

BULLETIN

Michigan Medicaid Policy (MMP) | Health Services

Bulletin Number: MMP 25-17

Distribution: All Providers

Issued: May 30, 2025

Subject: Updates to the MDHHS Medicaid Provider Manual

Effective: July 1, 2025

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 July 2025 update of the online version of the MDHHS Medicaid Provider Manual. The manual will be available July 1, 2025, 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.

The attachments describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change.

Manual Maintenance

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

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit questions, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Typical Providers may phone toll-free 1-800-292-2550. Atypical Providers may phone toll-free 1-800-979-4662.

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

Approved

A handwritten signature in black ink, reading "Meghan E. Groen". The signature is written in a cursive, flowing style.

Meghan E. Groen, Chief Deputy Director
Health Services



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TECHNICAL CHANGES*



CHAPTER	SECTION	CHANGE	COMMENT
Medicaid Provider Manual Overview	1.1 Organization	Information for the "Billing & Reimbursement for Dental Providers" chapter was revised to read: Affected Providers: Providers billing the ADA 2012 or 837 Dental claim formats.	Removing reference to a specific date for form. Providers should use the current ADA claim form.
Beneficiary Eligibility	2.1 Benefit Plans	Information regarding benefit plan 'Autism Related Services (AUT)' was removed.	Removal of obsolete information.
Billing & Reimbursement for Dental Providers	Section 1 General Information	Text was revised to read: This chapter applies to all providers billing the ADA 2012 or 837 Dental claim formats. It contains information needed to submit dental claims to the Michigan Department of Health and Human Services (MDHHS) for Medicaid and Children's Special Health Care Services (CSHCS). It also contains information about how claims are processed and how providers are notified of MDHHS actions. Dental providers must use the ASC X12N 837D 5010 dental format when submitting electronic claims and the ADA 2012 claim form for paper claims.	Removing reference to a specific date for form. Providers should use the current ADA claim form.
Billing & Reimbursement for Dental Providers	3.2 Paper Claims	The 1st paragraph was revised to read: The ADA 2012 claim form must be used when submitting paper claim forms. The MDHHS Optical Character Reader (OCR) scans paper claims.	Removing reference to a specific date for form. Providers should use the current ADA claim form.
Billing & Reimbursement for Dental Providers	3.2.A. Guidelines to Complete Paper Claim Forms	The 1st bullet point was revised to read: <ul style="list-style-type: none">American Dental Association (ADA) standard completion instructions should be followed in completing the ADA 2012 claim form.	Removing reference to a specific date for form. Providers should use the current ADA claim form.
Billing & Reimbursement for Dental Providers	4.1 Dental Claim Form Completion Instructions	Text was revised to read: American Dental Association (ADA) standard completion instructions should be followed in completing the ADA 2012 claim form.	Removing reference to a specific date for form. Providers should use the current ADA claim form.

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



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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Dental Providers	5.1 Supernumerary Teeth	The last paragraph was revised to read: Refer to the 2012 ADA Claim form instructions for additional information.	Removing reference to a specific date for form. Providers should use the current ADA claim form.
Billing & Reimbursement for Institutional Providers	4.2 Authorization of Admissions and Services	The 3rd paragraph was removed. CSHCS Exceptions: <ul style="list-style-type: none"> • Prior to October 1, 2012, beneficiaries with CSHCS coverage were excluded from enrollment in a MHP and the following applied: <ul style="list-style-type: none"> ➤ When a beneficiary was enrolled in CSHCS, they were disenrolled from the MHP. ➤ Upon review, MDHHS may have initiated a retroactive disenrollment from the MHP effective the first day of the month in which CSHCS medical eligibility was determined. ➤ Responsibility of payment transferred from the MHP to FFS on the effective date of the disenrollment. • After October 1, 2012, Medicaid beneficiaries who become eligible for CSHCS who are enrolled in an MHP will no longer be disenrolled from the MHP. 	Removal of obsolete information.
Billing & Reimbursement for Institutional Providers	4.4 Durable Items or Equipment	The subsection title was revised to read: Durable Items or Medical Equipment Text was revised to read: MDHHS policy directs providers to bill the date of delivery for durable items or medical equipment. However, when a beneficiary has a change in enrollment status and the responsible payer is different on the date of delivery than on the date of order, providers must bill the date of order and specify the date of delivery in the comments/remarks section. This is especially important when a person changes from FFS to a health plan.	Clarification and consistency in terminology.

