Michigan Medicaid Policy | MMP

BULLETIN

BEHAVIORAL AND PHYSICAL HEALTH AND AGING SERVICES ADMINISTRATION

MDHHS

Bulletin Number: MMP 22-45

Distribution: All Providers

Issued: December 1, 2022

Subject: Updates to the Medicaid Provider Manual

Effective: January 1, 2023

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 January 2023 quarterly update of the MDHHS Medicaid Provider Manual. The Manual is maintained on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Medicaid Provider Manual. A compact disc (CD) version of the manual is available to enrolled providers upon request.

The January 2023 version of the manual does not highlight changes made in 2022. Refer to the online version of this bulletin at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms to view the attachments that describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change. Subsequent changes made for the April, July, and October 2023 versions of the manual will be highlighted within the text of the on-line manual.

Manual Maintenance

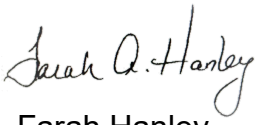
If utilizing the online version of the manual at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms, this bulletin and those referenced in this bulletin may be discarded. If using a CD version of the manual, providers should retain all bulletins issued since the version date of the CD. Providers 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 a question, 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.

An electronic copy of this document is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Approved



Farah Hanley
Chief Deputy Director for Health

Medicaid Provider Manual
January 2023 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	15.1 Waiver Supports and Services	Under **"Supported Employment"**, the 2nd paragraph was revised to read: Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training, job coach, employment specialist services (such as career planning/discovery, job development/placement and financial/benefit planning), personal assistance, ~~and~~ consumer-run businesses and self-employment. Supported employment services cannot be used for capital investment in a consumer-run business. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting or for any services that are the responsibility of another agency, such as Michigan Rehabilitation Services (MRS) or the Bureau of Services for Blind Persons (BSBP).	Adding examples to help providers understand how this service lines up with the codes and modifiers.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	17.3.M. 1915(c) Children's Serious Emotional Disturbance Home and Community-Based Services Waiver (SEDW)	The 6th bullet point was removed. • ~~Completion of the Michigan Wraparound Fidelity Index at six months and upon graduation.~~	Removal of obsolete information.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix	Section 2 – Covered Waiver Services	The 1st paragraph was revised to read: Each child must have a comprehensive IPOS that specifies the services and supports that the child and his family will receive. The IPOS is to be developed through the Wraparound Planning Process. Each child must have a Wraparound Facilitator who is responsible to assist the child/family in identifying, planning and organizing the Child and Family Team, developing the IPOS, and coordinating services and supports. The Wraparound Facilitator is responsible for monitoring supports and service delivery, as well as the health and safety of the child, as part of their regular contact with the child and family, ~~with oversight by the Community Team~~.	Removing as community teams are not to provide any oversight.
Behavioral Health and Intellectual and Developmental Disability Supports and Services Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix	2.9 Wraparound Services	All current text was removed and replaced with the following text: Refer to the Covered Services section, Wraparound Services for Children and Adolescents subsection in the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter for additional information regarding Wraparound program expectations.	Update.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix	4.2 Wraparound Facilitator	All current text was removed and replaced with the following text: Refer to the Covered Services section, Qualified Staff subsection in the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter for additional information regarding Wraparound program expectations.	Update.
Non-Emergency Medical Transportation	Section 1 – Introduction	The last paragraph was revised to read: Forms referenced in this chapter are accessed via the beneficiary's case worker and are maintained on MI Bridges. ~~The Medical Transportation Statement (MSA-4674) is also available on the Michigan Department of Health and Human Services (MDHHS) website. (Refer to the Directory Appendix for website information.)~~	Correction.
Nursing Facility Cost Reporting & Reimbursement Appendix	9.15 Quality Measure Initiative (QMI) Special Cost Reporting Requirements	The 3rd paragraph was revised to read: The QAAP tax assessed is adjusted from the cost report in accordance with the Quality Assurance Assessment Tax subsection of the Allowable and Non-Allowable Costs section of this Appendix. An adjustment is also made to the cost report to remove the Net QMI Amount. The QMI adjustment may not exceed zero (i.e., the adjustment is either a negative amount or zero), and the adjustment amount is made to "Miscellaneous – Base" in the Medicaid Routine Care Unit #1 and Medicaid Routine Care Unit #2 cost center of the cost report.	This change will align with the additional line on the NF cost report that is currently being included in the QMI calculations

