MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Health and Human Services

Bulletin Number: MSA 15-23

Distribution: All Providers

Issued: June 1, 2015

Subject: Updates to the Medicaid Provider Manual; ICD-10 Project Update; Changes to the Michigan Department of Community Health and the Michigan Department of Human Services

Effective: As Indicated

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

Updates to the Medicaid Provider Manual

The Michigan Department of Health and Human Services (MDHHS) has completed the July 2015 update of the online version of the Medicaid Provider Manual. The manual will be available July 1, 2015 at www.michigan.gov/medicaidproviders >> Policy and Forms >> Medicaid Policy Manual.

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

Please refer to the online version of this bulletin at www.michigan.gov/medicaidproviders >> Policy and Forms to view the attachments that describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change.

ICD-10 Project Update

In a final rule issued by the U.S. Department of Health and Human Services on July 31, 2014, the ICD-10 compliance date was changed from October 1, 2014 to October 1, 2015. For clarification, the October 1, 2015 implementation date replaces the previous date(s) provided in Bulletin MSA-13-33 regarding claims processing guidance. The continued use of ICD-9-CM will be required for Health Insurance Portability and Accountability Act (HIPAA) covered entities through September 30, 2015.

MDHHS encourages providers to continue communications with software vendors, billing agents and/or service bureaus to ensure systems and procedures will support the use of ICD-10 code sets on all HIPAA transactions by the compliance date of October 1, 2015. Testing of ICD-10 coded transactions remains available through Business-to-Business (B2B) testing with MDHHS. Instructions for testing ICD-10 coded claim transactions can be accessed on the MDHHS website at www.michigan.gov/5010icd10 >> ICD-10 Information >> Testing.

MDHHS continues to offer scenario-based testing for providers to assign ICD-10 diagnosis codes to outpatient medical scenarios that apply to their practice areas. These coding exercises allow providers to assess whether their current clinical systems and procedures provide for adequate data collection to support accurate ICD-10 coding. Scenario-based testing can be accessed on the MDHHS website at www.michigan.gov/5010icd10 >> ICD-10 Information >> Testing.

Any questions regarding ICD-10 implementation should be directed to MDCH-ICD-10@michigan.gov. Questions regarding B2B testing of ICD-10 coded transactions should be directed to MDCH-B2B-Testing@michigan.gov. Providers should continue to frequently check the MDHHS website at www.michigan.gov/5010icd10 for ICD-10 updates. ICD-10 training availability is posted on the MDHHS website at www.michigan.gov/medicaidproviders >>Hot Topics >> Medicaid Provider Training Sessions.

Changes to the Michigan Department of Community Health and the Michigan Department of Human Services

On February 6, 2015, Governor Rick Snyder signed Executive Order 2015-4 which created the Michigan Department of Health and Human Services (MDHHS) by combining the Department of Community Health (MDCH) and the Department of Human Services (DHS). The order took effect on April 10, 2015. The July 2015 version of the Medicaid Provider Manual has been updated to reflect the new department name.

In the coming months, MDHHS will continue work to update all references to MDCH on department webpages, forms, brochures, letters, and other publications. Providers should continue to use existing MDCH documents while the updates are being completed.

Manual Maintenance

If utilizing the online version of the manual at www.michigan.gov/medicaidproviders >> Policy and Forms, this bulletin and those referenced in this bulletin may be discarded. If using a CD version of the Medicaid Provider Manual, providers should retain all bulletins issued since the version date of the CD. Providers are encouraged to use the Michigan Medicaid Provider Manual on the MDHHS website; the online version of the manual is updated on a quarterly basis.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Michigan Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Stephen Fitton, Director
Medical Services Administration

