MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: All Providers 03-01

Issued: January 1, 2003

Subject: Revised Chapter II, Eligibility

Effective: Upon Receipt

Programs Affected: Medicaid, State Medical Program, Children's Special Health Care Services Program, Maternity Outpatient Medical Services

The attached Chapter II, Eligibility, has been revised to incorporate information about the **mihealth card**, updated telephone numbers, website addresses, etc., as well as to reflect current operating procedures.

Policy clarifications have also been made to Section 9, CSHCS Special Health Plans.

Manual Maintenance

Discard Chapter II of your Provider Manual and replace with the attached Chapter II.

Questions

Any questions regarding this bulletin should be directed to: Provider Support, P.O. Box 30731, Lansing, Michigan 48909, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary. Providers may phone toll free 1-800-292-2550.

Approved

James K. Haveman, Jr.
Director

Patrick Barrie
Deputy Director
Health Programs Administration

LOCAL FIA OFFICE DETERMINATION

Eligibility for Medicaid and most other health programs is determined at the local Family Independence Agency (FIA) office. **Exception:** Eligibility for Children's Special Health Care Services (CSHCS) is determined by Department of Community Health (DCH). The local Family Independence Agency (FIA) worker reviews the beneficiary's financial and nonfinancial (e.g., disability, age) factors and determines what type of assistance, if any, the beneficiary is eligible for.

Once eligibility is established, the data is entered on the electronic Eligibility Verification System (EVS) and a **mihealth card** is issued.

Some Medicaid beneficiaries are in a "spenddown" situation. That is, the beneficiary has met all Medicaid eligibility criteria except he has excess income. (Providers should refer to SPENDDOWN BENEFICIARIES, Section 4 of this Chapter, for more information.)

In addition, migrant agricultural workers may also be eligible for health care benefits. However, due to the transient nature of the migrant population, they might not receive their **mihealth card**. The provider must call EVS to verify eligibility using EVS when a beneficiary indicates he is a health care program beneficiary and does not have a **mihealth card**. (Refer to VERIFYING BENEFICIARY ELIGIBILITY, Section 3 of this chapter, for more information.)

ELIGIBILITY BEGIN DATE

Coverage is usually effective the first day of the month that the beneficiary becomes eligible. Not all beneficiaries, however, are eligible beginning the first day of the month. Coverage may become effective the actual day the beneficiary becomes eligible. In some instances, the beneficiary's eligibility may be retroactive up to three months prior to the month of application. This may occur if, during the retroactive period,:

- all eligibility requirements for the specific health care program were met, and
- medical services were rendered.

The provider may submit claims to the DCH for payment of any covered services rendered during the beneficiary's eligibility period. If the beneficiary has previously paid for services and the provider has billed DCH for the same services, the provider must refund to the beneficiary the portion of payment the beneficiary is responsible for, regardless of the amount DCH pays. (Refer to Chapter II, Section 4 of this manual, regarding spend-down information.)

REDETERMINATIONS

Beneficiary eligibility is redetermined annually or more often, if appropriate. Beneficiaries are notified of the need to have their cases redetermined and the process.

BENEFICIARY APPEALS

Beneficiaries may appeal their eligibility determination/redetermination by contacting their local FIA worker at the local FIA office.

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GENERAL INFORMATION

The provider **MUST** verify eligibility for Medicaid, Children's Special Health Care Services (CSHCS), Michigan Transitional Medical Assistance (MTMA) and Transitional Medical Assistance-Plus (TMA-Plus), and the Maternity Outpatient Medical Services (MOMS) programs on the **EVS** prior to rendering services. (Refer to VERIFYING BENEFICIARY ELIGIBILITY, Section 3 of this chapter, for more information.)

mihealth card information: The **mihealth card** is a plastic, magnetic strip identification card issued once to each beneficiary and will contain the beneficiary's name and beneficiary ID number on the front of the card. When a family is determined eligible for a health program, a **mihealth card** will be issued to each eligible person in the household. All cards for a household are mailed to the head of the household.

The **mihealth card** does **not** contain eligibility information and does **not** guarantee eligibility until verified through EVS that the person is covered. The provider can use the **mihealth card** to access a beneficiary's eligibility information on the EVS by entering the Medicaid ID number or swiping the card using a magnetic strip reader.*

The 8-digit beneficiary ID number, obtained from the EVS, must be used when billing the Medicaid Program.

> ***The **mihealth card** uses magnetic swipe technology that allows providers to access beneficiary eligibility information with the use of a magnetic strip reader. For more information on magnetic strip readers and software, contact the MediFAX EDI Inside Sales Representative at **1-800-819-5003**.

The provider should request the beneficiary present a **mihealth card** to access a beneficiary's information on the EVS to verify health program eligibility before rendering any service. If the beneficiary does not have a **mihealth card**, the provider can also access a beneficiary's eligibility information on the EVS with the following additional search methods:

1. Beneficiary ID number,
2. Beneficiary social security number and date of birth, or
3. Beneficiary name and SSN (or date of birth).

If the beneficiary has lost his/her **mihealth card**, a replacement card may be issued by contacting 1-800-642-3195.

The provider is encouraged to verify a beneficiary's identity by requesting additional identification (e.g., driver's license, State Police ID, Social Security Card). If the provider suspects fraud, the case should be reported to the Family Independence Agency, Office of Inspector General, P.O. Box 30037, Lansing, Michigan 48909. Suspected cases of beneficiary program abuse should be sent to Department of Community Health, Program Investigation Section, P.O. Box 30479, Lansing, Michigan 48909.

Statement of Medical Services Paid (MSA-110-EOB): Occasionally, the provider may see a Statement of Medical Services Paid (MSA-110-EOB). This statement is for the beneficiary's information only and indicates services received and paid on his behalf by the Department of Community Health.

SCOPE/COVERAGE CODES

THE PROVIDER MUST ALWAYS NOTE THE BENEFICIARY'S SCOPE/COVERAGE CODE. THIS INDICATES THE EXTENT OF MEDICAID COVERAGE.

The scope/coverage code is two characters. The first character (numeric) indicates the scope of eligibility. This code is used for administrative purposes only.

SCOPE CODE	PROGRAM	QUALIFYING INFORMATION
1	Medicaid	When used in conjunction with Coverage Codes E, F, P, Q, T, U, V
2	Medicaid	When used in conjunction with Coverage Codes B, C, E, F, J, H, or 0 (zero)
3	State Medical Program	When used in conjunction with Coverage Codes G, M, or R
4	Refugees and Repatriates	When used in conjunction with Coverage Code F

The second character (alpha) indicates the coverage available for this beneficiary. It is this part of the scope/coverage code that the provider should be aware of prior to rendering the service.

COVERAGE CODE	QUALIFYING INFORMATION (Refer to the Special Programs Chart on page 5)
0 (zero)	No Medicaid eligibility/coverage (Providers should refer to SPENDDOWN BENEFICIARY, Section 4 of this chapter, for more information).
B	Qualified Medicare Beneficiary
C	Specified Low Income Medicare Beneficiary
E	Emergency or urgent Medicaid coverage ONLY
F	Full Medicaid coverage
G	State Medical Program
H	Additional Low Income Medicare Beneficiary
J	Additional Low Income Medicare Beneficiary
M	PLUS CARE (Wayne County)
P	Transitional Medical Assistance-Plus (Full coverage)
Q	Medicare Qualified Disabled Working Individual
R	Resident County Hospitalization only (administered by the local FIA office)
T	Michigan Transitional Medical Assistance (MTMA) (Full coverage)
U	Transitional Medical Assistance-Plus (TMA-Plus) (Emergency Services Only)
V	Michigan Transitional Medical Assistance (MTMA) (Emergency Services Only)

PATIENT-PAY INFORMATION

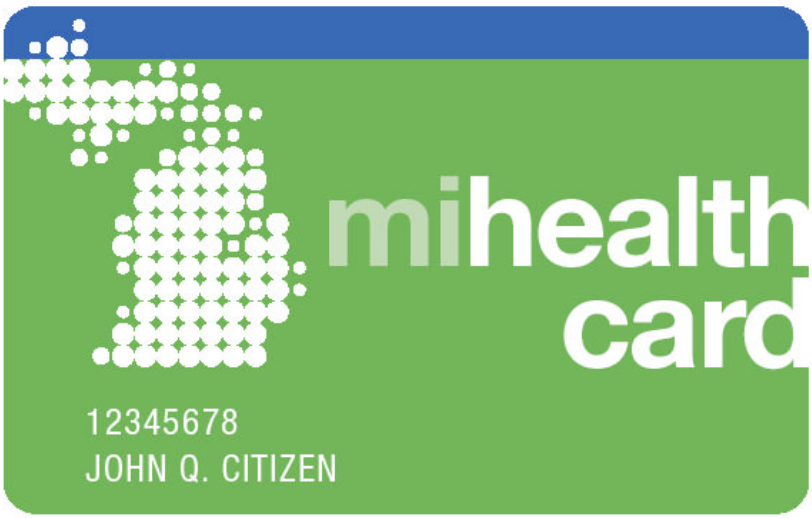
This amount is the beneficiary's liability. It is shown in whole dollars only (e.g., 00050 is $50.00, not 50 cents). This amount applies to inpatient hospitals, nursing facilities (including ICF/MR facilities), and hospice while in a nursing facility.

