MSA Bulletin

MEDICAL SERVICES ADMINISTRATION

Michigan Department of Community Health

Distribution: All Provider 01-05

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Subject: Chapter II

Effective: Upon Receipt

Affected Programs: Medicaid, CSHCS, SMP, MTMA, TMA-Plus

Chapter II of the provider manuals includes information regarding eligibility for Medicaid and other state-funded programs. Providers should review this revised chapter for updated information regarding:

- Determination of Medicaid Eligibility
- Medical Assistance Authorization (Medicaid ID Card)
- Verifying Beneficiary Eligibility
- Spenddown Beneficiaries
- Qualified Medicare Beneficiary
- Newborn Child Eligibility
- Beneficiary Utilization Review
- Health Maintenance Organizations
- Children's Special Health Care Services
- Application for Medical Assistance
- Eligibility for Determination of Institutional Care

Manual Maintenance

Discard the existing Chapter II in your manual and insert the attached revision. The revision includes the new layout and format for Medical Services Administration Manuals. Discard this bulletin upon completing manual maintenance.

Questions

Any questions regarding this bulletin should be directed to: Provider Inquiry, Medical Services Administration, P.O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at ProviderSupport@state.mi.us. Providers may phone toll free 1-800-292-2550. When you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary.

Approved

James K. Haveman, Jr.
Director

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LOCAL FIA OFFICE DETERMINATION

Eligibility for Medicaid is determined at the local Family Independence Agency (FIA) office. The local 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 for Medicaid is established, the worker enters the data on the eligibility verification system (EVS) and a Medical Assistance Authorization (Medicaid ID Card) is issued as evidence of Medicaid eligibility.

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 the SPENDDOWN Section of this Chapter for more information.

In addition, migrant agricultural workers may also be eligible for Medicaid benefits. However, due to the transient nature of the migrant population, they might not receive their Medicaid ID Cards. Therefore, the provider is encouraged to call EVS to verify eligibility when a beneficiary indicates he is a Medicaid beneficiary and does not have a current Medicaid ID Card. (The provider should refer to the section entitled VERIFYING BENEFICIARY ELIGIBILITY for information.)

ELIGIBILITY BEGIN DATE

Medicaid 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. Medicaid 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 past time

- all Medicaid eligibility requirements were met, and
- medical services were rendered.

The provider may submit claims to Medicaid 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 Medicaid for the same services, the provider must return the beneficiary's entire payment to the beneficiary, regardless of the amount Medicaid pays.

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 worker at the local FIA office.

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GENERAL INFORMATION

The Medical Assistance Authorization (Medicaid ID Card) contains beneficiary data needed to verify Medicaid eligibility and to bill the Medicaid Program. The Medicaid ID Card is usually issued on a monthly basis. The provider should request the beneficiary present a current Medicaid ID Card before rendering any service. It is very important the provider note the beneficiary's effective date of Medicaid coverage on the Medicaid ID Card.

If the beneficiary does not present a current Medicaid ID Card, the provider is encouraged to contact EVS.

When a family is determined eligible for Medicaid, usually one Medicaid ID Card is issued to the head of the household. Each eligible person in the family is listed on the Medicaid ID Card with specific information for each member (e.g., identification numbers, other insurance codes). In some situations, more than one card may be issued to a family.

If the beneficiary has lost his Medicaid ID Card, a replacement card may be issued. Replacement cards may indicate more than one month of eligibility.

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: Beneficiary Monitoring Unit, Medical Services Administration, P.O. Box 30479, Lansing, Michigan 48909.

Occasionally, the provider may see a Statement of Medical Services Paid (MSA-1689) attached to the Medicaid ID Card. This statement is for the beneficiary's information only and indicates services received and paid on his behalf by the Medical Services Administration.

The following is an explanation of the data as it appears on the Medicaid ID Card. Page 5 shows a facsimile of a Medicaid ID Card.

Michigan Family Independence Agency Return Address: The return address of the beneficiary's local FIA office appears in the upper left corner.

Beneficiary ID Number: A different 8-digit Medicaid identification number is assigned to each Medicaid-eligible individual in the case. This number is printed to the left of the beneficiary's name.

Eligible Person: Each beneficiary's name who is eligible for Medicaid is entered here.

If applicable, the beneficiary's Social Security claim number, insurance policy number(s), or insurance contract number(s) is printed under the eligible person's name. Also, if applicable, a message regarding any special programs (e.g., Beneficiary Utilization Review) is printed under the beneficiary's name. The provider should refer to the appropriate section of this Chapter for details regarding these programs.

