MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

Bulletin Number: MSA 21-35

Distribution: All Providers

Issued: September 1, 2021

Subject: Updates to the MDHHS Medicaid Provider Manual; Code Updates

Effective: As Indicated

Programs Affected: Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, Children's Waiver, Maternity Outpatient Medical Services, MI Choice Waiver

Updates to the MDHHS Medicaid Provider Manual

The Michigan Department of Health and Human Services (MDHHS) has completed the October 2021 update of the online version of the MDHHS Medicaid Provider Manual. The manual will be available October 1, 2021 at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Medicaid Provider Manual.

If changes were made in a chapter, a note will appear in the affected section/subsection title of that chapter's table of contents. If both technical and bulletin incorporation changes apply to the section/subsection, color coding will be limited to reflect a bulletin-related change.

Please refer to the online version of this bulletin at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms to view the attachments that describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change.

Code Updates

A. New Coverage of Codes

Listed below are Healthcare Common Procedure Coding System (HCPCS) codes being adopted by MDHHS for dates of service on and after July 1, 2021 and the provider groups allowed to bill these codes.

The symbol * will appear with those codes requiring prior authorization (PA).

1. Physicians, Practitioners, and Medical Clinics

J0224 J1951 J7168 J9348 J9353 Q5123

2. Federally Qualified Health Centers

J1951

3. Rural Health Clinics

J1951

4. Tribal Health Centers

J1951

5. Outpatient Prospective Payment System (OPPS)/Ambulatory Payment Classification (APC) and Ambulatory Surgical Centers (ASC)

Codes covered differently than Medicare or specific to Michigan Medicaid services will be identified on the July 2021 version of the OPPS and ASC Wrap-Around Code List on the MDHHS website:

www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Outpatient Hospitals

www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Ambulatory Surgical Centers

B. New Coverage of Existing Codes

Effective for dates of service on and after July 1, 2021, existing HCPCS codes will be activated for coverage as identified in the following provider categories:

1. Physicians, Practitioners, and Medical Clinics

99174 99177

2. Physicians, Practitioners, Medical Clinics, Podiatrists, Oral Surgeons, Federally Qualified Health Centers, Rural Health Clinics, and Tribal Health Centers:

Q4163

C. Retroactive Coverage of Existing Codes

1. Effective for dates of service on and after May 6, 2021, MDHHS will cover the following HCPCS codes for Physicians, Practitioners, Medical Clinics, Home Health Agencies, Advanced Life Support Ambulance, Federally Qualified Health Centers, Rural Health Clinics, and Tribal Health Centers:

   M0244 M0246

2. Effective for dates of service on and after May 26, 2021, MDHHS will cover the following HCPCS codes for Physicians, Practitioners, Medical Clinics, Federally Qualified Health Centers, Rural Health Clinics and Tribal Health Centers:

   M0247 M0248 Q0247

3. Effective for dates of service on and after May 26, 2021, MDHHS will cover the following HCPCS codes for Home Health Agencies:

   M0248 Q0247

4. Effective for dates of service on and after June 3, 2021, MDHHS will cover the following HCPCS code for Physicians, Practitioners, Medical Clinics, Advanced Life Support Ambulance, Federally Qualified Health Centers, Rural Health Clinics and Tribal Health Centers:

   Q0244

5. Effective for dates of service on and after June 8, 2021, MDHHS will cover the following HCPCS code for Physicians, Practitioners, Medical Clinics, Podiatrists, Certified Nurse Midwives, Local Health Departments, Child and Adolescent Health Centers & Programs, Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers, Home Health Agencies and Urgent Care Centers:

   M0201

D. Addition to Bulletin MSA 20-22

Per Bulletin MSA 20-22, during the COVID-19 Public Health Emergency, certain therapy codes will be allowed via telemedicine (simultaneous audio and video). See the COVID-19 database for a complete listing of allowable codes. After further review and determination of appropriateness, MDHHS is adding the following code:

92526

E. Discontinued HCPCS Procedure Codes for All Applicable Provider Types

The following HCPCS codes are discontinued effective June 30, 2021:

C9074 C9132

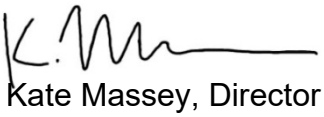
Manual Maintenance

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

Questions

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

Approved



Kate Massey, Director
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Michigan Department of Health and Human Services