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Professionals	5.1 Inpatient Hospital Admissions and Services	<p>The 3rd paragraph was removed.</p> <p>CSHCS Exceptions:</p> <ul style="list-style-type: none"> • Prior to October 1, 2012, beneficiaries with CSHCS coverage were excluded from enrollment in a MHP and the following applied: <ul style="list-style-type: none"> ➤ When a beneficiary was enrolled in CSHCS, they were disenrolled from the MHP. ➤ Upon review, MDHHS may have initiated a retroactive disenrollment from the MHP effective the first day of the month in which CSHCS medical eligibility was determined. ➤ Responsibility of payment transferred from the MHP to FFS on the effective date of the disenrollment. • After October 1, 2012, Medicaid beneficiaries who become eligible for CSHCS who are enrolled in an MHP will no longer be disenrolled from the MHP. 	Removal of obsolete information.
Billing & Reimbursement for Professionals	5.3 Durable Items or Equipment	<p>The subsection title was revised to read:</p> <p>Durable Items or Medical Equipment</p> <p>Text was revised to read:</p> <p>MDHHS policy directs providers to bill the date of delivery for durable items or medical equipment. However, when a beneficiary has a change in enrollment status and the responsible payer is different on the date of delivery than on the date of order, providers must bill the date of order and specify the date of delivery in the Comments/Remarks box on the claim. This is especially important when a beneficiary changes from FFS to a health plan.</p>	Clarification and consistency in terminology.
Billing & Reimbursement for Professionals	6.1 General Information	<p>Under "Place of Service Codes", the following bullet point was removed:</p> <ul style="list-style-type: none"> • 10 Telehealth Provided in Patient's Home 	Reflects information from bulletin MMP 24-06.

