

BULLETIN

Michigan Medicaid Policy (MMP) | Health Services

Bulletin Number: MMP 25-40

Distribution: All Providers

Issued: August 29, 2025

Subject: Updates to the MDHHS Medicaid Provider Manual; Behavioral and Physical Health and Aging Services Administration (BPHASA) Reorganized and Renamed Health Services

Effective: October 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 October 2025 update of the online version of the MDHHS Medicaid Provider Manual. The manual will be available October 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.

BPHASA Reorganized and Renamed Health Services

On March 31, 2025, MDHHS announced the reorganization and renaming of BPHASA, which will now be referred to as Health Services. Health Services will continue to bring together Medicaid, aging programs, and behavioral health services to focus programs on the individual served, regardless of the funding source. This builds on the collaboration and synergies developed under BPHASA, increases access to services, supports providers, and improves health care systems for the timely delivery of health care to people in Michigan.

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 fluid and cursive, with the first name "Meghan" and last name "Groen" clearly legible.

Meghan E. Groen, Chief Deputy Director
Health Services



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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Throughout the Manual		References to "Behavioral and Physical Health and Aging Services Administration" and "BPHASA" were revised to read "Health Services".	Updated to reflect organizational change within the Michigan Department of Health and Human Services (MDHHS).
General Information for Providers	1.3 File Transfer	<p>The 1st paragraph was revised to read:</p> <p>The MDHHS–File Transfer application allows for the secure electronic transfer of files between MDHHS and Medicaid providers, Medicaid Health Plans, and other organizations. This application is a front-end interface for secure file transfer protocol (FTP) functionality, is Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant, and uses 128-bit encryption. File types for transfer include, but are not limited to, Medicaid cost report software, Medicaid filed cost reports, Medicaid filed reconciliation reports, and claim and encounter files containing protected health information.</p>	Old terminology that is obsolete being updated.
General Information for Providers	14.7 Clinical Records	<p>The 1st paragraph was revised to read:</p> <p>The following table contains general guidelines for clinical documentation that must be maintained by all providers except nursing facilities. Clinical records other than those listed may also be needed to clearly document all information pertinent to services that are rendered to beneficiaries. All providers must refer to their specific coverage policy in this manual for additional documentation requirements. The clinical record must be sufficiently detailed to allow reconstruction of what transpired for each service billed. All documentation for services provided must be signed and dated by the rendering health care professional. Electronic signatures must be HIPPA compliant and specifically identify and authenticate the individual practicing practitioner. All providers must refer to their specific coverage policy in this manual for additional documentation and signature requirements.</p>	Clarification.

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



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CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	14.7 Clinical Records	<p>The 2nd paragraph was revised to read:</p> <p>For services that are time-specific according to the procedure code billed, providers must indicate in the medical record the actual begin time and end time of the particular service. For example, some Physical Medicine procedure codes specify per 15 minutes. If the procedure started at 3:00 p.m. and ended at 3:15 p.m., the begin time and end time must be recorded in the medical record. Physical, occupational, and speech language pathology therapy providers should refer to the Therapy Services chapter of this manual for therapy documentation requirements.</p>	Clarification.
General Information for Providers	Section 17 – Review of Proposed Changes	<p>The last paragraph was revised to read:</p> <p>MDHHS consults with the Medical Care Advisory Council Medicaid Advisory Committee (MAC) (composed of consumers, providers, and government officials) in the review of proposed policies and procedures prior to implementation. The MAC consists of consumers, representatives of consumer advocacy groups, government officials, providers, and other professionals serving Medicaid beneficiaries in Michigan. Numerous provider associations and organizations are also involved in the review process. Any provider who feels that their association or the Medical Care Advisory Council MAC adequately represents them may not wish to be included on the provider consultation list.</p>	Updated to reflect new title.
Coordination of Benefits	2.1 Commercial Health Insurance, Traditional Indemnity Policies, and Military/Veteran Insurance	<p>The 4th paragraph was revised to read:</p> <p>MDHHS payment liability for beneficiaries with other insurance is the lesser of the beneficiary's liability (including coinsurance, copayments, or deductibles), the provider's charge minus contractual adjustments, or the maximum Medicaid fee screen minus the insurance payments. Medicaid does not have payment liability for non-Medicaid covered services. For inpatient hospital claims, refer to the Hospital Claim Completion - Inpatient section (Medicare subsection) of the Billing & Reimbursement for Institutional Providers chapter for additional information.</p>	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	7.13 Hemodialysis (Hemodialysis and Peritoneal)	<p>Text was revised to read:</p> <p>MDHHS follows Medicare's billing requirements for outpatient and emergency outpatient 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.)</p> <p>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. The rate is the same whether the beneficiary dialyzes in the facility or at home, and includes all necessary home and facility dialysis maintenance services, supplies, equipment and supportive services such as</p> <ul style="list-style-type: none"> • Oxygen; • Filters; • Dec clotting of shunts; • Staff time to administer blood or oxygen; and • Routine parenteral items: Heparin, Protamine, Mannitol, saline, glucose, dextrose, topical anesthetics, and arrhythmics. <p>MDHHS reimburses the physician directly for professional services related to maintenance dialysis. Nonroutine additional services must be billed using the appropriate supporting HCPCS code.</p> <p>The facility is responsible for making arrangements with a DME provider for supplies not available from the dialysis facility. MDHHS does not reimburse the medical supplier separately. The facility is responsible for payment to the supplier or independent lab for services provided.</p>	Alignment with other references to dialysis in the manual.

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		<p>Payment for laboratory services related to maintenance dialysis is included in the composite rate regardless of whether the tests are performed in the facility or an independent laboratory. Laboratory services included in the composite rate should be billed to the dialysis facility when performed by an outside laboratory. The dialysis facility and the outside laboratory must coordinate billing to ensure duplicate payments do not occur. A freestanding dialysis center that performs its own laboratory tests and needs to bill for services outside of those included in the composite rate must enroll with Medicaid as an independent laboratory.</p> <p>Dialysis services provided to an Emergency Services Only (ESO) beneficiary must include a diagnosis code for End Stage Renal Disease on Dialysis.</p> <p>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.)</p>	
Billing & Reimbursement for Professionals	6.1 General Information	<p>Under "Place of Service Codes", the following bullet point was revised:</p> <ul style="list-style-type: none">54 – Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Known as Intermediate Care Facility/Mentally Retarded (ICF/MR) by CMS	Removal of obsolete text.

