MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: All Providers 03-12

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Subject: Children's Special Health Care Services Chapter

Effective: January 1, 2004

Programs Affected: Children's Special Health Care Services (CSHCS)

Purpose

This bulletin transmits a revised Children's Special Health Care Services (CSHCS) Chapter of the Medicaid Provider Manual (previously Chapter V). The revised chapter incorporates current CSHCS policies, processes, and procedures.

The following services are no longer covered for CSHCS clients age 21 and older and will continue to be non-covered until further notice:

- Podiatrists (Provider Type 13) – No services provided by a Podiatrist will be covered.
- Hearing Aid Dealers (Provider Type 90) – No services or products provided by a Hearing Aid Dealer will be covered.
- Chiropractic Services (Provider Type 14) - No services provided by a Chiropractor will be covered.
- Dental Services (Provider Types 12 and 74) – The adult dental benefit is limited to urgent/emergent services for the relief of pain and/or infection only. Routine examinations, prophylaxis, restorations, and dentures will not be covered. For a list of covered urgent/emergent dental services, refer to MSA Bulletin All Provider 03-09.

A current list of covered diagnoses used in determining medical eligibility for CSHCS can be found on the MDCH website at www.michigan.gov/mdch. Click on "Providers", next click on "Information for Medicaid Providers", and finally click on "Medicaid Fee Screens".

Manual Maintenance

Effective January 1, 2004, providers should discard all previous versions of CSHCS Chapter V and insert the attached version. This bulletin may be discarded after manual maintenance is completed.

Questions

Any questions regarding this bulletin should be directed to: Provider Support, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, 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

Paul Reinhart
Director
Medical Services Administration

CHILDREN'S SPECIAL HEALTH CARE SERVICES (CSHCS) PROGRAM

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SECTION 1 – GENERAL

Children's Special Health Care Services (CSHCS) is a program within the Michigan Department of Community Health (MDCH) created to find, diagnose, and treat children in Michigan who have chronic illnesses or disabling conditions. Title V of the Social Security Act, Michigan Public Act 368 of 1978, and the annual MDCH Appropriations Act mandate CSHCS. CSHCS promotes the development of service structures that offer specialty health care for the CSHCS qualifying condition that is family centered, community based, coordinated, and culturally competent.

MDCH covers medically necessary services related to the CSHCS qualifying condition for individuals who are enrolled in the CSHCS Program. Medical eligibility must be established by MDCH before the individual is eligible to apply for CSHCS coverage. Based on medical information submitted by providers, a medically eligible individual is provided an application for determination of nonmedical program criteria.

An individual may be eligible for CSHCS and eligible for other medical programs such as Medicaid, Adult Benefit Waiver I (ABW I), Medicare, or MIChild. To be determined dually eligible, the individual must meet the eligibility criteria for CSHCS and for the other applicable program(s).

SECTION 2 – APPROVED PROVIDERS

Physicians and hospitals approved as CSHCS providers must be authorized per client in the CSHCS system in order to be reimbursed for services.

2.1 PHYSICIANS

Physicians desiring to be CSHCS approved specialty care providers must:

- Be licensed to practice as a doctor of medicine (MD) or osteopathy (DO) by the state where the service is performed.
- Have successfully completed medical residency.
- Possess Specialty Board Certification. (Board eligible physicians in the process of completing certification requirements may be provisionally approved).
- Be enrolled in the Michigan Medicaid program. (Refer to the General Information for Providers Chapter of this manual for additional information.)
- Have clinical privileges in a CSHCS approved hospital/facility.
- Have documented clinical training or experience with children who have diagnoses eligible for CSHCS services. A physician not having experience treating infants and young children may be conditionally approved to supervise the care of children over 12 years of age.

2.2 HOSPITALS

Hospitals desiring to be CSHCS approved must:

- Be approved by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO);
- Be enrolled in the Michigan Medicaid program;
- Have an organized Pediatrics Unit with an average daily census of 6 or greater; and
- Have a medical staff structure, including an organized Pediatrics Department headed by a board certified pediatrician.

To request approval as a CSHCS provider, the physician or hospital must contact MDCH. (Refer to the Directory Appendix for contact information.)

SECTION 3 – MEDICAL ELIGIBILITY

CSHCS covers approximately 2,600 medical diagnoses that are handicapping in nature and require care by a medical or surgical subspecialist. A current list of covered diagnoses is maintained on the MDCH website. (Refer to the Directory Appendix for contact information.) Diagnosis alone does not guarantee medical eligibility for CSHCS. To be medically eligible, the individual must:

- Have at least one of the CSHCS qualifying diagnoses.
- Be within the age limits of the program:
  - Under the age of 21; or
  - Age 21 and above with cystic fibrosis or hereditary coagulation defects commonly known as hemophilia.
- Meet the medical evaluation criteria during the required medical review period as determined by a physician subspecialist regarding the level of severity, chronicity and need for treatment. (Refer to the Medical Renewal Period in the Coverage Period Section of this chapter.)