Michigan Department of Health and Human Services

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Throughout the Manual		Updates were made to reflect the new Michigan Department of Health and Human Services (revised Michigan Department of Community Health, MDCH, DCH, Michigan Department of Human Services, MDHS, DHS, etc.). Forms were modified to reflect the new department name.	Update.
Medicaid Provider Manual Overview	Section 1 – Introduction	The 3rd sentence was deleted.	Removal of obsolete information.
Medicaid Provider Manual Overview	3.1 Quarterly Updates	Text was revised to read: The Medicaid Provider Manual located on the MDHHS website is updated quarterly to reflect information that has been added, deleted or changed via policy bulletins and other communications during the previous quarter. The contact information contained in the Directory Appendix is also updated quarterly. A policy bulletin, detailing the manual changes made each quarter, is sent to all Medicaid enrolled providers and is communicated by e-mail to those subscribed to the Medicaid ListServ. A compact disc (CD) version of the Medicaid Provider Manual is available upon request. (Refer to the Directory Appendix for contact information.)	Update.
Medicaid Provider Manual Overview	3.2 Historic Manuals	The 1st sentence was revised to read: The current version of the manual is maintained on the MDHHS website.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	1.1 Bulletins	Text was revised to read: This manual is the provider's primary source of policy information. Revisions to the manual regarding policy and procedural changes are communicated to the provider via Policy Bulletins. Providers affected by a bulletin should retain it until it is incorporated into the online version of the manual unless instructed otherwise. Bulletins are numbered for the provider's reference. The first two digits of the bulletin number refer to the year. The next two digits refer to the specific sequence number assigned to the bulletin (e.g., 03-04). Bulletins are distributed to affected providers by U.S. mail or e-mail. Providers are expected to maintain current contact information in CHAMPS for timely notification. Bulletins are also posted on the MDHHS website. (Refer to the Directory Appendix for website and contact information.)	Clarification.
General Information for Providers	15.4 Availability of Records	In the 2nd paragraph, the 1st sentence was revised to read: Providers must, upon request from authorized agents of the state or federal government, make available for examination and photocopying all medical records, quality assurance documents, financial records, administrative records, and other documents and records that must be maintained.	This language is being added to further define what 'all records' refers to and was requested by MDHHS OHSIG.
General Information for Providers	15.7 Clinical Records	In the 5th paragraph, in the table "Clinical Documentation Requirements", under the category "Other documentation necessary to process request", an "X" was added to the column for "MIHP".	Update.
General Information for Providers	Section 18 - Review of Proposed Changes	In the 6th paragraph, the 1st sentence was revised to read: Copies of draft bulletins are sent to interested parties via e-mail and are posted on the MDHHS website for a minimum of 30 days.	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans	Addition of benefit plan: **Benefit Plan ID:** APS **Benefit Plan Name:** Ambulatory Prenatal Services **Benefit Plan Description:** This program provides presumptive eligibility for pregnant women limited to ambulatory prenatal care services only. Covered services include physician visits for prenatal care, prescription drugs related to pregnancy, and prenatal laboratory tests. **Type:** Fee-for-service **Funding Source:** XIX **Covered Services (Service Type Codes):** 4, 5, 50, 69, 88, 98, BU	Update.
Beneficiary Eligibility	9.7 Excluded Health Plan Services	The 1st bullet point was revised to read: • Dental custodial services. (Oral-maxillofacial surgeons providing medical services are included in the health plan's capitation rate and should follow health plan authorization rules.) The 2nd bullet point was revised to read: • Nursing facility (NF) custodial services. The health plan is responsible for restorative or rehabilitative care in a nursing facility up to 45 days in a rolling 12-month period. In order for a provider to receive Medicaid reimbursement for nursing care, the nursing facility beds must be Medicaid certified by the SMA and the provider must be enrolled with Medicaid. The SSA is responsible for conducting any required certification surveys for the SMA. If nursing facility services will exceed this coverage, the health plan may initiate the disenrollment process by submitting the Request for Disenrollment Long Term Care form (MSA-2007). The provider may bill Medicaid after the disenrollment is processed.	The incorporation of this information into the Beneficiary Eligibility Chapter will assist Health Plans and facilities in knowing if a facility bed needs to be Medicaid certified for reimbursement purposes.
Ambulance	Throughout the chapter	All references to “nonemergency” or “nonemergent” were revised to read “non-emergency” and “non-emergent”, respectively.	Consistency in terminology.

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CHAPTER	SECTION	CHANGE	COMMENT
Ambulance	1.1 General Information	In the 2nd paragraph, the 1st bullet point was revised to read: • Medical/surgical or psychiatric emergencies exist; or In the 3rd paragraph, the last bullet point was revised to read: • Nonambulance, nonemergency medical transportation arranged by either MDHHS or an MDHHS-contracted transportation broker who reimburses the beneficiary or the transportation provider directly.	Accounting for SE Michigan MDHHS broker contract.
Ambulance	1.2 Common Terms	Under the definition for "Medically Necessary Transport", the 2nd sentence was revised to read: The transport is required to transfer the patient to or from a medically necessary service not available at the primary location.	Clarification.
Ambulance	2.7 Mileage	The 1st paragraph was revised to read: Mileage reimbursement is a Medicaid benefit when: • A transport occurs. • Loaded mileage is billed. • Appropriate origin and destination modifier combinations are utilized. (Refer to the Billing & Reimbursement for Professionals or the Billing & Reimbursement for Institutional Providers chapters of this manual, as appropriate, for a list of origin and destination modifiers.)	Clarification.
Ambulance	2.9 Nonemergency	In the 6th paragraph, the 2nd sentence was revised to read: However, Medicaid beneficiaries or transportation providers may receive reimbursement for this type of transport directly from MDHHS, an MDHHS contracted transportation broker or, if the beneficiary is enrolled, an MHP.	Clarification.
Ambulance	Section 5 – Ambulance Quick Reference Guide	References to "Emergency Room" were revised to read "Emergency Department".	Consistency in wording.