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Billing & Reimbursement for Professionals	7.6 Dialysis Services (new subsection; following subsections were renumbered)	<p>New text reads:</p> <p>Hemodialysis codes (e.g., 90935, 90937) describe the hemodialysis procedure with all evaluation and management (E/M) services related to the beneficiary's renal disease on the day of the hemodialysis procedure.</p> <p>Dialysis codes (e.g., 90945, 90947) are reported for dialysis procedures other than hemodialysis (e.g., peritoneal dialysis, hemofiltration or continuous renal replacement therapies), and all E/M services related to the beneficiary's renal disease on the day of the procedure. Refer to the Outpatient Prospective Payment System (OPPS) Wrap Around Code List for additional information. (Refer to the Directory Appendix for website information.)</p> <p>Professional services for emergency dialysis must include an ESRD diagnosis and the "Y" Emergency Indicator.</p> <p>Most physician services are reported once per month, are age specific, and are based on the number of face-to-face visits. Reimbursement covers ESRD-related physician services in all settings necessary to manage the beneficiary's dialysis care, except declogging of shunts, dialysis training, and nonrenal-related medical services.</p>	Alignment with other references to dialysis in the manual.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	Section 21 – Certified Community Behavioral Health Clinic Demonstration	The section regarding "Certified Community Behavioral Health Clinic Demonstration" was relocated to the Special Programs chapter.	Section was moved to new chapter due to the transition to direct pay.
Behavioral Health and Intellectual and Developmental Disability Supports and Services - Non-Physician Behavioral Health Appendix	Section 2 – Provider Qualifications	<p>The 3rd paragraph was revised to read:</p> <p>LLPs are not eligible to be directly reimbursed by Medicaid. LLPs must enroll as Rendering/Servicing Only providers and associate themselves to at least one Billing Provider within CHAMPS. Associated Billing Providers may be either employers or organizations the LLP is contracted with to perform services (i.e., Community Mental Health Services Programs [CMHSPs], Prepaid Inpatient Health Plans [PIHPs]).</p>	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Federally Qualified Health Centers	1.3 Allowable Places of Services	<p>The 2nd paragraph was revised to read:</p> <p>If a practitioner employed by an FQHC provides services at an inpatient hospital, the service must be billed under the individual practitioner's NPI and will be reimbursed the appropriate fee screen rate. Services performed in an inpatient hospital setting are not included under the PPS or MOU. The costs that are associated with these services must be excluded from the FQHC's Medicaid Reconciliation Cost Report.</p>	Old terminology that is obsolete being updated.
Federally Qualified Health Centers	2.4 Advisory Committee on Immunization Practices (ACIP) Vaccines	<p>The subsection title was revised to read:</p> <p>Advisory Committee on Immunization Practices (ACIP) Vaccines Immunizations</p> <p>Text was revised to read:</p> <p>FQHCs providing Advisory Committee on Immunization Practices (ACIP) recommended vaccines medically necessary immunizations in accordance with currently accepted standards of medical or professional practice for beneficiaries 19 years of age and older in FQHC settings will be reimbursed outside of the Prospective Payment System (PPS) methodology. This includes, but is not limited to, all immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) or recommendations endorsed or developed by medical professional societies such as the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Physicians, and the American College of Obstetricians and Gynecologists.</p> <p>Reimbursement for ACIP recommended vaccines immunizations will be made up to the applicable Medicaid fee screen rates. Refer to the Medical Clinics and/or Federally Qualified Health Centers databases on the MDHHS website or the Medicaid Code and Rate Reference tool for additional information. (Refer to the Directory Appendix for website information.) FQHCs obtaining vaccines at a lower than normal cost through the 340B Program must report the 340B acquisition price on the claim. (text added per bulletin MMP-24-50)</p>	<p>Updated to better align with preventive services authority as described in the State Plan.</p> <p>Last sentence removed as vaccines are not available through 340B program.</p>

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Federally Qualified Health Centers	Section 4 – Billing	The 6th paragraph was revised to read: MDHHS will use the billing provider NPI field (Type 2 - Organization) to determine the number of encounters and calculate the settlement for the year-end annual reconciliation.	Revised to promote consistent terminology used in the Manual.
Federally Qualified Health Centers	Section 5 - Medicaid Reconciliation Report	The section title was revised to read: Medicaid Reconciliation Cost Report	Old terminology that is obsolete being updated.
Federally Qualified Health Centers	5.1 Reconciliation of Fee-For-Service	Text was revised to read: Each FQHC is required to submit an annual Medicaid Reconciliation Cost Report. MDHHS will include, as part of the annual Medicaid Reconciliation Cost Report, fee-for-service (FFS) primary care services claims that are approved through the claims system. In order for this to occur, all FFS primary care services must be submitted and processed through CHAMPS. (Refer to the Primary Care Services subsection in this chapter.) Every individual provider or electronic biller (the billing agent) receives a remittance advice (RA) for services that are billed. The RA informs the provider of the action taken on claims. It is the responsibility of FQHC providers to monitor claim activity and take appropriate steps to resolve suspended and rejected claims prior to the final reconciliation settlement . (Refer to the Billing & Reimbursement Chapters of this manual for additional billing information.) For non-primary care services, the FQHC will receive the Medicaid FFS amounts or the amount agreed to with the MHP as payment in full. The FQHC may enter into a risk contract with the MHP for services not included in the primary care definition. Non-primary care services and risk contracts will not be reconciled and are not included in the Medicaid Reconciliation Cost Report.	Old terminology that is obsolete being updated.

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Federally Qualified Health Centers	5.3 Reconciliation of Quarterly Advances	<p>The 1st paragraph was revised to read:</p> <p>Quarterly advances are included as Medicaid revenue on the Medicaid Reconciliation Cost Report and are reconciled with the FQHC PPS. The quarterly payment will be made on the RA at the beginning of each quarter.</p>	Old terminology that is obsolete being updated.
Federally Qualified Health Centers	5.5 Prospective Payment Rate	<p>Text was revised to read:</p> <p>An FQHC is reconciled to the prospective payment rate (PPR) determined under the PPS or the MOU. In accordance with section 1902(bb) of the Social Security Act, the PPS per visit payment is equal to 100 percent of the average of the FQHC reasonable costs of providing Medicaid services during Fiscal Years 1999 and 2000. The PPR amount is an all-inclusive rate that covers all defined primary care services. (Refer to the Medicaid Reconciliation Cost Report subsection of this section for a definition of reasonable costs.) The per visit amount is adjusted annually using the Medicare Economic Index (MEI) based on changes in the MEI for the prior calendar year.</p>	Old terminology that is obsolete being updated.
Federally Qualified Health Centers	5.10 Medicaid Reconciliation Report	<p>The subsection title was revised to read:</p> <p>Medicaid Reconciliation Cost Report</p> <p>Text was revised to read:</p> <p>Each FQHC must complete a Medicaid Reconciliation Cost Report for its fiscal year. The MDHHS HCRD must receive the report by the due date for the Medicare Cost Report in order for the FQHC to receive PPS reimbursement.</p> <p>The FQHC's authorized individual who certifies the report and accompanying worksheets for the period noted must sign its Medicaid Reconciliation Cost Report. If the required report and supplemental documents are not submitted within the required time limit, the FQHC waives its rights to PPS reimbursement for that year.</p> <p>The Medicaid Reconciliation Cost Report must be for the same fiscal period and cover the same sites as the Medicare Cost Report.</p>	Old terminology that is obsolete being updated.