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	10.7.D.3. QMI Payment Methodology	The 1st paragraph was revised to read: The Medicaid utilization rate will be determined from the immediate prior year-end cost report covering a period of at least seven months (e.g., 2016 year-end cost reports will set the utilization rate for the fiscal year beginning October 1, 2017). For the purposes of this section, a cost report refers to the uniform Medicaid nursing facility cost report or a less than complete cost report. The sum of the total Title XIX patient days in the Medicaid Routine Care Unit #1, Medicaid Routine Care Unit #2, and the Medicaid Special Care Unit #1 over the sum of the total inpatient days in all nursing facility units on the cost report will set the utilization rate (e.g., if the sum of the Title XIX inpatient days in the Medicaid Routine Care Unit #1, Medicaid Routine Care Unit #2, and the Medicaid Special Care Unit #1 is 1,000, while the sum of total inpatient days in all units is 1,500, the Medicaid utilization rate would be 66.7%). If the immediate prior year-end cost report does not cover a period of at least seven months, then the Medicaid utilization rate will be determined as follows.	This change will align with the additional line on the NF cost report that is currently being included in the QMI calculations.
Vision	3.4.A. Lenses	In the table, text for **"Polycarbonate Lenses"** was revised to read: For beneficiaries under age 21 ~~and over~~, polycarbonate lenses ~~are a Medicaid benefit when diopter criteria is met and the lenses are inserted into a safety frame marked "Z 87" or "Z 87-2". For beneficiaries under age 21, polycarbonate lenses~~ may be inserted into any covered Medicaid frame and do not require PA. For beneficiaries 21 and over, polycarbonate lenses are a Medicaid benefit when lenses are inserted into a safety frame marked "Z 87" or "Z 87-2" or if prior authorized. The last paragraph was revised to read: Oversized lenses, no-line~~,~~ or progressive style multi-focals~~, or transitions~~ are not Medicaid benefits.	Clarification of policy.

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CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Appeals	Under "**Appeals/Administrative Hearings (Provider)**", website paths were revised to read: http://www.michigan.gov/lara >> ~~Bureau List~~ Bureaus >> Michigan Office of Administrative Hearings and Rules >> Administrative Rules >> Publications >> Michigan Administrative Code: A compilation of all adopted rules and regulations that are in effect in the State of Michigan >> Select Department: Health and Human Services >> Bureau: Behavioral and Physical Health and Aging Services Administration >> ~~BPHASA~~ MSA Provider Hearings http://www.michigan.gov/lara >> ~~Bureau List~~ Bureaus >> Michigan Office of Administrative Hearings and Rules >> Benefit Services Hearings >> MDHHS Medicaid Provider and Women, Infants and Children Vendor (WIC) Under "**Appeals/Administrative Hearings/Informal Conferences (Provider)**", website paths were revised to read: http://www.michigan.gov/lara >> ~~Bureau List~~ Bureaus >> Michigan Office of Administrative Hearings and Rules >> Administrative Rules >> Publications >> Michigan Administrative Code: A compilation of all adopted rules and regulations that are in effect in the State of Michigan >> Select Department: Health and Human Services >> Bureau: Behavioral and Physical Health and Aging Services Administration >> ~~BPHASA~~ MSA Provider Hearings http://www.michigan.gov/lara >> ~~Bureau List~~ Bureaus >> Michigan Office of Administrative Hearings and Rules >> Benefit Services Hearings >> MDHHS Medicaid Provider and Women, Infants and Children Vendor (WIC)	Update.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
	Nursing Facility Resources	Under "Nurse Aide Trainers and Training Programs", the website path was revised to read: www.michigan.gov/lara >> ~~Bureau List~~ Bureaus >> Community and Health Systems >> Nurse Aide Training Program & Trainers	Update.