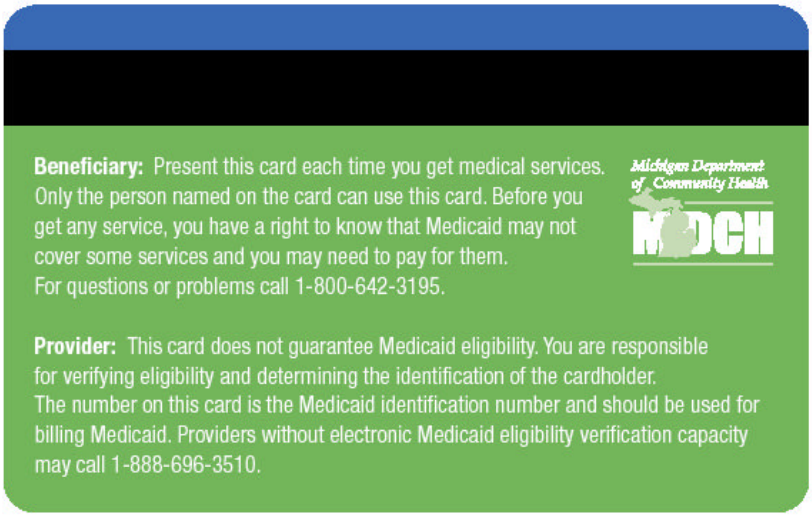
LEVEL OF CARE CODES

The EVS will indicate one of the following codes:

LEVEL OF CARE CODE	DESCRIPTION
Blank	No level of care code. Beneficiary is considered to be fee-for-service.
02	Beneficiary of nursing facility services (e.g., nursing home, medical care facility, hospital long-term care unit).
06	Beneficiary has State Medical Program authorization on file.
07	Beneficiary is enrolled in a Medicaid Health Plan, Children's Special Health Care Services – Special Health Plan, or P.A.C.E. (The provider should refer to HEALTH PLANS, Section 8 of this Chapter, for more information.)
08	Developmentally disabled beneficiary in an intermediate care facility for the mentally retarded (ICF/MR and Mount Pleasant Center only).
10	The beneficiary has a patient-pay amount for inpatient hospital acute care.
14	Beneficiary is on the Beneficiary Utilization Review Program. (The provider should refer to BENEFICIARY UTILIZATION REVIEW, Section 7 of this Chapter, for more information.)
16	Beneficiary is in a hospice program.
22	Beneficiary is enrolled in MI Choice, the Home and Community-Based Services Waiver for the Elderly and Disabled.
32	Administrative purposes. The beneficiary should be treated as if the level of care code was blank.
55	The need for long-term care has been disapproved by the agency responsible for certifying the need for nursing care.
56	Services provided/billed by a long-term care facility or waiver are NOT covered. Services provided by the facility may be billed to the beneficiary. Services provided/billed by other providers are covered if Program guidelines are met.
88	Administrative purposes. Medical exception to managed care enrollment. The beneficiary should be treated as if the level of care code was blank.

MIHEALTH CARD SAMPLE





SPECIAL PROGRAMS – BENEFICIARY IDENTIFICATION			
PROGRAM/ELIGIBILITY TYPE	**LEVEL OF CARE**	**SCOPE/ COVERAGE**	**MESSAGE**
Health Plan	07	1F 2F 4F	HMO ENROLLEE Health Plan Name and Phone Number
Wayne County PLUS CARE Also need County Code 82 (Wayne) and Program G or H to identify a PLUS CARE beneficiary	07	3M	PLUS CARE contractor's name and telephone number - ID Card is issued by Plus Care
State Medical Program (SMP)	06	3G	If authorization is/is not on file. If County Health Plan beneficiary, health plan name and phone number.
SMP - Emergency Services Only	06	1E 2E	Urgent/Emergent Services Only No **mihealth card** issued.
Beneficiary Utilization Review Program	14	1F 2F 4F	Restricted Provider Control Provider Name and ID Number
Qualified Medicare Beneficiary (QMB) Medicaid pays Medicare Part B premiums, coinsurance, and deductibles	Blank	2B	Medicare Co/Ded Only
Additional Low-Income Medicare Beneficiary (ALMB) Type 1 or Q1 Medicaid pays the entire Medicare Part B premium	Blank	2H	No **mihealth card** is issued No Medicaid coverage exists
Type 2 or Q2 Medicaid pays a portion of the annual Medicare Part B premium to the beneficiary	Blank	2J	No **mihealth card** is issued No Medicaid coverage exists
Qualified Disabled Working Individual (QDWI) Medicaid pays the Medicare Part A premium	--	1Q	No **mihealth card** is issued No Medicaid coverage exists
Specified Low Income Medicare Beneficiary (SLMB) Medicaid pays the Medicare Part B premium	--	2C	No **mihealth card** is issued No Medicaid coverage exists
Limited Medicaid Coverage (Medicaid will only cover urgent/emergent services)	Blank	1E 2E	Urgent/Emergent Servs. Only
Spenddown Scope/Coverage code 2F or 2E will be added when the beneficiary provides documentation of meeting the spenddown amount to the local FIA worker	Blank	20 (zero)	No Medicaid coverage exists until beneficiary incurs sufficient medical expenses to meet the spenddown amount
Spenddown and QMB Medicaid pays Medicare Part B premiums, coinsurance, and deductibles for the entire month.	06	2B 2C	No Medicaid coverage for Medicaid-covered services exists until beneficiary incurs sufficient medical expenses to meet the spenddown amount

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GENERAL INFORMATION

The **mihealth card** does not contain eligibility information and does not guarantee eligibility. The provider can use the **mihealth card** to access a beneficiary's eligibility information on the EVS, the Electronic Verification System.

ELIGIBILITY VERIFICATION SYSTEM (EVS)

Beneficiary information obtained from EVS is confidential under federal guidelines. EVS information must be used only for verifying beneficiary eligibility.

Information Available: If the beneficiary is eligible, the following information is available from the EVS:

- beneficiary name, beneficiary ID number, gender, date of birth.
- eligibility information for Medicaid, State Medical Program, Children's Special Health Care Services (CSHCS), Michigan Transitional Medical Assistance (MTMA), Transitional Medical Assistance-Plus (TMA-Plus), and Maternity Outpatient Medical Services (MOMS) beneficiaries for the date of service.
- program code, scope/coverage code, patient-pay amount, current county of residence, FIA case number, and FIA worker load number.

  NOTE: MOMS program beneficiaries are identified separately and do not use scope/coverage codes.
- verification of whether or not the provider is authorized by the CSHCS program to render services to this beneficiary on a particular date of service or period of time.
- third-party liability (TPL), other insurance information, carrier ID or other insurance code, policy number, contract number, and services code (if applicable) and employer name and policy holder name.
- level-of-care (LOC) information, such as Health Plan enrollment or Beneficiary Utilization Review program.

Additional information will **not** be provided by the EVS.

ACCESSING EVS

Providers may enter the EVS in one of two ways:

- by using a touch-tone telephone (or rotary telephone with a tone dialer), the provider will receive information through a voice response system. This method is free to the provider.

  1-888-696-3510

- Other methods for verifying eligibility are available that feature batch capabilities, quicker response time and offer printed verification of eligibility. These methods may involve a charge to the provider. For more information, contact MediFAX EDI Inside Sales Representative at 1-800-819-5003.

The **mihealth card** uses magnetic swipe technology that allows providers to access beneficiary eligibility information quicker and easier with the use of a magnetic strip reader. For more information on magnetic strip readers and software, contact MediFAX EDI Inside Sales Representative at 1-800-819-5003.

