MDHHS Michigan Department of Health & Human Services

Health and Aging Services Administration

BULLETIN

HASA

Attachment 1 revised 7-5-2022

Bulletin Number: HASA 22-18

Distribution: All Providers

Issued: June 1, 2022

Subject: Updates to the MDHHS Medicaid Provider Manual; Code Updates; Changes to the MDHHS Health and Aging Services Administration

Effective: As indicated

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

Updates to the MDHHS Medicaid Provider Manual

The Michigan Department of Health and Human Services (MDHHS) has completed the July 2022 update of the online version of the MDHHS Medicaid Provider Manual. The manual will be available July 1, 2022 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.

Code Updates

A. NEW COVERAGE OF CODES

Listed below are HCPCS codes being adopted by MDHHS for dates of service on and after April 1, 2022 and the provider groups allowed to bill these codes.

The symbol * will appear with those codes requiring prior authorization (PA).

1. Physicians, Practitioners, and Medical Clinics

   J0219 J0491 J0879 J9071 J9273 J9359 Q5124

2. Medical Suppliers, Orthotists, and Prosthetists

   K1030* K1031* K1032* K1033*

3. Outpatient Prospective Payment System (OPPS)/Ambulatory Payment Classification (APC) and Ambulatory Surgical Centers (ASC)

   Codes covered differently than Medicare or specific to Michigan Medicaid services will be identified on the April 2022 version of the OPPS and ASC Wrap-Around Code List on the MDHHS website:

   www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Outpatient Hospitals

   www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Ambulatory Surgical Centers

B. NEW COVERAGE OF EXISTING CODES

Effective for dates of service on and after April 1, 2022, MDHHS will cover the following HCPCS code for Optometry, Dispensing Ophthalmologists and Opticians:

V2522*

C. TELEMEDICINE- NEW COVERAGE OF EXISTING CODES

Listed below are HCPCS codes being adopted by MDHHS for dates of service on and after April 1, 2022, and the provider groups allowed to bill these codes. These codes must not be reported with POS 02 nor the GT modifier and will be represented on the applicable provider fee schedules and not the telemedicine database. They are, by definition, technology enabled and do not need the telemedicine POS or modifier to identify them appropriately.

1. School Services Program, Family Planning Clinic, Social Worker, Psychologist, Professional Counselor, Marriage and Family Therapists, Local Health Departments, Child and Adolescent Health Centers and Programs, Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers and Urgent Care Centers

   98966 98967 98968

2. School Services Program, Independent Diagnostic Testing Facility, Social Worker, Psychologist, Professional Counselor and Marriage and Family Therapists

   98970 98971 98972

3. Physicians, Practitioners, Medical Clinics, Certified Nurse Midwives and Independent Diagnostic Testing Facility

   99421 99422 99423

D. RETROACTIVE COVERAGE OF EXISTING CODES

1. Effective for dates of service on and after January 1, 2022, MDHHS will cover the following HCPCS code for Physicians, Practitioners, Medical Clinics:

   A9595

2. Effective for dates of service on and after January 1, 2022, MDHHS will cover the following HCPCS code for Physicians, Practitioners, Medical Clinics, Optometry, Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers and Independent Diagnostic Testing Facility:

   92229

3. Effective for dates of service on and after February 11, 2022, MDHHS will cover the following HCPCS codes for Physicians, Practitioners, Medical Clinics, Home Health Agency, Advanced Life Support Ambulance, Local Health Departments, Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers and Urgent Care Centers:

   M0222 Q0222

4. Effective for dates of service on and after February 11, 2022, MDHHS will cover the following HCPCS code for Physicians, Practitioners, Medical Clinics, Home Health Agency, Advanced Life Support Ambulance, Local Health Departments, Federally Qualified Health Centers, Tribal Health Centers and Urgent Care Centers:

   M0223

5. Effective for dates of service on and after February 21, 2022, MDHHS will cover the following HCPCS code for Laboratory Services:

   87913

6. Effective for dates of service on and after February 24, 2022, MDHHS will cover the following HCPCS code for Physicians, Practitioners, Medical Clinics, Home Health Agency, Advanced Life Support Ambulance, Local Health Departments, Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers and Urgent Care Centers:

   Q0221

7. Effective for dates of service on and after March 29, 2022, MDHHS will cover the following HCPCS codes for Physicians, Practitioners, Medical Clinics, Certified Nurse Midwives, Podiatry, School Services Program, Home Health Agency, Local Health Departments, Child and Adolescent Health Centers and Programs, Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers and Urgent Care Centers:

   91309 0094A

E. DISCONTINUED COVERAGE FOR ALL APPLICABLE PROVIDER TYPES

The following HCPCS code is discontinued effective March 31, 2022:

76390

F. DISCONTINUED HCPCS PROCEDURE CODES FOR ALL APPLICABLE PROVIDER TYPES

The following HCPCS codes are discontinued effective March 31, 2022:

0097U 0151U C9084 C9085 C9086 C9087 G1009

The following HCPCS code is discontinued effective February 27, 2022:

M1145

Changes to the MDHHS Health and Aging Services Administration

On March 3, 2022, MDHHS announced the renaming of the Health and Aging Services Administration to the Behavioral and Physical Health and Aging Services Administration (BPHASA). The administration, which already included Michigan's Medicaid Office and services for aging adults, now oversees community-based services for adults with intellectual and developmental disabilities, serious mental illness and substance use disorders. This builds upon the administration's existing efforts to deliver services to adults with mild to moderate mental illness.

All references to the Health and Aging Services Administration will be deemed references to the Behavioral and Physical Health and Aging Services Administration. In the coming months, MDHHS will continue to work to update all references to the Health and Aging Services Administration on department webpages, future policy bulletins, forms, brochures, letters, Medicaid Provider Manual, and other publications. Providers should continue to use existing MDHHS documents while the updates are being completed.

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

Farah Hanley
Chief Deputy for Health

Medicaid Provider Manual
July 2022 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	1.4 ListServ Communications	Text was revised to read: The MDHHS Behavioral and Physical Health and Aging Services Administration (BPHASA) offers individuals the option of receiving automated announcements regarding the Michigan Medicaid Program (i.e., changes to policy, billing issues, training opportunities, etc.) through subscription to an e-mail listserv. Subscription instructions are posted on the MDHHS website. (Refer to the Directory Appendix for website information.)	Reflects recent revisions to organization of MDHHS.
Beneficiary Eligibility	1.1 Local Michigan Department of Health and Human Services Office Determination	The textbox after the 1st paragraph was revised to read: The MDHHS Behavioral and Physical Health and Aging Services Administration (BPHASA) determines eligibility for Children's Special Health Care Services (CSHCS).	Reflects recent revisions to organization of MDHHS.
Beneficiary Eligibility	Section 10 – Children's Special Health Care Services	The 1st paragraph was revised to read: MDHHS BPHASA determines eligibility for the CSHCS Program. CSHCS provides medically necessary services to individuals who are eligible and apply under the following circumstances:	Reflects recent revisions to organization of MDHHS.
Beneficiary Eligibility	12.1.C. State-Owned and -Operated Facilities/PIHPs/CMHSPs	Text was revised to read: BPHASA or the PIHP/CMHSP determines a financial liability, or ability to pay, separate from the MDHHS patient pay amount. The ability to pay may be an individual, spouse, or parental responsibility. It is determined and reviewed as required by the Mental Health Code. The beneficiary or ~~his~~ their authorized representative is responsible for the ability to pay amount, even if the patient pay amount is greater.	Reflects recent revisions to organization of MDHHS.
Billing & Reimbursement for Professionals	2.3.D. Supervising Provider	Text was revised to read: The supervising physician NPI is a claim editing requirement which must be included on claims when physician services are rendered by an enrolled non-physician practitioner, such as a physician's assistant or ~~advanced practice registered nurse~~ registered nurse. Physician supervision and oversight must be consistent with Michigan Public Act 368 of 1978, as amended. The supervising physician must be enrolled with the program.	Language updated to remove direct reference to APRNs to allow for flexibility for APRN services which may not require physician supervision.