A MDCH medical consultant conducts the medical determination by reviewing the written report of a subspecialist physician. The medical information may be provided to CSHCS in the form of a comprehensive letter, hospital consultation or summary, or the Medical Eligibility Report Form (MERF), (MSA-4114). (A copy of the form is available in the Forms Appendix). Medical information is reviewed in the context of current standards of care, as interpreted by a MDCH medical consultant. All of the criteria described below must be met for the individual to be considered medically eligible:

Diagnosis	The individual must have a CSHCS qualifying diagnosis where his activity is or may become so restricted by disease or deformity as to reduce his normal capacity for education and self-support. Psychiatric, emotional and behavioral disorders, attention deficit disorder, developmental delay, mental retardation, autism, or other mental health diagnoses are not conditions covered by the CSHCS Program.
Severity of Condition	The severity criteria is met when it is determined by the MDCH medical consultant that specialty medical care is needed to prevent, delay, or significantly reduce the risk of activity becoming so restricted by disease or deformity as to reduce the individual's normal capacity for education and self-support.
Chronicity of Condition	A condition is considered to be chronic when it is determined to require specialty medical care for not less than 12 months.
Need for Treatment by a Physician Subspecialist	The condition must require the services of a medical and/or surgical subspecialist at least annually, as opposed to being managed exclusively by a primary care physician.

CSHCS covers diagnostic evaluations for individuals when symptoms and history indicate the possibility of a CSHCS qualifying condition but the appropriate medical information cannot be obtained from their current provider(s). Diagnostic evaluations are to determine whether an individual meets the medical eligibility criteria for CSHCS, not for providing treatment. The local health department (LHD) assists in obtaining these diagnostic evaluations. Treatment is not a CSHCS benefit until a qualifying diagnosis is established and the individual has enrolled in the CSHCS Program. Individuals currently enrolled in a commercial Health Maintenance Organization (HMO), Medicaid Health Plan (MHP), or with other

commercial insurance coverage must seek an evaluation by an appropriate physician subspecialist through their respective health plan or health insurance carrier to provide medical documentation of a CSHCS qualifying diagnosis.

Medical information submitted for the purpose of renewing CSHCS eligibility is generally considered current when it is no more than 12 months old. Initial determination of medical eligibility may require reports that are more current to document the individual's current medical status.

Covered medical diagnostic categories include, but are not limited to:

- Cardiovascular Disorders
- Certain chronic conditions peculiar to newborn infants
- Congenital anomalies
- Digestive Disorders
- Endocrine Disorders
- Genito-Urinary Disorders
- Immune Disorders
- Late effects of injuries and poisonings
- Musculoskeletal Disorders
- Neoplastic Diseases
- Neurologic Disorders
- Oncologic and Hematologic Disorders
- Respiratory Disorders
- Special Senses (e.g., vision, hearing)

CSHCS does not cover acute/specialty care that is not related to the CSHCS qualifying diagnosis. CSHCS also does not cover mental health care or primary care. Examples of diagnoses, conditions or procedures not covered include, but are not limited to:

- Acne
- Allergies, without anaphylaxis
- Anorexia Nervosa
- Appendicitis
- Attention Deficit Disorder
- Autism
- Behavioral Problems
- Bronchitis (acute), croup
- Childhood Illnesses (measles, mumps, chicken pox, scarlet fever, etc.)
- Cosmetic Surgery
- Depression
- Developmental Delay
- Headache, migraines
- Hernia (inguinal or umbilical)
- In utero treatment
- Pneumonia
- Refractive Errors and Astigmatism
- Sinusitis
- Tonsilitis, strep throat

SECTION 4 – APPLICATION PROCESS

When the MDCH medical consultant determines the individual is medically eligible for CSHCS, MDCH sends the individual an Application for Children's Special Health Care Services (MSA-0737). The individual must complete the application and return it to MDCH to be considered for enrollment in the program. (Refer to the Directory Appendix for contact information.) Applications submitted by the family cannot be processed until medical eligibility has been determined by MDCH.

Applications must be signed by the medically eligible individual (when legally responsible for self), or the person(s) who is legally and financially responsible for the individual. Verification of legal guardianship may be required.

Foster parents and stepparents are not considered the legally responsible persons to sign the application unless the following criteria are met:

- The foster parent is the child's court-appointed guardian; or
- The stepparent is in the legal process of adopting the child or is the child's court-appointed guardian.

The application must be completed and submitted to MDCH as directed on the application form. MDCH will notify the individual by mail if the application is incomplete and cannot be processed. The individual has 30 calendar days from the date of MDCH's letter to submit the required information in order to preserve the initial coverage date. Failure to submit the required information within the required timeframe may result in the coverage date being delayed.

SECTION 5 – FINANCIAL DETERMINATION

MDCH reviews the Financial Assessment for CSHCS form (MSA-0738) submitted by all individuals to evaluate the individual/family financial resources. The review is conducted in two steps and serves to:

- Determine whether the individual/family income is sufficient to establish a payment agreement to contribute toward the costs of the medical care received through CSHCS.
- Aid in identifying additional services or benefits for which the individual/family may be eligible.

5.1 FIRST STEP REVIEW

Individuals/families are determined to be eligible to participate in CSHCS without a payment agreement if at least one of the following applies:

- Individual, parents, legal guardian(s), or other minor siblings living in the household:
  - Has Scope 1 Medicaid coverage;
  - Is enrolled in Women, Infants and Children (WIC); or
  - Is enrolled in MIChild.
- Individual:
  - Is a ward of the county, state;
  - Lives in a foster home or a private placement agency;
  - Is deceased (retroactive coverage);
  - Was adopted with a pre-existing CSHCS eligible medical condition; or
  - Family income is below 250 percent of the Federal Poverty Level (FPL).