Birth Date: The date of birth for each beneficiary is indicated in the six-digit format.

OI (Other Insurance): This code identifies other insurance carrier(s). Up to two other insurance carriers, plus Medicare, may be indicated per beneficiary. The provider should refer to the Other Insurance Appendix, for more information regarding other insurance, Medicare, and third-party liability.

The other insurance code will print once on the line with the beneficiary's name and once below that line to indicate the other insurance information for each carrier. For example:

Jane Doe 05
C# 123456789 P#12345 05
C# 45678901 P#56778 01

This card indicates that Jane Doe has Blue Cross/Blue Shield and Aetna.

EXCEPTION:

- The other insurance code for Medicare only prints next to the beneficiary's name. The Social Security claim number prints on the next line but the other insurance code does not.

- For Other Insurance Code 89, the HMO insurance ID Number will print next to the Contract Number. The provider should refer to Appendix C, Other Insurance, Code 89, for the specific HMO identified by that HMO insurance ID Number.

Also, messages to indicate if this beneficiary is on any special program are printed here. The provider should refer to the appropriate section of this Chapter for details regarding these programs.

Eligible Period: The current time period for which the beneficiary is eligible for Medicaid is entered here. This period is usually one month. This period may be less than one month or up to three prior months. Coverage will extend to the end of the current month.

If the beneficiary is enrolled in a Medicaid health maintenance organization (HMO) or Beneficiary Utilization Review program, a message indicating such prints below the Eligible Period. The provider should refer to the appropriate section of this Chapter for more information on these programs.

Name and Address: The name and address of the head of the household are printed middle right of the Medicaid ID Card.

PROG (Program Code): This code indicates which type of assistance program the beneficiary (or family) is receiving.

CO (County): The county that manages the beneficiary's Medicaid case is indicated here.

District: If the county has local FIA offices in more than one location, this code indicates which district handles the beneficiary's case.

Unit: This code identifies the unit in the local FIA office that manages the Medicaid case.

WKR (Worker Code): This code identifies the specific local FIA worker who manages the beneficiary's case.

Case Number: This is the case number used by the local FIA office. IT IS NOT USED WHEN COMPLETING THE CLAIM.

Scope/Coverage: 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 Code E, F, P, Q, T, U, V
2	Medicaid	When used in conjunction with Coverage Code B, C, E, F, J, H, or 0 (zero)
3	State Medical Program	When used in conjunction with Coverage Code 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.

NOTE: Some of the explanation of coverage codes indicate that "No Medicaid ID Card is issued." This information will appear on EVS.

COVERAGE CODE	QUALIFYING INFORMATION (Refer to the Special Programs Chart on page 6)
0 (zero)	No Medicaid eligibility/coverage. (Providers should refer to the SPENDDOWN section 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 (Emergency Services Only)
V	Michigan Transitional Medical Assistance (MTMA) (Emergency Services Only)

If individual members within a family have different scope/coverage codes, then individual Medicaid ID Cards will be issued to those members.