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

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	2.4 Staff Provider Qualifications	In the 2nd paragraph, the description for "Aides" was revised to read: Must be able to perform basic first aid procedures. ~~Children's~~ Waiver aides must also successfully complete training in recipient rights and implementation of the ~~child's~~ individual plan of services. For the full list of aide qualifications, refer to the Habilitation Supports Waiver for Persons with Developmental Disabilities section, Aide Qualifications subsection. The last paragraph was revised to read: Refer to the Behavioral Health Code Charts and Provider Qualifications document on the MDHHS website for specific provider qualifications for each covered service. (Refer to the Directory Appendix for website information.)	The requirement for Recipient Rights training and IPOS training is consistent across all waivers. Update.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	21.5.A. Staffing Requirements	Text was revised to read: Staffing requirements include criteria that staff have diverse disciplinary backgrounds, have necessary state required license and accreditation, and are culturally and linguistically trained to serve the needs of the clinic's patient population. (Refer to the ~~Michigan Prepaid Inpatient Health Plan [PIHP]/Community Mental Health Services Program [CMHSP] Provider Qualifications Per Medicaid Services & Healthcare Common Procedure Coding System [HCPCS]/Current Procedural Terminology [CPT] Codes~~ Behavioral Health Code Charts and Provider Qualifications document on the MDHHS website for additional information. Refer to the Directory Appendix for website ~~location~~ information.) CCBHCs must provide an interdisciplinary team-based set of services to ensure the totality of one's needs (physical, behavioral, and/or social) are met through the provision of CCBHC services.	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Healthy Michigan Plan	5.6.B.1. Definition Of Terms	Text for "Behavioral Health Professional" was revised to read: For purposes of the Healthy Michigan Plan Chapter, this is a categorical description used to refer to the individuals who provide mental health and/or substance use disorder services that are identified in the ~~Provider Qualifications chart. (The Provider Qualifications chart is posted~~ Behavioral Health Code Charts and Provider Qualifications document on the MDHHS website. (Refer to the Directory Appendix for website information.)	Update.
Healthy Michigan Plan	5.6.B.6. Outpatient Counseling and Therapy	In the chart, under "**Provider Qualifications**", the 2nd paragraph was revised to read: All behavioral health organizations/providers of outpatient services must have appropriately licensed and credentialed staff and provide treatment that is within their established scope of practice. (Refer to the ~~Provider Qualifications Chart~~ Behavioral Health Code Charts and Provider Qualifications document that supports the Medicaid Provider Manual. The ~~Provider Qualifications chart~~ Behavioral Health Code Charts and Provider Qualifications document is posted on the MDHHS website. Refer to the Directory Appendix for website information.)	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
		In the chart, under "**Allowable Services**", text was revised as follows: • **Individual Therapy:** Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control or restore normalized psychological functioning, reality orientation, re-motivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. Evidence-based practices, such as Integrated Dual Disorder Treatment for Co-Occurring Disorders (IDDT/COD) and Dialectical Behavior Therapy (DBT), are included in this coverage. Individual therapy is provided by a Behavioral Health Professional practicing within their scope of practice and within the guidelines of the ~~Provider Qualifications Chart~~ Behavioral Health Code Charts and Provider Qualifications document which is posted on the MDHHS website. (Refer to the Directory Appendix for website information.) • **Group Therapy:** Face-to-face counseling with three or more beneficiaries, and can include didactic lectures, therapeutic interventions/counseling, and other group related activities. Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control or restore normalized psychological functioning, reality orientation, re-motivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. Evidence-based practices (such as IDDT/COD and DBT) are included in this coverage. Group therapy is provided by a Behavioral Health Professional practicing within their scope of practice and within the guidelines of the ~~Provider Qualifications Chart~~ Behavioral Health Code Charts and Provider Qualifications document which is posted on the MDHHS website. (Refer to the Directory Appendix for website information.) • **Family Therapy:** Family Therapy is therapy for a beneficiary and family member(s), or other person(s) significant to the beneficiary, for the purpose of improving the beneficiary/family function. Family therapy does not include individual psychotherapy or family planning (e.g., birth control) counseling. Family therapy is provided by a Behavioral Health Professional practicing within their scope of practice and within the guidelines of the ~~Provider Qualifications Chart. (The Provider Qualifications chart~~ Behavioral Health Code Charts and Provider Qualifications document which is posted on the MDHHS website. Refer to the Directory Appendix for website information.)	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	2.3.A.6. Special Circumstances	Under "Hospitals Outside Michigan", the 2nd paragraph was revised to read: Hospitals that have charges that exceed $250,000 during a single fiscal year (using the State of Michigan fiscal year – October 1st through September 30th) may be reimbursed the hospital's inpatient operating cost to charge ratio for those Michigan Medicaid DRGs reimbursed by percentage of charge. The hospital's chief financial officer must submit, and Behavioral and Physical Health and Aging Services Administration (BPHASA) must accept, documentation stating the hospital's Medicaid cost to charge ratio in the state that the hospital is located. Once accepted, the hospital's actual cost to charge ratio is applied prospectively to those DRGs and claims subject to percentage of charge reimbursement using the Michigan DRG payment system.	Reflects recent revisions to organization of MDHHS.
Hospital Reimbursement Appendix	2.3.B.3. New LTACHs, Freestanding Rehabilitation Hospitals, and Distinct Part Rehabilitation Units	The 1st paragraph was revised to read: If a hospital at least doubles the number of licensed beds in its distinct part unit and the number of licensed beds in the units increases by at least 20, the entire unit is treated as a new distinct part unit for determining the per diem rate. In order for this provision to apply, the hospital must request, in writing, that the unit is treated as a new unit. The new unit rate will become effective on the date that the number of licensed beds doubles and the increase is at least 20 beds, or the date on which the request is received by BPHASA, whichever is later.	Reflects recent revisions to organization of MDHHS.
Maternal Infant Health Program	5.3 Operations and Certification Requirements	The last bullet point was revised to read: • Follow all Medicaid policies as published in the MDHHS Medicaid Provider Manual, Behavioral and Physical Health and Aging Services Administration (BPHASA) Bulletins, and the Maternal Infant Health Program Operations Guide.	Reflects recent revisions to organization of MDHHS.
Medicaid Health Plans	1.1 Services Covered by Medicaid Health Plans (MHPs)	In the 1st paragraph, the following was added to the list of services: • Pregnant Women Dental Benefit (age 21 and over)	Clarification requested by MHPs.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Certification, Survey & Enforcement Appendix	Section 1 – Introduction	The 2nd paragraph was revised to read: As required by federal law, the State Medicaid Agency (MDHHS Behavioral and Physical Health and Aging Services Administration [BPHASA]) has entered into an interagency agreement with the State Survey Agency (Michigan Department of Licensing and Regulatory Affairs [LARA], Bureau of Community and Health Systems [BCHS]) to conduct surveys of Medicaid providers and applicants. The State Medicaid Agency (SMA) accepts State Survey Agency (SSA) certification decisions as final, but exercises its own determination whether to enter into agreements with providers.	Reflects recent revisions to organization of MDHHS.
Nursing Facility Certification, Survey & Enforcement Appendix	2.3 Criteria for Evaluation of Medicaid Bed Certification Applications	The 1st paragraph was revised to read: The SMA (MDHHS-BPHASA) will collaborate with the SSA (LARA-BCHS) when making a determination regarding the approval or denial of any application for Medicaid bed certification and provider enrollment. Approval or denial of an application to MDHHS for Medicaid bed certifications will be based on the following criteria:	Reflects recent revisions to organization of MDHHS.
Nursing Facility Cost Reporting & Reimbursement Appendix	Section 1 – Introduction	The 2nd paragraph was revised to read: Throughout the appendix, references will be made to the State Medicaid Agency (SMA) and the State Survey Agency (SSA). The Michigan Department of Health and Human Services (MDHHS), Behavioral and Physical Health and Aging Services Administration (BPHASA), is the designated SMA, and is responsible for administration of the Medicaid program. The Michigan Department of Licensing and Regulatory Affairs (LARA), Bureau of Community and Health Systems (BCHS) is the designated SSA.	Reflects recent revisions to organization of MDHHS.
Nursing Facility Cost Reporting & Reimbursement Appendix	Section 2 – Definitions	The definition for "State Medicaid Agency (SMA)" was revised to read: The Michigan Department of Health and Human Services (MDHHS). The work unit within MDHHS with administrative responsibility for the Medical Assistance (Medicaid) Program is the Behavioral and Physical Health and Aging Services Administration (BPHASA).	Reflects recent revisions to organization of MDHHS.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	10.13.F. Facility Innovative Design Supplemental (FIDS) Program	The 2nd paragraph was revised to read: The FIDS facility standards and required culture change must be maintained throughout the Medicaid supplemental payment program. FIDS participating facilities will be reviewed annually by BPHASA to certify continued participation in the culture change. Reimbursement of the FIDS payment will be terminated if it is determined that a facility is not compliant with the culture change requirement. FIDS participating nursing facilities receive increased capital reimbursement for FIDS construction and renovation projects. The increased reimbursement is paid through the claims reimbursement process. Reimbursement of the supplement amount is contingent upon sufficient appropriation to the Medicaid budget.	Reflects recent revisions to organization of MDHHS.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.13.F.1. Change of Ownership	Text was revised to read: A new owner may receive reimbursement for the balance of the facility's eligible years of participation in the FIDS program. The new owner must notify RARSS via File Transfer within 45 calendar days of the change of ownership if the facility is going to continue participation in the FIDS program, or RARSS will assume participation has been discontinued and end FIDS reimbursement supplemental payments. In order to receive the supplemental Medicaid payment, the new owner must continue the FIDS facility standards and culture change. If the new owner initially decides to discontinue participation as a FIDS facility and subsequently decides to participate as a FIDS facility, the provider must notify the LARA, Bureau of Community and Health Systems (BCHS) team manager and BPHASA. MDHHS will notify the provider of the supplemental payment amount upon reinstatement of participation in FIDS. MDHHS will notify the provider of the terminated supplemental payment if the facility is determined ineligible for the supplemental payment because the new owner has discontinued or plans to discontinue the FIDS facility standards or culture change.	Reflects recent revisions to organization of MDHHS.