Medicaid Provider Manual
October 2021 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	1.5 Corrective Action	The 4th paragraph was revised to read: To request a refund of medical expenses, the beneficiary must provide a copy of all bills for medical services received ~~on or after February 2, 2004~~ during the established eligibility period for which the beneficiary, or someone legally responsible for the beneficiary's bills, paid during the corrective action period to MDHHS.	Clarification.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	Landing page	The 3rd paragraph was revised to read: The **Non-Physician Behavioral Health Appendix** portion of the chapter includes requirements for psychologists, social workers, ~~and~~ professional counselors, and marriage and family therapists providing outpatient behavioral health services ~~for fee-for service beneficiaries~~ not included under the specialty services and supports benefit.	Clarification.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	1.7 Definition of Terms	Under "Child Mental Health Professional", the 1st bullet point was revised to read: • A person who is trained and has one year of experience in the examination, evaluation, and treatment of minors and their families and who is either a physician, psychologist, licensed professional counselor, licensed or limited licensed marriage and family therapist or registered professional nurse; or	Update.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	9.2 Children's Services	The 1st paragraph was revised to read: Intensive crisis stabilization services are structured treatment and support activities provided by a mobile intensive crisis stabilization team that are designed to promptly address a crisis situation in order to avert a psychiatric admission or other out of home placement or to maintain a child or youth in their home or present living arrangement ~~who has recently returned from a psychiatric hospitalization or other out of home placement~~. These services must be available to children or youth with serious emotional disturbance (SED) and/or intellectual/developmental disabilities (I/DD), including autism, or co-occurring SED and substance use disorder (SUD). The 3rd paragraph was revised to read: The goals of intensive crisis stabilization services for children are as follows:	Language adapted to match Medicaid enrollment document and to provide clarification for areas of confusion. Parental preference for response is being clarified.

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

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	9.2.C. Services	Text was revised to read: Component services include: • Assessments and identifying current strengths and needs of the child and family (rendered by the treatment team) • De-escalation of the crisis • Family-driven and youth-guided planning • Crisis and safety plan development • Brief intensive individual counseling/psychotherapy • Brief family therapy • Skill building • Psychoeducation • Referrals and connections to additional community resources • Collaboration and problem solving with other child- or youth-serving systems, as applicable • Psychiatric consult, as needed	Language adapted to match Medicaid enrollment document and to provide clarification for areas of confusion. Parental preference for response is being clarified.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	9.2.E. Location of Services	The 1st paragraph was revised to read: Intensive crisis stabilization services ~~must be provided where necessary~~ are to be provided in the home or community at the preference of the parent or caregiver to alleviate the crisis situation, and to permit the child or youth to remain in their usual home and community environment.	Language adapted to match Medicaid enrollment document and to provide clarification for areas of confusion. Parental preference for response is being clarified.

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	9.2.F. Individual Plan of Services	Text was revised to read: Intensive crisis stabilization services may be provided initially to alleviate an immediate crisis. However, following resolution of the immediate situation, an existing individual plan of service and crisis and safety plan must be updated or, for children or youth who are not yet recipients of CMHSP services but are eligible for such services, a family-driven and youth-guided follow-up plan must be developed. Children who are receiving home based services can also receive this mobile service. If it is clinically appropriate, the home based therapist is able to respond in person to the one hour urban and two hour rural time frame in lieu of the mobile team. If the child or youth is a current recipient of CMHSP services, mobile intensive crisis stabilization team members are responsible for notifying the primary therapist, case manager, or wraparound facilitator, as applicable, of the contact with the mobile intensive crisis stabilization team the next business day. It is the responsibility of the primary therapist, case manager, or wraparound facilitator to follow-up with the child or youth and parent/caregiver. The child or youth, parent/caregiver and the relevant ongoing treatment team members must revisit the current individual plan of service and crisis and safety plan and make adjustments where necessary to address current treatment needs. If the child or youth is not yet a recipient of CMHSP services but is eligible for such services, the follow-up plan must include appropriate referrals to mental health assessment and treatment resources and any other resources the child or youth and parent/caregiver may require. The mobile intensive crisis stabilization team is responsible for providing necessary information and referrals. The follow-up plan must also include the next steps for obtaining needed services, timelines for those activities, and identify the responsible parties. Mobile intensive crisis stabilization team members must contact the parent/caregiver by phone or face-to-face within seven business days to determine the status of the stated goals in the follow-up plan. Planned mobile intensive crisis stabilization services for children can occur as part of a crisis plan or proactive response to support the child and family. The goal would be to stabilize and connect to ongoing services. In these planned situations, the response time is not required.	Language adapted to match Medicaid enrollment document and to provide clarification for areas of confusion. Parental preference for response is being clarified.