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Michigan Department of Health and Human Services

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
HASA 22-08	4/1/2022	Billing & Reimbursement for Professionals	6.16 Maternity Care Services	Under "**Outpatient Lactation Support Provided by an Internationally Board Certified Lactation Consultant (IBCLC)**", the 2nd paragraph was revised to read: Medicaid will reimburse for evidence-based lactation support services provided up to and through ~~60 days~~ 12 months post-delivery. A maximum of two visits per pregnancy will be reimbursed for either a single or multiple gestation pregnancy. One visit is reimbursable per date of service. Medicaid will reimburse for the first eligible claims submitted for these services.
		Maternal Infant Health Program	2.13 Lactation Support and Counseling Services	The 1st paragraph was revised to read: Medicaid will reimburse for evidence-based lactation support services provided to post-partum women in the outpatient setting up to and through ~~60 days~~ 12 months post-delivery when services are provided by a qualified licensed MIHP registered nurse or licensed social worker in possession of a valid and current IBCLC certification. A maximum of two visits per pregnancy will be reimbursed for either a single or multiple gestation pregnancy. One visit is reimbursable per date of service.
		Practitioner	7.9 Lactation Support Services	Text was revised to read: Medicaid will reimburse for evidence-based lactation support services provided to Medicaid eligible postpartum women in the outpatient setting up to and through ~~60 days~~ 12 months post-delivery. Services must be rendered by a licensed, qualified health professional as outlined. A maximum of two visits per pregnancy will be reimbursed for either a single or multiple gestation pregnancy. One visit is reimbursable per date of service.
MMP 22-24	8/31/2022	Medicaid Provider Manual Overview	1.1 Organization	In the table, under the Dental chapter, **"Affected Providers"** was revised to read: ~~Dentists~~ Dental Providers/Dental Clinics

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Billing & Reimbursement for Dental Providers	Throughout the chapter	References to "dentist" were revised to read "dental provider" to reflect inclusion of dental therapists.
		Billing & Reimbursement for Dental Providers	3.3.B Rendering Provider	Text was revised to read: The rendering provider loop or field must be completed within the professional/dental claim formats only when the provider is enrolled with MDHHS. For an organization (such as clinics and group practices), the rendering provider will be required. If MDHHS does not recognize the rendering provider's NPI, services rendered by these providers (e.g., dental therapist, dental hygienists) must be billed under the supervising dentist's NPI. The supervising dentist is responsible for ensuring the medical necessity and appropriateness of the services.
		Dental	Throughout the chapter	References to "dentist" were revised to read "dental provider" to reflect inclusion of dental therapists.
		Federally Qualified Health Centers	3.1 Definition	The 3rd paragraph was revised to read: An encounter occurs between a dentist, ~~or~~ dental hygienist, or dental therapist and a patient when services are for the purpose of prevention, assessment, or treatment of a dental problem, including restoration. A dental hygienist and dental therapist ~~is~~ are credited with an encounter only when the professional provides a service independently, not jointly with a dentist. However, two encounters may not be billed for the dental clinic in one day.