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CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	1.9 Medicare Part D Benefit	The 1st paragraph was revised to read: The Medicare Modernization Act of 2003 provides a prescription drug benefit to Medicare beneficiaries. The benefit is commonly referred to as Medicare Part D. Dually enrolled Medicare/Medicaid beneficiaries must obtain all Part D covered drugs through their Medicare Part D Plan (PDP) or Medicare Advantage Prescription Drug Plan (MA-PD).	Clarification.
Practitioner	Section 1 - General Information	The 1st[t] paragraph was revised to read: This chapter applies to physicians (MD, DO), Oral-Maxillofacial Surgeons (MD, DO), Doctors of Podiatric Medicine (DPM), Physician Assistants (PAs), Medical Clinics, ~~Physical Therapists (PTs),~~ Advanced Practice Registered Nurses (APRNs) [including Certified Nurse Practitioners (NPs), Certified Clinical Nurse Specialists (CNSs), and Certified Nurse-Midwives (CNMs)], Certified Registered Nurse Anesthetists (CRNAs), and Anesthesiologist Assistants (AAs).	The Practitioner Chapter was historically updated to move the policy reference for physical therapists to the Therapy Chapter of the Manual.
Practitioner	14.2.C. Office-Based Alcohol Treatment (OBAT)/Office-Based Opioid Treatment (OBOT)	The 1st[t] paragraph was revised to read: OBAT/OBOT services may be reimbursed directly by MDHHS when provided to MHP enrollees and FFS beneficiaries. Primary healthcare providers (which encompasses the following healthcare providers: Physicians [MD/DO], Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, ~~Clinical~~ Certified Nurse Midwives, Obstetricians/Gynecologists, and Pediatricians) in an office-based setting who are …	Correction.

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CHAPTER	SECTION	CHANGE	COMMENT
School Based Services	6.1.D. Cost Reconciliation and Settlement	The 5th paragraph was revised to read: Within six months after the close of the school fiscal year, School Based Services providers will review, certify, and finalize the MAER and transmit the report to the MDHHS Behavioral and Physical Health and Aging Services Administration (BPHASA) for reconciliation. ~~The cost certification form (CMS-10231; Certification of Public Expenditures) must be signed and on file with MDHHS before a final settlement will be processed.~~ The final settlement process will begin within 12-18 months after the close of the school fiscal year. Settlements may take several months for completion. ~~(Refer to the Forms Appendix for a copy of the CMS-10231.)~~	Reflects recent revisions to organization of MDHHS. The CMS-10231 form is no longer used.
School Based Services	8.1 Cost Certification	Text was revised to read: Once all cost reports and financial worksheets have been received by MDHHS, the summary worksheet of the Medicaid Allowable Expenditure Report (MAER) will be completed. The summary report will combine the allowable cost data submitted by the ISDs for each LEA for all four cost pools (Direct Medical, Specialized Transportation, Personal Care and Targeted Case Management). The total will be entered into the cost certification form as the "Total Computable Expenditure". The ISD is responsible for ensuring that the total amount of expenditures for covered services has been expended and that none of the expenditures have been used as match for other programs or services. ~~MDHHS will be utilizing the CMS-10231, "Certification of Public Expenditures (CPE)" form, for this purpose. (Refer to the Forms Appendix.)~~	The CMS-10231 form is no longer used.
Acronym Appendix		The following acronyms were added: BPHASA – Behavioral and Physical Health and Aging Services Administration The following acronyms were removed: ~~HASA – Health and Aging Services Administration~~	Reflects recent revisions to organization of MDHHS.

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CHAPTER	SECTION	CHANGE	COMMENT

Directory Appendix		The following areas reflect a change in zip code from 48933 to 48913:
		• Policy/Forms/Publications; Medicaid Publications
		• Provider Resources; MDHHS Bureau of Purchasing, Grants Division/Electronic Grants Section
		• Nursing Facility Resources;
		  ○ Certificate of Need Commission
		  ○ Complaints
		  ○ Nursing Facility Rate Setting
		  ○ Informal Dispute Resolution (IDR) and Independent Informal Dispute Resolution (IIDR)
		  ○ MDHHS OBRA Office
		• Reporting Fraud, Abuse, or Misuse of Services;
		  ○ MDHHS OBRA Office
		  ○ Welfare Fraud Hotline
			Update.

Directory Appendix	Provider Assistance	Under "MI Care Team", the following website path was revised: www.michigan.gov/medicaidproviders >> Provider Enrollment >> Step-by-Step CHAMPS Enrollment Guides >> Billing Agent ~~User Guide~~ >> CHAMPS Enrollment Application Billing Agent User Guide	Update.
Directory Appendix	Appeals	Under "Appeals/Administrative Hearings (Provider)", the web address was revised to read: http://www.michigan.gov/lara >> Bureau List >> Michigan Office of Administrative Hearings and Rules >> Administrative Rules >> Publications >> Michigan Administrative Code >> Select Department: Health and Human Services >> Behavioral and Physical Health and Aging Services Administration >> BPHASA Provider Hearings	Reflects recent revisions to organization of MDHHS.

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CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Appeals	Under "Appeals/Administrative Hearings/Informal Conferences (Provider)", the web address was revised to read: http://www.michigan.gov/lara >> Bureau List >> Michigan Office of Administrative Hearings and Rules >> Administrative Rules >> Publications >> Michigan Administrative Code >> Select Department: Health and Human Services >> Behavioral and Physical Health and Aging Services Administration >> BPHASA Provider Hearings	Reflects recent revisions to organization of MDHHS.
Directory Appendix	Brain Injury Services (new section)	Addition of: **Content/Topic:** Brain Injury Services **Phone # Fax #:** 517-241-4100 **Mailing/Email/Web Address:** Home and Community-Based Services Section 400 S. Pine St. Lansing, MI 48913 Email: MSA-TBIWAIVER@michigan.gov **Information Available/Purpose:** general information	Update.
Directory Appendix	Community Transition Services	Under "Community Transition Services", addition of: **Phone # Fax #:** 517-241-4100 **Mailing/Email/Web Address:** Home and Community-Based Services Section 400 S. Pine St. Lansing, MI 48913 Email: MDHHS-MSA-NFTSERVICES@michigan.gov	Update.

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Directory Appendix	Mental Health/ Substance Abuse Resources	Under "**Certified Community Behavioral Health Clinic Demonstration**", text under "Information Available/Purpose" was revised to read: PPS-1 Rate: ~~PIHP/CMHSP Service Encounter Coding Chart and Provider Qualifications.~~ Behavioral Health Code Charts and Provider Qualifications document	Update.
Directory Appendix	MI Choice Waiver Resources	Under "MI Choice Waiver", addition of: **Phone # Fax #:** 517-241-4100 **Mailing/Email/Web Address:** Home and Community-Based Services Section 400 S. Pine St. Lansing, MI 48913 Email: MDHHS-MiChoice@michigan.gov	Update.
Directory Appendix	Nursing Facility Resources	Under "Pre-Eligibility Medical Expenses (PEME)", the mailing address was revised to read: MDHHS Behavioral and Physical Health and Aging Services Administration Attention: PEME PO Box 30479 Lansing, MI 48909-9634	Reflects recent revisions to organization of MDHHS.