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	17.3.E. Family Support and Training	In the last paragraph, the last bullet point was revised to read: • ~~Parent-to-Parent Support is designed to support parents/family of children with serious emotional disturbance or intellectual/developmental disabilities, including autism, as part of the treatment process to be empowered, confident and have knowledge and skills that will enable the parent/family to improve their child's and family's functioning. Utilizing their lived experience, the trained parent support partner, who has or had a child with special mental health needs, provides education, coaching, and support and enhances the assessment and mental health treatment process.~~ The Parent Support Partner service offers a parent-to-parent peer support approach. This unique intervention is designed to inspire hope, build confidence, and empower parent and caregiver voice. This parent peer-delivered service occurs as part of the treatment process to better align with family driven, youth guided policy and practice guidelines. The Parent Support Partner is trained and certified in the MDHHS approved model curriculum and has lived experience as a parent or primary caregiver of a child with behavioral and mental health needs and/or intellectual/developmental disability, including autism. The role of the Parent Support Partner is to support parent voice in the child's treatment and is not intended to provide case management or clinical interventions. The Parent Support Partner provides ~~these services to the~~ this intervention where parents/caregivers feel most comfortable in the home and community. ~~These activities are provided in the home and in the community.~~ The Parent Support Partner is an active member of the treatment team and ~~participates in team consultation with the treating professionals~~ informs the team consultation with the perspective of their lived experience as parents and caregivers. The Parent Support Partner is to be provided regular supervision by their direct supervisor. Parent Support Partner s may not have more than one provider role with any one family (i.e., may not be both parent support partner and peer support specialist for the same family).	Clarification.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services - Non-Physician Behavioral Health Appendix	Section 1 – General Information	Text was revised to read: This appendix applies to non-physician behavioral health providers, including psychologists, social workers, counselors, and marriage and family therapists, providing outpatient behavioral health services not included under the specialty services and supports benefit. Information is included to assist the practitioner in determining how the Michigan Department of Health and Human Services (MDHHS) covers specific services. This information should be used in conjunction with the Billing & Reimbursement Chapters of this manual, as well as the Medicaid Code and Rate Reference tool, MDHHS Practitioner and Medical Clinic Fee Schedule, and other related procedure databases/fee schedules located on the MDHHS website. (Refer to the Directory Appendix for website information.) ~~For beneficiaries not enrolled in Medicaid Health Plans and services not included in the capitation payments to the PIHP/CMHSP, behavioral health services are covered through Medicaid FFS.~~	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services - Non-Physician Behavioral Health Appendix	Section 3 – Covered Services	Text was revised to read: Medicaid beneficiaries ~~who are not enrolled in a Medicaid Health Plan, and~~ whose needs do not render them eligible for specialty services and supports through the PIHPs/CMHSPs~~,~~ may receive outpatient ~~mental~~ behavioral health services directly through the ~~Medicaid~~ Fee-for-Service (FFS) Medicaid program or Medicaid Health Plan. ~~Providers should refer to the Beneficiary Eligibility subsection in the General Information section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter for information on which services are covered by Medicaid FFS.~~ ~~FFS~~ Non-physician behavioral health services performed by psychologists, social workers, counselors, and marriage and family therapists are covered when performed in a non-facility setting or outpatient hospital clinic and provided within their specific profession's scope of practice guidelines as defined by State law. Providers should refer to the Medicaid Code and Rate Reference tool and the Non-Physician Behavioral Health Provider fee schedule on the MDHHS website for the current list of covered procedure codes. The list of allowable services is reviewed annually and updated as applicable. Services covered by the PIHPs/CMHSPs are available and reimbursed through the PIHP/CMHSP. Providers should refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter for additional information on these services. ~~Providers should refer to the Medicaid Code and Rate Reference tool and the Non-Physician Behavioral Health Provider fee schedule on the MDHHS website for the current list of covered procedure codes. The list of allowable services is reviewed annually and updated as applicable.~~	Clarification.
Behavioral Health and Intellectual and Developmental Disability Supports and Services - Non-Physician Behavioral Health Appendix	Section 5 – Claims Processing and Reimbursement Amounts	The following text was added after the last paragraph: For beneficiaries enrolled in a MHP, the provider must contact the MHP for applicable claim completion instructions as these may vary from the FFS Medicaid program.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Dental	2.5 Loss or Change in Eligibility	The last paragraph was removed. ~~**Billing instructions:** Billing instructions for loss/change in eligibility are as follows:~~ ~~• Electronic Claims: Treatment Start Date and Treatment Completion Date are required within Loop 2400 DPT.~~ ~~• Direct Data Entry (DDE) Claims: Treatment Start Date and Treatment Completion Date are required within the appropriate DDE fields.~~ ~~• Paper Claims:~~ ~~➢ For complete or partial dentures and laboratory processed crowns, the date of service on the claim should be the date of the initial impression (the completion date must be entered in the Remarks section).~~ ~~➢ For root canal therapy, the date of service should be the first treatment appointment (the completion date must be entered in the Remarks section).~~	This language was moved to the Billing & Reimbursement for Dental Providers chapter (5.2).
Dental	2.6 Incomplete Procedures	The last paragraph was removed. ~~**Billing instructions:** Billing instructions for incomplete procedures are as follows:~~ ~~• Incomplete crown:~~ ~~➢ Providers must bill procedure code D2999.~~ ~~➢ Date of service is the date of the impression.~~ ~~➢ Include the PA number on the claim.~~ ~~• Incomplete root canal:~~ ~~➢ Providers must bill procedure code D3999.~~ ~~➢ Date of service is the date of the first treatment appointment.~~ ~~➢ Include the PA number on the claim.~~ ~~• Incomplete denture:~~ ~~➢ Providers must bill procedure code D5899.~~ ~~➢ Date of service is the date of the initial impression.~~ ~~➢ Include the PA number on the claim.~~	This language was moved to the Billing & Reimbursement for Dental Providers chapter (5.3).