More information: Providers should refer to the EVS User's Guide for detailed information on EVS. The User's Guide is available from the Provider Support Section, Department of Community Health. The e-mail address is ProviderSupport@michigan.gov.

ELIGIBILITY VERIFICATION FOR DATES OF SERVICE OVER 12 MONTHS OLD

Providers may request eligibility data that is over one year old from the date of request by contacting MediFAX EDI at 1-800-819-5003 from 8 a.m. to 5 p.m., Central Standard Time. There will be a transaction fee to the requester, unless another fee has been agreed to with MediFAX EDI. Any contract vendors handling these requests should be advised of the availability and the contact person.

ELIGIBILITY

There are cases when beneficiaries have the medical need for Medicaid coverage but they have excess income. These beneficiaries are known as **spenddown beneficiaries.** Spenddown means that the beneficiary **must incur medical expenses EACH MONTH** equal to, or in excess of, an amount determined by the local FIA worker to qualify for Medicaid. Once their spenddown amount has been met, they become eligible for Medicaid benefits (Scope/Coverage Code 2F or 2E). Providers must verify Medicaid coverage using the Scope/Coverage Code available from the EVS.

The process for a spenddown beneficiary to become Medicaid eligible is as follows:

- The beneficiary presents proof of any medical expenses incurred (e.g., insurance premiums, bills for prescriptions and/or office visits) to the local FIA worker. Providers may estimate any other insurance or Medicare payment that may be applied to the incurred bill. If the exact charge is not immediately known, providers should estimate the charge on the incurred bill. This will expedite the eligibility process.
- The local FIA worker reviews the medical bills incurred and determines if the amount of beneficiary liability is met and the first date of Medicaid eligibility. (The provider is reminded it is fraud to provide beneficiaries with a notice of a bill incurred if no service has been rendered.)

  Bills for services rendered prior to the effective date of Medicaid eligibility are the beneficiary's responsibility.
- For the first date of eligibility, the local FIA worker will send letters to those providers whose services are:
  - entirely the beneficiary's responsibility, **or**
  - partly the beneficiary's responsibility and partly Medicaid's responsibility.
- A letter will also be sent to the beneficiary indicating which services are the beneficiary's responsibility for that first date of Medicaid eligibility.
- The beneficiary's Scope/Coverage Code will be changed to 2F or 2E to indicate the Medicaid eligibility period. The provider will need to verify eligibility on EVS when the beneficiary becomes eligible. Once the spenddown amount is met, eligibility is established through the end of the month.

The provider may bill Medicaid for any covered services rendered during that eligible period. **NOTE:** The provider is reminded to verify the Scope/Coverage Code on EVS before billing. This will assure that Scope/Coverage Code 2F or 2E has been put on the system and the claim will not be rejected for lack of eligibility.

RETROACTIVE ELIGIBILITY

Providers should be aware that, since bills have to be incurred before the spenddown amount is met, there will always be a period of retroactive eligibility. This may be several days or up to a period of three months from the current month. In this situation, the local FIA office may apply these "old" bills to the past three months or may prospectively apply them to the next several months, depending on the date of service and the date the bill was presented to the local FIA worker.

It is the provider's option to bill Medicaid if the beneficiary has paid the provider for services rendered. The Department of Community Health encourages the provider to return the amount the beneficiary paid and bill Medicaid for the service. If the provider decides to bill Medicaid, then he must return all money the beneficiary paid over and above the amount identified as the beneficiary's responsibility on the spenddown letter. If the beneficiary is accepted as a Medicaid beneficiary, he cannot be charged more than indicated on the letter from the local FIA office (plus applicable copayment amounts).

BILLING INSTRUCTIONS

There may be one service that is partly the beneficiary's liability and partly Medicaid's liability. If the provider chooses to bill Medicaid for this service, they should refer to the Billing and Reimbursement chapter of their Medicaid Provider Manual for instructions for submitting claims.

The beneficiary is responsible for payment of expenses that were incurred to meet the spenddown amount. Payment does **NOT** have to be made before Medicaid eligibility is approved.

NOTE: The provider should refer to QUALIFIED MEDICARE BENEFICIARY, Section 5 of this chapter, for information on spenddown beneficiaries and Scope/Coverage Code 2B.

QUALIFIED MEDICARE BENEFICIARY (QMB) (SCOPE/COVERAGE CODE 2B)

Federal regulations require that Medicaid purchase the Medicare coverage for some beneficiaries and reimburse providers for the Medicare coinsurance and deductible amounts. If these beneficiaries are not also eligible for Medicaid, they will have Scope/Coverage Code 2B, Qualified Medicare Beneficiary. Medicaid will **ONLY** reimburse providers for the Medicare coinsurance and deductible amounts up to the Medicaid maximum amount. Services not covered by Medicare will **NOT** be reimbursed by Medicaid.

SPENDDOWN BENEFICIARIES AND QMB

There are cases when the beneficiary is a Qualified Medicare Beneficiary (Scope/Coverage Code 2B) and also a spenddown beneficiary. Until the spenddown amount has been met, the EVS will show Scope/Coverage Code 2B. Once the spenddown amount is met, the Scope/Coverage Code will be changed to 2F, full Medicaid benefits, and EVS will be updated. For this Medicaid eligibility period, Medicaid will reimburse the provider for Medicaid-covered services, as well as the Medicare coinsurance and deductible amounts up to the Medicaid allowable.

If the service is covered by Medicare, the provider may bill Medicaid for the coinsurance and deductible amounts **only.** For any Medicare noncovered services, the beneficiary should obtain proof of the incurred medical expense to present to the local FIA worker so the amount may be applied toward the beneficiary's spenddown amount.

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GENERAL INFORMATION

A newborn is a child aged 0 to 1 year old. Generally, Medicaid will automatically cover a child born to a woman eligible for and receiving Medicaid at the time of the birth. The mother is required to notify the local FIA office of the birth of the newborn within ten (10) days of the birth.

If the mother is enrolled in a Medicaid health plan at the time of delivery, the newborn's services are also the responsibility of the health plan unless the child is placed in foster care or enrolled in CSHCS.

MSA-2565-C

In the few cases where this process may be delayed, any provider may notify the local FIA office of the newborn's birth by submitting a Facility Admission Notice, MSA-2565-C (Section 11, page 2). The form should be completed for the newborn.

- Item 6 must state the name of the mother.
- Item 20 must state "newborn."
- A copy of the mother's EVS information should be attached to the form, or Item 22 must contain the County, District, Unit, Worker, case number data from EVS separated by slashes (e.g., 33/01/01/08/K3300772A).

The local FIA office will enter the newborn's data on EVS and return the MSA-2565-C with the necessary billing information.

Eligibility information must be obtained from EVS using the newborn ID Number provided by DCH. Inquiries to obtain newborn ID Numbers for billing Medicaid, when an EVS query does not locate the newborn, will be handled within DCH. Inquiries should be sent to the following e-mail address or fax and include the information requested to assist DCH in locating newborn ID Numbers.

E-mail address: MSA-ESS@michigan.gov

Fax: (517) 373-1437

Requested information:

- Newborn’s name (last, first, middle initial)
- Newborn’s gender
- Newborn’s date of birth
- Mother’s name (last, first, middle initial)
- Mother’s Medicaid ID Number
- Requesting person’s name and telephone number.

BILLING

When billing the Program for medical services rendered to the newborn, providers **must use the newborn's Medicaid ID number.** The mother's number cannot be used.

EXCEPTION: If the newborn's care and circumcision are performed by the delivering physician during the mother's inpatient stay, the delivering physician may bill for the newborn care and circumcision on the same claim as the delivery under the mother's Medicaid ID number.

GENERAL INFORMATION

The Department of Community Health regularly reviews beneficiary utilization of Medicaid benefits. Some beneficiaries may be subject to the beneficiary utilization review where the beneficiary is restricted to a primary provider.

NOTE: The following services are **exempt** from beneficiary utilization control.

- emergency services,
- dental services,
- services rendered by a long-term care provider, or
- services rendered in an inpatient hospital.

Reimbursement for any ambulatory service will not be made unless the service rendered was provided, referred, or ordered by the primary provider.

NOTE: Any authorization by the restricted primary provider does NOT replace any prior authorization required by the Department of Community Health (e.g., vision services, cosmetic surgery).