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CHAPTER	SECTION	CHANGE	COMMENT
Forms Appendix		The following forms were revised to reflect recent revisions to the organization of MDHHS, i.e., "Health and Aging Services Administration" was revised to read "Behavioral and Physical Health and Aging Services Administration": • MSA-1302; Benefits Monitoring Program Referral • MSA-1550; Beneficiary Verification of Coverage • MSA-4240; Certification for Induced Abortion • MSA-1653-D; Complex Seating and Mobility Device Prior Approval – Request/Authorization • MSA-2081; Genetic and Molecular Laboratory Test Authorization Request • MSA-181; Home Health Aide Prior Approval Request/Authorization • MSA-1755; Medicaid Enrolled Birthing Hospital Agreement for Elective, Non-Medically Indicated Delivery Prior to 39 Weeks Completed Gestation • MSA-6544-B; Practitioner Special Services Prior Approval – Request/Authorization • MSA-0732; Private Duty Nursing Prior Authorization – Request for Service • MSA-1653-B; Special Services Prior Approval – Request/Authorization	Reflects recent revisions to organization of MDHHS.
Forms Appendix	CMS-10231; Certification of Public Expenditure	The form was removed.	Form is obsolete.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 21-49	12/1/2021	Pharmacy	8.5.B. Weight Loss	The subsection title was revised to read: ~~Weight Loss~~ Anti-Obesity Text was revised to read: • ~~Current medical status, including nutritional or dietetic assessment.~~ • ~~Current therapy for all medical conditions, including obesity.~~ • ~~Documentation of specific treatments, including medications.~~ • ~~Current accurate Body Mass Index (BMI), height, and weight measurements.~~ • ~~Confirmation that there are no medical contraindications to reversible lipase inhibitor use; no malabsorption syndromes, cholestasis, pregnancy and/or lactation.~~ • ~~Details of previous weight loss attempts and clinical reason for failure (at least two failed, physician-supervised, attempts are required).~~ Prior authorization criteria can be found on the PBM vendor website as 'Clinical and PDL PA Criteria'. (Refer to the Directory Appendix for website information.)
MSA 21-54	12/29/2021	Billing & Reimbursement for Institutional Providers	7.12 Dialysis (Hemodialysis and Peritoneal)	Text was revised to read: MDHHS follows Medicare's billing requirements for outpatient and emergency outpatient ~~chronic~~ dialysis services (e.g., the appropriate diagnosis code, patient weight, height, etc.); however, coverage and reimbursement policies differ. Refer to the outpatient portion of the Hospital Chapter of this manual and the MDHHS OPPS Wraparound Code List on the MDHHS website for additional information. (Refer to the Directory Appendix for MDHHS website information.)

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		Emergency Services Only	Section 3 – Coverage	In the 1st paragraph, the 3rd bullet point was revised to read: • treatment of chronic conditions (e.g., ~~ongoing dialysis,~~ chemotherapy, etc.) In the table in the 2nd paragraph, **Coverage** information for **Outpatient Hospital/Emergency Department** was revised to read: Limited to the treatment of emergency conditions. Follow-up care to emergency treatment and chronic care (e.g., ~~dialysis,~~ chemotherapy, etc.) is **not** covered.
		Hospital	3.12 Dialysis (Hemodialysis and Peritoneal Dialysis)	The 1st sentence was revised to read: MDHHS coverage and reimbursement is an all-inclusive rate for emergency ESRD dialysis services and maintenance outpatient dialysis services for beneficiaries receiving hemodialysis or peritoneal dialysis.
		Hospital Reimbursement Appendix	Section 1 – Outpatient	The following text was added after the 1st paragraph: Dialysis services provided to an Emergency Services Only (ESO) beneficiary must include a diagnosis code for End Stage Renal Disease on Dialysis.
		Pharmacy	11.6 Emergency Services Only (ESO) and End Stage Renal Disease (ESRD) (new subsection)	New subsection text reads: For coverage of medications related to ESRD for an ESO beneficiary, practitioners must identify the appropriate ESRD diagnosis code on prescriptions. Pharmacies should report both the ESRD diagnosis code and required level of service value of '3'.

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		Practitioner	4.3 Hemodialysis and Peritoneal Dialysis	Text was revised to read: Medicaid covers physician services required to manage care of beneficiaries with end-stage renal disease (ESRD) who are receiving ~~ongoing dialysis in an outpatient facility or at home~~ outpatient and emergency dialysis. Professional services for emergency dialysis must include an ESRD diagnosis and the "Y" Emergency Indicator. Most physician services are covered …
HASA 22-01	3/1/2022	Behavioral Health and Intellectual and Developmental Disability Supports and Services	17.3.G.3. Peer Recovery Coach Services	Under **"Peer Recovery Coach Services"**, text was revised to read: Peer Recovery Coach services are provided by a person in a journey of recovery from ~~addictions or co-occurring disorders~~ substance use, co-occurring disorders, and/or non-substance addictive disorders, and who identifies with a beneficiary based on a shared background and ~~life~~ lived experience. The Peer Recovery Coach ~~serves~~ serving in a role as a community health worker (CHW) operates as a personal guide and mentor for beneficiaries seeking, or already in, recovery from substance use disorders. Peer Recovery Coaches support a beneficiary's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports while role modeling the many pathways to recovery as each individual determines his or her own way. The Peer Recovery Coach helps to remove barriers and obstacles, assists with practices of harm reduction, and links the beneficiary to resources in the recovery community.

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				Services provided by ~~a~~ peer recovery coaches support beneficiaries to become and stay engaged in the recovery process and reduce the likelihood of relapse. Activities are targeted to beneficiaries at all places along the path to recovery~~, including outreach for persons who are still active in their addiction, up to and including individuals who have been in recovery for several years~~. Peer Recovery Coaches embody a powerful message of hope, ~~helping beneficiaries achieve a full and meaningful life in the community~~ assisting beneficiaries to achieve goals of community inclusion and participation, independence, recovery, resiliency and/or productivity. This medical necessity criteria assists the peer recovery coach with setting recovery goals, developing recovery action plans, and supporting beneficiaries to live a full and meaningful life in the community through the individualized treatment planning process. ~~The Peer Recovery Coach can assist with tasks such as setting recovery goals, developing recovery action plans, and solving problems directly related to recovery.~~ The peer recovery coach supports each beneficiary to fully participate in communities of their choosing in the environment most supportive of their recovery ~~and that promotes housing of their choice to build recovery connections and supports~~. Utilizing a strength-based perspective and emphasizing assessment of recovery capital (utilizing the total resources a beneficiary has to find and sustain recovery), services are designed to include prevention strategies and the integration and coordination of physical and behavioral health services to help attain and maintain recovery and prevent relapse. ~~Beneficiaries utilizing Peer Recovery Coach services must freely choose the individual who is providing Peer Recovery Coach services.~~ Building upon the strong foundation of a recovery-oriented philosophy and evidence-based practices (EBPs), peer recovery coaches may offer Screening, Brief Intervention, & Referral to Treatment (SBIRT) to a full continuum of SUD treatment and recovery supports.

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				Peer recovery coaches work in a variety of settings providing successful engagement in treatment and transitions across all levels of care for beneficiaries with high-risk and complex care needs. Some of the settings where peer recovery coaches may provide services include residential treatment facilities, Medication Assisted Treatment (MAT) programs, Recovery Community Organizations (RCO), hospital emergency rooms, Opioid Health Homes (OHH), housing programs, outpatient treatment and prevention, drug courts and other justice involved settings. Individuals who have been certified by Connecticut Community for Addiction Recovery (CCAR), Michigan Certification Board for Addiction Professionals (MCBAP), or Genesee Health System approved curriculum prior to January 1, 2018, may request a previous standards application. ~~The Peer Recovery Coach shall receive regular supervision by a case manager, treatment practitioner, prevention staff or an experienced Certified Peer Recovery Coach who has over two continuous years in recovery and over two years in the direct provision of recovery coach services and supports.~~ The following text was added after **Peer Recovery Coach Services**: **Supervision Requirements** The peer recovery coach shall be supervised by a Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when in a setting that receives Medicaid reimbursement. Programs funded by the Substance Abuse Block Grant (SABG) and/or Public Act 2 (PA2) funding shall receive ongoing supervision by a case manager, treatment practitioner, prevention staff, or an experienced Certified Peer Recovery Coach who has over two continuous years in recovery and over two years in the direct provision of recovery coach services and supports.