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Federally Qualified Health Centers	5.10.B. Maintenance of Medical and Financial Records	<p>The 1st and 2nd paragraphs were revised to read:</p> <p>The FQHC must maintain, for a period of not less than seven years, financial and clinical records for the period covered by the reconciliation cost report that are accurate and in sufficient detail to substantiate the cost data reported. The records must be maintained until all issues are resolved. Expenses reported as reasonable costs must be adequately documented in the financial records of the FQHC or the expenses will be disallowed.</p> <p>The MDHHS HCRD will maintain each required FQHC Medicaid Reconciliation Cost Report submitted by the provider for seven years following the date of submission of the report. In the event that there are unresolved issues at the end of this seven-year period, the report will be maintained until such issues are resolved.</p>	Old terminology that is obsolete being updated.
Federally Qualified Health Centers	6.1 Quarterly Advances and Risk Contracts	<p>Text was revised to read:</p> <p>The FQHC's quarterly advances will be reconciled annually on the reconciliation cost report. Risk contracts will not be reconciled.</p>	Old terminology that is obsolete being updated.
Federally Qualified Health Centers	6.2.A. Initial Settlements of FQHCs	<p>Text was revised to read:</p> <p>An initial settlement is calculated annually. Calculations are determined from the filed FQHC Medicaid Reconciliation Cost Report and Medicaid paid claims information. An initial settlement will be completed generally within three months of the receipt of a complete and acceptable reconciliation cost report. MDHHS retains the right to withhold a portion of an initial payment based on individual circumstances.</p>	Old terminology that is obsolete being updated.

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Federally Qualified Health Centers	6.2.B. Final Settlements of FQHCs	<p>Text was revised to read:</p> <p>Final settlements for FQHCs are generally completed within one year of the FQHC fiscal year end using updated Medicaid data for the period covered by the FQHC Medicaid Reconciliation Cost Report. This will allow sufficient time for all claims to clear the Medicaid payment system. Medicaid data will be updated using approved claims payment data, all other payments for Medicaid services, and Medicaid visits.</p> <p>The Medicare intermediary field and/or desk audit may cause MDHHS to process an additional final settlement. After review of the revised cost report and any statistical and audit findings pertaining to it, MDHHS may process a revised Medicaid final settlement for the period covered by the reconciliation cost report.</p>	Old terminology that is obsolete being updated.
Federally Qualified Health Centers	6.3 Response to the Audit Adjustment Report	<p>The 1st paragraph was revised to read:</p> <p>MDHHS staff prepares the Audit Adjustment Report, which contains a descriptive list of all Medicaid data adjustments made to the Medicaid Reconciliation Cost Report by MDHHS audit staff. The Audit Adjustment Report must be accepted or rejected by the FQHC within 30 calendar days of its mailing date.</p>	Old terminology that is obsolete being updated.
Home Help	Section 2 – Services	<p>The 1st paragraph was revised to read:</p> <p>Medicaid funds are available for Home Help services provided to clients who meet the requirements outlined in the Eligibility Section of this chapter. The client's ASW can authorize up to 179.9 179 hours and 59 minutes of Home Help services per month. Additional time may be authorized with approval from the MDHHS Home Help Policy Section. (Refer to the Directory Appendix for contact information.)</p>	Program policy clarification.
Home Help	8.6.A. Home Help Services Agreement	<p>The 2nd paragraph was revised to read:</p> <p>Individual caregivers and agency providers must sign an MSA-4676 for every Home Help client prior to delivering services. Payments cannot be authorized issued until the signed MSA-4676 is returned to the client's ASW or local MDHHS office.</p>	Program policy clarification.

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Hospice	3.4.B. Nursing Facility	<p>The 5th paragraph was revised to read:</p> <p>The Pre-Admission Screening/Annual Resident Review (PASARR) form (DCH-3877) must be completed for a hospice patient entering a NF unless the hospice beneficiary is entering for a five-day respite period. The DCH-3877 is not required for the respite period. The DCH-3877 is to identify individuals who may have a mental illness, intellectual/developmental disability or a related condition. If the patient is on antipsychotic or antidepressant psychotropic medications for purposes of pain control/symptom relief for end of life, it should be noted on the DCH-3877. This allows the Community Mental Health Services Program (CMHSP) worker to better evaluate the need for further (Level II) screening. If the patient is on any of the above mentioned psychotropic medications for a related mental illness, the CMHSP will determine the need for a Level II screening.</p>	<p>Update to terminology: "antipsychotic or antidepressant" changed to "psychotropic medications".</p>

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Hospital	3.13 Dialysis (Hemodialysis and Peritoneal Dialysis)	<p>Text was revised to read:</p> <p>MDHHS follows Medicare's billing requirements for outpatient and emergency outpatient dialysis services (e.g., the appropriate diagnosis code, patient weight, height, etc.); however, coverage and reimbursement policies differ.</p> <p>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. MDHHS follows the Medicare billing guidelines for hemodialysis and peritoneal dialysis for both in-person and telemedicine visits. Individual services may not be billed separately. The rate is the same whether the beneficiary dialyzes in the facility or at home, and includes all necessary home and facility dialysis maintenance services, supplies, equipment and supportive services such as:</p> <ul style="list-style-type: none"> • Oxygen; • Filters; • Dec clotting of shunts; • Staff time to administer blood or oxygen; and • Routine parenteral items: Heparin, Protamine, Mannitol, saline, glucose, dextrose, topical anesthetics, and arrhythmics. <p>MDHHS reimburses the physician directly for professional services related to maintenance dialysis. Nonroutine additional services must be billed using the appropriate supporting HCPCS code.</p> <p>Nonroutine additional services must be billed using the appropriate supporting HCPCS code. The facility is responsible for making arrangements with a DME provider for supplies not available from the dialysis facility. MDHHS does not reimburse the medical supplier separately. The facility is responsible for payment to the supplier or independent lab for services provided.</p>	Alignment with other references to dialysis in the manual.

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Hospital Reimbursement Appendix	7.4 Calculation of DSH Ceiling	<p>Under "1. DSH Ceiling Financial Elements", the 4th bullet point was revised to read:</p> <ul style="list-style-type: none"> Uninsured Costs – Multiply total base year uninsured charges times the hospital's cost to charge ratio to determine uninsured costs. (The cost to charge ratio should be inclusive of capital and medical education costs.) <p>➤ IMD Service Period: In alignment with Medicare, an inpatient psychiatric facility discharge occurs when benefits exhaust and the date benefits exhaust (if present) will substitute for the 'actual' discharge date.</p>	Addition for clarification.
Maternal Infant Health Program	1.1 Program Services	<p>The 1st paragraph was revised to read:</p> <p>MIHP services are preventive health services provided by an agency that is certified by the Michigan Department of Health and Human Services (MDHHS). MIHP services are provided by a licensed social worker and a licensed registered nurse. Licensed social workers and licensed registered nurses who are certified as an Internationally Board Certified Lactation Consultant (IBCLC) may provide services. An infant mental health specialist with an Infant Mental Health endorsement may be included. A registered dietitian may also provide services with a physician order. All physician orders for MIHP services must be in compliance with state and federal laws prohibiting self-referral. All physician orders for MIHP services must be in compliance with state and federal laws prohibiting self-referral.</p>	Removal of duplicative text.
Maternal Infant Health Program	1.4.E. Prior Authorization of Services	<p>Text was revised to read:</p> <p>MHPs may not require prior authorization for the Initial Risk Assessment visit, professional visits (including the complex home visit), drug-exposed infant visits, enhanced care coordination time, MIHP lactation support visits, childbirth education classes, or parenting education classes when provided within the criteria and limits established in policy. MIHP services in excess of limits established in policy may be subject to MHP prior authorization requirements.</p>	Clarification of Bulletin MMP 23-36.