IDENTIFYING ON EVS

A beneficiary subject to the Beneficiary Utilization Review program is identified on the EVS by:

- Level-of-Care Code 14,
- the message "RESTRICTED PROVIDER CONTROL," and
- the restricted primary provider's name and ID Number. Unless other family members are identified by the message, they are NOT affected by these restrictions.

REFERRAL SERVICES

It is the restricted primary provider's responsibility to supervise the case management of his patient and to coordinate all prescribed drugs, specialty care, and ancillary services. If a referred provider wishes to order any service that will be performed by another provider (e.g., laboratory tests, prescription drugs, physical therapy, outpatient services), the order for such services must be authorized or prescribed by the restricted primary provider. Only those services billed listing the restricted primary provider as the referring/prescribing physician will be reimbursed by Medicaid. This will eliminate costly and, what could be, harmful duplication of services and medication.

SPECIALTY CARE

The MSA-1302, Primary Provider Referral Notification/Request (Section 7, pages 3-4), must be completed by the primary provider to authorize care by other physicians (MD, DO, DPM), medical clinics, and outpatient hospitals. **NOTE**: The MSA-1302 does **not** authorize prescriptions ordered or written by the referred provider. (PRESCRIPTIONS, subsection below, contains more information.)

The MSA-1302 authorizes the referred medical provider to render the service. This form is valid for a 60-day period from the date of the first appointment with the referred provider.

The restricted primary provider must:

- retain one copy of the MSA-1302 for his records,
- forward one copy to the referred medical provider, and
- Mail one copy to: Department of Community Health, Beneficiary Monitoring Unit, Review and Evaluation Division, P.O. Box 30479, Lansing, Michigan 48909.

A telephone referral is adequate authorization to render the service. However, the restricted primary provider must immediately forward one copy of the MSA-1302 to the referred provider and one copy to the Beneficiary Utilization Review Program.

The referred provider must:

- receive his copy of the MSA-1302 BEFORE billing Medicaid for the service,
- retain the form in the beneficiary's file as authorization for the service, and
- use the provider ID Number identified on the MSA-1302 for billing.

PRESCRIPTIONS

If the referred provider determines that a prescription drug is medically indicated in the treatment of a condition or illness, he must contact the restricted primary provider to write/order the prescription. Both providers should keep documentation in the medical record of all prescription requests made by the referred provider and the diagnosis requiring treatment.

EMERGENCY SERVICES

Services provided in medical emergencies are excluded from the Beneficiary Utilization Review mechanism. For emergency treatment or prescriptions:

- the PHYSICIAN must:
  - write "Emergency Service" on any prescription or, for telephone prescriptions, identify to the pharmacy that the medication is for a restricted beneficiary as the result of an emergency service.
- the PHARMACY must:
  - enter the statement "Emergency Service" in the Remarks section of the claim, and
  - document a telephone request in his files by indicating the prescription was for a restricted beneficiary due to an emergency situation.

MSA-1302 (front)

BENEFICIARY MONITORING
PRIMARY PROVIDER REFERRAL NOTIFICATION / REQUEST

Michigan Department of Community Health
Medical Services Administration

- ***Read ALL instructions on the reverse side***
- ***See PA 431 and Non-discrimination information on the reverse side***

The beneficiary named below requires medical services in addition to those that I provide. I am referring this beneficiary to you as discussed with you and the beneficiary.

SECTION 1 – Beneficiary Information:

Beneficiary Name (Last, First, Middle)			Medical Assistance ID Number
Street Address			Home Telephone Number
City	State	ZIP Code	Work or Other Telephone Number

SECTION 2 – Primary Care Provider Information:

Name of Provider			Primary Care Provider ID Number
Business Address			Telephone Number
City	State	ZIP Code	

SECTION 3 – Referred Provider and Appointment Information:

Name of Provider			Date of First Appointment	Time of First Appointment : ☐ AM ☐ PM
Business Address / Location of Appointment			Telephone Number	
City	State	ZIP Code	Referred Provider Medical Provider ID Number	

SECTION 4 – Reason for Referral and Authorization:

Primary Care Provider Authorizing Signature	Date of Authorization

MSA-1302 (Rev. 9-00) (W) Previous Editions are Obsolete

Copy Distribution: **WHITE** - Mail to MSA, Beneficiary Monitoring Program
YELLOW - Primary Provider File Copy
PINK - Referred Medical Provider File Copy

MSA-1302 (back)

Instructions for form MSA-1302
Beneficiary Monitoring Primary Provider Referral Notification / Request

REFERRING PROVIDER INSTRUCTIONS:

- This form should be used ONLY for those beneficiaries that are restricted to a primary provider in the Beneficiary Monitoring Unit.
- Please type or clearly print all applicable information.
- **COPY DISTRIBUTION:**

  WHITE - Mail to MSA, Beneficiary Monitoring Unit

  YELLOW - Primary Provider File Copy

  PINK - Referred Medical Provider File Copy

- The primary provider must mail the original copy of this form to:

  BENEFICIARY MONITORING UNIT
  MEDICAL SERVICES ADMINISTRATION
  PO BOX 30479
  LANSING MI 48909-7979

BENEFICIARY INSTRUCTIONS:

- You are being referred to another medical provider.
- The name and address of that provider is shown in Section 3 on the front side of this form.
- Your appointment DATE and TIME are also shown in Section 3.
- You must keep this appointment or call this provider to make another appointment.

AUTHORITY: Title XIX of the Social Security Act

COMPLETION: Is Voluntary, but is required if Medical Assistance program payment is desired.

The Department of Community Health is an equal opportunity employer services and programs provider.

MSA-1302 (Rev. 9-00) (Back)

GENERAL INFORMATION

The Department of Community Health contracts with health plans in the state. The Medicaid health plans are paid a monthly capitation rate to provide specific covered services to enrolled Medicaid beneficiaries. The Medicaid health plan is responsible for providing, arranging, and reimbursing most medical services.

ENROLLMENT

Within the Medicaid-eligible population, there are groups that:

- must enroll in a Medicaid health plan,
- may voluntarily enroll in a Medicaid health plan, and
- are excluded from enrollment in a Medicaid health plan.

If the mother of a newborn child is enrolled in a Medicaid health plan at the time of the child's birth, the newborn child is automatically enrolled in that health plan. Health plan responsibilities begin at the time of the child's birth. (See NEWBORN CHILD ELIGIBILITY, Section 6 of this chapter, for more information.)

If one member of a family is enrolled in the Children's Special Health Care Services Program, resides in a nursing facility, or loses Medicaid eligibility, this does not exempt the other family members from enrollment in a health plan.

Mandatory Enrollment: Groups that **must** enroll in a Medicaid health plan:

- Most people who are receiving full Medicaid benefits
- People receiving Medicaid who participate in the Children's Home and Community Based Waiver or the Habilitation/Supports Home and Community Based Waiver
- Supplemental Security Income (SSI) beneficiaries who do not receive Medicare

Voluntary Enrollment: Groups that **may voluntarily** enroll in a Medicaid health plan:

- Pregnant Women whose pregnancy is the basis for Medicaid eligibility and pregnant women who are in their third trimester of pregnancy
- Migrants
- Native Americans

Excluded Enrollment: Groups that **are excluded** from enrollment in a Medicaid health plan:

- People without full Medicaid coverage (they receive emergency services only), or receive State Medical Program
- People in Plus Care
- People who are dually Medicaid/Medicare eligible
- People for whom Medicaid is purchasing Medicare coverage (QMB, SLMB, ALMB)
- People with Medicaid who reside in an ICF/MR (intermediate care facility for the mentally retarded or Mount Pleasant Center) or a state psychiatric hospital
- People in the MDCH traumatic Brain Injured residential rehabilitation program

- People receiving long-term care in a licensed nursing facility. (See EXCLUDED HEALTH PLAN SERVICES subsection for more information.)
- People being served under the MIChoice Home and Community Based Waiver (Level of Care Code 22)
- People enrolled in the Children's Special Health Care Services Program
- Spenddown beneficiaries. (SPENDDOWN BENEFICIARIES, Section 4 of this Chapter, contains further information regarding these beneficiaries.)
- People with commercial HEALTH PLAN coverage, including Medicare HEALTH PLAN coverage
- People in PACE (Program for All-Inclusive Care for the Elderly)
- Children in foster care or child caring institutions
- People in the Refugee Assistance Program
- People in the Repatriate Assistance Program
- People who have been disenrolled from a Medicaid health plan due to actions inconsistent with plan membership

MICHIGAN ENROLLS

Beneficiaries that are eligible to enroll in a Medicaid health plan are covered for Medicaid services on a fee-for-service basis until enrolled in a health plan.

