situations when a completed~~, original~~ DHS-5330 cannot be secured prior to a beneficiary's scheduled Medicaid-covered appointment, authorizing parties may approve and reimburse all necessary NEMT services if the DHS-5330 is completed and returned to the authorizing party within 10 business days of the appointment. In the 8th paragraph, the 1st sentence was revised to read: Authorizing parties must retain the completed~~, original~~ DHS-5330 in the beneficiary's file and make it available upon request.

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			Section 5 – Covered Services	The 4th paragraph was reformatted and revised to read: Transportation providers and beneficiaries may be reimbursed for mileage, tolls, parking fees, approved meals and lodging expenses, Medi-Van and wheelchair lift equipped transportation, and medically necessary attendants. The transportation provider or beneficiary must submit a complete~~, original~~ MSA-4674 (Medical Transportation Statement) for all trip-associated costs to the authorizing party to receive reimbursement. Medicaid FFS authorizing parties may accept the submission of a complete MSA-4674 form and receipts via fax and secure email. Transportation providers and beneficiaries may submit original forms and receipts if they choose, but sending original forms and receipts is not required for reimbursement. Providers and beneficiaries are encouraged to keep an original or copy of forms and receipts submitted to MDHHS for reimbursement. NEMT reimbursement must reflect the total incurred cost to the transportation provider(s) and to the beneficiary, and must be verified with ~~original,~~ itemized, unaltered receipts. All receipts must be legible and ~~attached to~~ included with the MSA-4674. Transportation providers must be enrolled in CHAMPS on the date of service to receive Medicaid NEMT reimbursement unless the provider is exempt from enrollment.
MSA 20-80	12/30/2020	Laboratory	Section 2 – Billing Information	Text was revised to read: ~~When billing Medicaid for services rendered, the date of service (DOS) indicated on the claim must be the date the specimen is collected.~~ Refer to the Billing & Reimbursement for Professionals Chapter of this manual for additional information about billing.

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			2.1 Date of Service (new subsection; following subsections were re-numbered)	New subsection text reads: When billing Medicaid for services rendered, the date of service (DOS) indicated on the claim must be the date the specimen is collected. Laboratory tests performed on a stored specimen must use the date the specimen was obtained from storage as the specimen collection date.
			5.5.B. Prior Authorization Requirements and Documentation	The subsection title was revised to read: ~~Prior~~ Authorization Requirements and Documentation Text was revised to read: ~~Prior~~ Authorization ~~(PA)~~ is required for most genetic and molecular laboratory tests. Refer to the Community Health Automated Medicaid Processing System (CHAMPS) Code Rate and Reference tool for ~~guidance~~ authorization necessity. Authorization requests must be ~~obtained prior to the test being performed and should be requested using the Practitioner Special Services Prior Approval Request/Authorization form (MSA-6544-B)~~ submitted to Medicaid within 30 days of the date of service using the Genetic and Molecular Laboratory Test Authorization Request form (MSA-2081). Specimen processing should not be completed until after the authorization request has been approved. (Refer to the Forms Appendix for a copy of the form, including form completion instructions.)

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				~~PA~~ Authorization requests require medical documentation submitted by the beneficiary's ~~attending~~ Medicaid enrolled treating/ordering provider (i.e., MD, DO, PA, NP). Medical necessity letters or ~~genetic~~ testi~~ng~~ request forms submitted by the performing laboratory and signed by the ~~attending~~ treating/ordering provider will not be accepted as a substitute for clinical documentation from the medical record or completion of MSA-2081. ~~The following must be submitted along with the MSA-6544-B:~~ The completed MSA-2081 and supporting clinical documentation must document the following: • Indication for the test. Indications should be beneficiary specific and clinical in nature. • Clinical notes that clearly detail the beneficiary's related signs and symptoms. • Family history relevant to the beneficiary's condition and test being requested. A family pedigree analysis must be made available upon request. • Other related testing or clinical findings of the beneficiary or family member. • Clinical documentation supporting that the test results will be used to significantly alter the management or treatment of the disease. This definitive treatment or action plan should be specific to the beneficiary and completed by the provider who will manage the patient using the test results. • The name and NPI number of the laboratory performing the test. • The name, specialty, and NPI number of the provider ordering the test.

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			5.5.B.1. Authorization Submission (new subsection)	New subsection text reads: The Genetic and Molecular Laboratory Test Authorization Request form (MSA-2081) must be: • Typed – All information must be clearly typed in the designated boxes; and • Thorough – Complete information, including the appropriate Healthcare Common Procedure Coding System (HCPCS) diagnostic testing procedure codes with applicable modifiers, must be provided on the form. Form MSA-2081 and all documentation must include the beneficiary's name and other identifying information (i.e., beneficiary identification [ID number] or date of birth [DOB]). Authorization requests must be submitted electronically to the MDHHS Program Review Division via Direct Data Entry (DDE) utilizing CHAMPS whenever possible. Providers should enter the request directly into the CHAMPS Prior Authorization Request List page. All authorization requests must include form MSA-2081 and supporting clinical documentation. Documents should be electronically uploaded within the Additional Documents section of the CHAMPS authorization request. If the supporting documentation is unable to be uploaded, items may be faxed separately to the MDHHS Program Review Division using the bar-coded fax cover sheet generated by CHAMPS when the fax option is selected. A notation that documentation has been separately faxed should be made in the Procedure Code Comment field of the electronic authorization request. If the correct bar-coded fax cover sheet is not used, faxed documentation may not be associated to the authorization request.

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				Providers unable to submit authorization requests electronically may submit authorization requests via fax or mail to the MDHHS Program Review Division. Providers must include only one authorization request per fax. Providers may check the status of an authorization request on the CHAMPS Prior Authorization Request List page. An electronic copy of the determination letter may also be viewed within CHAMPS. A copy of the letter will be mailed to the provider and beneficiary. The letter must be retained in the beneficiary's medical record.
			5.5.B.2. Beneficiary Eligibility (new subsection)	New subsection text reads: Approval of a laboratory test listed on form MSA-2081 confirms that the service is authorized for the beneficiary. Approval does not guarantee beneficiary eligibility or reimbursement. To ensure payment, the provider must verify the beneficiary's eligibility prior to processing the laboratory specimen.
			5.5.B.3. Billing Authorized Services (new subsection)	New subsection text reads: After an authorization is issued, the information (e.g., authorization number, procedure code, modifier, and quantity) that was approved must match the information submitted on the claim form.
			5.5.B.4. Reimbursement (new subsection)	New subsection text reads: Most laboratory services have established fee screens that are published in the MDHHS Laboratory Fee Schedule. For Not Otherwise Classified (NOC) procedure codes and procedure codes without established fee screens, the approved reimbursement amount is indicated on the authorized MSA-2081.

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			5.5.B.5. Retroactive Authorization (new subsection)	New subsection text reads: Laboratory authorizations must be requested within 30 days of the DOS unless the beneficiary was not eligible on the DOS and a subsequent eligibility determination was made retroactive to the DOS. If the MDHHS eligibility file does not show that retroactive eligibility was approved, requests for authorization received more than 30 days after the DOS will be denied.
		Forms Appendix	MSA-2081 (new form)	Addition of: MSA-2081; Genetic and Molecular Laboratory Test Authorization Request

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