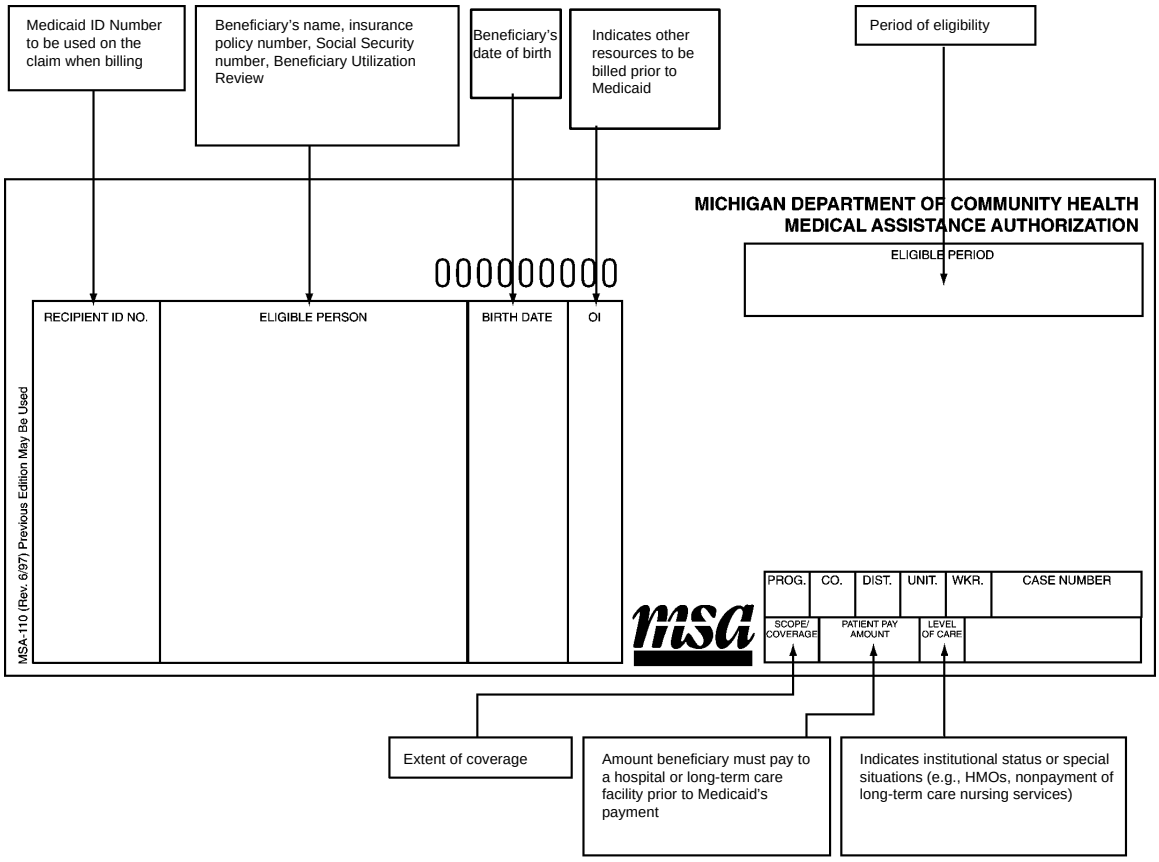
Patient-Pay Amount: This amount is the beneficiary's liability. It is shown in whole dollars only (e.g., 00050 is $50.00, not 50 cents). This amount applies to inpatient hospitals and long-term care facilities (including ICF/MR facilities).

Spenddown beneficiaries: This is always the spenddown amount for the entire month. Each individual on the case does not have to meet the spenddown amount; it is for the entire case.

Level of Care: The ID Card 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 home 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 HMO. The provider should refer to the HEALTH MAINTENANCE ORGANIZATION section of this Chapter.
08	Developmentally disabled beneficiary in an intermediate care facility for the mentally retarded (ICF/MR, Southgate Center and Mount Pleasant Center only).
10	The beneficiary has a patient-pay amount for inpatient hospital acute care.
11	Beneficiary is enrolled in a Medicaid HMO. The provider should refer to the HEALTH MAINTENANCE ORGANIZATION section of this Chapter.
14	Beneficiary is on the Beneficiary Utilization Review Program. The provider should refer to the BENEFICIARY UTILIZATION REVIEW section of this Chapter.
16	Beneficiary is in a hospice program.
22	Beneficiary is enrolled in MIChoice, 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. The beneficiary should be treated as if the level of care code was blank.

MEDICAID ID CARD SAMPLE



SPECIAL PROGRAMS – BENEFICIARY IDENTIFICATION			
PROGRAM/ELIGIBILITY TYPE	**LEVEL OF CARE**	**SCOPE/ COVERAGE**	**MESSAGE**
Health Maintenance Organization (HMO)	07	1F 2F 4F	HMO ENROLLEE HMO 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
Clinic Plan	11	1F 2F 4F	CLINIC PLAN ENROLLEE HMO Name and Phone Number
State Medical Program	06	3G	No ID Card is Issued
State Medical Program and Emergency Medicaid Services Only (SMP pays the ambulatory services and Medicaid pays the emergent/urgent services)	06	1E 2E	Urgent/Emergent Servs. Only
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 Type 2 or Q2 Medicaid pays a portion of the annual Medicare Part B premium to the beneficiary		2H 2J	No ID Card is Issued No Medicaid Coverage Exists No ID Card is Issued No Medicaid Coverage Exists
Qualified Disabled Working Individual (QDWI) Medicaid pays the Medicare Part A premium	--	1Q	No ID Card is Issued No Medicaid Coverage Exists
Specified Low Income Medicare Beneficiary (SLMB) Medicaid pays the Medicare Part B premium	--	2C	No ID Card is Issued No Medicaid Coverage Exists
Limited Medicaid Coverage (Medicaid will only cover emergent/urgent 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	20 (zero)		No ID Card is Issued 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

GENERAL

In most instances, provision of a current Medicaid ID Card is sufficient verification of Medicaid eligibility. The Medicaid ID Card contains the current month of eligibility, the level of care code, patient-pay amount, and managed care or Beneficiary Utilization Review information.