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Children's Special Health Care Services	2.4 Children's Multi-Disciplinary Specialty (CMDS) Clinic Enrollment	Subsection title was revised to read: Children's Multi-Disciplinary Specialty (CMDS) Clinic Requirements	Clarifying what is required for a CMDS clinic
Children's Special Health Care Services	2.4.D. Additional Responsibilities	The following text was added as a 3rd paragraph: CMDS Clinic fees must be billed according to instructions contained in the Billing & Reimbursement for Professionals Chapter of this Manual. CMDS Clinics must bill clinic fees following Uniform Billing (UB) guidelines on the professional CMS-1500 claim format or the electronic Health Care Claim Professional (837) ASC X12N version 5010 information. CHAMPS NPI claim editing will be applied to the billing, rendering, supervising, attending, servicing and referring providers as applicable for payment.	Re-located from 2.4.E. CMDS Clinic Fee Billing Instructions. (2.4.E. was eliminated.)
Children's Special Health Care Services	2.4.E. CMDS Clinic Fee Billing Instructions	Subsection was eliminated. • Text in the 1st paragraph was re-located to 2.4.D. Additional Responsibilities. • Code information in the 2nd paragraph is now available on the MDHHS website so that information can be revised as visit type, codes and fees change.	Update.
Dental	2.3 CHAMPS Website	The following text was added at the beginning of the 1st paragraph: Information on specific coverage and reimbursement policies can be accessed using the Medicaid Code and Rate Reference tool in CHAMPS.	Updated information for providers on external links in CHAMPS.
Dental	2.4 Approved Prior Authorization Requests	The 6th paragraph was revised to read: If a change in the treatment plan is necessary, dentists should submit a new MSA-1680-B with appropriate images and information to the Dental Prior Authorization Unit.	Updated language to include all current methods.

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Dental	Section 3 - Copayment	Section text was revised to read: A copayment of $3 for each separately reimbursable Medicaid visit may be required for beneficiaries age 21 years and older with the following limitations: • When more than one reimbursable service is provided during a visit, only one $3 copayment may be charged. • Where several visits are required to complete a service (such as dentures), only one $3 copayment may be charged. • Beneficiaries cannot be charged a copayment for procedures that are considered part of normal office operations. A provider cannot refuse to render service if the beneficiary is unable to pay the required copayment on the date of service. Some beneficiaries, programs, and places of service are exempt from co-payment requirements. (Refer to the General Information for Providers Chapter for information on exceptions to Medicaid copayment requirements.)	Rewording for clarification.
Dental	6.7.C. Alveoloplasty	Subsection text was revised to read: Alveoloplasty is a covered benefit for all beneficiaries. Alveoloplasty performed in conjunction with extractions is a separate procedure performed at the time of the extractions in the surgical preparation of the ridge for complete or partial dentures. Alveoloplasty in an edentulous area not performed in conjunction with extractions (secondary alveoloplasty) is not covered if recent extractions have been performed in that quadrant.	Rewording for clarification.
Dental	9.1 Coverage and Service Area Information	In the 1st paragraph, the 1st sentence was revised to read: MDHHS contracts for the administration of the Medicaid dental benefit called ***Healthy Kids Dental*** in 80 counties.	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Family Planning Clinics	4.3 Reimbursement Policy for Sterilization	In the 3rd paragraph, the last sentence was removed.	Update. Reimbursement is provided for female sterilization when performed in a Family Planning Clinic (e.g., Essure procedure).
Hospice	3.1 Beneficiary Enrollment Determination	In the 2nd paragraph, the 3rd bullet point was revised to read: • If the beneficiary is currently enrolled in a Medicaid Health Plan (MHP), the hospice services must be arranged and reimbursed by the MHP.	Clarification. Medicaid does cover hospice when a beneficiary is in a MHP.
Hospice	6.9.D. MI Health Link (new subsection)	New subsection text reads: Beneficiaries enrolled in MI Health Link are dually eligible for both Medicare and Medicaid. While hospice is not a benefit offered by MI Health Link, beneficiaries in the program may still elect hospice and begin receiving hospice services at any time. When a beneficiary who is enrolled in MI Health Link elects hospice, the hospice agency will submit a Hospice Membership Notice (DCH-1074) to the MDHHS Enrollment Services Section. However, the hospice must indicate within the DCH-1074 remarks section the last date of the beneficiary's participation in MI Health Link (the last day of the month) and the start date of FFS Medicaid (the first day of the following month). The level of care (LOC) 16 will be placed on the beneficiary's file on the first day of the following month; however, a beneficiary does not need to wait until they are disenrolled from MI Health Link to receive hospice services. Hospice services may begin at the time of hospice election and will be reimbursed based on the beneficiary's location. Medicare will pay for hospice services in the home setting between the time that a MI Health Link beneficiary elects hospice services and the time they are disenrolled from MI Health Link. If a MI Health Link beneficiary resides in a nursing facility when hospice is elected, Medicare will pay for hospice services and the MI Health Link health plan will continue to pay for the nursing facility stay until disenrollment from MI Health Link has occurred.	Per provider letter L 15-15.
Hospital	1.4 Copayments	In the 2nd paragraph, the 2nd bullet point was revised to read: • $1 for an outpatient hospital clinic visit	Correction.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital	3.1 Abortions	Subsection text was revised to read: Medicaid only covers an abortion performed by a physician and related hospital charges (e.g., room, supplies) when it has been determined medically necessary to save the life of the mother or the pregnancy is the result of rape or incest. Medicaid funding is not available for any elective therapeutic abortion or service related to the performance of such abortion unless one of these criteria has been met. Physicians must certify on a completed Certification for Induced Abortion form (MSA-4240) that, for medical reasons, an abortion was necessary to save the life of the mother or the beneficiary's medical history indicates that the terminated pregnancy was the result of rape or incest. The physician who completes the MSA-4240 must also ensure completion of the Beneficiary Verification of Coverage form (MSA-1550) and is responsible for providing copies of the forms for billing purposes to any other provider (e.g., anesthesiologist, hospital, laboratory) that would submit claims for services related to the abortion. Copies of the MSA-4240 and the MSA-1550 are not required for claims for ectopic pregnancies or spontaneous, incomplete, or threatened abortions. Providers may attach copies of the MSA-4240 and the MSA-1550 to the claim or submit them via fax. Federal regulations require that these forms be submitted to Medicaid before reimbursement can be made for any abortion procedure. The medical record must include a complete beneficiary history, including the medical condition that made the abortion necessary to save the life of the mother. When the pregnancy is the result of rape or incest, the medical record must include the circumstances of the case and that the pregnancy was the result of rape or incest.	Revised to align with Practitioner Chapter.