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Dental	8.2.A.2. Interceptive Orthodontic Treatment	Text after the 1st paragraph was removed. ~~For interceptive orthodontic treatment, a single claim is submitted and the reimbursement is all-inclusive.~~ ~~**Billing instructions:** Billing instructions for interceptive orthodontic treatment are as follows:~~ ~~• Submit a single claim for the entire interceptive treatment phase.~~ ~~• The date of service is the banding/start date.~~ ~~• Include the PA number on the claim.~~ • ~~Reimbursement is made for the entire treatment time period and is considered payment in full.~~	This language was moved to the Billing & Reimbursement for Dental Providers chapter (5.6.A.).
Dental	8.2.A.3. Comprehensive Orthodontic Treatment	Text after the 1st paragraph was removed. ~~Comprehensive orthodontic treatment procedure codes are used in the first stage of each comprehensive treatment phase. An initial payment is made with a claim submission using the comprehensive orthodontic procedure code, and subsequent payments are made bi-annually using the periodic orthodontic treatment procedure code.~~ ~~**Billing instructions:** Billing instructions for comprehensive orthodontic treatment are as follows:~~ ~~• The date of service is the banding insertion date.~~ ~~• Include the PA number on the claim.~~ ~~• An initial payment is made with a claim using the comprehensive orthodontic procedure code.~~ • ~~Subsequent payments are made bi-annually using the periodic orthodontic treatment procedure code.~~	This language was moved to the Billing & Reimbursement for Dental Providers chapter (5.6.B.).