Beneficiaries who are required or are eligible to enroll in a health plan have the opportunity to choose their health plan. They are given a pamphlet, Choosing Your Health Plan, which provides them information on this process. If no selection is made, the beneficiary is automatically enrolled with a health plan in the beneficiary's county of residence. Those beneficiaries automatically enrolled are identified on EVS by the acronym MCEP (Managed Care Enrollment Plan). The beneficiary has 90 days after assignment or choosing a health plan to change the health plan. After 90 days, the beneficiary is required to remain in the chosen health plan until the next open enrollment period.

The Department of Community Health has contracted with MICHIGAN ENROLLS to:

- tell beneficiaries which physicians, pharmacies, and hospitals are part of each health plan
- provide information to help the beneficiary choose a primary provider (a physician, nurse practitioner, or physician assistant who manages all of the beneficiary's health care)
- answer beneficiaries' questions regarding how to use the health plan
- enroll the beneficiaries in the health plan they choose or automatically enroll them in a health plan
- change the beneficiaries health plan
- provide a Request for an Administrative Hearing and Instructions form, DCH-0092
- provide a Medical Exception Request form, MSA-1628 for medical exception from Managed Care
- provide Beneficiary Complaint form, MSA-0300

The toll-free telephone number for MICHIGAN ENROLLS is:

1-888-ENROLLS (1-888-367-6557)
TTY: 1-888-263-5897

The hours are:

Monday - Wednesday, 8 a.m. - 8 p.m.
Thursday - Friday, 8 a.m. - 6 p.m.
Saturday, 9 a.m. - 1 p.m.

IDENTIFIED ON EVS

The EVS will indicate the following for a beneficiary in a Medicaid health plan:

- Level of Care Code 07
- the message "HMO ENROLLEE"
- the name of the health plan
- the telephone number of the health plan.

HEALTH PLAN MEMBERSHIP

Once enrolled in the health plan, that health plan sends member information to the beneficiary. The appropriate level of care code is entered on EVS with the name and toll-free telephone number of the Medicaid health plan. The beneficiary also receives a membership card from the health plan.

COVERED HEALTH PLAN SERVICES

Services may be provided directly by the health plan or arranged through the health plan. Coverages include current Medicaid-covered services and any additional services the health plan may decide to provide that may not be Medicaid-covered services, other than excluded services listed below.

EXCLUDED HEALTH PLAN SERVICES

Services are either included or excluded from the health plan's monthly capitation rate. The following services are **not** included in the monthly capitation rate and may be provided by an enrolled provider who would be directly reimbursed by Medicaid.

- dental services for Provider Type 12 or 74. Oral surgeons providing services as Provider Type 10 are included in the health plan's capitation rate and should follow health plan authorization rules.
- nursing facility services. The provider may bill Medicaid after the disenrollment is processed. The health plan must initiate a request for disenrollment by submitting the Request for Disenrollment Long Term Care, form MSA-2007. (Refer to page 5 in this section for a sample form.)

  The health plan is responsible for providing up to 45 days of restorative health care, which is intermittent or short-term restorative or rehabilitative nursing care in a nursing facility.
- mental health services in excess of 20 outpatient mental health visits each contract year.

- services provided to persons with developmental disabilities and billed through the Community Mental Health Services Program (CMHSP).
- substance abuse treatment services.
- inpatient hospital psychiatric services and outpatient partial hospitalization psychiatric services.
- personal care authorized through the Family Independence Agency.
- school-based services.
- pharmacy and related services prescribed by providers under the State's contract for specialty behavior services.

- Private Duty Nursing Services, for beneficiaries under 21 years. Beneficiaries over 21 may receive private duty nursing services through the Habilitation/Support or MI Choice waiver programs.

HEALTH PLAN AUTHORIZATIONS

The health plan must provide or arrange for its services. Those services that are not covered by the health plan do **not** require the health plan's authorization.

If a provider is rendering both a health plan-covered and a heath plan non-covered service, the health plan is responsible for providing/arranging and reimbursing for those health plan-covered services.

It is, therefore, imperative that the health plan provider obtain authorization from the health plan for their services.

For Medicaid-covered services:

- **Non-emergency care -** health plan authorization is required before rendering the service.
- **urgent care -** health plan authorization is required before rendering the service.
- **emergency care** to the point of stabilization - no authorization is required. The health plan is responsible for reimbursement of the service. The provider must contact the health plan as soon as possible to obtain emergency care authorization.

If a service requires prior authorization from a health plan and from the Department of Community Health (e.g., cosmetic surgery), the provider must obtain the authorization from the health plan but does **not** have to obtain the second prior authorization from the Department of Community Health.

MSA-2007

REQUEST FOR DISENROLLMENT LONG TERM CARE

Michigan Department of Community Health
Medical Services Administration

Comprehensive Health Plan Contract:
Long Term Custodial Care Disenrollment

Beneficiary Name	
Beneficiary ID Number	Beneficiary Case Number
Beneficiary Telephone Number ( )	Date Initiated
Plan Name	Plan ID Number
Date Enrollment Effective	Disenrollment Date Requested

INSTRUCTIONS:

- Requests should be submitted by the health plan to the following address or Fax number:

LONG TERM CARE SECTION
MEDICAL SERVICES ADMINISTRATION
PO BOX 30233
LANSING MI 48909

- FAX NUMBER: **(517) 241-8995**
- Attach detailed documentation that explains the reason for requesting disenrollment.
- The Plan must submit documentation that supports the need for long term custodial care in a nursing facility. Also, reasons why the beneficiary's care cannot be met in a less restrictive environment, such as in-home care, adult foster care, home for the aged, or assisted living.
- Attached documentation may include, but is not limited to, the items listed below:

Check ALL that apply to the documentation you are submitting;

- ☐ All medical diagnoses and onset dates.
- ☐ Current medical condition, treatment and medications. Including:
  - How the current problem is related to other existing conditions.
  - Recent and significant episodes or changes.
  - What has caused the symptoms, and their onset.
  - History and Physical.
- ☐ Therapy progress notes. Including:
  - Initial assessments, and discharge summaries.
  - Current goals and treatment plans.
  - Potential for rehabilitation.
- ☐ Physician orders. Including:
  - Hospital discharge treatment plan..
- ☐ Social History. Including:
  - Previous living arrangements.
  - Reason(s) beneficiary cannot return to previous setting.
  - Previous functional level.
- ☐ Medicare skilled nursing care exhaust date or denial/termination of treatment.
- ☐ OTHER (explain):

PLAN Representative's Name	PLAN Telephone Number ( )
PLAN Representative's Signature	Date of Request

Nursing Facility Name			Nursing Facility Contact Person Name
Facility Street Address (No. and Street, etc.)			Nursing Facility Phone Number ( )
City	State	ZIP Code	Anticipated Admission Date to Nursing Facility

Authority: Title XIX of the Social Security Act **Completion:** VOLUNTARY but required if Requested Action is to be Considered.	The Department of Community Health is an equal opportunity employer, services and programs provider.

MSA-2007 (Rev. 1/01) Previous Edition Obsolete

COPAYMENTS

Health plan beneficiaries may be charged a copayment for pharmacy, podiatric, chiropractic, vision, or hearing services. The copayment requirements and amounts may not exceed the Medicaid fee-for-service copayments. Providers should charge health plan members copayment as directed by the health plan.

Dental services are not provided by health plans. They are provided on a fee-for-service basis or through the Healthy Kids Dental Program. The dental provider should charge the beneficiary 21 years of age or older a copayment, even if the beneficiary is enrolled in a health plan. The dental provider should refer to Chapter III of the Dental Manual for more information regarding the application of the copayment.

BILLING

Health Plan Members: The health plan receives a monthly capitation fee for each Medicaid beneficiary enrolled in the plan as part of its contract with DCH. The health plan or provider may not bill the beneficiary for services not authorized by the health plan unless the beneficiary was informed of his/her financial responsibility prior to receiving the service. A provider may bill Medicaid for a service that is excluded from the health plan contract but Medicaid covered under fee-for-service (e.g., dental services).

Referral Providers: If the health plan refers a beneficiary to a provider for health plan-covered services, the health plan is responsible for reimbursement of those services.