5.2 SECOND STEP REVIEW

Individuals/families who do not meet the above criteria must be evaluated as follows:

- When the individual is a legally responsible adult (age 18 or over), married, or an emancipated minor:
  - The income of the client and spouse (if any) is included; and
  - Deductions of eligible expenses for the individual, spouse and children (if any) are allowed.
- When the individual is a minor living with both birth/adoptive parents or legal guardians:
  - The income of both parents/legal guardians is included; and
  - Deductions for the parents/legal guardians, individual, any children of the individual, and any minor siblings living in the home is allowed.
- When the individual is a minor living with only one birth/adoptive parent or legal guardian and that parent is applying for CSHCS for the individual:
  - Only that parent's/legal guardian's income is included; and

- Deductions for that parent/legal guardian, the individual, any children of the client and any minor siblings living in the home are allowed.

- When the individual is a minor living with only one birth/adoptive parent or legal guardian and the individual is not living with the parent applying for CSHCS:
  - The income of the applying parent/legal guardian is included; and
  - Deductions for that parent/legal guardian, the individual, and any siblings living with the applying parent are allowed.
- When the individual is a minor living with a stepparent, it is not required that the stepparent's income be included. If the stepparent's income is not included, then the deductions for the stepparent or children legally affiliated with the stepparent cannot be included.

Examples of income and deductions include, but are not limited to:

Income	Allowable Deductions
▪ Wages from employment ▪ Other income	▪ Work related expenses ▪ Alimony/child support paid ▪ Child care expenses for working parents ▪ Health/hospitalization insurance premiums ▪ Family medical expenses paid out-of-pocket

5.3 Verification of Income and Deductions

Individuals/families self declare income at the time of CSHCS application and renewal. Periodic reviews of randomly selected individual/family financial documentation are conducted. When an individual/family is randomly selected for verification of income, the following may be requested:

- Current paycheck stubs.
- Individual's Medicaid or CSHCS ID number.
- Household family member's Medicaid ID number.
- Current 1040 Federal Income Tax form and relevant schedules.

5.4 Payment Agreement

CSHCS is required to determine an individual's/family's ability to contribute toward the cost of the client's care through the financial determination process. Those determined to be below the financial threshold for financial contribution are not required to share in any of the CSHCS covered costs. Those determined to be at or above the financial threshold are required to contribute toward the cost of care covered by CSHCS. The individual/family contribution is established through a sliding scale based on the level of family income after allowed deductions. The financial threshold is 250 percent of the Federal Poverty Level (FPL) for the "adjusted" resources for the individual/family. Financial reviews occur and new payment agreements are redetermined annually and implemented (if still applicable) according to the client's CSHCS coverage period.

If the adjusted resources are equal to or above the threshold, a CSHCS Payment Agreement (MSA-0787) must be signed for CSHCS coverage to be implemented. The amount of the payment agreement is the total client/family financial obligation for one year, regardless of how many children in the family have CSHCS coverage. Payments are distributed equally over a 12-month period for the ease of the family in meeting the financial obligation. The full year payment agreement is still a financial responsibility of the client/family, even if they choose to end CSHCS coverage during that year.

Costs and payment agreements are monitored by MDCH. In the event the client/family contribution exceeds the costs expended by MDCH, a refund will be made for the difference between the expenditures for the client's care and the amount contributed by the family. Because providers are allowed up to one year to bill for services, which could occur at the end of the coverage year, any refund due the family will not occur until approximately one year after the end of the coverage period. This assures that all expenditures made by the MDCH on behalf of the client have been made before issuing a refund.

SECTION 6 – OTHER ELIGIBILITY CONSIDERATIONS

6.1 CITIZENSHIP STATUS

The parent or legal guardian of the individual must be a citizen of the U.S. or a noncitizen lawfully admitted for permanent residence. Any individual born in the United States, or a child or individual who is a noncitizen lawfully admitted migrant who meets all other program eligibility criteria, is deemed eligible regardless of the citizenship status of the parents/legal guardian.

- Noncitizens who have been granted admission to the U.S. for a temporary or specific period of time are not eligible for CSHCS coverage other than as specified below.
- MDCH requires a statement of citizenship status from the family if the information is unclear from the application.

There are some exceptions by the Bureau of Citizenship and Immigration Services (formerly known as Immigration and Naturalization Services [INS]) that allow legal status for individuals with specific reasons for nonpermanent entry in the U.S who are recognized as potentially eligible for full Medicaid coverage (as opposed to Emergency Services Only coverage). CSHCS recognizes the same individuals for coverage when all other CSHCS qualifying criteria are met.

6.2 RESIDENCY

The individual, parent, legal guardian, or foster parent of the individual must be:

- A Michigan resident(s);
- Working or looking for a job in Michigan, and living in Michigan (including migrant status);
- In Michigan with the clear intent to make Michigan their home; or
- A Michigan resident who is temporarily absent from the state (due to out-of-state college attendance or is a member of a family stationed out-of-state for military service or other extenuating circumstances allowed by MDCH) and agrees to return to Michigan at least annually for subspecialty medical treatment of the qualifying diagnosis(es).

CSHCS does not issue or maintain coverage when the individual/client is known to be out-of-state (except for the circumstances listed above) for an extended period of time even if the parent, legal guardian or foster parent meets the criteria for residency. An extended period of time is defined as more than 12 consecutive months.

SECTION 7 – EFFECTIVE DATE

Once the application is complete, the effective date of CSHCS coverage is dependent upon the individual's other health care coverage. When the individual has:

- Commercial insurance coverage or no other health care coverage - The CSHCS effective date is the day the application was signed when submitted* within 30 days of the signature. Applications submitted later than 30 days of the signature are made effective on the submission date*.
- Medicaid, Transitional Medical Assistance (TMA), TMA-Plus, ABW I, or MIChild - The CSHCS effective date is prospective to the first day of the first available month after the CSHCS application has been processed, according to the **mihealth** card cut-off processing timeframes. This could result in the CSHCS effective date for coverage being as early as two weeks or as late as six weeks from the time of processing.

