

Bulletin Number: MMP 25-01

Distribution: All Providers

Issued: January 13, 2025

Subject: Clarification of Enrollment Requirement for Prescribers

Effective: February 15, 2025

Programs Affected: Medicaid, Plan First, Children's Special Health Care Services (CSHCS), Healthy Michigan Plan, Maternity Outpatient Medical Services (MOMS)

Section 6401 of the Patient Protection and Affordable Care Act and Section 5005(b)(2) of the 21st Century Cures Act established a requirement that all states must enroll providers in their state Medicaid program who prescribe drug products to Medicaid beneficiaries. On August 2, 2019, the Michigan Department of Health and Human Services (MDHHS) issued bulletin [MSA 19-20](#) (effective October 1, 2019) to establish the provider enrollment requirements of prescribing providers in accordance with these acts.

The MDHHS Medicaid provider enrollment process still adheres to the criteria set forth by the 21st Century Cures Act and by [MSA 19-03](#) (provider enrollment fitness criteria). The purpose of this bulletin is to provide clarifications to the framework that establishes exceptions to these requirements based on the [Medicaid Provider Enrollment Compendium](#) (MPEC), published by the Centers for Medicare & Medicaid Services (CMS).

Since October 1, 2019, pharmacy benefit claims submitted by a prescriber who is not enrolled in the Community Health Automated Medicaid Processing System (CHAMPS) have been denied per NCPDP Code 889: PRESCRIBER NOT ENROLLED IN STATE MEDICAID PROGRAM. However, in order for MSA 19-20 to be compliant with [42 CFR § 435.930\(c\)](#), which allows emergency coverage, pharmacies have been allowed to utilize Submission Clarification Codes (SCC) in NCPDP field 420-DK in accordance with MSA 19-20. These include:

- 13 – Payer-Recognized Emergency/Disaster Assistance Request
- 55 – Prescriber Enrollment in State Medicaid Program has been validated

Utilization of SCC 55 will continue to be allowed as originally established in MSA 19-20. However, beginning February 15, 2025, the submission of SCC 13 may only be utilized during an emergency circumstance in accordance with the MPEC, which only allows exceptions for each of the scenarios below where all respective criteria has been met:

1. Ordering Referring Providers are Ineligible to Enroll in the State Medicaid Program

- Providers that are allowed to function under a scope of practice that authorizes them to order or refer, but they are not eligible to enroll in the state Medicaid program.

2. Medicaid Beneficiary Secures Order or Referral Prior to Participation

- If the order or referral was made before the beneficiary was Medicaid eligible, then the beneficiary may have the order filled or the referral fulfilled and the claim for the order or referral will be paid. ([76 FR 5905](#))

3. Services Ordered or Referred by an Out-of-State Professional

- An item or service is furnished by:
 - An institutional provider at an out-of-state practice location (i.e., located outside the geographical boundaries of the reimbursing state's Medicaid plan);
 - An individual practitioner in an institutional setting at an out-of-state practice location (i.e., located outside the geographical boundaries of the reimbursing state's Medicaid plan); or
 - A pharmacy, pursuant to an order (i.e., prescription) written by an individual practitioner in an institutional setting at an out-of-state practice location (i.e., located outside the geographical boundaries of the reimbursing state's Medicaid plan).
- The NPI of the ordering referring provider is represented on the claim;
- The prescribing provider is enrolled and in an "approved" status in Medicare or in another state's Medicaid plan;
- The claim represents services provided;
- The claim represents services covered under the state plan; and
- The claim represents either:
 - A single instance of care or order over a 180-day period; or
 - Multiple instances of care provided to a single beneficiary, over a 180-day period.

Monitoring and Post Payment Audit Recovery

Factors taken into consideration when approving a retrospective billing date may include, but are not limited to:

- Emergency access
- Prior authorization
- Whether a provider is enrolled in Medicare or another states' Medicaid program

Providers utilizing the override exceptions may be subject to ongoing monitoring to ensure compliance with any conditions associated with the exception and to assess the continued need for the exception. Exceptions may be reviewed randomly and periodically to determine if they remain justified and necessary. Post payment audit recovery will take place if a provider fails to comply with the conditions of the exceptions or if circumstances justifying the exception change.

Manual Maintenance

Retain this bulletin until the information is incorporated into the MDHHS Medicaid Provider Manual.

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-mailed to ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Typical Providers may phone toll-free 800-292-2550. Atypical Providers may phone toll-free 800-979-4662.

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

Approved

A handwritten signature in black ink that reads "Meghan E. Groen". The signature is fluid and cursive, with the first name "Meghan" and last name "Groen" clearly legible.

Meghan E. Groen, Director
Behavioral and Physical Health and Aging Services Administration