Other forms of verification include the Medicaid approval from the local FIA office. The beneficiary will receive a letter from the local FIA office indicating medical assistance coverage and the begin date of that coverage.

ELIGIBILITY VERIFICATION SYSTEM (EVS)

There may be situations when the beneficiary does not present a current Medicaid ID Card, or eligibility must be verified for another date of service. EVS can provide this information.

IT IS NOT NECESSARY FOR THE PROVIDER TO CONTACT EVS IF THE BENEFICIARY PRESENTS A CURRENT MEDICAID ID CARD. EVS does not replace the beneficiary's ID card. EVS is intended to help in those instances when the ID card is not available.

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 EVS.

- eligibility information for Medicaid, Children's Special Health Care Services (CSHCS), State Medical Program (SMP), Michigan Transitional Medical Assistance (MTMA) and Transitional Medical Assistance-Plus (TMA-Plus) beneficiaries for the date of service.
- program code, scope/coverage code, patient-pay amount, date of birth, and current county of residence.
- 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 HMO or Beneficiary Utilization Review program.

Requests for additional information will not be answered by EVS.

Accessing EVS: Providers may enter 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.

1-888-696-3510

- Other methods for verifying eligibility are available. These feature batch capabilities, quicker response time and offer printed verification of eligibility. For more information contact MediFAX's® Inside Sales Representative at 1-800-819-5003.

More information: Providers should refer to the EVS Users Guide for detailed information on EVS. The User's Guide is available from the Provider Support Section, Medical Services Administration. The e-mail address is ProviderSupport@State.MI.US.

WRITTEN INQUIRIES

Providers may request eligibility data that is **over one year old** from the date of request by contacting MediFax®. The individual that will be coordinating these requests is Jason Irvin and he can be reached at 1-800-444-4336, extension 2850 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®. Any contract vendors handling these requests should be advised of the availability and 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). No Medicaid ID Cards are issued for these beneficiaries until they become Medicaid eligible. Providers can verify Medicaid coverage using the Scope/Coverage Code available from 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 Medicaid eligibility. A Medicaid ID Card will be issued indicating the eligible period (i.e., the date the spenddown amount was met through the end of the month).

The provider may bill Medicaid for any covered services (in excess of the beneficiary's liability) 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 worker.

It is the provider's option to bill Medicaid if the beneficiary has paid the provider for services rendered. The Medical Services Administration 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,

- and the beneficiary has no other insurance, the claim must indicate:
  - Other Insurance Code "9" (beneficiary's spenddown liability),
  - the provider's usual and customary charge for the service billed,
  - the amount of the beneficiary's liability for this service in the "Other Insurance Paid" item,
  - the difference in the "Amount Billed" item, and
  - the Remarks section must indicate that this bill is in excess of the spenddown amount.
- and the beneficiary has other insurance, the claim must indicate:
  - the appropriate Other Insurance Code for the action taken by the other insurance (e.g., 5 = payment made if the other insurance made a payment),
  - the provider's usual and customary charge for the service billed,
  - the beneficiary's liability plus the other insurance payment in the "Other Insurance Paid" item,
  - the difference in the "Amount Billed" item, and
  - the Remarks section must indicate that this bill is in excess of the spenddown amount.

NOTE: It is not necessary to attach a copy of the spenddown letter to the claim.

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 the QUALIFIED MEDICARE BENEFICIARY section 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. They are issued Medicaid ID Cards with 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 Medicaid ID Card will show Scope/Coverage Code 2B. Once the spenddown amount is met, the Scope/Coverage Code will be changed to 2F, full Medicaid benefits, EVS will be updated, and a new Medicaid ID Card will be issued. 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 worker so the amount may be applied toward the beneficiary's spenddown amount.

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GENERAL

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 HMO at the time of delivery, then the newborn's services are also the responsibility of the HMO unless the child is placed in foster care or enrolled in CSHCS.

MSA-2565C

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-2565C (Section 11, page 2). The form should be completed for the newborn.

- Item 7 must be the name of the mother.
- Item 20 must state "newborn."
- A copy of the mother's Medicaid ID card should be attached to the form, or Item 22 must contain the County, District, Unit, Worker, case number data from the ID card 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-2565C 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: MSAESS@state.mi.us

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 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 Medical Services Administration 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 Medical Services Administration (e.g., vision services, cosmetic surgery).