When information is missing, the individual has 30 days from the date of the letter sent from MDCH requesting the missing information to submit* the information in order to preserve the initial effective date of coverage. Failure to submit the required information within the timeframe indicated results in the effective date of coverage being delayed until the date that all necessary information has been submitted to MDCH. Individuals/families are required to provide complete and accurate information at the time of application and as circumstances change. At a minimum, changes in address and insurance must be reported as they occur.

* Submission date is considered the date the document is received by MDCH.

SECTION 8 – COVERAGE PERIOD

Upon completion of the application or renewal process (including completion of the Temporary Eligibility Period (TEP) requirement as specified below), CSHCS coverage is typically issued in 12-month increments.

Clients/families are required to provide updated financial information during the annual renewal of the coverage period to determine financial participation with the CSHCS Program. Those with Medicaid, MIChild, WIC or adopted with a pre-existing CSHCS qualifying diagnosis are determined as complete in the annual financial review each year those circumstances remain true. Clients are requested to provide updated information during the annual renewal of the coverage period regarding current providers, address, other insurance, etc.

8.1 MEDICAL RENEWAL PERIOD

CSHCS medical renewal period is established according to the following timeframes:

- One year for those receiving the Private Duty Nursing (PDN) benefit regardless of the CSHCS qualifying diagnosis and a limited group of additional CSHCS qualifying diagnoses; or
- Two years, three years, or five years, depending upon the CSHCS primary diagnosis.

Medical reports for renewal of coverage (refer to the Renewal of Coverage subsection) are required consistent with the timeframes indicated by the CSHCS medical renewal period.

When the client has more than one CSHCS qualifying diagnosis, the diagnosis determined by MDCH to be primary is used to determine the time interval for required medical information to be submitted for all covered diagnoses. This results in a single periodic medical review process per client. When the medical review process results in the elimination of one of the qualifying diagnoses, while maintaining another diagnosis, the new coverage period is based on the timeframe associated with the new primary diagnosis.

Example: Client has three diagnoses, each related to a different medical review period. All new medical information is required according to the medical renewal time period of the primary diagnosis.

A change of primary diagnosis during the medical renewal period does not change the time period unless and until the current medical renewal period has been completed and a new one is established.

All coverage periods end on the last day of a month, or the client's 21st birthday if the client does not have a qualifying diagnosis that is covered beyond age 21.

8.2 RETROACTIVE COVERAGE

In some instances, the client's coverage may be retroactive up to three months when requested by the family. This may occur if, during that time:

- All CSHCS medical and nonmedical eligibility requirements were met; and
- Medical services related to the qualifying diagnosis(es) were rendered and remain unpaid with no other responsible payer (e.g., Medicaid, private insurance, etc.).

Coverage does not guarantee that providers of services already provided will accept CSHCS payment. CSHCS does not reimburse families directly for payments made to providers.

8.3 Partial Month Coverage

If a client enters or leaves a facility that is not a covered facility (e.g., incarcerating facility, nursing home, or intermediate care facility) during a month of eligibility, the client remains a CSHCS client for the remainder of that month. However, services provided to the client while in the facility are not covered (i.e., reimbursable) by CSHCS, as these facilities are responsible for providing the medical care. CSHCS follows Medicaid policy regarding coverage of individuals who are inmates in an incarcerating facility. (Refer to the General Information Chapter in this manual for additional information.)

8.4 Renewal of Coverage

The client's coverage may be renewed as needed if all eligibility criteria continue to be met and the family completes the renewal process. Medical review reports are required according to the timeframes established based on the primary diagnosis for the client. An annual financial review is also required. If all of the criteria continue to be met for CSHCS coverage, a new coverage period is typically issued in 12-month increments. When the client lives in a county with CSHCS Health Plan options and has chosen a Health Plan in a previous coverage period, the full new coverage period is issued. When the client living in a county with health plan options has not chosen a CSHCS Health Plan in a previous coverage period, a Temporary Eligibility Period (TEP) is issued as the last step in completing the renewal process (see below).

8.5 Temporary Eligibility Period (TEP)

At the time of initial CSHCS coverage, or renewal of CSHCS coverage, those clients residing in a county with an active SHP are given a TEP of 90 to 124 days (if they have not yet made a Health Plan choice). As the final step of completing their application/renewal process, clients are required to choose a CSHCS Health Plan to deliver their health care services. CSHCS coverage terminates at the end of the TEP if clients fail to make a health plan choice. CSHCS Health Plan choices include the Basic Health Plan (BHP) and at least one of the Special Health Plans (SHPs). (Refer to the Health Plan Options Section for additional information.)

SECTION 9 - HEALTH PLAN OPTIONS

Certain counties have multiple health plan options. In theses counties most CSHCS clients have the option of receiving services through the Basic Health Plan (BHP), which operates the same as the Fee-For-Service (FFS) system, or through a CSHCS SHP. When multiple health plans are active in a given county, clients must choose either the BHP or a SHP to provide their services. A list of active health plan counties can be found on the MDCH website. To enroll, a client must:

- Have CSHCS coverage; and
- Be living in a county where a SHP has been approved to deliver CSHCS services; and
- Not be exempt from CSHCS health plan enrollment.