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		Rural Health Clinics	4.1 Definition	The 4th paragraph was revised to read: Encounters include provision of service by the following professionals: • Licensed physicians (MD, DO), dentists, optometrists, podiatrists, chiropractors, CNPs (who have a collaborative agreement with a physician), CNMs, physician assistants, ~~or~~ dental hygienists, or dental therapists. • Clinical psychologists or clinical social workers.
		Tribal Health Centers	3.1 Covered Services	In the 1st paragraph, the 5th bullet point was revised to read: • Dental (DDS, DT, RDH) services
		Acronym Appendix		Addition of: DT – Dental Therapist RDH – Registered Dental Hygienist
		Forms Appendix	MSA-1680-B; Dental Prior Approval Authorization Request	Under "Instructions", the 2nd paragraph was revised to read: The MSA-1680-B must be completed by ~~private dentists~~ dental providers or community-based dental clinics (e.g., local health departments, Federally Qualified Health Centers (FQHC)). MDHHS requires that the MSA-1680-B be typewritten; handwritten forms will not be accepted.
MMP 22-26	8/31/2022	Therapy Services	1.3 Documentation in Beneficiary Medical Record	Text was revised to read: Therapy providers must retain all applicable documentation in the beneficiary's medical record for seven years. For audit purposes, the beneficiary's medical record must substantiate the medical necessity of the service performed. Documentation must also include the treatment time of the services performed.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			4.1.E. Co-Treatment Therapy (new subsection; following subsections were re-numbered)	New subsection text reads: Co-treatment is a single treatment session in which two therapists from different disciplines work together as a team to address a beneficiary's condition and meet their treatment goals. Medicaid covers outpatient and nursing facility co-treatment therapy when medically necessary for the beneficiary to receive multi-disciplinary therapy during the same treatment session. The two therapists must not work on duplicate treatment goals. Standards of coverage and service limitations for each discipline participating in the co-treatment are identical to those applicable to therapy provided on an individual basis. The decision to co-treat should be made on a case-by-case basis and be provided solely for the medical benefit of the beneficiary. Co-treatment therapy is not covered when provided for convenience purposes or when the assistance of an additional therapist is requested solely for safety reasons.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			4.1.E.1. Prior Authorization (new subsection)	New subsection text reads: Co-treatment therapy must be prior authorized (PA). Each therapist requesting co-treatment must submit a separate PA to MDHHS; however, both requests should be submitted at the same time. If a PA request includes both individual and co-treatment therapy, the therapist must designate which procedure code, units, frequency, or service dates will be utilized in the co-treatment intervention. Documentation of the beneficiary's evaluation/re-evaluation, individualized treatment plan and short- and long-term goals, and progress should be submitted with each of the therapist's PA requests. In addition, the documentation must: • Support the clinical need and appropriateness of the co-treatment services; • Demonstrate how the co-treatment will help achieve the therapist's goals more effectively than separate, individual treatment sessions; • Identify the co-treating discipline; and • Indicate the anticipated length of time (in sessions or weeks/months) that the beneficiary will require co-treatment rather than individual sessions.
			4.1.E.2. Billing Requirements (new subsection)	New subsection text reads: When two therapists provide services to the beneficiary at the same time, one therapist can bill for the entire service, or the service units can be divided between the two therapists. If the service units are split, both therapists may not bill for the same minutes. The combined units requested and billed must not exceed the total time the beneficiary received co-treatment services. Documentation must substantiate treatment time billed by each discipline.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			4.2.E. Co-Treatment Therapy (new subsection; the following subsections were re-numbered)	New subsection text reads: Co-treatment is a single treatment session in which two therapists from different disciplines work together as a team to address a beneficiary's condition and meet their treatment goals. Medicaid covers outpatient and nursing facility co-treatment therapy when medically necessary for the beneficiary to receive multi-disciplinary therapy during the same treatment session. The two therapists must not work on duplicate treatment goals. Standards of coverage and service limitations for each discipline participating in the co-treatment are identical to those applicable to therapy provided on an individual basis. The decision to co-treat should be made on a case-by-case basis and be provided solely for the medical benefit of the beneficiary. Co-treatment therapy is not covered when provided for convenience purposes or when the assistance of an additional therapist is requested solely for safety reasons.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			4.2.E.1. Prior Authorization (new subsection)	New subsection text reads: Co-treatment therapy must be prior authorized (PA). Each therapist requesting co-treatment must submit a separate PA to MDHHS; however, both requests should be submitted at the same time. If a PA request includes both individual and co-treatment therapy, the therapist must designate which procedure code, units, frequency, or service dates will be utilized in the co-treatment intervention. Documentation of the beneficiary's evaluation/re-evaluation, individualized treatment plan and short- and long-term goals, and progress should be submitted with each of the therapist's PA requests. In addition, the documentation must: • Support the clinical need and appropriateness of the co-treatment services; • Demonstrate how the co-treatment will help achieve the therapist's goals more effectively than separate, individual treatment sessions; • Identify the co-treating discipline; and • Indicate the anticipated length of time (in sessions or weeks/months) that the beneficiary will require co-treatment rather than individual sessions.
			4.2.E.2. Billing Requirements (new subsection)	New subsection text reads: When two therapists provide services to the beneficiary at the same time, one therapist can bill for the entire service, or the service units can be divided between the two therapists. If the service units are split, both therapists may not bill for the same minutes. The combined units requested and billed must not exceed the total time the beneficiary received co-treatment services. Documentation must substantiate treatment time billed by each discipline.