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CHAPTER	SECTION	CHANGE	COMMENT
Dental	8.2.A.4. Periodic Orthodontic Treatment	Text after the 2nd paragraph was removed. ~~The periodic orthodontic treatment visit is authorized for a six-month time period. If treatment ends prior to the completion of the six-month time period, the provider pro-rates the charges according to the treatment time period.~~ ~~**Billing instructions:** Billing instructions for periodic orthodontic treatment are as follows:~~ ~~• The date of service is the first day of the six-month treatment period.~~ ~~• The date of service cannot be the same as the banding insertion date.~~ ~~• Include the PA number on the claim.~~ ~~• The beginning and end dates for the entire time period should be entered in the Remarks section of the claim.~~ ~~• If treatment ends prior to the completion of the six-month time period, the fee for the treatment time frame must be pro-rated.~~ ~~➢ The date of service is the first day of the periodic treatment time period.~~ ~~➢ Include the PA number on the claim.~~ ~~➢ The fee charged should reflect the treatment time period (e.g., if only three months are needed to complete treatment, the charges should reflect half of the current periodic orthodontic treatment fee).~~ ~~➢ The entire pro-rated time period is entered into the Remarks section of the claim.~~ ~~When paid reimbursement to the provider has met the maximum allowable for the specific phase of treatment, no additional reimbursement will be made and the case is considered paid in full.~~	This language was moved to the Billing & Reimbursement for Dental Providers chapter (5.6.C.).

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CHAPTER	SECTION	CHANGE	COMMENT
Early and Periodic Screening, Diagnosis and Treatment	9.6 Blood Lead Screening	The 2nd paragraph was revised to read: For children who have been tested, the following questions are intended to assist the PCP in determining if further testing is necessary in addition to that completed at the mandated ages: • ~~Does the child live in (or often visit) a house built before 1950 with peeling or chipping paint? This could include day care, preschool, or home of a relative.~~ • ~~Does the child live in (or often visit) a house built before 1978 that has been remodeled within the last year?~~ • ~~Does the child have a brother or sister (or playmate) with blood lead poisoning?~~ • ~~Does the child live with an adult whose job or hobby involves lead? (The chart following these questions presents examples.)~~ • ~~Does the child's family use any home remedies that may contain lead? (The chart following these questions presents examples.)~~ • Does the child live in or regularly visit a home built before 1978? (Note: Recent or planned renovations can greatly increase risk of lead exposure in homes built before 1978.) • Does the child live in or regularly visit a home that had a water test with high lead levels? • Does the child have a brother, sister, or friend that has an elevated blood lead level? • Does the child come in contact with an adult whose job or hobby involves exposure to lead (e.g., smelting, indoor shooting/firing ranges, pottery, stained glass, refinishing old furniture)? (The chart following these questions presents examples.) • Does the child's caregiver use home remedies that may contain lead (e.g. ba-baw-san, daw tway, greta, azarcon, balguti kesaria, ghasard)? (The chart following these questions presents examples.)	Request to update questions was approved following discussions with the MDHHS Childhood Lead Poisoning Prevention Program (CLPPP).