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CHAPTER	SECTION	CHANGE	COMMENT
Non-Emergency Medical Transportation	Section 6 – Covered Services	<p>The 4th paragraph was revised to read:</p> <p>Transportation providers and beneficiaries may be reimbursed for mileage, tolls, parking fees, approved meals and lodging expenses, Medi-Van and wheelchair lift equipped transportation, and medically necessary attendants. The transportation provider or beneficiary must submit a complete MSA-4674 (Medical Transportation Statement) for all trip-associated costs to the authorizing party within 12 months from the date of service to receive reimbursement. Medicaid FFS authorizing parties may accept the submission of a complete MSA-4674 form and receipts via fax and secure email. Transportation providers and beneficiaries may submit original forms and receipts if they choose, but sending original forms and receipts is not required for reimbursement. Authorizing parties receiving a completed MSA-4674 may obtain missing information, including signatures, via telephone conversation with the appropriate party. This verification method should only be used to obtain missing information related to a submitted form and not as a method for completing the full MSA-4674. Providers and beneficiaries are encouraged to keep an original or copy of forms and receipts submitted to MDHHS for reimbursement.</p>	Addition of timely filing requirement language.
Nursing Facility Coverages	Section 8 – PASARR Process	<p>In the 3rd paragraph, the 5th bullet point was revised to read:</p> <ul style="list-style-type: none"> A beneficiary receiving Medicaid hospice services (Benefit Plan ID of Hospice) entering a nursing facility for the five-day hospice respite benefit. A Level I screening must be completed if the beneficiary enters the facility for a length of time beyond the five-day respite period. <p>The purpose of the Level I screening is to identify individuals who may have a mental illness, intellectual/developmental disability or a related condition. If the patient is on psychotropic or antidepressant medications for purposes of pain control/symptom relief for end of life, note that information on the DCH-3877. This allows the Community Mental Health Services Program (CMHSP) to better evaluate the need for Level II screening. If the patient is on any of the above mentioned psychotropic medication groups for a related mental illness, the CMHSP will determine the need for Level II screening.</p>	Update to terminology: "antipsychotic or antidepressant" changed to "psychotropic medications".

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Nursing Facility Coverages	8.1 Level I Screening	<p>The 3rd paragraph was revised to read:</p> <p>The following table contains a list of psychopharmacological drugs that may indicate the presence of a mental illness. Included are examples of anti-depressant and psychotropic medications, defined as any drug that affects brain activities associated with mental processes and behavior.</p> <p>In the last paragraph, the tables (medications and products) were revised/reformatted.</p>	Update to terminology: "antipsychotic or antidepressant" changed to "psychotropic medications".
Pharmacy	14.16 Vaccines	<p>The 1st paragraph was revised to read:</p> <p>The program covers the cost of the vaccine and administration of all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), including seasonal influenza vaccines, administered by pharmacists are covered medically necessary vaccines and their administration when administered by pharmacists in accordance with currently accepted standards of medical or professional practice for adults aged 19 years and older for Fee-For-Service Medicaid, Healthy Michigan Plan, and MOMS program beneficiaries 19 years of age and older. This includes, but is not limited to, all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) or those endorsed or developed by medical professional societies such as the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Physicians, and the American College of Obstetricians and Gynecologists. Additionally, pharmacies approved to participate in the Vaccines for Children (VFC) program may administer ACIP recommended vaccines to Medicaid, Healthy Michigan Plan, and MOMS beneficiaries ages 3 through 18 years. The cost of the VFC vaccine is at no cost to participating pharmacies. VFC enrolled pharmacies can bill administration fees for VFC vaccines as a Medicaid Fee-For-Service pharmacy benefit, including for beneficiaries ages 3 through 18 years of age who are enrolled in a Medicaid Health Plan. (Refer to the Directory Appendix for information on the Vaccines For Children program.)</p>	Updated to better align with preventive services authority as described in the State Plan.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	Section 22 - Outcomes Based Contract Arrangements	<p>Text was revised to read:</p> <p>MDHHS utilizes outcomes-based contract arrangements with drug manufacturers for certain high-cost drug products. Under these arrangements, supplemental rebates paid by participating drug manufacturers help offset some of the costs to MDHHS. Drug products for which MDHHS has an outcomes-based contract arrangement are posted on the PBM's website. (Refer to the Directory Appendix for website information.)</p> <p>Reimbursement for these products will be in accordance with established policies and dependent on whether the coverage is billed as a medical or pharmacy benefit. Providers must refer to this list for additions and deletions of drug products. Specific notification of changes will not be issued. Drug manufacturers that are interested in an outcomes-based contract with MDHHS may refer to the PBM's website for MDHHS' CMS-approved Contract Template. (Refer to the Directory Appendix for website information.)</p>	Removal of obsolete information as we do not provide the CMS-approved contract template on our PBM site.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	3.15 Immunizations (Vaccines and Toxoids)	<p>The 1st and 2nd paragraphs were revised to read:</p> <p>Immunizations are covered when given according to the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) recommendations. This includes ACIP recommendations based on risk due to health condition, occupation, and travel. MDHHS encourages providers to immunize all Medicaid beneficiaries according to the recommended immunization schedules. medically necessary and provided in accordance with currently accepted standards of medical or professional practice. Medical necessity may be established with an evidence-based recommendation developed or endorsed by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) or medical professional societies such as the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Physicians, and the American College of Obstetricians and Gynecologists. This includes recommendations that are routine, based on health condition, occupation, shared clinical decision making, and travel.</p> <ul style="list-style-type: none"> For Medicaid children 18 years and younger, the Vaccine for Children (VFC) Program provides covered immunizations at no cost to the provider. Medicaid covers immunizations for beneficiaries 19 years of age or older. Any Local Health Department (LHD) in the state can be contacted for specifics about the VFC program, what immunizations are available, and instructions on enrolling and obtaining immunizations. <p>Medicaid does not pay for immunization costs for any product that is available free of charge for Medicaid beneficiaries. An administration fee is covered separately for immunizations given to Medicaid beneficiaries whether the immunization is free or not, and without regard to other services provided on the same day. The administration fee is set for each immunization.</p>	Updated to better align with preventive services authority as described in the State Plan.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	4.3 Hemodialysis and Peritoneal Dialysis	<p>Text was revised to read:</p> <p>Medicaid covers physician services required to manage care of beneficiaries with end-stage renal disease (ESRD) who are receiving outpatient and emergency dialysis.</p> <p>Professional services for emergency dialysis must include an ESRD diagnosis and the "Y" Emergency Indicator.</p> <p>Most physician services are covered through a monthly capitation payment (MCP) to the managing physician. The MCP covers ESRD related physician services in all settings necessary to manage the beneficiary's dialysis care, except declothing of shunts, dialysis training, and nonrenal related medical services.</p> <p>Self-dialysis training services provided by the physician are covered.</p> <p>Refer to the Billing & Reimbursement for Institutional Providers Chapter for additional information.</p>	Alignment with other references to dialysis in the manual.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	4.8 Preventive Services	<p>The 1st paragraph was revised to read:</p> <p>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.)</p> <p>The program covers medically necessary preventive services when provided in accordance with currently accepted standards of medical or professional practice. This includes, but is not limited to, the United States Preventive Services Task Force (USPSTF) grade A or B recommendations and all vaccines and their administration recommended by the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) for beneficiaries age 19 years and older. Medical necessity may be established with an evidence-based recommendation developed or endorsed by medical professional societies such as the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Physicians, and the American College of Obstetricians and Gynecologists. (Refer to the Directory Appendix for USPSTF and ACIP website information.)</p> <p>The last paragraph was revised to read:</p> <p>Providers submitting claims for services in accordance with the USPSTF grade A and B recommendations qualified preventive services are to identify the service with the appropriate International Classification of Diseases (ICD) diagnosis code(s). To identify the service as a preventive service, providers are encouraged to include HCPCS Modifier 33, Preventive Services. (Refer to the Billing & Reimbursement for Professionals Chapter for specific information.)</p>	Updated to better align with preventive services authority as described in the State Plan.
Rural Health Clinics	4.2 Eligibility Groups Subject to PPS Methodology	<p>In the table, under "Healthy Kids Dental", text was revised to read:</p> <p>Dental services provided to Medicaid beneficiaries enrolled in the Healthy Kids Dental program are eligible for the PPR. RHCs should report Medicaid information on encounters and revenue in the annual reconciliation cost report. The RHC receives the difference between the PPR and the revenue received as part of the annual reconciliation.</p>	Old terminology that is obsolete being updated.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Rural Health Clinics	6.1 Billing Rural Health Clinic Services	<p>The 6th paragraph was revised to read:</p> <p>MDHHS will use the billing provider NPI field (Type 2 - Organization) to determine the number of encounters and calculate the settlement for the year-end annual reconciliation.</p>	Revised to promote consistent terminology used in the Manual.
Rural Health Clinics	Section 8 - Reconciliation Reporting	<p>The subsection title was revised to read:</p> <p>Reconciliation Reporting Medicaid Cost Report</p> <p>The 1st and 2nd paragraphs were revised to read:</p> <p>Medicaid Reconciliation Cost Reports must be completed by each RHC in order to receive reimbursement under the PPS.</p> <p>The RHC must file the following documents at the end of its fiscal year for PPS reimbursement:</p> <ul style="list-style-type: none"> • A copy of its filed Medicare Cost Report and Trial Balance • A completed copy of the Medicaid Reconciliation Cost Report 	Old terminology that is obsolete being updated.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Rural Health Clinics	8.1 Report Filing	<p>Text was revised to read:</p> <p>RHCs must file Medicaid Reconciliation Cost Reports and supplemental documents to the MDHHS HCRD annually. Due dates are consistent with the Medicare Cost Report filing requirement. If the required reconciliation cost report and supplemental documents are not submitted within the required time limit, the RHC waives its right to the PPS reimbursement for that year.</p> <p>The reconciliation cost report is the basis for determining future quarterly payments and the current year's reconciliation. The report must be an original(s) and signed by the authorized individual who normally signs the RHC's federal income tax return or similar reports and should be for the same fiscal period and cover the same sites as the Medicare Cost Report. Improperly completed or incomplete filings are returned to the facility for proper completion and must be resubmitted to MDHHS within 30 days of date of receipt.</p>	Old terminology that is obsolete being updated.
Rural Health Clinics	8.2 Accounting and Record Keeping	<p>Text was revised to read:</p> <p>RHCs must maintain, for a period of not less than seven years from the end of the fiscal year of the Reconciliation cost report, financial and clinical records for the period covered by the reconciliation cost report that are accurate and in sufficient detail to substantiate the information reported. If there are unresolved issues at the end of this seven-year period, the records must be maintained until these issues are resolved.</p> <p>The MDHHS HCRD retains each required Reconciliation cost report and supplemental documents submitted by the RHC for seven years after issuance of a final decision. In the event there are unresolved issues at the end of this seven-year period, the report is maintained until such issues are resolved.</p>	Old terminology that is obsolete being updated.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Rural Health Clinics	Section 9 – Audit, Settlements, and Appeals	Text was revised to read: An annual reconciliation is performed to assure that the prospective payment rate is paid to the RHC for all eligible encounters. The reconciliation process begins with the receipt of the Reconciliation cost report and supplemental documents and ends with the issuance of the Notice of Amount of Program Reimbursement.	Old terminology that is obsolete being updated.
Rural Health Clinics	9.1 Desk Reviews and Field Audits	Text was revised to read: The desk review may include procedures that: <ul style="list-style-type: none"> • Verify the completeness and mathematical accuracy of all schedules in the report. • Compare the Reconciliation cost report with MDHHS paid claim and encounter data. • Identify the need for supporting documentation and arrange to receive same. • Identify the need for a field audit examination necessary to conclude final reconciliation settlement calculations. • Compare reported data with industry norms as an aid to the audit scope determination. Field audits may be conducted to verify information on the Reconciliation cost report.	Old terminology that is obsolete being updated.
Rural Health Clinics	9.3 Initial Reconciliation and Settlement	Text was revised to read: An initial reconciliation is calculated after the annual reconciliation cost report is received. The initial reconciliation is processed approximately four months after the reconciliation cost report is received, with the payment or recovery made at that time. Future quarterly payments are adjusted based on the information in the initial reconciliation.	Old terminology that is obsolete being updated.