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			4.3.D. Co-Treatment Therapy (new subsection; the following subsections were re-numbered)	New subsection text reads: Co-treatment is a single treatment session in which two therapists from different disciplines work together as a team to address a beneficiary's condition and meet their treatment goals. Medicaid covers outpatient and nursing facility co-treatment therapy when medically necessary for the beneficiary to receive multi-disciplinary therapy during the same treatment session. The two therapists must not work on duplicate treatment goals. Standards of coverage and service limitations for each discipline participating in the co-treatment are identical to those applicable to therapy provided on an individual basis. The decision to co-treat should be made on a case-by-case basis and be provided solely for the medical benefit of the beneficiary. Co-treatment therapy is not covered when provided for convenience purposes or when the assistance of an additional therapist is requested solely for safety reasons.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			4.3.D.1. Prior Authorization (new subsection)	New subsection text reads: Co-treatment therapy must be prior authorized (PA). Each therapist requesting co-treatment must submit a separate PA to MDHHS; however, both requests should be submitted at the same time. If a PA request includes both individual and co-treatment therapy, the therapist must designate which procedure code, units, frequency, or service dates will be utilized in the co-treatment intervention. Documentation of the beneficiary's evaluation/re-evaluation, individualized treatment plan and short- and long-term goals, and progress should be submitted with each of the therapist's PA requests. In addition, the documentation must: • Support the clinical need and appropriateness of the co-treatment services; • Demonstrate how the co-treatment will help achieve the therapist's goals more effectively than separate, individual treatment sessions; • Identify the co-treating discipline; and • Indicate the anticipated length of time (in sessions or weeks/months) that the beneficiary will require co-treatment rather than individual sessions.

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			4.3.D.2. Billing Requirements (new subsection)	New subsection text reads: When two therapists provide services to the beneficiary at the same time, one therapist can bill for the entire service, or the service units can be divided between the two therapists. If the service units are split, both therapists may not bill for the same minutes. The combined units requested and billed must not exceed the total time the beneficiary received co-treatment services. Documentation must substantiate treatment time billed by each discipline. If co-treatment therapy includes speech therapy services that are reported as an untimed session, they may be billed by the SLP as one unit. The therapy session must be at least 38 minutes in length to bill both speech therapy and occupational or physical therapy.
MMP 22-29	9/19/2022	Pharmacy	Section 2 – Prescriber Requirements	The 1st paragraph was revised to read: All MDHHS-covered legend and over-the-counter drugs (OTCs), except condoms, require a prescription order by a licensed ~~prescriber~~ professional acting within their scope of practice as defined by state and federal laws, rules, and regulations.
MMP 22-30	9/30/2022	Practitioner	14.3.D. Collaborative Care Team Criteria	In the table, under **"Psychiatric Consultant"**, the 1st paragraph in the description was revised to read: Medical professional (MD, ~~or~~ DO or Mental Health Nurse Practitioner [MHNP]) who is trained in psychiatry or behavioral health and qualified to prescribe the full range of medications. The psychiatric consultant will:

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			14.3.E. Coverage of CoCM Services	The 1st paragraph was revised to read: CoCM is a covered service for beneficiaries who are diagnosed with a psychiatric disorder that requires behavioral health care assessment; establishing, implementing, revising, or monitoring a care plan; and brief interventions. For primary medical care practices that meet all CoCM team criteria, Medicaid will cover CoCM services provided by the care team and rendered by the primary care provider for six months of care. After the initial ~~six~~ twelve months, prior authorization is required for ~~six~~ twelve additional calendar months if the beneficiary shows improvement and there is a need for continued care. If no improvement occurs … In the 3rd paragraph, the 1st bullet point was revised to read: CoCM services must include: • Initial assessment: ~~Face-to-face visit~~ Visit occurring either in-person or via audio-visual telemedicine in which the beneficiary sets goals and is screened by a diagnosis-appropriate and consistent validated clinical rating scale, such as the PHQ-9 or GAD-7, which also must be done prior to subsequent CoCM services.
			14.3.G. Prior Authorization	Text was revised to read: After ~~an initial six-month episode~~ the initial twelve-months of care, prior authorization is required for an additional ~~six~~ twelve months. Prior authorization requests must include documentation showing progress toward beneficiary goals through validated screening tool scores and an explanation for the medical necessity of continued services. ~~If a six-month lapse in CoCM occurs, a new episode of care can begin without prior authorization.~~ (Refer to the Prior Authorization subsection of this chapter for additional information.)