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				Under **"Requirements"**, text was revised to read: Individuals who work as a Peer Recovery Coach serving beneficiaries with substance use or co-occurring disorders must: • Be at least 18 years of age; • Have a high school diploma, General Education Diploma (GED), or provide college transcripts in lieu of a high school diploma or GED; • Have a SUD, co-occurring disorder(s), and/or non-substance addictive disorder(s) and have received treatment from a public or private provider; • Have two continuous years in recovery ~~from addition(s), with experience in navigating treatment services and/or prevention~~ at some point in time after the age of 18; • Share their recovery story as a tool in helping others; • ~~Have experience receiving publicly-funded treatment and recovery services for addiction(s);~~ • ~~Be employed at least 10 hours per week by a licensed Substance Use Disorder Treatment Organization, a PIHP, a Community Mental Health Services Program, or another organization under contract to one or more of the forgoing organizations that provide substance abuse treatment and/or recovery support services; and~~ • ~~Attend and successfully complete the MDHHS Peer Recovery Coach training and certification.~~

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				• Have personal experience in navigating complex SUD, co-occurring disorder(s), and/or non-substance addictive disorder(s) treatment services (self-help groups are not included); • Self-identifies as having a substance use disorder, co-occurring disorder(s), and/or non-substance addictive disorder(s) with a substantial life disruption and shares their recovery story in supporting others; • Be employed by a CMHSP or contract provider at the beginning of training; • Meet the MDHHS application approval process for specialized training and certification. The process includes: ➢ Completed peer recovery coach application ➢ Supervisor signature and acknowledgment form ➢ Two written letters of reference ➢ Current job description ➢ Read, understand, and agree to the MDHHS Peer Recovery Coach Code of Ethics ➢ Acknowledgement of truthfulness and accuracy of application ➢ Peer-to-peer interview ➢ Training fee paid by the agency that employs the peer recovery coach; • Be freely chosen by beneficiaries utilizing peer recovery coach services; and • Adhere to the MDHHS Peer Recovery Coach Code of Ethics.

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		Acronym Appendix		Addition of the following: EBP - evidence-based practice GED - General Education Diploma OHH - Opioid Health Homes RCO - Recovery Community Organizations SBIRT - Screening, Brief Intervention, & Referral to Treatment
HASA 22-03	2/8/2022	Medical Supplier	2.13.A. Enteral Nutrition (Administered Orally)	Under "PA Requirements", the following code was added to the list of codes requiring authorization via a telephone authorization process: S9432
		Medical Supplier	2.13.B. Enteral Nutrition (Administered by Tube)	Under "PA Requirements", the following code was added to the list of codes requiring authorization via a telephone authorization process: S9432
		Practitioner	4.8 Preventive Services	The 1st[t] paragraph was revised to read: The program covers preventive services assigned a grade A or B by the USPSTF and all adult vaccines and their administration recommended by ACIP for beneficiaries age 21 years and older. (Refer to the Directory Appendix for USPSTF and ACIP website information.) Vaccine counseling visits are covered for all Medicaid beneficiaries when individuals are counseled regarding the importance of vaccines but the vaccine is not administered.

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HASA 22-05	3/1/2022	Home Help	8.8.B.1. Electronic Service Verification (ESV)	Text was revised to read: An individual caregiver with CHAMPS access must verify authorized services provided by submitting an electronic service verification (ESV) through CHAMPS. The individual caregiver must: • Submit the ESV monthly. A separate ESV must be submitted for each client served during the month. • Accurately report the services provided on each day of the month. In addition to submitting the ESV monthly, the individual caregiver must report any change in services to the client's ASW within 10 business days. An individual caregiver will ONLY be paid for: • The tasks they provide and check on the ESV. • Travel time they spend on laundry and/or shopping and check on the ESV ~~In addition to submitting the ESV monthly, the individual caregiver must report any change in services to the client's ASW within 10 business days.~~

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				An ESV can be modified as follows: **Adding Provided Tasks to the ESV:** An individual caregiver who forgets to check a task(s) they provided or travel time they incurred before submitting the ESV may still be eligible for payment for these services. The individual caregiver must reopen the ESV, check the missed task(s) and/or travel time, then resubmit the ESV. MDHHS will issue a separate payment for the eligible tasks and/or travel time the individual caregiver added to the ESV. To be eligible for payment, tasks must be added and the ESV resubmitted within 365 days of the last date of service on the ESV. NOTE: If an individual caregiver receives a retroactive authorization for services and needs additional time to resubmit the ESV, they must contact the client's ASW. **Removing Tasks from the ESV that were Checked but not Provided:** The ESV must include only the tasks an individual caregiver provided and can be corrected to remove tasks that were checked in error. An individual caregiver can only remove tasks from the ESV during the current month and before submitting the ESV. For previous months, the individual caregiver must provide the client's ASW with a list of tasks and/or travel time on the ESV that need to be removed. The ASW will use the information to recoup payment for services the individual caregiver did not provide.

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HASA 22-06	3/2/2022	Billing & Reimbursement for Professionals	Section 1 - General Information	In the 2nd paragraph, the following was added to the list of providers: • Genetic Counselors In the 4th paragraph, the following was added to the list of services: • Genetic Counseling
		Laboratory	5.5.E. Genetic Counseling (new subsection)	New subsection text reads: Medicaid covers medically necessary genetic counseling services as defined in section 333.17001 (Act 368 of 1978) when ordered and performed by a Medicaid-enrolled physician, PA, or APRN (NPs, CNSs, and CNMs). Genetic counseling may also be provided by a Medicaid-enrolled licensed Genetic Counselor. Genetic Counselors should refer to the Practitioner Chapter for additional information. Counseling is covered when provided in consideration of, or in conjunction with, genetic testing, or provided in relation to a genetic or congenital condition. Services are considered medically necessary when there is an expectation that a genetically inherited or acquired condition exists, and the beneficiary displays clinical features or is at risk of inheriting the disease/ condition based upon factors including, but not limited to, personal history, family history, documentation of a genetic mutation, and/or ethnic background.
		Practitioner	Section 1 – General Information	The 1st paragraph was revised to read: This chapter applies to physicians (MD, DO), Oral-Maxillofacial Surgeons (MD, DO), Doctors of Podiatric Medicine (DPM), Physician Assistants (PAs), Medical Clinics, ~~Physical Therapists (PTs),~~ Advanced Practice Registered Nurses (APRNs) [including Certified Nurse Practitioners (NPs), Certified Clinical Nurse Specialists (CNSs), and Certified Nurse-Midwives (CNMs)], Certified Registered Nurse Anesthetists (CRNAs), ~~and~~ Anesthesiologist Assistants (AAs), and Genetic Counselors.

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			3.13 Genetic Counseling (new subsection)	New subsection text reads: Medicaid covers medically necessary genetic counseling services as defined in section 333.17001 (Act 368 of 1978) when provided by a Medicaid-enrolled physician, PA, or APRN (NPs, CNSs, and CNMs). Genetic counseling may also be provided by a licensed Medicaid-enrolled Genetic Counselor when ordered by a physician, PA, or APRN. Counseling is covered when provided in consideration of, or in conjunction with, genetic testing, or provided in relation to a genetic or congenital condition. Counseling is considered medically necessary when there is an expectation that a genetically inherited or acquired condition exists, and the beneficiary displays clinical features or is at risk of inheriting the disease/condition based upon factors including, but not limited to, personal history, family history, documentation of a genetic mutation, and/or ethnic background. Genetic tests recommended as a result of genetic counseling may be covered when provided in accordance with Medicaid's Genetic and Molecular Testing policy. Providers should refer to the Genetic and Molecular Testing subsection of the Laboratory Chapter for information on genetic testing.
			Section 26 – Genetic Counselors (new section)	

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			26.1 Covered Services (new subsection)	New subsection text reads: Medicaid covers medically necessary genetic counseling services, as defined in section 333.17001 (Act 368 of 1978), when provided by a licensed Genetic Counselor and ordered by a Medicaid-enrolled physician, PA, or APRN (NPs, CNSs, and CNMs). Genetic counseling is covered when provided in consideration of, or in conjunction with, genetic testing, or provided in relation to a genetic or congenital condition. Counseling is considered medically necessary when there is an expectation that a genetically inherited or acquired condition exists, and the beneficiary displays clinical features or is at risk of inheriting the disease/condition based upon factors including, but not limited to, personal history, family history, documentation of a genetic mutation, and/or ethnic background. Services are only covered when the genetic counselor has personally performed the genetic counseling and no other provider or entity has billed or been paid for the service. Genetic counseling services provided jointly by the genetic counselor and a collaborating physician or qualified non-physician medical practitioner are covered for a single practitioner only. Genetic tests recommended as a result of genetic counseling may be covered when provided in accordance with Medicaid's Genetic and Molecular Testing policy. Providers should refer to the Genetic and Molecular Testing subsection of the Laboratory Chapter for information on genetic testing.