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CHAPTER	SECTION	CHANGE	COMMENT
Rural Health Clinics	9.4 Audit Adjustment Report	Text was revised to read: The Audit Adjustment Report contains a list of all Program data adjustments made to the Medicaid Reconciliation Cost Report by MDHHS audit staff.	Old terminology that is obsolete being updated.
Special Programs	9.3 Indications for Services (Section 9 – Pediatric Outpatient Intensive Feeding Program Services)	The 1st paragraph was revised to read: Pediatric Outpatient Intensive Feeding Program services may be considered medically necessary for individuals with anatomical, physiological, congenital, or cognitive conditions and/or complications of severe illness who experience significant feeding difficulties. Eligible beneficiaries must meet all the following criteria: <ul style="list-style-type: none"> • Significant oral-motor problems and/or chronic medical conditions exist; • Normal feeding milestones have not been met through previous therapies and treatment; • Suboptimal nutritional status or risk of suboptimal nutrition status has been determined; and • Inadequate responsiveness to less intensive treatment has been clinically documented. 	Clarification.
Special Programs	10.9 Claims Submission and Payment	The 3rd paragraph was revised to read: Providers participating as an MDHHS-certified CCBHC do not enroll through CHAMPS as a TCM service provider for recently incarcerated beneficiaries. CCBHCs enroll in a separate program and are reimbursed through a PPS methodology in which they receive a daily clinic-specific rate based on the average expected daily cost to deliver core CCBHC services which includes TCM services for recently incarcerated beneficiaries. (Refer to the Certified Community Behavioral Health Clinic Demonstration section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services this chapter for more information.)	Updated to reflect relocation of policy text.