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			14.3.J. Indian Health Center Reimbursement (new subsection; the following subsection was re-numbered)	New subsection text reads: CoCM services provided by a Tribal Health Center (THC) or Tribal Federally Qualified Health Center (FQHC) provider (e.g., MD/DO, certified NP, certified CNS, PA) do not qualify as an encounter. It may, however, be reimbursed outside of the All Inclusive Rate (AIR).
		Acronym Appendix		Addition of: MHNP - Mental Health Nurse Practitioner
MMP 22-32	9/30/2022	Medicaid Provider Manual Overview	1.1 Organization	In the table, text for **"Laboratory"** was revised to read: **Affected Providers:** ~~Independent Clinical Labs~~ Providers of laboratory tests and services **Chapter Content:** ~~Coverage policy for laboratory services~~ Coverage, billing, and reimbursement policies related to laboratory tests and services.
		Family Planning Clinics	Section 3 - Laboratory	The last paragraph was revised to read: Laboratory tests other than those listed in the Medicaid Code and Rate Reference tool or on the MDHHS Family Planning Clinics Fee Schedule are available to beneficiaries when medically necessary, ordered by a physician or other licensed practitioner working within their scope of practice as determined under State law, and provided by an independent laboratory or outpatient hospital laboratory. For additional information, refer to the Laboratory ~~Subsection in the Practitioner~~ Chapter of this manual.

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		Hospital	3.13.A. Dialysis Laboratory Services	The 1st and 2nd paragraphs were revised to read: Payment for laboratory services related to maintenance dialysis is included in the composite rate regardless of whether the tests are performed in the facility or an independent laboratory. Laboratory services included in the composite rate should be billed to the dialysis facility when performed by an outside laboratory. The dialysis facility and the outside laboratory must coordinate billing to ensure duplicate payments do not occur. A freestanding dialysis center that performs its own laboratory tests and needs to bill for services outside of those included in the composite rate must enroll with Medicaid as an independent laboratory. Freestanding dialysis centers enrolled as independent laboratories are subject to the Out of State /Beyond Borderland Provider Medicaid policy. The following laboratory tests are considered to be a routine part of maintenance dialysis (Hemodialysis, Peritoneal Dialysis, and Continuous Cycling Peritoneal Dialysis) and may not be billed separately unless it is medically necessary to perform them in excess of the frequencies indicated: ~~Laboratory tests for Hemodialysis, Peritoneal Dialysis, and Continuous Cycling Peritoneal Dialysis (CCPD) that are included in the composite rate:~~

BULLETINS INCORPORATED*

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			3.21 Laboratory	Text was revised to read: Medicaid covers laboratory services performed by a clinical laboratory located in or as part of a hospital when it is certified to perform the specialties or subspecialties of tests billed. The laboratory must hold a CLIA certificate of registration, compliance (COC), or accreditation (COA) from the Centers for Medicare & Medicaid Services (CMS). Medicaid covers hospital laboratory services and pathology procedures reasonable and necessary to guide detection, diagnosis, management, and/or treatment of a specific medical condition, illness, or injury and laboratory tests associated with preventive services assigned a grade A or B by the United States Preventive Services Task Force (USPSTF). Covered laboratory and pathology services must be: • Recommended and ordered by the beneficiary's treating physician, podiatrist, physician assistant, nurse practitioner, clinical nurse specialist, dentist, or CNM according to their scope of practice. • Provided in accordance with evidence based generally accepted standards of medical practice. • Clinically appropriate in terms of type, frequency, extent, site, and duration for the beneficiary's symptoms, diagnosis, illness, or injury. • Used in the clinical management of the beneficiary's specific medical condition. • Provided in accordance with all applicable Medicaid clinical criteria, requirements, policies, and/or provisions of coverage. • Performed in a laboratory appropriately certified by the Clinical Laboratory Improvement Amendments (CLIA).