MDCH's enrollment contractor contacts CSHCS clients with active TEPs by mail to notify them of the CSHCS requirement to make a health plan choice and to provide information about their health plan options. (Refer to the Eligibility Chapter of this manual for more information.) Clients may call the enrollment contractor to obtain more information or make a Health Plan selection by telephone. They may also complete a mail-in Health Plan enrollment form. (Refer to the Directory Appendix for contact information.)

- Clients who make a choice during the TEP receive coverage that is extended to a minimum of 12 months of coverage unless the client reaches the age of 21 prior to the end of the 12-month coverage period.
- CSHCS coverage terminates at the end of the TEP if clients fail to make a Health Plan choice.
- Clients who make a Health Plan choice within six months after the expiration of the TEP receive a new period of CSHCS eligibility effective the date the client made the Health Plan choice. The new eligibility date is not retroactive.

The characteristics of SHPs and the BHP are discussed in detail in the Eligibility Chapter of this manual.

SECTION 10 - BENEFITS

CSHCS covers services that are medically necessary, related to the client's qualifying diagnosis(es), and ordered by the client's CSHCS authorized specialist(s) or subspecialist(s). Services are covered and reimbursed according to Medicaid policy unless otherwise stated in this chapter. Authorization for services for a client enrolled in a SHP must be obtained from the SHP.

The primary CSHCS benefits may include:

- Ambulance
- Care Coordination*
- Case Management*
- Dental (Specialty and General, Refer to the Dental Sections)
- Dietary Formulas (limited)
- Durable Medical Equipment (DME)
- Emergency Department (ED)
- Hearing and Hearing Aids
- Home Health (intermittent visits)
- Hospice*
- Hospital at approved sites (Inpatient/Outpatient)
- Incontinence Supplies
- Laboratory Tests
- Medical Supplies
- Monitoring Devices (Nonroutine)
- Office Visits to CSHCS Authorized Physicians
- Orthopedic Shoes
- Orthotics and Prosthetics
- Parenteral Nutrition
- Pharmacy
- Physical/Occupational/Speech Therapy
- Radiological Procedures
- Respite*
- Transplants and Implants
- Vision

(* Refer to the information and authorization requirements stated in this Section.)

Private Duty Nursing (PDN) may be available for CSHCS clients who also have Medicaid coverage.

10.1 SPECIALTY DENTAL BENEFITS

Specialty dentistry is limited to specific CSHCS qualifying diagnoses and refers to services routinely performed by dental specialists. Examples include: orthodontia, endodontia, prosthodontia, oral surgery and orthognathic surgery. CSHCS diagnoses covered for specialty dental services include:

- Amelogenesis imperfecta, Dentinogenesis imperfecta
- Anodontia which has significant effect of function
- Cleft palate/cleft lip
- Ectodermal dysplasia or epidermolysis bullosa with significant tooth involvement
- Juvenile periodontosis

- Juvenile rheumatoid arthritis and related connective tissue disorders with jaw dysfunction secondary to tempromandibular joint arthritic involvement
- Post-operative care related to neoplastic jaw disease
- Severe malocclusion requiring orthognathic surgery
- Severe maxillofacial or cranialfacial anomalies that require surgical intervention
- Traumatic injuries to the dental arches

To request approval as a CSHCS provider, dentists must contact MDCH. (Refer to the Directory Appendix for contact information.)

10.2 General Dental Benefits

General dentistry refers to diagnostic, preventive, restorative and oral surgery procedures. MDCH may determine a client eligible for certain general dentistry services when the CSHCS qualifying diagnosis is related to conditions eligible for this coverage as identified below:

- Chemotherapy or radiation which results in significant dental side effects
- Cleft lip/palate/facial anomaly
- Convulsive disorders with gum hypertrophy
- Cystic Fibrosis
- Dental care that requires general anesthesia in an inpatient or outpatient hospital facility for those with certain CSHCS diagnoses
- Hemophilia and/or other coagulation disorders
- Pre- and post-transplant

To request approval as a CSHCS provider, dentists must contact MDCH. (Refer to the Directory Appendix for contact information.)

10.3 Care Coordination Benefit

Clients enrolled in CSHCS with identified needs may be eligible to receive Care Coordination services.

Care Coordination services may be provided by the local health department. LHD staff includes registered nurses (RNs), social workers, or paraprofessionals under the direction and supervision of RNs. Staff must be trained in the service needs of the CSHCS population and demonstrate skill and sensitivity in communicating with children with special needs and their families. For individuals enrolled in a SHP, LHD staff must be authorized by the SHP to provide the services.

There are two levels of Care Coordination - Level I/IHCP and Level II Care Coordination.

- Level I/IHCP consists of identification and documentation of a SHP enrollee's medical, social, educational, functional status, and requirements to treat and support those needs through the development of a comprehensive plan of care or Individualized Health Care Plan (IHCP). IHCPs are developed or renewed on an annual basis. Initial IHCP development may require completion of a long form or short form as determined by the SHP of enrollment. IHCP renewals also require completion of a long form or short form as determined by the SHP of enrollment. The LHDs are responsible for completion of IHCPs within 45 days of receipt of referral. The LHDs are limited to one Level I/IHCP event per the client's eligibility year.

- Level II Care Coordination consists of interaction with the client/family and others involved with care of the client by telephone, in person or in writing. Care Coordination activities include, but are not limited to, arranging for service delivery from CSHCS qualified providers, client advocacy, assisting with needed social, education, or other support services, facilitating transitional services for CSHCS/Medicaid clients at age 21 regarding the MHP selection process, participating in meetings to collaborate with other programs servicing the same client, updating of an existing IHCP and processing Children with Special Needs Fund (formerly known as the Trust Fund) applications. In addition, these services must be nonroutine, involve multiple contacts, and be substantive. The LHDs are limited to a maximum of ten Level II Care Coordination events per the client's eligibility year.