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	4.3 Essential Elements	<p>Under "Team Composition and Size", 2nd paragraph, the 1st bullet point was revised to read:</p> <ul style="list-style-type: none"> A full-time team leader whose experience includes at least two years post-degree clinical work with adults who have a serious mental illness, and is fully licensed, minimally possesses a master's degree in a relevant discipline, with appropriate licensure to provide clinical supervision to the ACT team staff. The ACT team leader leads the team, provides clinical supervision to team members, and provides direct services to beneficiaries in the community within their individual scope of practice. The fully licensed ACT team leader also meets the requirements of a MHP. The ACT team leader also meets the requirements of a MHP and licensing requirements in accordance with Licensing and Regulatory Affairs (LARA) for their position description and provider qualifications. 	Changes to provide consistency with SAMHSA ACT Implementation Fidelity.
Hospital	Section 2 – Prior Authorization	<p>For Service "* Off Label Use of Drugs", the following text was revised:</p> <p>Obtained Via: Contact the OMA Practitioner Special Services Prior Approval – Request/Authorization form (MSA-6544-B)</p>	Updated to reflect the actual process of obtaining PA. Providers do not directly contact the OMA.
Maternity Outpatient Medical Services	2.1 Covered Services	<p>The following bullet point was added:</p> <ul style="list-style-type: none"> Transportation to and from pregnancy-related services covered under the MOMS program. (Refer to the Non-Emergency Medical Transportation chapter for additional information.) 	Program policy clarification.
Maternity Outpatient Medical Services	2.2 Noncovered Services	<p>Text was revised to read:</p> <p>The following services are not covered under the MOMS benefit:</p> <ul style="list-style-type: none"> Postpartum outpatient lactation support and counseling services provided by an IBCLC are not covered. Postpartum MIHP coverage is limited to the prenatal period only. Dental services. 	Program policy clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
MI Choice Waiver	4.1.M. Private Duty Nursing/Respiratory Care	<p>Under "Limitations", the 6th paragraph was revised to read:</p> <p>PDN/RC services provided 24/7 cannot be authorized for participants who cannot direct their own services and supports, make informed decisions for themselves, or engage their emergency backup plan without assistance. These participants must have informal caregivers actively involved in providing some level of direct services to them on a routine basis. A need for 24/7 PDN/RC cannot be used as a primary reason for denying MI Choice eligibility or enrollment as there are circumstances when 24/7 PDN/RC may be appropriate for MI Choice participants. For all individuals requiring 24/7 PDN/RC, an assessment, person-centered service plan, backup/contingency plan, and order from a medical professional must be submitted to MDHHS for review and decision.</p>	Offer clarification as to the intent of the current language in the policy to avoid unintended denials.
MI Choice Waiver	6.4.B. Person-Centered Service Plan	<p>The 4th paragraph was revised to read:</p> <p>Informal Supports are unpaid supports that choose to volunteer their time to assist participants in lieu of MI Choice services and supports. If informal supports are involved as providers of services, they are not required to sign the PCSP, but must be notified about the duties they are expected to perform for the participant. The participant or legal representative takes responsibility for ensuring these duties are completed and ...</p>	Provide clarification of what "informal supports" means and align with federal regulations.
Pharmacy	14.8 Inhalers	<p>Text was revised to read:</p> <p>Depending on the beneficiary's condition, several inhalers per month may be necessary. If dispensing limitations allow and the prescriber writes accordingly, the beneficiary may obtain more than one inhaler per prescription. A dispensing fee for inhalers inhaler assist devices is not paid to pharmacies.</p>	Previous language using only the word "inhaler" was confusing as inhalers DO have a dispensing fee, but the assist devices (chambers, masks, etc.) are considered a medical supply and do not have a dispensing fee.
Tribal Health Centers	3.1 Covered Services	<p>In the 3rd paragraph, under "Pharmacy Services", the 2nd paragraph was revised to read:</p> <p>Practitioner pharmacy services do not include drugs provided by a pharmacy. THC's with enrolled pharmacy providers may continue to bill prescription claims for FFS beneficiaries to the MDHHS Pharmacy Benefits Manager (PBM). For beneficiaries enrolled in a health plan, prescription claims are billed to the health plan's PBM.</p>	Revised for clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Billing Resources	Addition of: Contact/Topic: American Dental Association Mailing/Email/Web Address: https://www.ada.org/ Information Available/Purpose: Obtain ADA claim forms and ADA claim completion instructions.	Addition of ADA website for claim form information.
Directory Appendix	Claim Submission/ Payment	Under " Paper Claim Submission ", text was revised as follows: INFORMATION AVAILABLE/PURPOSE: CMS-1500 (02-12), CMS-1450 (UB-04), and ADA 2012 claims are to be mailed to the address indicated. No other paper claim formats are accepted.	Removing reference to a specific date for form. Providers should use the current ADA claim form.

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MMP 24-51	11/13/2024	Behavioral Health and Intellectual and Developmental Disability Supports and Services	18.13 ABA Rate (new subsection)	New subsection text reads: All PIHPs will reimburse BHT-ABA services at a minimum to the rate outlined with the most recent executed PIHP contract.
MMP 25-02	1/30/2025	Emergency Services Only Medicaid	Section 3 – Coverage	In the 2nd paragraph, addition of the following: Service: Ventilator Services Coverage: Covered for life-supporting mechanical ventilating services and equipment due to a medical condition where the absence of such treatment could reasonably be expected to cause a medical emergency and place the person's health in serious jeopardy; cause serious impairment to bodily functions; or cause serious dysfunction of any bodily organ or part. Ventilator services shall be prior authorized by the MDHHS Program Review Division (PRD) for up to six months. For additional needed ventilator services, the provider must obtain further prior authorization. Providers must submit documentation supporting the medical necessity of requiring ventilator services to treat a diagnosed medical condition.
MMP 25-03	1/30/2025	Hearing Services and Devices	6.3.C.1. Audiological Criteria	Under " Unilateral or Bilateral Conductive or Mixed Hearing Loss ", text was revised to read: <ul style="list-style-type: none"> PTA bone conduction threshold less than or equal to 65 dB HL or level appropriate for model to be implanted using the four-frequency average of 500, 1000, 2000 and 4000 Hz in ear to be implanted; and Speech recognition scores greater than or equal to 60 percent using age appropriate speech recognition testing or other age appropriate developmental testing in the best aided condition.