IDENTIFIED ON THE MEDICAID ID CARD

A beneficiary subject to the Beneficiary Utilization Review program is identified on the Medicaid ID Card by:

- Level-of-Care Code 14,
- the message "RESTRICTED PROVIDER CONTROL" on the right side of the card, and
- the restricted primary provider's name and ID Number printed under the restricted beneficiary's name. Other family members may be listed on the Medicaid ID Card with the restricted beneficiary. 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 referral 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, page 4-5), 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, 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: Beneficiary Monitoring Unit, Review and Evaluation Division, Medical Services Administration, 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:
  - enter Emergent Condition Code "1" on the claim to denote emergency services, and
  - 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.

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GENERAL INFORMATION

The Department of Community Health contracts with health maintenance organizations (HMOs) in the State. The Medicaid HMO is responsible for providing, arranging, and reimbursing most medical services.

ENROLLMENT

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

- must enroll in the HMO,
- may voluntarily enroll in the HMO, and
- are excluded from enrollment in the HMO.

If the mother of a newborn child is enrolled in the HMO at the time of the child's birth, the newborn child is automatically enrolled in the HMO. HMO responsibilities begin at the time of the child's birth. (See NEWBORN CHILD ELIGIBILITY for more information.)

If one member of the case is enrolled in the Children's Special Health Care Services Program, resides in a long-term care facility, or loses Medicaid eligibility, the rest of the family may/must enroll in the HMO.

Mandatory Enrollment: Groups that **must** enroll in the HMO:

- 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 the HMO:

- Pregnant Women
- Migrants
- Native Americans
- People in the Traumatic Brain Injured Program

Excluded Enrollment: Groups that **are excluded** from enrollment in the HMO:

- People without full Medicaid coverage (they receive emergency services only)
- People in the State Medical Program or 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; Southgate Center or Mount Pleasant Center) or a state psychiatric hospital
- People receiving long-term care (custodial care) in a licensed nursing facility. See EXCLUDED SERVICES.
- 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. The SPENDDOWN section of this Chapter contains further information regarding these beneficiaries.
- People with commercial HMO coverage, including Medicare HMO 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

MICHIGAN ENROLLS

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

Beneficiaries who are required or eligible to enroll in a HMO have the opportunity to choose their HMO. 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 HMO in the beneficiary's county of residence. Those beneficiaries automatically enrolled are identified on their Medicaid ID Card by the acronym MCEP (Managed Care Enrollment Plan). The beneficiary has 90 days 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 Medical Services Administration has contracted with MICHIGAN ENROLLS to:

- tell beneficiaries which physicians, pharmacies, and hospitals are part of each HMO
- 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 HMO
- enroll the beneficiaries in the HMO they choose, or they are automatically enrolled in

- change the HMO the beneficiary is enrolled in
- provide Request for Hearing forms
- provide exception from Managed Care (Medical Exception Request, MSA-1628)

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 THE MEDICAID ID CARD

The Medicaid ID Card and EVS will indicate the following for a beneficiary in a Medicaid HMO:

- Level of Care Code 07 or 11
- the message "HMO ENROLLEE" or "CLINIC PLAN ENROLLEE" on the right side of the card
- the name of the HMO
- the telephone number of the HMO.

NOTE: The LOC 11 is used to distinguish those managed care organizations whose capitation rate does not include inpatient hospital care. Effective October 1, 2001, the clinic plans will cease to be identified on the ID card. LOC 11 will be ended. All LOC 11 codes will be changed to LOC 07.

The beneficiary also receives an enrollment card from the HMO.

HMO MEMBERSHIP

Once enrolled in the HMO, that HMO sends member information to the beneficiary. The appropriate level of care code is entered on EVS and the name and toll-free telephone number of the Medicaid HMO are printed on the Medicaid ID Card.

COVERED HMO SERVICES

Services may be provided directly by the HMO or arranged through the HMO. Coverages include current Medicaid coverages and any additional services the HMO may decide to provide that may not be Medicaid-covered services other than prohibited services.

EXCLUDED HMO SERVICES

Most services are included in the HMO's monthly capitation rate. The following services may be provided by an enrolled provider and directly reimbursed by Medicaid.

- dental (Provider Type 12 or 74) for services other than provided by an oral surgeon enrolled as a Provider Type 10 are included in the HMO's capitation rate
- long-term care facility custodial services. The HMO must initiate a request for disenrollment by submitting the Request for Disenrollment Long Term Care, MSA-2007.