Level II Care Coordination is not reimbursable for clients also receiving Case Management services during the same LHD billing period, which is usually a calendar quarter. In the event Care Coordination services are no longer appropriate, and Case Management services are needed, the change in services may only be made at the beginning of the next billing period.

Clients/families can contact the LHD or SHP as appropriate for assistance in obtaining care coordination services.

10.4 CASE MANAGEMENT BENEFIT

CSHCS clients may be eligible to receive Case Management services if they have complex medical care needs and/or complex psychosocial situations which require that intervention and direction be provided by an outside, independent professional. Eligible clients include, but are not limited to, the Private Duty Nursing (PDN) population. LHDs or their contractors may provide Case Management services. Case Management requires the development of a comprehensive care/service plan meeting the minimum elements as determined by MDCH. All services must relate to objectives/goals documented in the comprehensive plan of care. For individuals enrolled in a SHP, LHD staff must be authorized by the SHP to provide the services.

Case Management requires that services be provided in the home setting or other noninstitutional setting based on family preference, and be provided face-to-face. Clients are eligible for a maximum of six services per eligibility year. PDN clients eligible for and desiring Case Management services are to receive a minimum of four services per eligibility year. Services above the maximum of six would require prior approval by MDCH. To request approval, the Case Management provider must send a detailed request including documentation and the rationale for additional services to MDCH. (Refer to the Directory Appendix for contact information.)

Each case manager must be licensed to practice as a registered professional nurse in the State of Michigan and be employed as a Public Health nurse at the entry level or above by a LHD, or be able to demonstrate to MDCH that comparable qualifications are met.

Case Management is not reimbursable for clients also receiving Level II Care Coordination services during the same LHD billing period, which is usually a calendar quarter. In the event Case Management services are no longer required, but Care Coordination services would be of assistance, the change may only be made at the beginning of the next billing period.

Clients/families can contact the LHD or SHP as appropriate for assistance in obtaining case management services.

10.5 Hospice Benefit

Hospice provides assistance to the family when palliative care and treatment are appropriate services for the client. Hospice is intended to maximize quality of life when there is no reasonable expectation of recovery. To be eligible and authorized for hospice, MDCH must receive a medical report for review that includes:

- A statement that the client has reached the terminal phase of illness where the physician deems palliative measures necessary and appropriate rather than the ongoing aggressive treatment typically engaged for curative measures;
- Documentation from the treating specialty physician indicating the need to pursue the palliative measures;
- A statement of limited life expectancy (approximately six months or less); and
- A proposed plan of care for services that are consistent with the philosophy/intent of hospice and are clinically and developmentally appropriate to the client's needs and abilities.

Clients receiving services through any of the following publicly funded programs or benefits are not eligible for the CSHCS Hospice benefit:

- Private Duty Nursing Benefit
- Children's Waiver
- Habilitation/Support Services Waiver
- MI Choice Waiver

Requests for hospice care must address the criteria above and be made in writing to MDCH or SHP as appropriate. (Refer to the Directory Appendix for contact information.) MDCH responds to all requests for hospice services in writing.

10.6 Respite Benefit

Respite services provide limited and temporary relief for families caring for clients with complex health care needs when the care needs require nursing services in lieu of the trained caregivers. Services are provided in the family home by hourly skilled and licensed nursing services as appropriate. To be eligible and authorized for respite, MDCH must determine the CSHCS client to have:

- Health care needs that meet the following criteria:
  - That skilled nursing judgments and interventions be provided by licensed nurses in the absence of trained and/or experienced parents/caregivers responsible for the client's care; and
  - That the family situation requires respite; and
  - That no other community resources are available for this service.
- No other publicly or privately funded hourly skilled nursing services in the home.
- Service needs which can reasonably be met only by the CSHCS Respite benefit, not by another service benefit.

A maximum of 180 hours of CSHCS Respite services may be authorized per family during the 12-month eligibility period. When there is more than one respite-eligible client in a single home, the respite service is provided by one nurse at an enhanced reimbursement rate for the services provided to multiple clients. Allotted respite hours may be used at the discretion of the family within the eligibility period. Unused hours from a particular eligibility period are forfeited at the end of that period and cannot be carried forward into the next eligibility period.

Clients receiving services through any of the following publicly funded programs and benefits are not eligible for the CSHCS Respite benefit:

- Private Duty Nursing Benefit
- Children's Waiver
- Habilitation/Support Services Waiver
- MI Choice Waiver

Requests for respite must be made in writing to MDCH or SHP (refer to the Directory Appendix for contact information) as appropriate and include the following information:

- The health care needs of the child;
- The family situation that influences the need for respite; and
- Other community resources or support systems that are available to the family (e.g., CMH services, FIA services, adoption subsidy, SSI, trust funds, etc.).

MDCH responds to all requests for respite in writing.

10.7 Insurance Premium Payment Benefit

Clients may lose private insurance coverage due to a change in family circumstances (loss of job, etc.) or have difficulty continuing to pay the insurance premium. In some cases, CSHCS may consider paying the cost of the insurance premium or Medicare Part B if requested and if it is deemed by MDCH to be cost-effective. The LHD assists families who would like to be considered for this benefit.