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			26.2 Enrollment of Genetic Counselors (new subsection)	New subsection text reads: Licensed genetic counselors may enroll with Medicaid for reimbursement of genetic counseling services. To enroll as a Medicaid provider, the Genetic Counselor must complete an online application in the Community Health Automated Medicaid Processing System (CHAMPS) and enroll with an Individual (Type 1) National Provider Identifier (NPI) as either a Rendering/Servicing-Only or Individual/Sole Provider. Genetic counselors in Michigan must be currently licensed by the Department of Licensing and Regulatory Affairs (LARA) and certified by the American Board of Genetic Counseling (ABGC) or American Board of Medical Genetics (ABMG). Out-of-state counselors must be currently licensed by the appropriate standard-setting authority in the state where they are practicing and must comply with Michigan Medicaid policy requirements regarding the provision of out-of-state services. Individuals holding temporary genetic counselor licenses are not eligible to enroll as providers or be directly reimbursed by Medicaid. Services performed by these individuals must be performed under the supervision of a fully licensed, qualified genetic counselor as defined in section 333.6109 (Act 368 of 1978). Services must be billed to Medicaid under the NPI of the supervising genetic counselor. Licensed genetic counselors may not be employed by or contracted with a commercial genetic testing laboratory. Genetic counselors working within an integrated, comprehensive health care delivery system that operates a laboratory but also routinely delivers health care services beyond laboratory testing are not excluded from enrollment.
		Acronym Appendix		Addition of: ABGC - American Board of Genetic Counseling ABMG - American Board of Medical Genetics

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HASA 22-09	4/7/2022	Behavioral Health and Intellectual and Developmental Disability Supports and Services	Section 20 – Behavioral Health Home	The 1st paragraph was revised to read: Pursuant to the requirements of Section 2703 of the Patient Protection and Affordable Care Act/Section 1945 of the Social Security Act, the purpose of ~~this policy~~ the Behavioral Health Home (BHH) is to provide for the coverage and reimbursement of six required Behavioral Health Home ~~(BHH)~~ services. This ~~policy~~ benefit is effective for dates of service on and after October 1, 2020. The ~~policy~~ benefit applies to Fee-for-Service and managed care beneficiaries enrolled in Medicaid, the Healthy Michigan Plan, Freedom of Choice, or MIChild who meet BHH eligibility criteria. In addition, MDHHS created a companion operation guide for providers called the Behavioral Health Home (BHH) Handbook which is available on the MDHHS website. (Refer to the Directory Appendix for website information.)
			20.1 General Information	Text was revised to read: The BHH ~~will~~ provides comprehensive care management and care coordination services to beneficiaries with a select serious mental illness/serious emotional disturbance. The goals of the ~~program~~ benefit are to ensure seamless transition of care and to connect eligible beneficiaries with needed clinical, behavioral, and social services. MDHHS expects the benefit will enhance beneficiary outcomes and quality of care, while simultaneously shifting people from emergency departments and hospitals to a behavioral health care setting.
			20.2 Beneficiary Eligibility	Text was revised to read: Eligible beneficiaries meeting geographic area requirements cited in the Provider Eligibility Requirements subsection include those enrolled in Medicaid, the Healthy Michigan Plan, Freedom of Choice, or MIChild who have a diagnosis of a Serious Mental Illness or Serious Emotional Disturbance.

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			20.3.C. Provider Recommended Identification of Potential Enrollees	Text was revised to read: HHPs are permitted to recommend potential enrollees for the BHH benefit via the WSA. BHH providers must provide documentation that indicates whether a potential BHH enrollee meets all eligibility for the health home benefit, including diagnostic verification, obtaining consent, and establishment of a~~n individualized~~ Behavioral Health Home care plan. The PIHP must review and process all recommended enrollments in the WSA. MDHHS reserves the right to review and verify all enrollments.
			20.3.F. Beneficiary Disenrollment	In the 2nd paragraph, the 2nd bullet point was revised to read: • Beneficiaries who are unresponsive for reasons other than moving or death. The PIHP or HHP must make at least three unsuccessful beneficiary contact attempts within ~~six~~ three consecutive months for MDHHS to deem a beneficiary as unresponsive. The PIHP and MDHHS must maintain a list of disenrolled beneficiaries in the WSA. The PIHP must attempt to re-establish contact with these beneficiaries at least every six months after disenrollment~~, as applicable~~ for a year or until eligibility changes.
			20.4 Covered Services	In the 1st bullet point, the 4th sub-bullet point was revised to read: ➢ Documentation of assessment and ~~individualized~~ behavioral health home care plan in the Electronic Health Record (EHR); and

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			20.5.A. Geographic Area	The following counties were added: • Lenawee • Livingston • Monroe • Washtenaw • Wayne
			20.5.B. Provider Types	Text was revised to read: The PIHP will be responsible for providing health home services in partnership with community-based HHPs. PIHPs currently contract with the State of Michigan for Medicaid services. HHPs are permitted to recommend prospective BHH beneficiaries for enrollment into the BHH via the PIHP. BHH providers must provide documentation that indicates whether a prospective BHH beneficiary meets all eligibility for the benefit, including diagnostic verification, obtaining consent (MDHHS-5515), and establishment of ~~an individualized~~ a care plan. The PIHP must review and process all recommended enrollments in the WSA.
		Acronym Appendix		Addition of: HHP – Health Home Partner; Health Home Provider

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		Directory Appendix	Mental Health/Substance Abuse	Under "**Behavioral Health Home**", text under "Information Available/Purpose" was revised to read: Provider Resources: Behavioral Health Home Handbook; Policy Bulletin MSA 20-48; Policy Bulletin HASA 22-09; State Plan Amendment Approval Letter; Health Home Provider Application; Behavioral Health Home Brochure and Poster; Behavioral Health Home Directory; Behavioral Health Home Encounter Codes and Rates.; Care Plan Example
HASA 22-10	4/1/2022	General Information for Providers	9.4 Clinical Trials (new subsection; the following subsection was re-numbered)	New subsection text reads: PA requirements that apply to services provided outside of a clinical trial apply to routine services within a clinical trial. PA requests, when required, must contain the clinical trial number, be complete, and submitted electronically via FFS Direct Data Entry (DDE) in CHAMPS to allow for expedited review.
		Billing & Reimbursement for Institutional Providers	6.3 Clinical Trials (new subsection; the following subsections were re-numbered)	New subsection text reads: All claims for routine patient costs associated with participation in a clinical trial must include the National Clinical Trial (NCT) number and an ICD-10 diagnosis code indicating the services are associated with a clinical trial.

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			6.3.A. Reporting Covered Services (new subsection)	New subsection text reads: Submit claims for services on the CMS UB04/837I institutional claim format as follows: • Report Z00.6 in the primary or secondary position. • Report condition code 30 whether all services are related to the clinical trial or not. • For paper/direct data entry, report the clinical trial number in Field Locators (FL) 39-41 for value code D4. • For electronic claim 837I, report the clinical trial number in Loop 2300 REF02 (REF01=P4).
			6.3.B. Reporting Non-Covered Services (new subsection)	New subsection text reads: Generally, services, investigational drugs, or items that are part of the clinical trial and considered experimental or investigational should not be reported on a claim. In instances when claims processing edits require non-covered services be billed with their associated procedures, or when it is necessary for a provider to show the items and services provided free-of-charge to receive payment for the covered routine costs, providers are instructed to report non-covered services/charges on a separate claim using Type of Bill (TOB) 0110 (no-pay claim). The non-covered claim must be billed with the same Statement Covers Period (From and Through date) as the payable TOB 011X submitted for the same stay as the covered services related to the clinical trial. Include the clinical trial identifiers listed above on the no-pay claim. Claims submitted with TOB 0110 will result in a denial. Refer to the Billing & Reimbursement for Professionals chapter for additional information.