Health Plan as a Private Insurance (Other Insurance Code 89): A beneficiary who has an existing private health plan through employment, spouse or other source cannot be enrolled in a Medicaid health plan at the same time. The DCH will disenroll that beneficiary from the Medicaid health plan. The Medicaid health plan must pursue payment from the private health plan prior to considering the service a Medicaid cost.

There may be fee-for-service beneficiaries who are enrolled with a health plan as a private insurance. For example, the provider receives a monthly capitation rate for a beneficiary covered by a private health plan policy (such as Blue Care Network). These beneficiaries are identified by Other Insurance Code 89 on EVS, and a private health insurance name if on the TPL file.

The monthly capitation payment must **not** be reflected on the Medicaid claim. In most instances, the provider is billing Medicaid for the copayment amount only. Medicaid will only reimburse the provider for the Medicaid fee screen or copayment amount, whichever is less.

Billing Instructions: Refer to the Billing & Reimbursement Chapter for claim completion instructions.

If Medicaid's maximum allowable amount is less than the copayment amount billed, the beneficiary or his representative may **not** be billed for the difference. The amount paid by Medicaid is considered as payment in full.

GENERAL INFORMATION

Eligibility for the Children's Special Health Care Services (CSHCS) Program is determined by the Department of Community Health. CSHCS provides medically necessary services to individuals who are eligible and apply under the following circumstances:

- persons under the age of 21 with one or more qualifying medical diagnosis, or
- person age 21 and older with cystic fibrosis or hemophilia.

Medical eligibility must be established by DCH before the individual is eligible to apply for program coverage. Based on medical information submitted by providers, a medically-eligible individual is provided an application for determination of other program criteria. An individual may be eligible for CSHCS and eligible for other medical programs such as Medicaid, State Medical Program, Medicare, or MIChild. To be determined dually eligible, the individual must meet the eligibility criteria for CSHCS and all eligibility criteria for the other applicable program.

COVERAGES

The CSHCS coverage is limited to specialty health care services for the treatment of the beneficiary's qualifying medical condition.

Dental interventions may be covered for certain qualifying diagnoses. The beneficiary must receive services from a Medicaid-enrolled dentist/orthodontist. Services must be related to the qualifying diagnosis and authorized by CSHCS.

CSHCS does not cover the treatment service needs related to developmental delay; mental retardation; autism; psychiatric, emotional, behavioral, or other mental health diagnoses. A beneficiary who has both CSHCS and Medicaid or CSHCS and MIChild benefits receives his Medicaid or MIChild covered mental health services from the local Community Mental Health Services Program (CMHSP).

CSHCS does not cover substance abuse treatment services. A beneficiary who has both CSHCS and Medicaid or CSHCS and MIChild benefits receives his Medicaid or MIChild covered substance abuse treatment services from the local Coordinating Agency (CA).

SERVICE PROVISION

CSHCS beneficiaries have the option of receiving services through the Basic Health Plan (BHP), also referred to as Fee for Service System, or through a CSHCS Special Health Plan (SHP), if a SHP is available in their county of residence. Once a SHP becomes active in a given county, beneficiaries must choose which health care delivery system, BHP or SHP, they want to receive their services through. An individual must have CSHCS coverage to enroll into a SHP and must be living in a county where a SHP has been approved to deliver CSHCS services at the time of enrollment. Providers should call the Eligibility Verification System (EVS) each month to verify beneficiary eligibility and enrollment in a health plan as described below.

BASIC HEALTH PLAN (BHP)

The Fee for Service, also known as the Basic Health Plan, is the historical method of service delivery and reimbursement method for CSHCS beneficiaries. BHP is available in every county in Michigan. Unlike SHPs, the BHP does not include well child visits or immunizations. Those with additional coverage (e.g., Medicaid, MIChild) continue to receive their well child visits, immunizations, etc., through that source of coverage. CSHCS coverage is limited to specialty health care services for the beneficiary's qualifying medical condition. BHP beneficiaries must obtain authorization for providers and some services (e.g., medical equipment and supplies). The BHP is an option for all CSHCS beneficiaries in every county in Michigan and operates in the same way as the Fee for Service system.

SPECIAL HEALTH PLAN (SHP)

SHPs are managed care plans specifically designed to address the unique needs of CSHCS beneficiaries. SHPs are responsible for arranging, coordinating and providing quality health care service for their CSHCS beneficiaries enrolled in their health plan. Services are provided in a manner that is family centered, community based, coordinated and culturally competent. In addition to providing CSHCS covered services (and Medicaid and MIChild, if applicable), the SHPs provide a comprehensive Individualized Health Care Plan (IHCP) that is an annual plan of care that pre-approves services needed for the year and provides referrals for other non-covered services. SHP members select a Principal Coordinating Physician who will help them navigate through the system and assure coordinated care.

The two CSHCS SHPs are:

- Children's Choice of Michigan
- Kids Care of Michigan

The SHPs are operating in approved counties with the expectation of expanding statewide. For current information on specific counties of operations, see the Children's Special Health Care Services web page at the Michigan Department of Community Health website www.michigan.gov/mdch.

Beneficiaries with CSHCS coverage, living in a county with a SHP option, must indicate whether they want BHP or SHP enrollment. Beneficiaries may change their choice at any time. Enrollment effective dates are the first day of the next month within processing constraints based on Medicaid card cut-off dates; disenrollment effective dates occur the last day of a month.

Beneficiaries who choose to enroll in a SHP will receive covered services based on their type of eligibility:

- Track I: Beneficiaries who have CSHCS only (and may have other commercial insurance coverage with which the SHP coordinates). The SHP provides comprehensive care necessary to treat the qualifying diagnosis, but is not responsible for covering preventive and primary care, except for periodic well child visits and immunizations which are additional benefits offered by the SHP. All care is coordinated through the SHP regardless of the provider of services.
- Track II: Beneficiaries who have both CSHCS and Medicaid (and may have other commercial insurance coverage with which the SHP coordinates). The SHP provides coverage for the specialty services related to the beneficiary's CSHCS qualifying diagnosis, and the primary, preventive and other specialty health care services covered by Medicaid. All care is coordinated through the SHP, except for primary dental services not related to the CSHCS qualifying diagnosis or mental health services beyond the SHP contractual requirements. When a beneficiary is enrolled in a SHP and receives services

through a waiver program or specialized support services from a Community Mental Health Services Program, services must be coordinated under the authority of the respective program.

- Track III: Beneficiaries who have both CSHCS and MIChild. The SHP provides coverage for the specialty services related to the beneficiary's qualifying diagnosis and the primary, preventive and other specialty health care covered by MIChild. All care is coordinated through the SHP, except for primary dental services not related to the CSHCS qualifying diagnosis or mental health services beyond the SHP contractual requirements.

SHP Enrollment: Enrollment is available to beneficiaries not excluded as listed below, who live in a county with an active SHP, including those with other health coverage such as Medicaid, MIChild, Medicare, and commercial health insurance. Beneficiaries who have commercial health insurance (HMO) coverage may enroll in a SHP if the commercial HMO agrees to coordinate with the SHP regarding covered services. Beneficiaries living in a county without an active SHP are not yet eligible to join a SHP except as follows:

Those beneficiaries who are current SHP members and move from a SHP county to a non-SHP county can remain in the SHP if there is agreement with both the beneficiary/family and the SHP, and the SHP is able to deliver required covered services. The beneficiary must still meet the residency criteria for CSHCS eligibility.

EXCLUDED GROUPS FROM SHP ENROLLMENT

The following CSHCS beneficiaries are excluded from enrolling in a SHP:

- Beneficiaries with Medicaid spenddown;

  NOTE: Beneficiaries with both Medicaid spenddown and MIChild are not excluded from SHP enrollment.
- Emergency Services Only (ESO) Medicaid beneficiaries;
- State Medical Program (SMP) beneficiaries;
- Residents of nursing care facilities, including beneficiaries in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) or an Alternative Intermediate Services (AIS) home;
- Beneficiaries residing in a rehabilitation facility, e.g. Traumatic Brain Injury;
- Beneficiaries who are identified as incarcerated or residing in detention facilities;
- Beneficiaries in state psychiatric hospitals;
- Beneficiaries receiving services through the Home and Community Based Services Waiver for the Elderly or Disabled, also known as MIChoice Waiver;
- Beneficiaries identified by a SHP or a Medicaid Health Plan as being non-compliant, abusive, or fraudulent;
- Beneficiaries who have moved and are temporarily living outside the state of Michigan;
- Beneficiaries requesting to enroll in a SHP who are within six (6) months of aging out of CSHCS. Current SHP enrollees who are aging out of CSHCS may maintain their SHP enrollment until CSHCS coverage expires on their 21st birthday.
- Refugees from Kosovo.