SECTION 11 – OUT-OF-STATE MEDICAL CARE

CSHCS covers out-of-state **emergency** medical care when services are related to the qualifying diagnosis. Emergency medical care is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the client;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Nonemergency medical care related to the qualifying diagnosis is defined as not meeting the definition of emergency medical care and is covered out-of-state only when comparable care cannot be provided within the State of Michigan and:

- The service is prior authorized by MDCH;
- Medicare has paid part of the service and the provider is billing for the coinsurance and/or deductibles; or
- The service has been determined medically necessary by MDCH (either pre- or post-service) because the client's health would be endangered if he were required to travel back to Michigan for services.

Medical care provided in "borderland" areas is allowed without application of the Out-of-State Medical Care criteria if the provider is enrolled in the Michigan Medicaid Program. Borderland is defined as counties outside of Michigan that are contiguous to the Michigan border and the major population centers (cities) beyond the contiguous line as recognized by MDCH. (Refer to the General Information Chapter of this manual for more information.)

The LHD CSHCS offices, or the SHP as appropriate, authorize and assist families with travel for care received in borderland areas in the same manner as for travel in-state.

SECTION 12 – TRAVEL ASSISTANCE

CSHCS reimburses for travel to assist clients in accessing and obtaining authorized specialty medical care and treatment (in-state and out-state, as appropriate) when the family's resources for the necessary travel pose a barrier to receiving care. Travel assistance is allowed for the client and one adult to accompany the client. The treatment must be related to the qualifying medical diagnosis and provided by a CSHCS approved provider. The travel benefit is not intended to assume the entire cost for the expenses incurred.

12.1 IN-STATE TRAVEL

Requests for transportation assistance must be made as follows:

- Clients enrolled in a SHP must request all travel assistance from the SHP.
- Clients not enrolled in a SHP, and who are not covered by Medicaid, must request travel assistance from the LHD.
- Clients who are not enrolled in a SHP and have Medicaid coverage can request travel assistance from the LHD. Travel must be related to the CSHCS qualifying diagnosis. If the request for travel is not related to the CSHCS qualifying diagnosis, but is a Medicaid covered service, the LHD will refer the family to the local FIA for assistance.

To be eligible and authorized for CSHCS in-state travel assistance, the client must be determined by MDCH or the SHP to meet the following criteria:

- The client has CSHCS coverage at the time of the travel*;
- The Travel Assistance is for obtaining CSHCS specialty medical care and treatment from a CSHCS approved provider for the CSHCS medically-eligible diagnosis;
- The client/family lacks the financial resources to pay for all or part of the travel expenses (families who are not on a payment agreement);
- Other travel/financial resources are unavailable or insufficient; and
- The mode of travel to be used is the least expensive and most appropriate mode available.

SHP enrollees with a payment agreement may receive in-state travel assistance as needed, which is included as a State paid benefit in the payment agreement reconciliation process. (Refer to the Payment Agreement subsection.) Travel to borderland providers is considered the same as travel to in-state providers and follows the same requirements and rules.

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* Travel assistance may be authorized for individuals who do not have CSHCS, but need travel assistance to participate in a diagnostic evaluation that is performed for the purpose of determining CSHCS eligibility. There must be verification that no other resources are available and the individual is otherwise unable to access the site of the diagnostic evaluation

Clients who meet the criteria outlined in this policy are eligible for transportation assistance through CSHCS and receive reimbursement according to the rates established in subsequent sections of this chapter.

Reimbursement for CSHCS clients with Medicaid coverage, who request in-state travel assistance from their local FIA office, is provided in accordance with the Medicaid/FIA transportation policy.

12.2 OUT-OF-STATE TRAVEL

Requests for transportation for out-of-state travel assistance must be made as follows:

- Clients enrolled in a SHP must request all travel assistance from the SHP.
- Clients not enrolled in a SHP, and who are not covered by Medicaid, must request travel assistance from the LHD or by calling the CSHCS Family Phone Line. (Refer to the Directory Appendix for contact information.)
- Clients who are not enrolled in a SHP and have Medicaid coverage can request travel assistance from the LHD. Travel must be related to the CSHCS qualifying diagnosis. If the request for travel is not related to the CSHCS qualifying diagnosis, but is a Medicaid covered service, the LHD will refer the family to the local FIA for assistance.

To be eligible and authorized for CSHCS out-of-state travel assistance, the client must be determined by MDCH or SHP to meet the following criteria:

- The client has CSHCS coverage at the time of the travel;
- Comparable medical care is not available to the client within the State of Michigan or borderland areas;
- The travel assistance is for obtaining CSHCS specialty medical care and treatment from a CSHCS approved provider for a CSHCS medically-eligible diagnosis(es);
- Prior approval for the out-of-state medical care and treatment was obtained from MDCH or the SHP before the travel assistance was requested;
- Prior approval for travel assistance has been obtained;
- The client/family lacks the financial resources to pay for all or part of the travel expenses;
- Other travel/financial resources are unavailable or insufficient; and
- The mode of travel to be used is the least expensive and most appropriate mode available.

Clients who have a payment agreement with MDCH may request out-of-state travel assistance. Out-of-state travel assistance reimbursement is included as a State paid benefit in the payment agreement reconciliation process. (Refer to the Payment Agreement subsection of this chapter.)

Travel assistance consists of reimbursement up to the allowable rate set by MDCH, as indicated in subsequent sections of this chapter, for expenses affiliated with approved travel.