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			7.9 Clinical Trials (new subsection; the following subsections were re-numbered)	New subsection text reads: All outpatient hospital facility claims for routine patient costs associated with participation in a clinical trial must adhere to the inpatient hospital claim guidelines for reporting covered services using the CMS UB04/837I institutional claim format. (Refer to the Hospital Claim Completion – Inpatient section, Clinical Trials subsection for additional information.) In addition, outpatient hospital facility claims must include: • Clinical trial and non-clinical trial services on separate line items when claims are submitted for both types of services on the same claim. • Each line identified with the appropriate Healthcare Common Procedure Coding System (HCPCS) Modifier Q0 or Q1. ➢ HCPCS Modifier Q0 - **investigational clinical service** provided in a clinical research study that is in an approved clinical research study. ➢ HCPCS Modifier Q1 – **routine clinical service** provided in a clinical research study that is in an approved clinical research study.
			7.9.A. Reporting Non-Covered Services (new subsection)	New subsection text reads: Report non-covered services/charges with the appropriate modifier and a token charge ($1) for a 'no cost' item in the covered charge field. Refer to the Billing & Reimbursement for Professionals and the Practitioner Chapters for additional information.

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		Billing & Reimbursement for Professionals	6.8 Clinical Trials (new subsection; the following subsections were re-numbered)	New subsection text reads: All claims for routine patient costs associated with participation in a clinical trial must include the National Clinical Trial (NCT) number and an ICD-10 diagnosis code indicating the services are associated with a clinical trial.
			6.8.A. Reporting Covered Services (new subsection)	New subsection text reads: Submit claims for services using the CMS 1500/837P professional claim format as follows: Paper/direct data entry — Report the clinical trial number in FL 19. Electronic claim form 837P — Report the clinical trial number in Loop 2300 NTE.
			6.8.B. Reporting Non-Covered Services (new subsection)	New subsection text reads: Generally, services, investigational drugs, or items that are part of the clinical trial and considered experimental or investigational should not be reported on a claim. In instances when claims processing edits require non-covered services be billed with their associated procedures, or when it is necessary for a provider to show the items and services provided free-of-charge to receive payment for the covered routine costs, providers are instructed to report non-covered services/charges on a separate claim line with the appropriate modifier and a charge of $0. Refer to the Billing & Reimbursement for Institutional Providers and the Practitioner Chapters for additional information.

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		Federally Qualified Health Centers	4.3 Clinical Trials (new subsection; the following subsections were re-numbered)	New subsection text reads: The program covers routine patient costs furnished in connection with participation in a qualifying clinical trial. Refer to the Practitioner Chapter for additional coverage information. All FQHC claims for routine patient costs associated with participation in a clinical trial must adhere to the inpatient hospital claim guidelines for reporting covered services using the CMS UB04/8371 institutional claim format. (Refer to the Clinical Trials subsection of the Billing & Reimbursement for Institutional Providers chapter for additional information.) In addition, FQHC claims must include: • Clinical trial and non-clinical trial services on separate line items when claims are submitted for both types of services on the same claim. • Each line identified with the appropriate Healthcare Common Procedure Coding System (HCPCS) Modifier Q0 or Q1. ➢ HCPCS Modifier Q0 - **investigational clinical service** provided in a clinical research study that is in an approved clinical research study ➢ HCPCS Modifier Q1 – **routine clinical service** provided in a clinical research study that is in an approved clinical research study.

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			4.3.A. Reporting Non-Covered Services (new subsection)	New subsection text reads: Generally, services, investigational drugs, or items that are part of the clinical trial and considered experimental or investigational should not be reported on a claim. In instances when claims processing edits require non-covered services be billed with their associated procedures, or when it is necessary for a provider to show the items and services provided free-of-charge to receive payment for the covered routine costs, providers are instructed to report non-covered services with the appropriate modifier and a charge of $0.
		Hospital	3.11 Clinical Trials (new subsection; the following subsections were re-numbered)	New subsection text reads: The program covers routine patient costs furnished in connection with participation in a qualifying clinical trial. Routine patient costs are defined as any item or service provided to prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial to the extent that the provision of such items or services to the beneficiary would otherwise be covered outside the course of participation in the qualifying clinical trial under the state plan or waiver. Routine patient costs also include any item or service required solely for the provision of the investigational item or service that is the subject of the qualifying clinical trial, including the administration of the investigational item or service. Refer to the Billing & Reimbursement for Institutional Providers, the Billing & Reimbursement for Professionals, and the Practitioner chapters for information related to coverage of routine patient costs furnished in connection with participation in a clinical trial.
		Practitioner	3.6 Clinical Trials (new subsection; the following subsections were re-numbered)	New subsection text reads: The program covers routine patient costs furnished in connection with participation in a qualifying clinical trial. Routine patient costs are any item or service provided to the beneficiary under the qualifying clinical trial.

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			3.6.A. Covered Items and Services (new subsection)	New subsection text reads: Routine patient costs include any item or service provided to prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial to the extent that the provision of such items or services to the beneficiary would otherwise be covered outside the course of participation in the qualifying clinical trial under the state plan or waiver. Routine patient costs also include any item or service required solely for the provision of the investigational item or service that is the subject of the qualifying clinical trial, including the administration of the investigational item or service. Examples of routine costs include otherwise covered physician services or laboratory or medical imaging services that assist with prevention, diagnosis, monitoring, or treatment of complications arising from clinical trial participation.
			3.6.B. Non-covered Items and Services (new subsection)	New subsection text reads: Items and services considered experimental or investigational are not a covered benefit. This includes the experimental or investigational drug, item, or service that is the subject of the qualifying clinical trial. Other non-covered items and services include: • Items and services not otherwise covered by the Medicaid program; • Items and services provided to the beneficiary solely to satisfy data collection and analysis for the qualifying clinical trial that are not used in the direct clinical management of the beneficiary; and • Items and services provided by the trial sponsor without charge.

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			3.6.C. Qualifying Clinical Trial (new subsection)	New subsection text reads: A qualifying clinical trial is defined to include a clinical trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition. A qualifying clinical trial must also be one or more of the following: • A study or investigation that is approved, conducted, or supported (including funding through in-kind contributions) by one or more of the following: ➢ the National Institutes of Health (NIH); ➢ the Centers for Disease Control and Prevention (CDC); ➢ the Agency for Healthcare Research and Quality (AHRQ); ➢ the Centers for Medicare & Medicaid Services (CMS); ➢ a cooperative group or center of any of the entities described above, or the Department of Defense or the Department of Veterans Affairs; and ➢ a qualified non-governmental research entity identified in the guidelines issued by NIH for center support grants. • A clinical trial, approved or funded by any of the following entities, that has been reviewed and approved through a system of peer review in compliance with Section 210 of the Consolidated Appropriations Act: ➢ the Department of Energy ➢ the Department of Veterans Affairs ➢ the Department of Defense

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				• A clinical trial that is one conducted pursuant to an investigational new drug exemption under section 505(i) of the Federal Food, Drug, and Cosmetic Act or an exemption for a biological product undergoing investigation under section 351(a)(3) of the Public Health Service Act; or • A clinical trial that is a drug trial exempt from being required to have one of the exemptions in the prior bullet.
			3.6.D. Determination for Coverage (new subsection)	New subsection text reads: Determination for coverage of costs associated with a beneficiary participating in a qualifying clinical trial shall be made with the following considerations: • Expedited and completed within 72 hours; • Made without limitation on the geographic location of where the clinical trial is conducted or based on the network affiliation of the principal investigator or provider treating the beneficiary in connection with the clinical trial; • Based on attestation of the principal investigator or provider regarding the appropriateness of the qualifying clinical trial; and • Shall not require the submission of protocols of the qualifying clinical trial or any other documentation that may be proprietary.
			3.6.E. Prior Authorization (new subsection)	New subsection text reads: Not all services and costs associated with a clinical trial require prior authorization (PA). All PA requirements that apply to services provided outside of a clinical trial apply to routine services within a clinical trial. Refer to the General Information for Providers Chapter for additional PA requirements.