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CHAPTER	SECTION	CHANGE	COMMENT
Special Programs	Section 13 – Certified Community Behavioral Health Clinic Demonstration	The section regarding “Certified Community Behavioral Health Clinic Demonstration” was previously part of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter (Section 21).	Section was moved to new chapter due to the transition to direct pay.
Special Programs	13.3 Enrollment	Text was revised to read: All eligible Medicaid beneficiaries will be automatically enrolled into the CCBHC benefit plan. Additional beneficiaries may be added as appropriate. Non-Medicaid individuals are not automatically enrolled in the CCBHC benefit plan but should be tracked using encounter reporting and other methods outlined in the CCBHC Demonstration Handbook. MDHHS reserves the right to review and verify all enrollments.	With the transition to CCBHC direct pay, CCBHCs will no longer be able to report non-Medicaid claims.
Special Programs	13.4.E. Quality and Other Reporting	Text was revised to read: CCBHCs must collect, report, and track encounter service , outcome, and quality data, and other data as federally required or requested by MDHHS. Measures and specifications for reporting are listed in the CCBHC Demonstration Handbook.	Removing reference to “encounter” to avoid confusion with managed care reporting requirements.
Special Programs	13.6.B. Payment for DCOS	Text was revised to read: Payment for DCO services is included within the scope of the CCBHC PPS, and DCO encounters daily visits will be treated as CCBHC encounters daily visits for purposes of the PPS. Payment will be provided directly to the DCO from the CCBHC based on agreed upon contractual service rates.	Removing reference to “encounter” to avoid confusion with managed care reporting requirements. In this case, the encounter means daily visit.
Special Programs	13.7 Payment Methodology	The 2nd paragraph was revised to read: CCBHCs must submit valid CCBHC Encounter Procedure Codes cited in Appendix A of the CCBHC Demonstration Handbook with a corresponding T1040 service encounter procedure code to receive payment.	Removing reference to “encounter” to avoid confusion with managed care reporting requirements.

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CHAPTER	SECTION	CHANGE	COMMENT
Therapy Services	1.3 Documentation in Beneficiary Medical Record	Text was revised to read: Therapy providers must retain all applicable documentation in the beneficiary's medical record for seven years. For audit purposes, the beneficiary's medical record must substantiate the medical necessity of the service performed. Documentation must also include the treatment time of the services performed. Documentation for each service date must also contain the total treatment minutes of all timed procedure codes to support the number of units and codes billed and the total active treatment minutes, including all timed and untimed services. For example, if a therapist performed 10 minutes of a service represented by a 28-minute timed procedure code and 17 minutes of another service represented by an untimed procedure code, documentation should indicate that the total treatment minutes of all timed procedure codes was 28 minutes, and the total active treatment time was 45 minutes.	Clarification.
Therapy Services	1.6 Reimbursement	The following text was added (after 1st paragraph): Some therapy modalities, interventions, and tests are reported under a time-based procedure code. If more than one service represented by a time-based procedure code is performed in a single day, the total number of timed units billable to Medicaid is determined by the total minutes of all timed services.	Clarification.
Tribal Health Centers	Section 7 – Billing	The last paragraph was revised to read: MDHHS will use the billing provider NPI field (Type 2 - Organization) to determine the number of encounters and calculate the settlement for the year-end annual reconciliation.	Revised to promote consistent terminology used in the Manual.
Acronym Appendix		Text was revised as follows: ICF/IID - Intermediate Care Facility for Individuals with Intellectual Disabilities [previously known as Intermediate Care Facility for the Mentally Retarded (ICF/MR)]	Removal of dated information.

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CHAPTER	SECTION	CHANGE	COMMENT
Acronym Appendix		Revised as follows: MAC - Monitored Anesthesia Care; Maximum Allowable Cost; Master Addictions Counselor; Medicaid Advisory Committee	Update.
Directory Appendix	Behavioral Health/SUD Resources	The following topic was removed: Contact/Topic: Certified Community Behavioral Health Clinic Demonstration	Information was relocated to the Special Programs section.
Directory Appendix	Special Programs (new section)	Contact/Topic: Certified Community Behavioral Health Clinic Demonstration Mailing/Email/Web Address: Email address: MDHHS-CCBHC@michigan.gov Website: www.michigan.gov/ccbhc Information Available/Purpose: General information. Consumer resources: • CCBHC Directory Provider resources: • CCBHC Demonstration Handbook • MMP 23-56 • CCBHC Directory	Updated to reflect relocation of policy text from the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter to the Special Programs chapter.
Directory Appendix	Pharmacy Resources	Contact/Topic text was revised as follows: Provider Pharmacy Liaison Meeting Calendar	For consistency with PBM website and meeting materials.

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CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Pharmacy Resources	<p>Addition of new category:</p> <p>Contact/Topic: List of Outcomes-Based Contract Arrangements</p> <p>Web Address: https://mi.primetherapeutics.com/ >> Provider Portal >> Documents >> Other Drug Information</p> <p>Information Available/Purpose: List of Outcomes-Based Contract Arrangements between drug manufacturers and MDHHS for certain high-cost drugs or therapies.</p>	Section 22 of the Pharmacy Chapter mentions this list.
Directory Appendix	Miscellaneous Contact Information	<p>Information was revised to read:</p> <p>Contact/Topic: Medical Care Advisory Council (MCAC) Medicaid Advisory Committee (MAC) Meetings</p> <p>Email: MDHHS-MAC@michigan.gov</p> <p>Web Address: www.michigan.gov/medicaid >> Program Resources >> Medical Care Advisory Council www.michigan.gov/mdhhs >> Assistance Programs >> Medicaid >> Medicaid >> Medicaid Resources >> Medicaid Advisory Committee (MAC)</p> <p>Information Available/Purpose: MCAC MAC roster, meeting agendas and minutes, and meeting dates.</p>	Updated to reflect new title.

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CHAPTER	SECTION	CHANGE	COMMENT
Forms Appendix		<p>The following forms were revised to reflect changes to "Behavioral and Physical Health and Aging Services Administration" and "BPHASA".</p> <ul style="list-style-type: none"> MSA-181; Home Health Aide Prior Approval Request/Authorization MSA-0732; Private Duty Nursing Prior Authorization – Request for Services MSA-1302; Benefits Monitoring Program Referral MSA-1550; Beneficiary Verification of Coverage MSA-1653-B; Special Services Prior Approval – Request/Authorization MSA-1653-D; Complex Seating and Mobility Device Prior Approval-Request/Authorization MSA-1755; Medicaid Enrolled Birthing Hospital Agreement for Elective, Non-Medically Indicated Delivery Prior to 39 Weeks Completed Gestation MSA-4240; Certification for Induced Abortion MSA-6544-B; Practitioner Special Services Prior Approval – Request/Authorization MSA-2081; Genetic and Molecular Laboratory Test Authorization Request 	Updated to reflect organizational change within the Michigan Department of Health and Human Services (MDHHS).
Forms Appendix	DHS-54A; Medical Needs	Sample updated to reflect current version of form.	Update.
Forms Appendix	DCH-3877; Pre-Admission Screening/Annual Resident Review (PASARR)	The form was updated to reflect change in terminology from "antipsychotic or antidepressant" to "psychotropic medications".	Update to terminology: "antipsychotic or antidepressant" changed to "psychotropic medications".