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CHAPTER	SECTION	CHANGE	COMMENT
		• Is the child in a special population group such as foreign adoptee, refugee, migrant, immigrant, or foster child? • Does the child's caregiver have reason to believe the child is at risk for lead exposure (e.g., exhibiting pica behavior, developmental delays)? If answered "yes" or "don't know" to any of these questions, lead testing is recommended.	
Hospice	7.3.H. Room and Board to Nursing Facilities	In the 2nd bullet point, the 5th paragraph was revised to read: Patient-pay amounts and billing methods are not affected by this hospital leave day policy. The hospice/NF should continue to collect any patient-pay amount, typically on the first day of the month, and indicate the amount collected on the Medicaid claim. CHAMPS automatically deducts the patient-pay amount and reimburses the provider for the balance. If the hospice bills Medicaid for hospital leave days that occur at the beginning of the month, then the hospice should collect the patient-pay amount as usual. The hospice should charge the amount against the patient-pay that Medicaid pays for that day. For example, if a beneficiary has a patient-pay of $200 and is in the hospital for an emergency condition for the first five days of the month (the stay totals no more than 10 consecutive days), the hospice should collect the patient-pay amount from the beneficiary and then submit a Medicaid claim. Medicaid reimburses the hospice for the hospital leave day per diem rate, minus the patient-pay amount. ~~The hospice reimbursement, based on 2003 rates, would be $132.80 [($66.56 x 5) – $200].~~	Removal of obsolete information.
Hospital Reimbursement Appendix	2.3 All Patient Refined Diagnosis Related Grouper System	The subsection title was revised to read: 2.3 3M™All Patient Refined Diagnosis Related ~~Grouper~~ Groups System Text was revised to read: Effective for inpatient discharges on or after October 1, 2015, the Medicaid diagnosis related grouper (DRG) reimbursement system uses the 3M™ All Patient Refined Diagnosis Related ~~Grouper~~ Groups (3M™ APR-DRG) system. The following sections apply to the 3M™ APR-DRG reimbursement system.	3M has requested that MDHHS update its references to its APR DRG product. The correct attribution is 3M™ All Patient Refined Diagnosis Related Groups or 3M™ APR DRG.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	2.3.A.3. APR-DRG Relative Weights	The subsection title was revised to read: 3M™ APR-DRG Relative Weights	3M has requested that MDHHS update its references to its APR DRG product. The correct attribution is 3M™ All Patient Refined Diagnosis Related Groups or 3M™ APR DRG.
Hospital Reimbursement Appendix	2.3.C. Frequency of Updates	Text was revised to read: The State will update area wage index, cost to charge ratio, relative weights, 3M™ APR-DRG grouper, DRG rates, and per diem rates on an annual basis.	3M has requested that MDHHS update its references to its APR DRG product. The correct attribution is 3M™ All Patient Refined Diagnosis Related Groups or 3M™ APR DRG.
Hospital Reimbursement Appendix	5.3 Limits on Capital	The subsection was deleted, and the following subsections were re-numbered. ~~The limits on capital described in this section apply for fiscal years beginning on and after October 1, 1990.~~	Update.
Hospital Reimbursement Appendix	6.4 Reconciliation	The 2nd paragraph was revised to read: ~~For~~ Capital cost settlements ~~for hospitals with fiscal years ending on and after January 1, 2002,~~ use filed Medicaid Cost Reports~~, instead of audited Medicaid Cost Reports, are used~~ to complete a hospital desk review and settlement prior to issuing a Notice of Program Reimbursement. MDHHS does not wait for Medicare to complete its audit of a hospital's cost report before MDHHS does its cost settlement. In order to capture the maximum paid claims data, Medicaid final settlements and corresponding final reconciliations are not calculated earlier than 27 months after the end of a hospital's fiscal year end.	Update.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	7.1.B. Medicaid Utilization Rate	The 2nd paragraph was revised to read: Days are taken from filed hospital Medicaid Cost Reports for fiscal years ending during the second previous state fiscal year. All charge, cost and payment data must be on an accrual basis for each hospital's cost reporting period ending during the second previous state fiscal year (~~i.e.,~~ e.g., DSH payments for state FY ~~1998~~ 2021 are calculated using data collected in state FY ~~1996~~ 2019).	Update.
Hospital Reimbursement Appendix	7.3.B. University With Both a College of Allopathic Medicine and a College of Osteopathic Medicine	The 1st paragraph was revised to read: A separate $3.5 million dollar pool will be created annually ~~in the following amounts: $2,772,003 in fiscal year 2005, $2,764,340 for fiscal years 2006 – 2012, and $3,500,000 for each subsequent fiscal year~~. The purpose of the pool is to:	Update.