  The HMO is responsible for providing up to 45 days of restorative health care, which is intermittent or short-term restorative or rehabilitative nursing care.
- mental health services in excess of 20 outpatient mental health visits each contract year
- services provided to persons with developmental disabilities and billed through Provider Type 21
- substance abuse treatment services
- inpatient hospital psychiatric services and outpatient partial hospitalization psychiatric services
- personal care provided by the Family Independence Agency
- school-based services

HMO AUTHORIZATIONS

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

However, if a provider is rendering a HMO-noncovered service and HMO-covered services are provided in conjunction with the noncovered service, then the HMO is responsible for providing/arranging and reimbursing for those HMO-covered services.

It is, therefore, imperative that the HMO provider obtain authorization for their services.

For Medicaid-covered services:

- **nonemergency care,** HMO authorization is required before rendering the service.
- **urgent care,** HMO authorization is required before rendering the service.
- **emergency care** to the point of stabilization, no authorization is required. The HMO is responsible for reimbursement of the service. However, the provider must contact the HMO as soon as possible.

If a Medicaid-covered service requires prior authorization from the Medical Services Administration (e.g., cosmetic surgery), this authorization is **not** required in addition to the HMO's authorization.

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

HMO 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 HMO members copayment as directed by the HMO.

Dental services are not provided by the HMO. 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 HMO. The dental provider should refer to Chapter III of the manual for more information regarding the application of the copayment.

BILLING

HMO Members: The HMO will receive a monthly capitation fee for each of its Medicaid enrollees from the DCH as part of its contract. The HMO must not bill the beneficiary for services not authorized by the HMO unless the beneficiary was informed of his financial responsibility prior to receiving the service.

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

Excluded Providers: Those providers whose services are NOT covered by the HMO may render services and submit claims to Medicaid.

HMO as a Private Insurance (Other Insurance Code 89): A beneficiary must not be enrolled in a Medicaid HMO as well as a private HMO. The DCH will disenroll that person from the Medicaid HMO.

There may be fee-for-service beneficiaries who are enrolled with an HMO as a private insurance. For example, the provider receives a monthly capitation rate for a beneficiary covered by a private HMO policy (such as Blue Care Network). These beneficiaries are identified by Other Insurance Code 89 on the Medicaid ID Card.

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:** The Other Insurance Code must be "6," service not covered. The Charge item and the Amount Billed item are the copayment amount only. The Other Insurance Paid item must be left blank. The Remarks section of the claim must indicate "Billing for copayment amount only" AND the appropriate documentation for Other Insurance Code "6" (as indicated in Appendix C, Other Insurance).
>
> 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

The Children's Special Health Care Services (CSHCS) Program provides services to:

- persons under the age of 21 with a qualifying medical diagnosis, and
- persons of any age with cystic fibrosis or certain blood coagulation disorders.

Medical eligibility must be established by CSHCS before the individual is eligible to apply for program coverage. The individual may have CSHCS and also be dually eligible for other medical programs such as Medicaid, SMP, 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 coverages are limited to specialty health care services for the beneficiary's qualifying medical condition.

Dental interventions may be covered for certain qualified diagnoses. The beneficiary must receive services from a Medicaid-enrolled dentist/orthodontist. Services must be authorized by CSHCS.

CSHCS does not cover services 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 must receive his Medicaid or MIChild 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 must receive his Medicaid or MIChild substance abuse treatment services from the local Coordinating Agency (CA).

SERVICE PROVISION

CSHCS beneficiaries/families have the option of receiving services through the Basic Health Plan (BHP) (previously known as the Fee For Service Health Plan, or FFS) or through a CSHCS Special Health Plan (SHP), if a SHP is available in their county of residence. An individual must have CSHCS coverage to enroll into a SHP and must be living in a county where a SHP participates at the time of enrollment.

BASIC HEALTH PLAN (BHP)

The BHP is an option for all beneficiaries in every county in Michigan. The BHP (previously known as the FFS Health Plan) is the historical method of service delivery for CSHCS beneficiaries and is reimbursed on a FFS basis. Unlike SHPs, the BHP does not include well child visits or immunizations. BHP beneficiaries must obtain authorization for providers and some services (e.g. medical equipment and supplies). Coverages are limited to specialty health care services for the beneficiary's qualifying medical condition.

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 membership. Services are provided in a manner that is family centered, community based, coordinated and culturally competent.

The two CSHCS SHPs are:

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

At the time of this publication, the SHPs are operating in approved counties with the expectation of expanding statewide.

Beneficiaries with CSHCS coverage, living in a county with a SHP, must indicate whether they want BHP or SHP enrollment. Beneficiaries may change their choice at any time. Effective dates generally occur the next available month according to processing constraints. Enrollments occur the first day of a month; disenrollments 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. The SHP provides comprehensive care necessary to treat the qualifying diagnosis, but is not responsible for covering preventive and primary care except for 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. 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. When a beneficiary is receiving hourly nursing services through the Children's Waiver Program, the SHP is required to coordinate with the CMHSP.
- 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.