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BULLETINS INCORPORATED*



BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MMP 25-10	4/1/2025	Medicaid Provider Manual Overview	1.1 Organization	Under "Provider/Service Specific Chapters", text was added for the new Psychiatric Residential Treatment Facilities chapter.
		Psychiatric Residential Treatment Facilities (new chapter)		New chapter added to address subject matter.
		Acronym Appendix		Addition of: ICTS - Intensive Community Transition Services PRTF – Psychiatric Residential Treatment Facility
		Directory Appendix	Psychiatric Residential Treatment Facilities (new section)	New section added to support references in the Psychiatric Residential Treatment Facilities chapter.
		Forms Appendix		Addition of forms: MDHHS-6087 - Certification of Need for Care MDHHS-6089 - PRTF/ICTS Extension Request

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MMP 25-13	5/30/2025	Billing & Reimbursement for Dental Providers	5.4 Medicare Dental Service Billing (new subsection; following subsections were re-numbered)	<p>New text reads:</p> <p>Dental services provided to Medicare/Medicaid dually eligible beneficiaries are only applicable to Medicare enrolled dental providers. Secondary claims submitted on the 837D, 837P, or 837I electronic form for Medicare/Medicaid dually eligible beneficiaries only must include the submission of the KX modifier and ICD-10 diagnosis on claims for dental services that are inextricably linked to covered Medicare Part A or B medical services.</p> <p>Refer to 42 CFR § 411.15(i)(3) for examples of dental services inextricably linked to covered medical services furnished in the inpatient or outpatient setting. The valid ICD-10 diagnosis is not required to be the diagnosis for the covered medical service; it may be a diagnosis reflective of the dental treatment. Providers must be enrolled in Medicare to bill for Medicare-covered dental services. The beneficiary's medical record must include appropriate documentation to support the medical necessity of the service and its linkage to a Medicare-covered medical service.</p>

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MMP 25-16	5/30/2025	Federally Qualified Health Centers	5.10 Medicaid Reconciliation Report	<p>Text was revised to read:</p> <p>Each FQHC, unless specifically exempt, must complete a Medicaid Reconciliation Report for its fiscal year. The MDHHS HCRD must receive and accept the report by the due date for the Medicare Cost Report on or before the last day of the fifth month following the close of its cost reporting period in order for the FQHC to receive PPS reimbursement. The FQHC's authorized individual who certifies the report and accompanying worksheets for the period noted must sign its Medicaid Reconciliation Report. If the Medicaid Cost Report is not submitted and accepted by the filing deadline, an extension request may be submitted to the Facility Settlement subsystem in the Community Health Automated Medicaid Processing System (CHAMPS). MDHHS HCRD grants extensions only when a clinic's operation is adversely affected due to circumstances beyond its control (e.g., staffing turnovers are considered within the control of the clinic, whereas fires and floods would be considered beyond its control).</p> <p>If a clinic fails to submit a completed Medicaid Cost Report on time and has not been granted an extension of the time limit, a notice of delinquency is issued. If the Medicaid Cost Report is not submitted within 30 calendar days from the date of the notice of delinquency, the FQHC's FFS payments and gross adjustment payments are suspended until the Medicaid Cost Report is received and accepted by MDHHS HCRD. Payments withheld due to late submission are paid upon acceptance of the Medicaid Cost Report.</p>

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				<p>The FQHC's authorized individual who certifies the report and accompanying worksheets for the period noted must sign its Medicaid Reconciliation Report. If the required report and supplemental documents are not submitted within the required time limit, the FQHC waives its rights to PPS reimbursement for that year.</p> <p>The Medicaid Reconciliation Report must be for the same fiscal period and cover the same sites as the Medicare Cost Report.</p>
		Rural Health Clinics	8.1 Report Filing	<p>Text was revised to read:</p> <p>RHCs must file Reconciliation Reports and supplemental documents to the MDHHS HCRD annually. Due dates are consistent with the Medicare Cost Report filing requirement. If the required reconciliation report and supplemental documents are not submitted within the required time limit, the RHC waives its right to the PPS reimbursement for that year.</p> <p>Each RHC, unless specifically exempt, is required to submit a Medicaid Cost Report to MDHHS HCRD on or before the last day of the fifth month following the close of its cost reporting period. If the Medicaid Cost Report is not submitted and accepted by the filing deadline, an extension request may be submitted to the Facility Settlement subsystem in the Community Health Automated Medicaid Processing System (CHAMPS). MDHHS HCRD grants extensions only when a clinic's operation is adversely affected due to circumstances beyond its control (e.g., staffing turnovers are considered within the control of the clinic, whereas fires and floods would be considered beyond its control).</p>

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				<p>If a clinic fails to submit a completed Medicaid Cost Report on time and has not been granted an extension of the time limit, a notice of delinquency is issued. If the Medicaid Cost Report is not submitted within 30 calendar days from the date of the notice of delinquency, the RHC's FFS payments and gross adjustment payments are suspended until the Medicaid Cost Report is received and accepted by MDHHS HRCD. Payments withheld due to late submission are paid upon acceptance of the Medicaid Cost Report.</p> <p>The reconciliation report is the basis for determining future quarterly payments and the current year's reconciliation. The report must be an original(s) and signed by the authorized individual who normally signs the RHC's federal income tax return or similar reports and should be for the same fiscal period and cover the same sites as the Medicare Cost Report. Improperly completed or incomplete filings are returned to the facility for proper completion and must be resubmitted to MDHHS within 30 days of date of receipt.</p>
MMP 25-19	5/30/2025	Pharmacy	Section 23: High-Cost Physician-Administered Drug Products or Therapies (new section)	<p>New section text reads:</p> <p>Pharmacies may bill for eligible high-cost drugs/therapies, including gene therapies, as a Medicaid Fee-for-Service pharmacy benefit. These are typically physician-administered and otherwise billed along with related services on the professional claim format. Providers should refer to individual policy documents for criteria and coverage specifics.</p> <p>Products that are eligible to be billed through the pharmacy benefit are listed on the Select High-Cost Physician-Administered Injectable Drug Products and Therapies list maintained on the MDHHS PBM website. Prescribers should refer to this list for updates. (Refer to the Directory Appendix for website information.) For other physician-administered injectables not documented on the list, refer to the Physician-Administered Injectable Drugs subsection.</p> <p>Eligible high-cost physician-administered drugs and therapies require the prescribing practitioner to submit a request for prior authorization. The</p>

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				<p>prescribing practitioner must then provide proof of prior authorization approval and prescription to the pharmacy for further processing. (Refer to the Prior Authorization Requirements for Carve-Out Injectable Drugs and Biological Products subsection of the Practitioner Chapter for additional information.)</p> <p>For billing information on high-cost physician-administered drug products or therapies, refer to the Pharmacy Claims Processing Manual. (Refer to the Directory Appendix for document location.)</p>
		Directory Appendix	Pharmacy Resources	<p>Addition of new category:</p> <p>Contact/Topic: Select High-Cost Physician-Administered Injectable Drug Products and Therapies list</p> <p>Web Address: https://mi.primetherapeutics.com/ >> Provider Portal >> Documents >> Other Drug Information</p> <p>Information Available/Purpose: List of high-cost drug products and therapies that are eligible to be billed through the Medicaid Pharmacy benefit.</p>
MMP 25-20	5/30/2025	To be identified and reported in future update of the Manual.	To be identified and reported in future update of the Manual.	
		Ambulance	2.6 Emergency	<p>The 2nd paragraph was revised to read:</p> <p>Claims for emergency ambulance transports must be coded with both an emergency procedure code and an appropriate ICD diagnosis code whenever the service results in transport to a hospital, or other approved alternate destination as allowed by state law or assessment and treatment/stabilization determines that no further transport is necessary. Claims for emergency transports without this information will be rejected. Documentation supporting the emergency diagnosis code must be retained in the ambulance provider's records for audit purposes.</p>