HOW A BENEFICIARY ENROLLS IN A SHP

Beneficiaries who live in a SHP and BHP county receive a notification informing them of the need to choose either SHP or BHP. Beneficiaries who would like to enroll in a SHP should call Michigan ENROLLS at 1-888-367-6557. Beneficiaries may change enrollment between BHP or a SHP at any time.

IDENTIFYING CSHCS ON EVS

When a CSHCS beneficiary is enrolled in a CSHCS Special Health Plan (SHP), the **first** MediFAX EDI screen will indicate a "Y" in the Managed Care Organization (MCO) box.

Information regarding a beneficiary's CSHCS eligibility, if any, is listed on the **second** MediFAX EDI screen in the CSHCS Enrollment section. This includes the:

- SHP's name,
- SHP's provider ID number,
- SHP's provider type code, and
- SHP's telephone number.

This section indicates whether there is CSHCS coverage for the date of service being checked. This section also indicates whether or not the provider is authorized to render services to the beneficiary on that date of service. Providers should request that the family present their CSHCS Eligibility Notice to verify the services being provided are appropriate to the CSHCS diagnosis.

NOTE: Certain provider types (e.g., pharmacies, hearing and speech centers, hearing aid dealers, home health agencies, medical suppliers, durable medical equipment providers, and orthotics/prosthetics suppliers) do not require CSHCS authorization to serve Basic Health plan beneficiaries who have CSHCS covered diagnoses applicable to the services. Families are able to access these providers as they choose and the CSHCS qualifying diagnosis warrants.

Identifying the SHP: Providers must obtain the identifying information through the EVS system.

REIMBURSEMENT

When a beneficiary is enrolled in a SHP, authorization of, and reimbursement for, covered goods and services must be obtained from the SHP. The SHP is required to authorize and reimburse established providers for covered services while an Individualized Health Care Plan (IHCP) is under development. Continuity of care for CSHCS beneficiaries newly enrolled in a SHP is maintained and paid by the SHP through the continuation of service delivery through existing CSHCS and/or Medicaid providers at least until the IHCP is completed, if not after, at Medicaid fee-for-service reimbursement rates.

The provision to continue services during the IHCP development phase is also intended:

- to support communication and continuity of care while negotiations take place between the provider and the SHP to include the provider in the SHP's network or,
- to provide the beneficiary's care as an out-of-network provider, without disrupting services.

BENEFICIARY REVIEWS

Beneficiaries may request a Department Review for denial of eligibility determinations/re-determinations and denial of services. They may contact their local health department or the CSHCS Plan Division through the Parent Participation Program Family Phone Line at 1-800-359-3722 for further information or assistance.

QUESTIONS ABOUT THE SHPs

Providers with general questions about the Special Health Plans should call the Provider Hotline at 1-800-292-2550.

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GENERAL INFORMATION

If a person is potentially eligible for health care coverage, excluding CSHCS, but has not applied for assistance, an application form should be completed. If the person is unable to complete the application form and a relative, guardian, or other representative of choice is not available to complete the form, then the hospital or nursing facility may do so. The actual application form will vary depending upon the situation presented (e.g., Healthy Kids, individual, family).

All application forms may be obtained from the local FIA office or:

Office Services Division
Family Independence Agency
Grand Tower, Ste. 203
P.O. Box 30037
Lansing, MI 48909

The combined Healthy Kids/MIChild application (DCH-0373-D) may be obtained by calling the MIChild toll-free number at 1-888-988-6300 or through the Department's web site at www.michigan.gov/mdch.

Instructions for completing the application forms are basically self-explanatory. Questions should be referred to the local FIA office.

MOST APPLICANTS

The FIA-1171, Medicaid Application/Redetermination, is the form used for most potentially eligible beneficiaries.

HEALTHY KIDS

The DCH-0373-D, Healthy Kids/MIChild application, may be used as an alternative to the FIA-1171. It is used to determine Medicaid eligibility only under the Healthy Kids categories for children under age 19 and pregnant women of any age. Persons can also apply for Healthy Kids/MIChild on-line at the following address: https://eform.state.mi.us/michild/intro1.htm or through the local health department.

The MIChild Renewal Form is considered a Medicaid application for a child who was receiving MIChild and, at redetermination, is now eligible for Healthy Kids Medicaid.

NOTE: The FIA-1171 **must** be used instead of the DCH-0373-D in the following situations:

- the family needs/wants other types of assistance in addition to Medicaid (e.g., cash assistance [FIP], Food Stamps, Emergency Needs), or
- other family members need/want health care coverage. (In this case, the entire family must use the FIA-1171.)

NURSING FACILITIES

The FIA-4574, Medicaid Application (Patient of Nursing Home) may be used as an alternative to the FIA-1171. The FIA-4574 is a Medicaid application/redetermination form used to determine Medicaid eligibility for the nursing facility patient only.

HOSPITALS AND NURSING FACILITIES

The application should be signed by the person or his authorized representative when possible. **NOTE**: Medicaid eligibility must be determined by the local FIA office even if the beneficiary is receiving Social Security benefits. A beneficiary is **NOT** automatically eligible for Medicaid just because he has Social Security benefits and resides in a long-term care facility.

State-owned and -operated facilities: If the person is unable to sign and the authorized representative is not available, the Reimbursement Office's authorized representative may sign the application using his personal signature and position title.

If retroactive Medicaid eligibility is requested, the FIA-3243, Retroactive Medicaid Application must be completed for each retroactive month that eligibility is requested in addition to the application form.

INITIAL ASSESSMENT OF ASSETS

The local FIA office must make an initial assessment* of an institutionalized or MIChoice waiver patient's assets upon request from that patient. This assessment should be requested even if the patient is not currently applying for Medicaid benefits. This assessment must be made from the DATE OF ADMISSION to the facility.

The nursing facilities are required to notify patients, their families, or authorized representatives of the need to request the initial assessment in case of future Medicaid application. The FIA-4574B, Asset Declaration - Nursing Home Resident and Spouse, is to be completed by the patient and submitted to the local FIA office to request that an initial assessment be completed. The facility may assist the patient with the completion of this form. Any questions regarding the form, or requests for copies of the form, should be directed to the local FIA office.

The patient may refuse to complete the assessment, but it should be stressed that it is easier to obtain the assessment at the time of admission than it is to try to recreate the situation at a future date.

* An initial assessment is a determination of the total amount of countable assets owned by an institutionalized or MIChoice waiver patient and/or his spouse on a given day. The day is usually the day the patient was admitted to the nursing facility or MIChoice waiver.

FACILITY ADMISSION NOTICE (MSA-2565-C)

In addition to the Assistance Application/Redetermination (FIA-1171), the Facility Admission Notice (MSA-2565-C) is used by institutional providers to notify the local FIA office of the admission of a beneficiary or potentially-eligible Medicaid beneficiary. It should be submitted even if the person's stay is covered by Medicare or other insurance. (A sample of the Facility Admission Notice (MSA-2565-C) appears on page 2 of this section.)

Hospitals and Nursing Facilities: The Facility Admission Notice must be completed by facility personnel and signed by the beneficiary or his authorized representative. When a Hospice beneficiary enters a nursing facility, the Facility Admission Notice should state "Hospice" in the Remarks section.

State-owned and -Operated Facilities and Community Mental Health Services Program (CMHSP) Facilities: If no authorized representative is available, an authorized representative of the Reimbursement Office may sign the MSA-2565-C on behalf of the beneficiary. The facility's representative from the Reimbursement Office must use his personal signature and position title.

Completion: Instructions for completing the MSA-2565-C are basically self-explanatory. The facility should contact the local FIA office with any questions regarding completion of this form.

The following items may need clarification for state-owned and -operated facilities.

ITEM 13: ATTENDING PHYSICIAN
This item may be left blank.

ITEM 16: IF AIS HOME, NAME OF DCH FACILITY
This item applies only to state-owned and -operated facilities and CMHSP facilities.

ITEM 19: IF NURSING FACILITY, SPECIFY PER DIEM RATE
The facility should enter its private pay routine nursing care per diem rate to facilitate determination of Medicaid eligibility.

Mailing: The facility must retain Part 1 of the admission notice in the beneficiary's file. Parts 2, 3, and 4 of the admission notice (MSA-2565-C) must be sent to the local FIA office.