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		(Refer to the Forms Appendix for copies of MSA-4240 and MSA-1550. The forms are also available on the MDHHS website. Refer to the Directory Appendix for website and contact information.)	
Hospital	3.5 Apheresis	Bullet points in the 1st paragraph were revised to read: • Plasma exchange for acquired myasthenia gravis; • Leukapheresis in the treatment of leukemia; • Plasmapheresis in the treatment of primary macro-globulinemia (Waldenstrom); • Treatment of hyperglobulinemia, including (but not limited to) multiple myelomas, cryoglobulinemia, and hyperviscosity syndromes; • Plasmapheresis or plasma exchange in the last resort treatment of thrombotic thrombocytopenic purpura (TTP); • Plasmapheresis or plasma exchange in the last resort treatment of life-threatening rheumatoid vasculitis; • Plasma perfusion of charcoal filters for treatment of pruritus of cholestatic liver disease; • Plasma exchange in the treatment of life-threatening forms of Goodpasture's Syndrome; • Plasma exchange in the treatment of glomerulonephritis associated with antiglomerular basement membrane antibodies and advancing renal failure or pulmonary hemorrhage; • Treatment of chronic relapsing polyneuropathy for beneficiaries with severe or life-threatening symptoms who have failed to respond to conventional therapy; • Treatment of life-threatening scleroderma and polymyositis when the beneficiary is unresponsive to conventional therapy; • Treatment of Guillain-Barre Syndrome; and • Treatment of life-threatening Systemic Lupus Erythematosus (SLE) when conventional therapy has failed to prevent clinical deterioration.	Revised to align as closely as possible with Medicare's coverage and guidelines following OMA review.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital	3.6 Apnea Monitors	The 1st paragraph was deleted.	Removal of obsolete information.
Hospital Reimbursement Appendix	7.3.D. Outpatient Uncompensated Care DSH Pool	In the 5th paragraph, the 2nd sentence was revised to read: Specifically, data reported on Worksheet S-3, Part 1, Column 2, Line 14 (or comparable lines from succeeding cost reports) will be assessed to determine the number of total hospital beds.	The Cost Report Worksheet was updated to a new version, and the line reference for this data changed.
Maternal Infant Health Program	Section 2 - Program Components	Section text was revised to read: The assessment visit is the initial visit with the beneficiary. The appropriate Risk Identifier is a mandatory part of the initial assessment visit. It should be billed and paid using the appropriate place of service code. Rarely on the same day as the initial visit will a problem need to be addressed immediately. In these cases, a professional visit can be made later the same day by a different professional discipline. This professional visit must last at least 30 minutes. If the Risk Identifier indicates a need for MIHP services, an appropriate POC must be developed that clearly outlines the beneficiary's problems/needs, objectives/outcomes, and the intervention(s) to address the problem(s). The Risk Identifier and POC must be completed and entered into the MIHP database before professional visits are initiated. If the Risk Identifier does not indicate the need for MIHP services, then the POC is not developed and the Discharge Summary is completed accordingly. No follow-up services should be provided; however, the beneficiary is to receive the informational packet. (Refer to the Maternal Infant Health Program Operations Guide for additional information.)	Update and clarification. • If no risks are identified, the initial visit does not require the POC to be completed. • Information must be entered into the database. • It was determined with MIHP staff that the POC is not to be developed if no risks are identified.
Maternal Infant Health Program	2.2 Infant Risk Identifier	In the 2nd paragraph, the 1st sentence was revised to read: The Infant Risk Identifier must be entered into the MIHP database.	Clarification. The Infant Risk Identifier must be entered into the database.