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			3.6.F. Claims for Services (new subsection)	New subsection text reads: All claims for routine patient costs associated with participation in a clinical trial must include the National Clinical Trial (NCT) number and an ICD-10 diagnosis code indicating the services are associated with a clinical trial, such as Z00.6 (encounter for examination for normal comparison and control in clinical research program). Claims may also include any future ICD-10 diagnosis code(s) that falls within the structure and conventions of the classification and general guidelines applicable to clinical trial services as established by CMS and National Center for Health Statistics (NCHS) services. Refer to the Billing & Reimbursement for Institutional Providers and the Billing & Reimbursement for Professionals chapters for additional claim requirements for services associated with participation in a clinical trial.

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		Rural Health Clinics	6.3 Clinical Trials (new subsection; the following subsections were re-numbered)	New subsection text reads: The program covers routine patient costs furnished in connection with participation in a qualifying clinical trial. Refer to the Practitioner Chapter for additional coverage information. All RHC claims for routine patient costs associated with participation in a clinical trial must adhere to the inpatient hospital claim guidelines for reporting covered services using the CMS UB04/8371 institutional claim format. In addition, RHC claims must include: • Clinical trial and non-clinical trial services on separate line items when claims are submitted for both types of services on the same claim. • Each line identified with the appropriate Healthcare Common Procedure Coding System (HCPCS) Modifier Q0 or Q1. ➢ HCPCS Modifier Q0 - **investigational clinical service** provided in a clinical research study that is in an approved clinical research study. ➢ HCPCS Modifier Q1 – **routine clinical service** provided in a clinical research study that is in an approved clinical research study.
			6.3.A. Reporting Non-Covered Services (new subsection)	New subsection text reads: Generally, services, investigational drugs, or items that are part of the clinical trial and considered experimental or investigational should not be reported on a claim. In instances when claims processing edits require non-covered services be billed with their associated procedures, or when it is necessary for a provider to show the items and services provided free-of-charge to receive payment for the covered routine costs, providers are instructed to report non-covered services with the appropriate modifier and a charge of $0.

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		Tribal Health Clinics	7.1 Clinical Trials (new subsection; the following subsections were re-numbered)	New subsection text reads: The program covers routine patient costs furnished in connection with participation in a qualifying clinical trial. Refer to the Practitioner Chapter for additional coverage information. All THC claims for routine patient costs associated with participation in a clinical trial must adhere to the inpatient hospital claim guidelines for reporting covered services using the CMS UB04/8371 institutional claim format. In addition, THC claims must include: • Clinical trial and non-clinical trial services on separate line items when claims are submitted for both types of services on the same claim. • Each line identified with the appropriate Healthcare Common Procedure Coding System (HCPCS) Modifier Q0 or Q1. ➢ HCPCS Modifier Q0 - **investigational clinical service** provided in a clinical research study that is in an approved clinical research study. ➢ HCPCS Modifier Q1 – **routine clinical service** provided in a clinical research study that is in an approved clinical research study.
			7.1.A. Reporting Non-Covered Services (new subsection)	New subsection text reads: Generally, services, investigational drugs, or items that are part of the clinical trial and considered experimental or investigational should not be reported on a claim. In instances when claims processing edits require non-covered services be billed with their associated procedures, or when it is necessary for a provider to show the items and services provided free-of-charge to receive payment for the covered routine costs, providers are instructed to report non-covered services with the appropriate modifier and a charge of $0.

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		Acronym Appendix		Addition of: AHRQ - Agency for Healthcare Research and Quality NCHS - National Center for Health Statistics NCT - National Clinical Trial NIH - National Institutes of Health
HASA 22-11	4/1/2022	Early and Periodic Screening, Diagnosis and Treatment	9.6 Blood Lead Screening	In the last paragraph, text was revised to read: There is no established safe level of lead for children. While the below recommendations indicate that certain actions should begin at a blood lead ~~level of 5 µg/dL~~ reference value (BLRV) of 3.5 µg/dL, providers may use … At the end of the subsection, the "Recommendations on Medical Management of Childhood Lead Exposure and Poisoning" chart was replaced in its entirety.
			13.5 Blood Lead Poisoning Follow-Up Services	In the 1st paragraph, the 1st sentence was revised to read: Many LHDs provide blood lead poisoning follow-up services which consist of environmental investigations and ~~blood lead nursing assessment visits~~ case management services.

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			13.5.B. Blood Lead Nursing Assessment Visits	The subsection title was revised to read: ~~Blood Lead Nursing Assessment Visits~~ Case Management Services The 1st sentence was revised to read: ~~Blood lead nursing assessment visits~~ Case management services for children with ~~blood lead levels of 5 mcg/dL~~ a BLRV of 3.5 µg/dL or greater are covered under the CSHCS case management benefit.
		Local Health Departments	2.2.B. Blood Lead Poisoning Follow-Up Services	The 1st paragraph was revised to read: LHDs may provide blood lead poisoning follow-up services which consist of environmental investigations and ~~nursing assessment visits~~ case management services. The last paragraph was revised to read: Documentation of the child's blood lead poisoning level that initiated service must be maintained, as well as documentation of all environmental investigations and ~~nursing assessment visits~~ case management services.

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			2.2.B.1. Blood Lead Nursing Assessment Visits	The subsection title was revised to read: ~~Blood Lead Nursing Assessment Visits~~ Case Management Services The 1st sentence was revised to read: ~~Blood lead nursing assessment visits~~ Case management services for children with ~~blood lead levels of 5 mcg/dL~~ a blood lead reference value (BLRV) of 3.5 µg/dL or greater are covered under the Children's Special Health Care Services (CSHCS) case management benefit.
			2.2.B.2. Environmental Investigations	In the 1st paragraph, the last sentence was revised to read: To be eligible for the service, the beneficiary must be under 21 years of age and have a confirmed ~~elevated blood lead level~~ ~~of 5 mcg/dL~~ BLRV of 3.5 µg/dL or greater.
			2.2.C. Blood Lead Resource Documents	The 1st paragraph was revised to read: Providers may obtain the Protocol for Environmental Investigations for Children with Elevated Blood Lead Levels, a list of certified risk assessors, applications for training and certification, and education materials from the MDHHS ~~Lead Hazard Remediation Program~~ Healthy Homes Section. (Refer to the Provider Resources section of the Directory Appendix for contact information.)
		Acronym Appendix		Addition of: BLRV – blood lead reference value

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HASA 22-12	4/1/2022	Family Planning Clinic	Section 5 – Pharmaceuticals	The 2nd paragraph was revised to read: ~~Oral contraceptives dispensed may not exceed a six-month supply, and the Nuvaring and contraceptive patches should not exceed a three month supply.~~ Dispensed oral contraceptives, vaginal rings, and contraceptive hormonal patches may not exceed a 12-month supply. All other contraceptive supplies should be dispensed for one month, with the exception of implants and hormonal contraceptives such as Depo Provera.
		Pharmacy	11.1 Days Supply	The 1st paragraph was revised to read: Prescription quantities are limited to the quantity specified by the prescriber. MDHHS covers up to a 34-day supply for acute medications, ~~and~~ up to a 102-day supply for maintenance medications, and up to a 12-month supply of contraceptives, including oral, vaginal ring, and contraceptive hormonal patches.
			14.11 Oral Contraceptives	Text was revised to read: Prescriptions for oral contraceptives may be dispensed for a ~~three~~-12-month supply when the prescriber writes the prescription accordingly.

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HASA 22-13	5/2/2022	Pharmacy	5.1.B. Proof of Delivery (new subsection)	New subsection text reads: Pharmacy providers must maintain a log verifying proof of delivery for all prescriptions delivered by common carrier (i.e., FedEx, UPS, USPS, etc.). Pharmacies should be able to link the tracking information to the prescription record through supporting documents if requested. Pharmacies must validate the member's address prior to mailing the prescription. A tracking number alone is not considered a valid proof of member receipt. The tracking number must be accompanied by either: • the tracking detail from the carrier showing medication was delivered, including date and time of delivery; or • the manual or electronic signature of the member or that of their representative at the time of delivery.
MSA 21-25	7/30/2021	Behavioral Health and Intellectual and Developmental Disability Supports and Services	19.5.A. Geographic Area	The following counties were added: • Keweenaw • Leelanau • Luce • Mackinac • Macomb ***NOTE:*** These counties were inadvertently omitted when bulletin MSA 21-25 was incorporated for the April 2022 update of the Medicaid Provider Manual.

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