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				The beneficiary's medical record must include sufficient documentation to support the medical necessity of the laboratory service regardless of where the tests are performed. The documentation must include a description of the beneficiary's symptomatology and other findings that have led the practitioner to order the test(s). An explanation of the laboratory testing method or the results of diagnostic tests, whether normal or abnormal, is not considered documentation of medical necessity. For approval of payment, the laboratory procedure(s) must be specific and appropriate to the beneficiary's documented condition and diagnosis. Generally, MDHHS follows Medicare's current OPPS laboratory coverage policies as closely as possible and appropriate. In those instances where program differences require coverage disparity, the differences will be reflected through the application of the MDHHS specific status indicator. Procedure codes associated with the identified services will appear on the MDHHS OPPS Wraparound Code List and reimbursement rates will appear on the Carrier Priced Laboratory Codes List. Both lists are available on the MDHHS website. (Refer to the Directory Appendix for website information.) Refer to the Laboratory chapter for additional information regarding coverage parameters, ordering limitations, and prior authorization requirements. ~~MDHHS policy covers hospitals for medically necessary laboratory tests when:~~ • ~~Performed in a laboratory certified by the Clinical Laboratory Improvement Amendments (CLIA);~~ • ~~Needed to diagnose a specific condition, illness, or injury; and~~ • ~~Ordered by physicians (MD or DO), physician assistants, podiatrists, dentists, or advanced practice registered nurses.~~

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				~~MDHHS requires medical record documentation of medical necessity. An explanation of the laboratory testing method or the results of diagnostic tests, whether normal or abnormal, is not considered documentation of medical necessity. For approval of payment, the laboratory procedure(s) must be specific and appropriate to the beneficiary's documented condition and diagnosis.~~ ~~Reimbursement to the inpatient hospital is through the DRG payment.~~ ~~Reimbursement for outpatient services is billed using the appropriate HCPCS code and includes the collection of the specimen(s), the analysis, and the lab test results. MDHHS performs pre- and/or post-payment reviews to monitor laboratory procedures for medical necessity and appropriate practitioner orders. Outpatient hospitals are subject to corrective action, including the recovery of funds, for laboratory services not specifically ordered by a practitioner.~~ ~~MDHHS does not cover:~~ • ~~Screening or routine laboratory testing, except as specified for EPSDT Program or by Medicaid policy;~~ • ~~"Profiles", "batteries" or "panels" of tests that include tests not necessary for the diagnosis or treatment of the beneficiary's specific condition; or~~ • ~~Multiple laboratory tests performed as a part of the beneficiary evaluation if the history and physical examination do not suggest the need for the tests.~~ ~~Services performed by an outpatient hospital laboratory or its employees may not be billed to, or by, the ordering practitioner.~~
			3.21.A. Pregnancy Related-Laboratory Services	Subsection was deleted.
			3.21.B. Blood Handling	Subsection was deleted.

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			3.21.C. Hematology Studies	Subsection was deleted.
			3.21.D. Microbiology Studies	Subsection was deleted.
			3.21.E. Pap Smear	Subsection was deleted.
			3.21.F. Substance Abuse	Subsection was deleted.
			3.21.G. Creatinine Blood Tests	Subsection was deleted.
			3.21.A. Billing and Reimbursement (new subsection)	New subsection text reads: Laboratory services provided by outpatient hospitals are reimbursed through the Medicaid Outpatient Prospective Payment System (OPPS). Laboratory tests provided in conjunction with other hospital services are generally packaged as ancillary services and do not receive separate reimbursement unless otherwise indicated by the procedure code's OPPS payment status indicator and/or determined under OPPS claim processing rules. Laboratory services performed (either directly or under arrangement) for non-hospital patients (i.e., those who are neither a registered outpatient nor inpatient hospital patient) are considered performed by a hospital outreach laboratory and may be eligible for separate Medicaid reimbursement. The laboratory's CLIA number must be present on the claim for laboratory services to be considered for reimbursement.