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CHAPTER	SECTION	CHANGE	COMMENT
Maternal Infant Health Program	2.7 Professional Visits	The 5th paragraph was revised to read: Family planning options must be discussed throughout the course of care, giving the woman time to consider her options.	Clarification. Aligns with wording in 2.14 Immunizations. Immunization status must be discussed throughout the course of care.
Maternal Infant Health Program	5.3 Operations and Certification Requirements	The 5th bullet point was revised to read. • Complete the Risk Identifier based on a home visit as required for the infant and, if possible, for the pregnant woman. The 24th bullet point was revised to read: • Be actively linked to or a member of the Great Start Collaborative. When providing infant services, in addition to the Great Start Collaborative, providers must also be actively linked to or be a member of the local Part C/Early On Interagency Coordinating Council.	Update and clarification. • The plan of care is not required when no risks are identified. • Providers caring for pregnant women (and NOT infants) only need to be linked to, or a member of, the Great Start Collaborative Council. Those providing services to infants must be a member of the Great Start Council as well as Early On.
Medical Supplier	Section 1 - Program Overview	In the 7th paragraph, under "Durable Medical Equipment (DME)", the 1st sentence was revised to read: DME are those items that are registered with the Food and Drug Administration (FDA), can stand repeated use, are ...	Clarification.
Medical Supplier	2.3 Blood Glucose Monitoring Equipment and Supplies	Under "Standards of Coverage", 3rd paragraph, the 2nd sentence was revised to read: Refer to the Medicaid Code and Rate Reference tool in CHAMPS for quantity and frequency information.	Clarification.
Medical Supplier	2.25 Orthotics (Cervical)	Under "Standards of Coverage", under "Cervical helmets", the 2nd bullet point was revised to read: • The use of a FDA registered helmet.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Medical Supplier	2.47 Wearable Cardioverter-Defibrillators	Under "PA Requirements", 1st paragraph, the 1st sentence was revised to read: Food and Drug Administration (FDA)-registered WCDs are covered under the Medicaid and CSHCS programs with prior authorization (PA).	Clarification.
Mental Health/ Substance Abuse	2.3 Location of Service	The 5th paragraph was revised to read: Medicaid does not cover services delivered in Institutions of Mental Disease (IMD) for individuals between ages 22 and 64, as specified in §1905(a)(B) of the Social Security Act. 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 case needs to be open to the CMHSP/PIHP) may be provided within the designated timeframes: • Assessment of a child's needs for the purpose of determining the community based services necessary to transition the child out of a CCI or Hawthorn Center. This should occur up to 60 days prior to the anticipated discharge from a CCI or Hawthorn Center. • Wraparound planning or case management. This should occur up to 60 days prior to discharge from a CCI or Hawthorn Center.	The statutory references for this decision are the Supplemental Appropriations Act, 2008, Pub. L. 110-252, which was signed into law on June 30, 2008 and a July 25, 2000 State Medicaid Director letter which summarizes CMS policy clarifications designed to support State efforts to transition individuals from institutions and expand availability of home and community-based services. In summary, Wraparound, which is the equivalent of targeted case management, can be provided for a child transitioning out of Hawthorn Center to the community for a period of 60 days prior to discharge.
Mental Health/ Substance Abuse	17.3.E. Family Support and Training	In the 4th paragraph, the 5th (last) bullet point was deleted.	Information was relocated to a new subsection: 17.3.G.3. Youth Peer Support Services.