Hospital Reimbursement Appendix	7.5 Disproportionate Share Hospital (DSH) Process	Under "Step 1: Initial DSH Calculation", the 1st paragraph was revised to read: MDHHS will calculate hospital-specific DSH ceilings, DSH payment allocations and Medicaid utilization rates as part of its Initial DSH Calculation. Inpatient and outpatient data from the hospital's cost reporting period ending during the second previous state FY will be used for the DSH ceiling, DSH payment and Medicaid utilization rate calculations. The data will be trended to the current FY for DSH ceiling calculation purposes. For example, data from hospital Medicaid Cost Reports with FYs ending between October 1, ~~2009~~ 2018 and September 30, ~~2010~~ 2019 will be used to complete the FY ~~2012~~ 2021 Initial DSH Calculation.	Update.
Hospital Reimbursement Appendix	7.6.D.1. Inpatient Paid Claims File	Text was revised to read: To determine each hospital's share of a pool, MDHHS will use paid claims for the fiscal year ending two years prior to the current fiscal year. Claims will be restricted to those paid by June 30th of the following year (e.g., paid claims from FY ~~2004~~ 2019 paid by June 30, ~~2005~~ 2020 will be used to calculate the FY ~~2006~~ 2021 MACI payments). The paid claims file will ….	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	8.2 Distribution of GME Funds	In the 2nd paragraph, the 1st bullet point was revised to read: • To obtain an average FTE payment for dental and podiatry residents, the GME liability for hospitals operating dental and podiatry residency programs only are summed. ~~Hospital GME liability data is drawn from calendar year 1995 filed hospital cost reports used to calculate GME payments made to hospitals between July 1, 1997 and December 31, 2001.~~ The summed total of these liabilities is divided by the total number of dental and podiatry FTEs as reported by the same hospitals and from the same filed cost reports that the GME liability data is drawn. The product is an average dental and podiatry FTE payment that is made to all hospitals reporting these FTEs.	Update.
Hospital Reimbursement Appendix	Section 9 - Cost Reporting Requirements	In the last paragraph, the 4th bullet point was revised to read: • Data meet a set of reasonableness checks, or variances are explained. Hospital charges on cost reports must be supported with approved Medicaid claims data. The DSH audit survey (42 CFR 455.301 and 42 CFR 455.304) allows hospitals to complete a reconciliation between MMIS and internal hospital data to assure that all eligible claims are accounted for during the audit.	Clarification.
Local Health Departments	5.3 Payment Methodology	The 2nd paragraph was revised to read: This calculation and a notice are sent to the public dental clinic indicating the amount of local share that must be received from the public dental clinic. The local share must be received prior to the submission of the federal claim. The local share is sent from the public dental clinic to MDHHS via the Intergovernmental Transfer process. After receipt of the local share, MDHHS will process a payment to the public dental clinic for the entire amount of difference between the FFS payments and the average commercial rate. The settlements are performed for each public dental clinic ~~and~~ for each fiscal year ~~ending after March 31, 2005~~.	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Medicaid Health Plans	2.7 Mental Health	Text was revised to read: MHPs are required to provide behavioral health services not included under the Prepaid Inpatient Health Plan (PIHP) specialty services and supports benefit. ~~under the Mental Health Outpatient benefit, consistent with the policies and procedures established by Medicaid.~~ The Non-Physician Behavioral Health Appendix of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter provides coverage policies and procedures related to these outpatient behavioral health services. Services ~~may~~ should be provided through ~~contracts with Prepaid Inpatient Health Plans (PIHP) and/or Community Mental Health Services Programs (CMHSP) or through contracts with other~~ appropriate providers within the service area and may include contracted Community Mental Health Service Program (CMHSP) providers. For ~~mental~~ specialty behavioral health needs ~~that do not meet Medicaid's established criteria~~, MHPs must coordinate with the appropriate PIHP/CMHSP to ensure that medically necessary mental health services are provided to the beneficiary. The Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter provides coverage policies for PIHPs/CMHSPs.	Clarification.
Medical Supplier	1.1.A. Provider Enrollment	1st paragraph: Providers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) must be enrolled as a Medicare provider ~~effective September 30, 2009~~. Each DMEPOS provider must enter their Medicare Provider Transaction Access Number (PTAN) in the CHAMPS Provider Enrollment subsystem. (Refer to the General Information for Providers chapter for provider enrollment policy that applies to all providers.)	
Nursing Facility Coverages	10.20.C. CMHSP Responsibilities	In the 2nd paragraph, the 1st sentence was revised to read: ~~In 1991, funds were~~ Every year, funds are made available to local CMHSPs to provide specialized services and other mental health services to individuals residing in nursing facilities.	