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Ambulance	Section 5 – Ambulance Quick Reference Guide	Section was removed in its entirety.
MMP 25-21	7/1/2025	Hospital Reimbursement Appendix	8.7.A. GME Innovations Hospital Program	In the 1st paragraph, the 3rd bullet point was revised to read: <ul style="list-style-type: none"> Pine Rest Christian Mental Health Services for \$3,960,000 in FY 17, \$6,336,000 in FY 18, and \$7,603,200 in FY 19 through FY 24, and \$10,373,250 in FY25 and future years.
			8.7.C. GME Innovations Michigan Doctors (MIDOCs) Program	The 2nd paragraph was revised to read: The single state agency will approve four (4) agreements with MIDocs-participating medical schools statewide each state fiscal year (SFY), covering residencies for the academic year (July-June (AY)) beginning within the SFY. The agreements will total \$1.52 million in fiscal year 2019, \$10.73 million in fiscal year 2020, \$19.98 million in fiscal year 2021, \$27.75 million in fiscal year 2022, \$28.5 million in fiscal year 2023, and \$22.8 million in fiscal year 2024, and \$32 million in fiscal year 2025.
MMP 25-22	7/1/2025	Special Programs	11.3 Beneficiary Eligibility	The 1st paragraph was revised to read: RC is covered for Medicaid-enrolled homeless beneficiaries over 18 years old enrolled in fee-for-service (FFS) Medicaid, Healthy Michigan Plan, and Managed Care, and MI Health Link . Emergency Services Only Medicaid, Plan First, and other limited coverage plans are excluded from coverage for recuperative care.
			11.4 Prior Authorization	The last paragraph was revised to read: For Medicaid Health Plan (MHP) and Mi Health Link (MHL) beneficiaries, the PA must be obtained from PRD for room & board (S9976) and the MHP or MHL Integrated Care Organization (ICO) must be contacted for PA for care coordination (G9002).

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			11.10 Billing Requirements	<p>The 6th, 7th and 8th paragraphs were revised to read:</p> <p>For care coordination (G9002), if the beneficiary is enrolled in a MHP or with MHL, it should be billed to the MHP or ICO. If the beneficiary is FFS, it should be billed through CHAMPS as an FFS claim.</p> <p>For room and board (S9976), both MHP, MHL, and FFS enrolled beneficiary claims should be submitted through CHAMPS for Medicaid FFS reimbursement.</p> <p>PA requirements apply to MHP, MHL, and FFS claims for RC services.</p>
MMP 25-23	7/1/2025	Electronic Visit Verification	3.4. Program-Specific Requirements (new subsection)	
			3.4.A. Home Help Program (new subsection)	
			3.4.A.1. EVV Requirements for Services Provided Outside the Home Help Client's Home (new subsection)	<p>New subsection text reads:</p> <p>A client may receive Home Help services at a location other than their home when approved to meet their care needs. The client's home is defined as their permanent, primary address. Home Help services provided outside the client's home must be logged in HHAeXchange or an alternative EVV system.</p> <p>The following requirements apply to Home Help services logged in a mobile application. Home Help providers using an alternative EVV system must ensure its mobile application is able to a) capture services provided in the community or a secondary address, and b) send this information to HHAeXchange.</p>

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				<p><u>Community Visit</u></p> <p>Home Help services in the community are limited to:</p> <ul style="list-style-type: none">• Shopping for food and medications.• Washing clothes outside the client's home.• Providing services at the client's workplace.• Providing services during a client's stay in a location other than their home when the stay is less than 30 consecutive days. Common examples include a vacation or a client's stay at a family member's home. <p>The client or their designee must share the address of the location with the client's ASW. This should happen before services are provided at the location.</p> <p>NOTE: When logging a visit that both starts and stops in the community, a caregiver using the HHAExchange+ mobile application must select "Community" as the Service Delivery Location. A caregiver using an alternative EVV system must use that system's method for recording a visit in the community.</p> <p><u>Secondary Address</u></p> <p>A caregiver must use an approved secondary address when Home Help services are provided:</p> <ul style="list-style-type: none">• To a client living at an address other than their home while attending a college, university, trade school or other educational setting.

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				<ul style="list-style-type: none">During a client's stay at an allowable location when the stay is 30 consecutive days or longer. For more information on allowable locations, refer to the Service Setting section in the Home Help chapter. <p>The client or their designee must share the address of the location with the client's ASW. This should happen before the date services are provided at the location.</p> <p>NOTE: When logging a visit that starts and stops at a secondary address, a caregiver using the HHAExchange+ mobile application must select "Home" as the Service Delivery Location. A caregiver using an alternative EVV system must use that system's method for recording a visit at a secondary address.</p>
MMP 25-24	7/1/2025	Billing & Reimbursement for Institutional Providers	9.1.A. Electronic Visit Verification (new subsection)	<p>New subsection text reads:</p> <p>The 21st Century Cures Act (the Cures Act), enacted by the U.S. Congress in December 2016, added Section 1903(l) to the Social Security Act to require all states to use electronic visit verification (EVV) for personal care services (PCS) and home health care services (HHCS) provided under a Medicaid State Plan of the Social Security Act or under a waiver of the State Plan. HHCS provided through Home Health must meet EVV requirements. Refer to the Electronic Visit Verification chapter of this Manual for more information and HHCS codes that require EVV.</p> <p>Two or more HHCS visits occurring at the same time are considered "overlapping visits." If a single service visit overlaps with another, it is also considered an "overlapping visit." For example, if a service visit start time is prior to the end time of a service visit on the same day, it is considered an "overlapping visit".</p>

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				Overlapping visits for any HHCS EVV service will not be paid. The first HHCS visit submitted will be processed. If another HHCS visit uses the same time in full or in part, it will not be paid. If overlapping visits are submitted simultaneously, the visit with the earlier start time will be processed.
MMP 25-25	7/2/2025	Nursing Facility Coverages	10.8.A. Standard Equipment	In the 1st paragraph, the following bullet points were added: <ul style="list-style-type: none"> Bilevel positive airway pressure (BiPAP) device Continuous Positive Airway Pressure (CPAP) Some surgical supplies
		Nursing Facility Cost Reporting & Reimbursement Appendix	8.14 Medical Supplies, Durable Medical Equipment (DME), Orthotics and Prosthetics	In the 1st paragraph, the following bullet point was deleted: <ul style="list-style-type: none"> Bilevel positive airway pressure (BiPAP) device
			9.9.E. Medication Aide (new subsection)	New subsection text reads: A medication aide is a nurse aide who holds a registration to regularly administer scheduled medications to residents of a nursing home or skilled nursing facility while under the supervision of a licensed registered professional nurse.

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				<p>Effective March 7, 2024, the medication aide training and registration fees found in MCL - Section 333.21920 are considered an allowable support cost on the NF cost report. Allowable costs will include the fees for registration, training, examination, and certification renewal for certified medication aide staff either paid directly by the nursing facility or reimbursed to the employee. Travel-related costs for staff attending training or testing, or any costs the provider may incur in attempting to become a medication aide trainer or training site, are not allowable and will be removed from the cost report. Documentation may be required during the audit process.</p> <p>Per the guidelines, a nurse aide must hold a current registration and have worked at least 2,000 hours during the two-year period immediately preceding the date of registration to be eligible for registration in a medication aide training program. A person may not engage in practice as a medication aide or a medication aide trainer without the appropriate registration or permits. All medication aide training programs must be approved by the Bureau of Community and Health Systems (BCHS). All approved training programs can be found on the BCHS website. (Refer to the Directory Appendix for website information.)</p>

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