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CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	17.3.G.3. Youth Peer Support Services (new subsection)	New subsection text reads: Youth Peer Support is designed to support youth with a serious emotional disturbance through shared activities and interventions. The goals of Youth Peer Support include supporting youth empowerment, assisting youth in developing skills to improve their overall functioning and quality of life, and working collaboratively with others involved in delivering the youth's care. Youth Peer Support services can be in the form of direct support, information sharing and skill building. Youth Peer Support Services are provided by trained youth peer support specialists, one-on-one or in a group, for youth with serious emotional disturbance who are resolving conflicts, enhancing skills to improve their overall functioning, integrating with community, school and family and/or transitioning into adulthood. Services provide support and assistance for youth in accordance with the goals in their plan of service to assist the youth with community integration, improving family relationships and resolving conflicts, and making a transition to adulthood, including achieving successful independent living options, obtaining employment, and navigating the public human services system. Youth Peer Support Specialists must have lived experience navigating behavioral health systems and must participate in and complete the approved MDHHS training curriculum. Youth Peer Support activities are identified as part of the assessment and the person-centered/family-driven, youth-guided planning process. The goals of Youth Peer Support services shall be included in the individualized plan of service where interventions are provided in the home and community. These goals will be mutually identified in active collaboration with the youth receiving services and must be delivered by a Youth Peer Support Specialist with lived experience. The Youth Peer Support Specialist shall receive regular supervision by a child mental health professional and shall participate as an active member of the treatment team.	New subsection allows for separation of information and ease in finding specific information.

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		Qualifications for the Youth Peer Support Specialist include: • Young adult, ages 18 through 26, with lived experience who received mental health services as a youth. • Willing and able to self-identify as a person who has or is receiving behavioral health services and is prepared to use that experience in helping others. • Experience receiving services as a youth in complex, child serving systems preferred (behavioral health, child welfare, juvenile justice, special education, etc.). • Employed by PIHP/CMHSP or its contract providers. • Trained in the MDHHS approved curriculum and ongoing training model.	
Nursing Facility Coverages	9.1 Medicare-Covered Services	In the 6th paragraph, the 2nd sentence was removed.	Conflicting information.
Nursing Facility Certification, Survey & Enforcement Appendix	2.3 Criteria for Evaluation of Medicaid Bed Certification Requests	In the 1st paragraph, 2nd bullet point, the 11th sub-bullet point was revised to read: ➢ An outstanding debt to MDHHS (i.e., cost settlement, civil money penalty [CMP] fine, provider Quality Assurance Assessment Program (QAAP) tax, licensing fees). This does not include financial issues that are in the appeal process. NOTE: When a provider sells a nursing facility, the provider is responsible for all QAAP assessments billed and incurred prior to the date of the sale. The purchaser(s) must assure escrow of any outstanding QAAP amounts owed, or the purchaser(s) becomes responsible for payment of the QAAP and penalty amounts owed before Medicaid participation is granted.	Clarification.
Nursing Facility Cost Reporting & Reimbursement Appendix	8.28 Taxes and Fees	In the 1st paragraph, the 2nd sentence was revised to read: The Michigan Business Tax and the Michigan Corporate Income Tax are allowable variable support costs.	The Michigan Corporate Income Tax replaced the Michigan Business Tax for many businesses in 2012; this change is to clarify that the Corporate Income Tax is an allowable cost.

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Practitioner	4.1 Apheresis, Therapeutic	Bullet points in the 1st paragraph were revised to read: • Plasma exchange for acquired myasthenia gravis; • Leukapheresis in the treatment of leukemia; • Plasmapheresis in the treatment of primary macro-globulinemia (Waldenstrom); • Treatment of hyperglobulinemia, including (but not limited to) multiple myelomas, cryoglobulinemia, and hyperviscosity syndromes; • Plasmapheresis or plasma exchange in the last resort treatment of thrombotic thrombocytopenic purpura (TTP); • Plasmapheresis or plasma exchange in the last resort treatment of life-threatening rheumatoid vasculitis; • Plasma perfusion of charcoal filters for treatment of pruritus of cholestatic liver disease; • Plasma exchange in the treatment of life-threatening forms of Goodpasture's Syndrome; • Plasma exchange in the treatment of glomerulonephritis associated with antiglomerular basement membrane antibodies and advancing renal failure or pulmonary hemorrhage; • Treatment of chronic relapsing polyneuropathy for beneficiaries with severe or life-threatening symptoms who have failed to respond to conventional therapy; • Treatment of life-threatening scleroderma and polymyositis when the beneficiary is unresponsive to conventional therapy; • Treatment of Guillain-Barre Syndrome; and • Treatment of life-threatening Systemic Lupus Erythematosus (SLE) when conventional therapy has failed to prevent clinical deterioration.	Revised to align as closely as possible with Medicare's coverage and guidelines following OMA review.
Vision	1.2 Prior Authorization	In the 1st paragraph, the 2nd sentence was removed.	Removal of obsolete information.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Vision	1.3 Coding of Services	In the 1st paragraph, the 2nd and 3rd sentences were revised to read: Vision providers must use CPT codes in effect on the date of service to describe and identify the services and procedures performed. Optometrists must be Therapeutic Pharmaceutical Agent certified in order to use many of these codes.	Clarification.
Vision	1.4 Medicare	The 2nd paragraph was revised to read: If a service requires PA by Medicaid and is covered by Medicare, vision providers do not have to obtain PA, nor does the vision provider have to obtain lenses or frames through the volume purchase program.	Clarification.
Vision	3.1 Diagnostic Services	In the 1st paragraph, the 1st sentence was revised to read: In providing services, it is the responsibility of the optometrist or ophthalmologist to determine that the services are medically necessary, appropriate, and within the scope of current medical practice and Medicaid limitations. In the 2nd paragraph, under "Eye Examinations", the 2nd bullet point was revised to read: • Nonroutine eye examinations are a Medicaid benefit for the purpose of evaluation and treatment of chronic, acute, or sudden onset of abnormal ocular conditions. (Use appropriate CPT/HCPCS procedure codes.)	Clarification.
Vision	3.6.B.2. Fitting	The 1st bullet point was revised to read: • determination of appropriate initial contact lens parameters based on clinical observation, and measurements of the eye with or without a trial (sample) contact lens.	Clarification.