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				Outpatient laboratory services are billed using the appropriate HCPCS code and reimbursement includes the collection of the specimen(s), the analysis, and the lab test results. MDHHS performs pre- and/or post-payment reviews to monitor laboratory procedures for medical necessity and appropriate practitioner orders. Outpatient hospitals are subject to corrective action, including the recovery of funds, for laboratory services not specifically ordered by a practitioner. Services performed by an outpatient hospital laboratory or its employees may not be billed to, or by, the ordering practitioner. Medicaid covers laboratory services provided in a provider-based outpatient hospital clinic when they are appropriate to be performed in a clinic setting. Beneficiaries are treated as hospital outpatients for billing purposes and laboratory services must be reported using the institutional claim format. Refer to the Hospital chapter for complete billing and reimbursement information. Laboratory reimbursement to the inpatient hospital is through the DRG payment.
		Laboratory		The Laboratory Chapter was revised in its entirety and replaced with a new version.
		Practitioner	3.17 Laboratory	Subsection text was revised in its entirety. New text reads: Medicaid covers diagnostic laboratory services and pathology procedures reasonable and necessary to guide detection, diagnosis, management, and/or treatment of a specific medical condition, illness, or injury and a limited number of screening laboratory tests, including but not limited to, those associated with preventive services assigned a grade A or B by the United States Preventive Services Task Force (USPSTF).

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				Covered laboratory and pathology services must be: • Recommended and ordered by the beneficiary's treating physician, podiatrist, physician assistant, nurse practitioner, clinical nurse specialist, dentist, or CNM according to their scope of practice. • Provided in accordance with evidence based generally accepted standards of medical practice. • Clinically appropriate in terms of type, frequency, extent, site, and duration for the beneficiary's symptoms, diagnosis, illness, or injury. • Used in the clinical management of the beneficiary's specific medical condition. • Provided in accordance with all applicable Medicaid clinical criteria, requirements, policies, and/or provisions of coverage. • Performed in a laboratory appropriately certified by the Clinical Laboratory Improvement Amendments (CLIA). Refer to the Laboratory chapter for additional information regarding coverage parameters, ordering limitations, and prior authorization requirements.
			3.17.A. Medical Necessity	Text was revised to read: The beneficiary's medical record must include sufficient documentation to support the medical necessity of the laboratory service regardless of where the tests are performed. The documentation ~~of medical necessity~~ must include a description of the beneficiary's symptomatology and other findings that ~~have~~ led the practitioner to order the test(s). An explanation of the laboratory testing method or the results of diagnostic tests, whether normal or abnormal, is not considered documentation of medical necessity. For approval of payment, the laboratory procedure(s) must be specific and appropriate to the beneficiary's documented condition and diagnosis.

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			3.17.B. Referred Services	Text was revised to read: If a practitioner refers a beneficiary to an outside laboratory (e.g. independent clinical lab~~,~~ or hospital outreach lab~~, clinic lab, or physician office lab~~) for testing, the practitioner must indicate ~~his~~ their NPI number on the referral. A practitioner may not charge for laboratory tests when a specimen is obtained but sent out of the office (i.e., skin lesions, pap smears, etc.) for analysis. **~~A physician cannot refer a beneficiary to an outside laboratory where he or an immediate family member has a financial relationship. Noncompliance may result in corrective action by MDHHS or other agencies.~~** ~~A beneficiary cannot be charged for any covered laboratory procedure, including those that are determined to be not medically necessary.~~
			3.17.C. Non-Covered Services	Subsection was deleted.
			3.17.D. Children's Special Health Care Services Coverage	Subsection was deleted.

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			3.17.C. Practitioner's Office Laboratory (new subsection)	New subsection text reads: Medicaid covers laboratory services provided in a practitioner's office laboratory (POL) when they are appropriate to be performed in the office and the POL is certified to perform the specialties or subspecialties of tests billed. The laboratory must hold a CLIA certificate of registration, compliance (COC), accreditation (COA), waiver (COW) or a certificate of Physician Performed Microscopy Procedures (PPMP) from the Centers for Medicare & Medicaid Services (CMS). The POL's CLIA number must be present on the claim for laboratory services to be considered for reimbursement. POL reimbursement is limited to services listed on the applicable provider's fee schedule.
		Tribal Health Centers	3.1 Covered Benefits	In the table, under **"Laboratory Services"**, the 1st paragraph was revised to read: The ~~Practitioner~~ Laboratory Chapter of this manual explains the coverages and limitations of the Medicaid laboratory benefit. Laboratory services billed under the practitioner's NPI number are included in the THC encounter rate but do not constitute a separate encounter for reimbursement purposes as they are considered part of the office visit.
		Acronym Appendix		Addition of: PPMP – Physician Performed Microscopy Procedures

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