12.3 Travel Reimbursement for CSHCS Only Clients

Transportation	▪ Actual mileage by private car to and from the health care service at eight cents per mile. ▪ Parking costs and highway, bridge, and tunnel tolls require original receipts. ▪ Bus or train fare, when it is the least expensive, most appropriate mode of transportation available and supported by original receipts. ▪ Air travel must be arranged by MDCH through the State approved travel agency or the SHP. The family cannot be reimbursed for airline tickets they have booked themselves.
Lodging	The client must be required to stay overnight to obtain in-patient or out-patient treatment related to the CSHCS covered diagnosis, performed by a CSHCS approved provider and at a CSHCS approved medical facility in order for the family to be reimbursed for lodging. ▪ Inpatient Requirements: Reimbursement is for the accompanying adult as needed. ▪ Outpatient Requirements: Reimbursement is for the client and the accompanying adult as needed. MDCH reimburses lodging at no more than $32.15 per night regardless of cost; original receipts are required.
Meals	Meal expenses are only reimbursable when they have occurred as the result of a necessary and prior approved daily or overnight stay(s). The stay must be for an inpatient or an outpatient treatment that is related to the CSHCS covered diagnosis, performed by a CSHCS approved provider, and at a CSHCS approved facility. ▪ Inpatient Requirements: ➢ Meal reimbursement is for the client and accompanying adult during travel time if applicable, and only for the accompanying adult during the period of client hospitalization. ➢ Meals are reimbursed by CSHCS at the standard reimbursement rate regardless of cost as stated below. ▪ Outpatient Requirements: ➢ Meal reimbursement is for the accompanying adult and the CSHCS client. ➢ Meals are reimbursed by CSHCS up to $12 per person per day or the actual cost submitted on a receipt, whichever is less. Hospitals sometimes supply meal tickets for parents/caretakers of hospitalized children. For the hospital to be reimbursed, meals must have been approved by the CSHCS office in the LHD of the client's county of residence or the SHP.

12.4 Nonemergency Medical Transportation

Nonemergency Medical Transportation (e.g., Ambu-cabs, Medi-Vans, etc.) must be prior approved by the LHD or the SHP. Payment is made directly to the transportation provider by MDCH. The client/family should not pay the provider directly since the client/family cannot be reimbursed.

To be eligible and authorized for the Nonemergency Medical Transportation service, the client must be:

- Wheelchair bound;
- Bed bound; or
- Medically dependent on life sustaining equipment which cannot be accommodated by standard transportation.

12.5 Emergency and Special Transportation Coverage

CSHCS follows the same policies and procedures regarding emergency and special medical transportation coverage as the Medicaid Program. Coverage must be related to the CSHCS qualifying diagnosis. (Refer to the Ambulance Chapter of this manual for additional information.)

An additional person, such as a donor related to the medical care of the client, may be considered for the travel assistance when approved by a MDCH medical consultant. The treating specialist must provide CSHCS with documentation of the relationship between the client and the additional person.

SECTION 13 – INTERACTION WITH OTHER PROGRAMS

Clients may have coverage through CSHCS and another program simultaneously.

13.1 MEDICAID

Clients may have both Medicaid and CSHCS coverage. For services not covered by CSHCS and covered by Medicaid (primary care, other specialty services, etc.), the client must comply with Medicaid requirements.

13.2 MICHILD

Clients may have both MIChild and CSHCS coverage. The client may enroll with a CSHCS SHP in counties that have a SHP option available, or with the Blue Cross/Blue Shield MIChild plan. For services not covered by CSHCS and covered by MIChild, the client must comply with MIChild requirements. CSHCS is not considered health insurance for purposes of MIChild eligibility.

13.3 TRANSITIONAL MEDICAL ASSISTANCE (TMA AND TMA-PLUS)

Clients may have both TMA and CSHCS or TMA-Plus and CSHCS coverage. For services not covered by CSHCS and covered by TMA or TMA-Plus, the client must comply with TMA and TMA-Plus requirements.

13.4 MATERNAL OUTPATIENT MEDICAL SERVICES (MOMS)

Clients may have both MOMS and CSHCS coverage. For services not covered by CSHCS and covered by MOMS, the client must comply with MOMS requirements.

13.5 ADULT BENEFIT WAIVER I (ABW I)

Clients may have both ABW I and CSHCS coverage. CSHCS is not considered health coverage for purposes of ABW I eligibility. For services not covered by CSHCS and covered by ABW I, the client must comply with ABW I requirements.

13.6 COURT-ORDERED MEDICAL INSURANCE

CSHCS cannot be used as court-ordered medical insurance.

13.7 DEPARTMENT REVIEWS

CSHCS clients without Medicaid coverage are entitled to appeal MDCH negative actions, and to a Department Review when they have been denied CSHCS eligibility or services, or when established CSHCS services have been reduced, changed, or terminated. The client will be notified in writing of the negative action and the right to appeal. CSHCS follows the same appeal and request for hearing policies and procedures as established by MDCH for all MDCH programs. Clients without Medicaid coverage who are enrolled in a SHP must exhaust the SHP appeals process before requesting a MDCH Department Review.

13.8 ADMINISTRATIVE HEARINGS

CSHCS clients who also have Medicaid coverage have a right to an Administrative Hearing when services have been denied, reduced, changed or terminated. The client will be notified in writing of the negative action and the right to appeal. Dually eligible SHP members may request an Administrative Hearing, either concurrently or in lieu of a SHP appeal, when a Medicaid covered service is in dispute. The requesting client may receive an Administrative Hearing if the circumstances suggest that Medicaid reimbursement is involved in the coverage or service in question. The requesting client may receive a Department Review if the circumstances indicate that Medicaid reimbursement is in no way involved in the coverage or service in question. The MDCH Administrative Tribunal determines which hearing is appropriate once a client has requested a hearing.