A copy of the MSA-2565-C will be returned to the facility, noting the eligibility status and patient-pay amount of the beneficiary.

State-owned and -Operated Facilities and Community Mental Health Services Program Facilities: The first and second copies of the MSA-2565-C (and the completed Assistance Application Redetermination, FIA-1171, if necessary) must be forwarded to the local FIA office as soon as possible following admission.

The facility will not be paid by the Program for services rendered if:

- the returned copy of the MSA-2565-C indicates the person is not eligible for the Medicaid Program, or
- the person has a divestment penalty (Level of Care Code 56).

MSA-2565-C

FACILITY ADMISSION NOTICE

See Instructions on Reverse Side

Michigan Department of Community Health

1. Patient Name *(Last, First, Middle)*	2. Gender ☐ M ☐ F	3. Birth Date	4. Social Security No.
5. Home Address (No. & Street)	City	State	ZIP Code
6. Name of Person Responsible for Patient *(Last, First, Middle)*	7. Phone No.		8. Relationship to Patient
9. Home Address (No. & Street)	City	State	ZIP Code
10. Name of Provider	12. Provider ID No.		
11. Provider Address (No. & Street)	13. Attending Physician Name		
City / State / ZIP Code	14. Hospital Case No. (If Applicable)		

15. Type of Facility: *(Check ONE)*

☐ Hospital ☐ Long Term Care in Hospital ☐ Nursing Facility ☐ OTHER (Explain):
☐ Special MR Nursing Home ☐ ICF / MR Care in a DCH Facility ☐ ICF / MR Care in an AIS Facility
☐ Medical Care Facility ☐ Psychiatric Care in a DCH Facility (Name of AIS Facility): _____

16 Date of Admission	17. If LTC Facility, Specify Private Rate $ per diem	18. Is this Admission Likely to be 30 days or Longer? ☐ NO ☐ YES (If YES, Estimate Total Length of Stay):

19. Present Status of Patient

☐ Still a Patient ☐ Discharged (Date): _____ ☐ Deceased (Date): _____

20. Primary Diagnosis	21. Secondary Diagnosis

22. Patient Admitted to Facility From: *(Check ONE)*

☐ HOME ☐ Long Term Care Facility or Unit ☐ AFC or Home for the Aged ☐ OTHER (Specify):
☐ HOSPITAL *(Enter applicable dates)* ⇒ Admission Date: _____ Discharge Date: _____

23. Indicate Medicare or Private Health Insurance coverage available to patient and complete the following as applicable

☐ MEDICARE ☐ NO Other Insurance Coverage Available
☐ Private Health Insurance *(Complete Items 24 thru 29 below)* ☐ Private LTC Coverage *(Complete Items 30 thru 35 below)*

24. Name of Policyholder (Private Health Ins.)	25. Policyholder's SS No.	30. Name of Policyholder (Private LTC Ins.)	31. Policyholder's SS No.
26. Name of Insurance Company		32. Name of Insurance Company	
27. Location (City) / State / ZIP Code		33. Location (City) / State / ZIP Code	
28. Group / Policy Number	29. Cert. / Contract No.	34. Group / Policy Number	35. Cert. / Contract No.

PATIENT CERTIFICATION

I certify that the information furnished by me in applying for skilled nursing home, other long term care or hospital services under Michigan Public Acts: 321 of 1966; 280 of 1939; and 368 of 1978 is correct. Further, I declare and hereby affirm that I have disclosed to the facility named in item 10 above, the name(s) and address(es) of all parties liable or who may be liable in whole or part for payment of care received in the named facility. By accepting services, I hereby authorize the named facility to release all information and records for purposes of determining the respective liability and / or liabilities of all parties responsible in whole or in part for the payment of services received in this facility. I hereby authorize and assign directly to the named facility any or all benefits I may be entitled to and otherwise payable to me for the period of service in this facility.

36. Signature of Patient or Patient's Representative / Date Signed	37. Signature of Person Completing This Form / Date Signed

STATEMENT OF ELIGIBILITY (To be completed by MDCH / FIA for MA eligibility)

Eligibility is:

☐ DENIED (Contact Patient or Patient's Representative for Explanation) ☐ APPROVED (See the Billing Information Below)

Eligible Person's Name / Program		Grantee Name	
Recipient ID No.	MA Eligibility Effective Date	Grantee Client ID No.	FIA Case No.
Patient Pay Amount $	Patient Pay Amt. Effective Date	County / District / Section / Unit	Worker Name
Insurance, Medicare, Third Party Name		Signature of Worker	

MSA-2565-C (Rev. 3-97) Previous edition obsolete

See Instructions on Reverse Side

FACILITY (PATIENT RECORD)

PATIENT-PAY AMOUNT

Nursing Facility Determinations: After the Medicaid application and MSA-2565-C have been submitted, the local FIA office determines eligibility for medical assistance. All allowable expenses and income are calculated, and any remaining income is considered "excess income." Such excess income is then considered in determining the amount the beneficiary must pay toward his medical expenses **each month.** This monthly contribution by the beneficiary toward his care is called the patient-pay amount.

Notification:

FIA-3227 – If the local FIA office is unable to determine final eligibility status within five working days of receipt of the application for medical assistance, form FIA-3227, Tentative Patient-Pay Amount Notice, will be sent to the facility as notification of the person's tentative patient-pay amount. When the final determination is made, a copy of the MSA-2565-C will be returned to the facility. (The facility should refer to the Facility Admission Notice (MSA-2565-C) subsection for more information on this form.)

FM-160 - At the end of each month, the Department of Community Health mails to each nursing home provider a list of their residents with Level of Care Code 02. The LTC Eligibility List (FM-160 Report) is generated from the Medicaid Management Information System (MMIS). This list is sorted by provider identification number, and shows eligibility, authorization, level of care, and patient-pay information for each resident for the following month.

The identity of residents in each facility is determined from the Provider ID Number entered on the Admission Notice (MSA-2565-C) submitted at admission or re-admission. It is very important that providers ensure that their Provider ID Numbers are current and correct.

The FM-160 Report should be used in preparation of bills for services provided in that month. This will avoid many billing problems stemming from eligibility information. It is, therefore, imperative that providers assist in maintaining correct data on the Client Information System. The facility may contact the resident's local FIA office as identified on EVS if information on the FM-160 is incorrect.

In case of non-receipt of the FM-160 or for answers to billing questions, the provider should call Provider Inquiry at 1-800-292-2550.

Collection: The facility is responsible for collecting the patient-pay amount. If the facility receives the FIA-3227, it will indicate a tentative patient-pay amount. This amount is to be collected by the facility. **The patient-pay amount is not prorated for partial months.** This amount is subject to change as the beneficiary's financial eligibility changes. The patient-pay amount must be exhausted before any Medicaid payment is made.

A beneficiary who has a patient-pay amount cannot legally be charged more than the Medicaid rate for a short stay in a facility. For example, if a beneficiary is in a long-term care facility for two days in a month, the provider must collect no more than the Medicaid rate for two days from the patient-pay amount (even if the patient-pay amount is great enough to cover the higher "private pay" rate). The balance, or unused portion, of the patient-pay amount must be returned to the beneficiary or his family.

Offsetting the Patient-Pay Amount: For necessary medical or remedial care recognized under the State law but not covered by the Medicaid Program, the Medicare Catastrophic Coverage Act of 1988, Public Law 100-360, allows nursing facility beneficiaries to use their patient-pay amount to obtain these services. For additional information, the facility may contact the DCH, Long Term Care Programs at 517-241-4293.

Hospitals: The hospital is not notified of a tentative patient-pay amount via the FIA-3227. The hospital may obtain this amount by:

- waiting for the **mihealth card** to be issued to the beneficiary or verify eligibility using the EVS,
- submitting a claim to the Department of Community Health. (The patient-pay amount will be deducted by Medicaid and the claim processed accordingly.), or
- checking with the local FIA office.

State-Owned and -Operated Facilities/CMHSPs: The Department of Community Health or CMHSP will determine a financial liability, or **ability to pay**, separate from the Family Independence Agency patient-pay amount. The ability to pay may be an individual, spouse, or parental responsibility. It is determined and reviewed as required by the mental health code. The beneficiary or his authorized representative is responsible for the ability to pay, even if the patient-pay amount is greater.

PREADMISSION SCREENING

Hospitals: If a beneficiary is to be transferred from an acute-care hospital to a long-term-care facility, preadmission screening for mental illness/mental retardation **MUST** be completed prior to transfer.