*Bulletin inclusion updates are color-coded to the quarter in which the update was made (April 1 = Blue; July 1 = Pink; October 1 = Green; January 1 = Orange)



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MMP 25-05	2/13/2025	Medical Supplier	2.6 Children's/Adolescent Products	<p>Under "Parent(s)/Legal Guardian Agreement/Consent", the 2nd paragraph was revised to read:</p> <p>The parent(s)/legal guardian's approval of equipment is especially important when recommending multiple pieces of equipment to be used within the home. Providers are reminded that the child's home must be evaluated to ensure the equipment can fit in the home and be used within the intended space (e.g., the shower chair can fit through the bathroom door, can be moved, or leave ample space if other family members use the same bathroom). If the delivered equipment does not fit in the intended space, the child is unable to use the equipment, or it does not properly fit the child, the item is considered unsuitable and the DME provider must accept return of the item(s). Refer to the Provider Enrollment subsection of this chapter regarding beneficiary returns. The DME provider must obtain the parent(s)/legal guardian's approval following the evaluation and trial of equipment in the home for each piece of equipment via the parent(s)/legal guardian's signed and dated written statement or on the DME provider's generated document. Only handwritten parent/legal guardian signatures will be accepted. The parental/legal guardian signature may be either handwritten or digitally drawn. The signed and dated approval must be kept in the beneficiary file and, if prior authorization is required, submitted with the prior authorization request.</p>
MMP 25-08	4/1/2025	Medical Supplier	2.37 Prosthetics (Lower Extremities)	<p>The subsection was reformatted as follows (title revisions and re-numbering):</p> <p>2.37 Prostheses 2.37.A. Lower Extremity Prostheses 2.37.A.1. Microprocessor Knee-Shin Systems 2.37.B. Upper Extremity Prostheses</p>
			2.37.B. Upper Extremity Prostheses (new subsection)	<p>New policy is reflected in chapter with addition of new subsection.</p>

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MMP 25-11	4/1/2025	Early and Periodic Screening, Diagnosis and Treatment	9.10 Human Immunodeficiency Virus (HIV) Screening	Text was revised to read: A risk assessment for the human immunodeficiency virus (HIV) is to be performed annually for children beginning at 11 years of age and as recommended by the AAP periodicity schedule. A routine HIV screening should be offered to all individuals at least one time between 15 and 18 21 years of age, making every effort to preserve confidentiality of the adolescent and the young adult. After initial screening, youth at increased risk of HIV infection (including those who are sexually active, participate in injection drug use, or are being tested for other STIs) should be retested for HIV and reassessed annually or more frequently. The PCP should verify the results, follow-up, and refer as appropriate.
MMP 25-12	4/1/2025	Hospital	Section 2 – Prior Authorization	In the table, the category “* Off Label Use of Drugs” was revised to read: * Off Label Use of Non-Protected Drugs Classes
		Practitioner	1.9 Prior Authorization	The 2n bullet point was revised to read: <ul style="list-style-type: none"> Procedures/items that are normally noncovered but may be medically necessary for select beneficiaries (e.g., surgery normally cosmetic in nature, obesity surgery, off-label use drugs of non-protected drug classes, etc.).

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		Practitioner	3.16.A.1. Off-Label Use of Physician-Administered Drugs (new subsection)	<p>New subsection text reads:</p> <p>Off-label uses of physician-administered drugs generally require a prior authorization. However, certain drug classes are protected from prior authorization requirements by state law.</p> <p>Claims submitted for FDA off-label use of physician-administered drugs within the protected drug classes, as identified in MCL 400.109h, must include documentation to support the indication is evidence-based and that it is being administered within generally accepted standards of practice. This may include, but is not limited to, documents from medical compendia, peer reviewed studies, progress notes, or provider letters that demonstrate other failed lines of treatment.</p> <p>Prior authorization is required for off-label uses of drugs not included in the protected drug classes.</p> <p>This policy does not apply to claims for physician-administered drugs billed under the outpatient pharmacy benefit. Refer to the Pharmacy chapter of this manual for coverage requirements of physician-administered drugs billed under the pharmacy benefit.</p>

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