SHP Enrollment: Enrollment is available to most beneficiaries living in a county with an active SHP, including those with other health coverage such as Medicaid, MIChild, Medicare, and private health coverage. Beneficiaries who have a commercial 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;*
- ESO Medicaid beneficiaries;
- Nursing home and other LTC residents (usually not eligible for CSHCS);
- Most beneficiaries who are identified as incarcerated or residing in specified detention facilities;
- Beneficiaries in state psychiatric hospitals (usually not eligible for CSHCS);
- Beneficiaries who have been identified by a SHP or a Medicaid HMO as being violently abusive, non-compliant, or fraudulent;
- SMP beneficiaries;
- Beneficiaries who have moved and are temporarily living outside the state of Michigan;
- Beneficiaries who are 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.

* Beneficiaries with both Medicaid spenddown and MIChild are not excluded from SHP enrollment.

HOW A BENEFICIARY ENROLLS IN A SHP

Beneficiaries living in a county where a SHP is available who would like to enroll in a SHP should call Michigan Enrolls at 1-888-367-6557.

IDENTIFYING CSHCS ON EVS

When a CSHCS beneficiary is enrolled in a CSHCS Special Health Plan (SHP), the **first** MediFax® 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® 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 only 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.

Note: Certain provider types (e.g., pharmacies, hearing and speech centers, hearing aid dealers, and home health agencies) do not require CSHCS authorization to serve Basic Health Plan beneficiaries who have CSHCS covered diagnoses applicable to the services.

Identifying the SHP: Each SHP will provide their members with a Plan ID card. If the beneficiary also has Medicaid, the SHP's name is listed on the front of the beneficiary's Medicaid card with a Level of Care (LOC) Code 7. Providers may also obtain this 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 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 family, providers, and the SHP to provide ongoing care without disrupting services.

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 child's care as an out-of-network provider, without disrupting services.

BENEFICIARY REVIEWS

Beneficiaries may request a Department Review of eligibility determinations/re-determinations by contacting their local health department or the CSHCS Plan Division through the Parent Participation Program Family Phone Line at 1-800-359-3722.

QUESTIONS ABOUT THE SHP'S

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

GENERAL INFORMATION

If a person is potentially eligible for Medicaid but has not applied for assistance, a Medicaid 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 long-term care facility may do so. The actual Medicaid 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, Suite 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.

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, 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.

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 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 Medicaid. (In this case, the entire family must use the FIA-1171.)

LONG-TERM CARE 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 long-term care patient only.

HOSPITALS AND LONG-TERM CARE 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 Statement of Need (FIA-3243) 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 long-term-care 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 long-term care facility or MIChoice waiver.

FACILITY ADMISSION NOTICE (MSA-2565C)

In addition to the Assistance Application/Redetermination (FIA-1171), the Facility Admission Notice (MSA-2565C) 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-2565C) appears on page 2 of this section.

Hospitals and Long-Term-Care Facilities: The Facility Admission Notice must be completed by facility personnel and signed by the beneficiary or his authorized representative. **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-2565C 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-2565C 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 LTC 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 l of the admission notice in the beneficiary's file. Parts 2, 3, and 4 of the admission notice (MSA-2565C) must be sent to the local FIA office.

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

MSA-2565C

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	18. Is this Admission Likely to be 30 days or Longer?
	$ **per diem**	☐ **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

Long-Term Care Facilities Determination: After the Medicaid application and MSA-2565C 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, a form letter (FIA-3227) 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-2565C will be returned to the facility. The facility should refer to the Facility Admission Notice (MSA-2565C) section for more information on this form.

FM-160 - At the end of each month, the Medical Services Administration 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 Client Information System. 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-2565C) submitted at admission or re-admission. It is, therefore, 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 the Medicaid ID Card if information on the FM-160 is incorrect.

In case of nonreceipt 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, Review and Evaluation Division, at 1-800-622-0276. The Long-Term Care Manual contains special billing instructions for the patient-pay amount.

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 Medicaid ID Card to be issued to the beneficiary,
- submitting a claim to the Medical Services Administration. (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 on a monthly or annual basis and reviewed periodically. 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.

CERTIFICATE OF NEED FOR INPATIENT PSYCHIATRIC SERVICES FOR INDIVIDUALS UNDER AGE 21:

Elective Admissions: Certification is to be made by the CMHSP (Provider Type 21) using the MSA-4486, Certification of Need for Inpatient Psychiatric Services for Individuals Under Age 21 (Section 11, page 5). The certification must be on or before the day of admission.