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

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CHAPTER	SECTION	CHANGE	COMMENT
Vision	3.7 Strabismus and/or Amblyopia Examination	The subsection title was revised to read: Strabismus and Amblyopia Examination Text was revised to read: Strabismus and amblyopia examinations (sensorimotor examination) are Medicaid benefits and do not require PA.	Clarification.
Vision	3.8 Orthoptics and/or Pleoptics Training	The subsection title was revised to read: Orthoptics and Pleoptics Training	Clarification.
Forms Appendix	DCH-1074; Hospice Membership Notice	Update of form.	Per Letter L 15-20.

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Medicaid Provider Manual
July 2015 Updates

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MSA 15-04	3/2/2015	Dental	Section 4—Place of Service	The 1st sentence was revised to read: All dental services must be performed in the dental office, public health department dental clinic, dental school, dental hygiene program, or Federally Qualified Health Centers (FQHCs).
			4.1.D. Mobile Dental Facilities (new subsection; following subsection re-numbered)	New subsection text reads: A mobile dental facility is defined as a self-contained, intact facility in which dentistry or dental hygiene is practiced that may be transported from one location to another, or a site used on a temporary basis to provide dental services using portable equipment. A mobile dental permit must be obtained by an operator before providing dental services. Requirements include: • Completion of the permit application; • Submission of the required documents; • Submission of the administrative fee; and • Memorandum of agreement for follow-up services. Mobile dental operators can access the Mobile Dental Facility Application and additional information and requirements on the MDHHS website. (Refer to the Directory Appendix for website information.) To provide dental services and bill Medicaid, a provider must be enrolled in the Community Health Automated Medicaid Processing System (CHAMPS). Instructions for provider enrollment, as well as updating enrollment, can be found on the MDHHS website. (Refer to the Directory Appendix for website information.) Enrollment as a mobile dental provider is required within 30 days of approval of the Mobile Dental Facility Permit. Groups may select more than one specialty. Dental Hygienists operating in mobile facilities will need to enroll as a mobile provider.

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			4.1.E. Other Sites (re-numbered)	In the 1st paragraph, the 1st sentence was revised to read: All other sites must be prior approved. The 2nd paragraph was deleted.
		Directory Appendix	Provider Resources	Addition of: Contact/Topic: MDHHS Mobile Dentistry Web Address: www.michigan.gov/oralhealth >> Mobile Dentistry Information Available/Purpose: Mobile Dental Facility Application
MSA 14-42	10/1/2014	Nursing Facility Cost Reporting & Reimbursement Appendix	10.13.A. Eligibility Criteria	The 4th bullet point was revised to read: ▪ The nursing facility provider must also meet at least one of the following six criteria: And a 6th sub-bullet point was added: ➢ The provider's current Variable Rate Base is less than or equal to 60 percent of the corresponding rate year's Variable Cost Limit. A facility is not eligible under this criterion if an owner's or administrator's compensation is above the current compensation limit. A provider with non-allowable related party transaction costs or non-allowable related party lease costs is not eligible under this criterion.
			10.13.I. Rate Relief for a Current Provider in a Medicaid Enrolled Nursing Facility with a Variable Rate Base Less Than or Equal to 60 Percent of the Variable Cost Limit (new subsection)	New subsection text reads: A current provider in a Medicaid enrolled nursing facility with a Variable Rate Base of less than or equal to 60 percent may request rate relief.

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			10.13.I.1. Rate Relief Methodology (new subsection)	New subsection text reads: A new Variable Rate Base of the rate is calculated that will be no more than 50 percent of the difference between the Class I Average Variable Cost and the existing Variable Rate Base for the current rate year. The resulting new Variable Cost Component will thereby adjust the facility's per diem rate. This Variable Rate Base will remain in effect through the current State fiscal year rate period ending September 30. **Example:** A nursing facility has a current Variable Rate Base of $96, the Variable Cost Limit is $160, and the Class I Average Variable Cost is $150 (none of the figures are based on actual data, they are used for example purposes). Based on the facility's request for rate relief, they are found eligible for the maximum 50 percent of the difference between their current Variable Rate Base and the Average Variable Cost. Their Variable Rate Base will then increase from $96 to $123. The provider receiving rate relief in this category must utilize the standardized data to file a Class I Rate Relief Interim Cost Statement at the time of application for relief. The Interim Cost Statement excerpted worksheets from the Medicaid annual cost report (Medicaid cost reporting formats identified below) must reflect actual or expected costs incurred by the nursing facility for the provider's cost reporting period. A facility with less than seven months remaining in its cost reporting period may file a second Interim Cost Statement at the end of that fiscal year. The Rate Relief Interim Cost Statement must contain the following completed schedules of the cost report in the MDHHS required electronic format: • Checklist • Worksheet A • Worksheet B • Worksheet 1 • Worksheet 1-C (only if claiming allocated related party costs) • Worksheet 2

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				The Interim Cost Statement is used to determine the interim rate for the remainder of the rate period. The interim rate is revised when the acceptable annual cost report is submitted and used for accelerated rebasing. Effective October 1 of the following State fiscal year rate period, MDHHS determines the Variable Rate Base using accelerated rebasing. The accelerated rebasing utilizes the provider's first cost reporting period that reflects at least seven months of nursing facility operation after rate relief. The cost reporting time period is based on the provider's established fiscal year. The nursing facility allowable variable cost is indexed to October 1 of the year that is one year prior to the new rate year being calculated by applying the appropriate cost index. The subsequent rate year calculation is in accordance with standard reimbursement methodology. **Example 1 - Request Received with Less Than Seven Months in the Cost Reporting Period:** A provider has a cost reporting period ending on December 31 of each year. The provider is approved for rate relief for rate year October 1, 2014 to September 30, 2015. The facility per diem rate is set using a new Variable Rate Base of no more than 50 percent of the difference between the Variable Rate Base and Class I Average Variable Costs effective for the rate year beginning October 1, 2014. The provider must complete an Interim Cost Statement for variable costs for their cost report period that must be filed with their rate relief request. In this instance, they may submit a revised Interim Cost Statement for the provider's cost reporting period January 1, 2015 through December 31, 2015. The rate year beginning October 1, 2015 would then utilize the accelerated rebasing to determine the rate for that period based on the December 31, 2015 fiscal year. **Example 2 - Request Received with Seven Months or More in the Cost Reporting Period:** A provider has a cost reporting period ending December 31 of each year. The provider is approved for rate relief and submits their Interim Cost Statement ending on February 1, 2014. The facility per diem rate is set using a new Variable Rate Base of no more than 50 percent of the difference between the Class I Average Variable Cost and the Variable Base Cost effective for the rate period February

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				1, 2014 through September 30, 2014. The rate relief would be effective through the end of the rate relief period of September 30, 2014. The rate year beginning October 1, 2014 would then utilize the accelerated rebasing to determine the rate for that period based on the December 31, 2014 fiscal year. Rate relief is subject to audit and settlement, with reimbursement adjustment using the principles and guidelines outlined in Medicaid policy. Rate relief reimbursement cannot exceed the appropriate cost and rate limitations. The provider is reimbursed by Medicaid for any underpayment, and the provider must reimburse Medicaid for any overpayment. If the interim Variable Rate Base determined for rate relief reimbursement to the provider exceeds the audited Variable Rate Base reimbursement by more than three percent, the provider will be assessed a penalty equal to 10 percent of the total overpayment amount. A nursing facility provider receiving rate relief is allowed to participate in any other add-on reimbursement programs at their election. These programs are defined under the Medicaid policy applicable to the program. The costs associated with these add-on programs are not included in the cost settlement of the variable costs for rate relief as previously described.
			10.13.I.2. Rate Relief Documentation (new subsection)	New subsection text reads: It is the provider's responsibility to submit supporting documentation with the rate relief petition. A petition from the provider must include: • Identification of the criteria under which rate relief is requested. • Supporting documentation for the criteria. • Detail of the circumstances causing the need for the rate relief request. • A requested effective date (the actual effective date of the rate relief is based on the date that the petition is received by Medicaid). The earliest effective date would be the first day of the next month (i.e., a petition received on August 31 may be effective as soon as September 1). • The services time period that is the basis for which rate relief is requested.

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				• Detail of the expenses that are not in the base period for the current or subsequent fiscal year Medicaid rate and how these expenditures relate to the provision of resident care. • Plans on how these changes will ensure the required level of resident care.

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