Other certifications are to be made by the hospital-based teams responsible for the plan of care.

Payment will be recovered on retrospective review when certification dates are found to be outside specified time limits.

MSA-4486: Completion instructions are self-explanatory. The original MSA-4486 must be retained in the beneficiary's medical record at the hospital. Copies of the MSA-4486 must be retained by the certifying CMHSP.

MSA-4486 (Front)

CERTIFICATION OF NEED FOR PSYCHIATRIC INPATIENT SERVICES FOR INDIVIDUALS UNDER AGE 21

Michigan Department of Community Health

Authority:	Title XIX of the Social Security Act
Completion:	Is Voluntary, but is required if payment from the Medical Assistance program is desired.

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability.

SECTION I - General Information:

Hospital Name	Medicaid PROVIDER ID No.	Admission Date	
Patient Name	Medicaid RECIPIENT ID No.	Patient Age	Patient Birth Date

Emergency or Urgent Admission?

☐ **YES** ► If "Yes", see **Section II** of the Instructions on the BACK of This Form.

☐ **NO** ► If "No", please answer the next question.

Did Patient have Medicaid when Admitted?

☐ **YES** ► If "Yes", see **Section I** of the Instructions on the BACK of This Form.

☐ **NO** ► If "No", see **Section II** of the Instructions on the BACK of This Form.

SECTION II - CERTIFICATION TEAM INFORMATION:

- Certification of the need for psychiatric inpatient services for individuals **UNDER AGE 21** must be made by one of the teams specified on the back of this form.

Check the Type of Team Completing this Form:

☐ 1 Community Mental Health (CMH) Board OR Persons Designated by that Board.

_____
County / Board Name

☐ 2 Team Responsible for Plan of Care.

SECTION IIII - CERTIFICATION TEAM AFFIDAVIT:

We certify that:

1) Ambulatory care resources available in the community DO NOT meet the treatment needs of the recipient, **and**
2) Proper treatment of the patient's psychiatric condition requires services on an INPATIENT basis under the direction of a physician, **and**
3) The services can reasonably be expected to improve the patient's condition or prevent further regression so that the services will no longer be needed.

NOTE: All signers must be Licensed as indicated on the back of this form.

NAME (Please Print)	Degree(s)	Signature	Date
NAME (Please Print)	Degree(s)	Signature	Date
NAME (Please Print)	Degree(s)	Signature	Date

MSA-4486 (Rev. 3-98)

Previous Edition May Be Used

COPY DISTRIBUTION: PART 1 (White) - Must be retained in patient hospital records.
PART 2 (Yellow) - Must be retained by CMH Boards:
Elective admissions by certifying boards.
Emergency or urgent admissions by local boards

MSA-4486 (Back)

INSTRUCTIONS FOR CERTIFICATION

(form MSA-4486)

SECTION 1:

For elective Medicaid admissions, certification must be made by an independent team (CMH Board or persons designated by the CMH board) that:

1) Includes a physician licensed to practice medicine or osteopathy, **and**
2) Has competence in diagnosis and treatment of mental illness, preferably in child psychiatry, **and**
3) Has knowledge of the individual's situation.

SECTION II :

For emergency or urgent admissions or for persons who become Medicaid eligible after admission, certification must be made by the team responsible for the plan of care. It must cover any period before the date is completed for which Medicaid reimbursement claims are made, i.e., certifying statements must be true of the entire claim period. Emergency and urgent admissions must be certified within 14 days after the admission.

The certifying team must be capable of:

1) Assessing the recipient's immediate and long range therapeutic needs, developmental priorities, and personal strengths and liabilities, **and**
2) Assessing the potential resources of the recipient's family, **and**
3) Setting treatment objectives, **and**
4) Prescribing therapeutic modalities to achieve the plan's objectives.

The certifying team must include, as a minimum, professionals described in both categories A and B below.

A. 1) A Board-eligible or Board-certified psychiatrist, **or**

2) Both a licensed clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy, **or**

3) Both a physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a licensed psychologist who has a master's degree in clinical psychology.

B. 1) A psychiatric social worker with an MSW degree, **or**

2) A registered nurse with specialized training or one year's experience in treating mentally ill individuals, **or**

3) An occupational therapist who is licensed by the State and who has specialized training or one year of experience in treating mentally ill individuals, **or**

4) A licensed psychologist who has a master's degree in clinical psychology.