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

CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	5.1 Signature Log	Text was revised to read: Pharmacy providers must document receipt or delivery of new or refilled medications to the intended Medicaid beneficiary. This documentation serves as verification of the beneficiary receiving the prescription billed. The absence of the appropriate verification indicates the beneficiary did not receive the prescription, and funds will be recouped from the pharmacy. Documentation described below must be retained for review by MDHHS or the MDHHS agent for seven years and is subject to audit. Any method of reproducing past signatures is not acceptable. ~~Pharmacy providers must maintain a log containing the following information:~~ ~~• Beneficiary's name;~~ ~~• The signature of the beneficiary or that of his representative; and~~ ~~• The date of receipt of the prescription.~~ ~~The log must effectively differentiate between prescriptions received by a beneficiary for which counseling was accepted and provided, and those for which counseling was offered and was declined. This log must be retained for review by MDHHS or the MDHHS agent for seven years and is subject to audit.~~ ~~The signature log serves as verification of the beneficiary receiving the prescription billed. The absence of the appropriate signature indicates the beneficiary did not receive the prescription, and funds will be recouped from the pharmacy.~~	Clarified in letter L 21-31.

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CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	5.1.A. Signature Log (new subsection)	New subsection text reads: Pharmacy providers must maintain a log containing the following information: • Beneficiary's name; • The manual or electronic signature of the beneficiary or that of his representative; and • The date of receipt of the prescription. The log must effectively differentiate between prescriptions received by a beneficiary for which counseling was accepted and provided, and those for which counseling was offered and was declined.	Clarified in letter L 21-31.
Pharmacy	5.1.B. Proof of Delivery (new subsection)	New subsection text reads: Pharmacy providers must maintain a log verifying proof of delivery for all prescriptions delivered by common carrier (i.e., FedEx, UPS, USPS, etc.). Pharmacies should be able to link the tracking information to the prescription record through supporting documents if requested. Pharmacies must validate the member's address prior to mailing the prescription. A tracking number alone is not considered a valid proof of member receipt. The tracking number must be accompanied by either: • the tracking detail from the carrier showing medication was delivered, including date and time of delivery; or • the manual or electronic signature of the member or that of his representative at the time of delivery.	Clarified in letter L 21-31.
Pharmacy	13.6.A. Medicaid Copayments	In the table for "Copayment Exemptions", under "Other Exclusions", the following text was added after the 1st bullet point: • Native American Indians/Alaska Natives consistent with federal regulations at 42 CFR §447.56(a)(1)(x)	To coordinate with information in the General Information for Providers Chapter.

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CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	3.3 Audiological and Hearing Services	Text was revised to read: Medicaid covers hearing evaluations and other audiological function testing by a physician, physician assistant, or advanced practice registered nurse. Hearing evaluations are covered when they include pure-tone audiometry, speech audiometry, and a report of findings. A hearing aid is covered if all of the following criteria are met: • The ~~physician~~ practitioner performs a~~n~~ medical evaluation within six months prior to the beneficiary obtaining a hearing aid. For beneficiaries under age 18, an otolaryngologist or other appropriate specialty physician must complete the evaluation. • The evaluation reveals that the beneficiary needs a hearing aid and that there is no contraindication to the use of a hearing aid. • The ~~physician~~ practitioner prescribes a hearing aid. • The beneficiary presents the prescription and a written statement of the ~~evaluation~~ medical clearance to an enrolled hearing center or audiologist for audiological testing and a hearing aid exam. • ~~The enrolled hearing center determines the type of hearing aid that is needed.~~ • The beneficiary is referred to an enrolled hearing aid dealer, hearing center, or audiologist for the selection and ~~or~~ provision of the aid.	Clarification.
Vision	3.1 Diagnostic Services	The 2nd paragraph was revised to read: *Documentation Guidelines for Evaluation and Management Services*, ~~1995, 1997, or latest version thereof,~~ as described in the latest version developed jointly by CMS and the AMA, must be adhered to when using the CPT/HCPCS procedure codes.	
Acronym Appendix		Text was revised to read: 3M™ APR-DRG = 3M™ All Patient Refined Diagnosis Related ~~Grouper~~ Groups	3M has requested that MDHHS update its references to its APR DRG product. The correct attribution is 3M™ All Patient Refined Diagnosis Related Groups or 3M™ APR DRG.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Glossary Appendix		The definition for "Physician (MD or DO)" was revised to read: An individual licensed under the Michigan Public Health Code (~~1978~~ P.A. 368 of 1978) to engage in the practice of medicine or osteopathic medicine and surgery.	

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Medicaid Provider Manual
October 2021 Updates

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 21-07	5/3/2021	Children's Special Health Care Services	Section 3 – Medical Eligibility	The last paragraph was revised to read: CSHCS does not cover acute/specialty care that is not related to the CSHCS qualifying diagnosis. CSHCS also does not cover mental health care, primary care, well child visits, or immunizations with the exception of seasonal influenza and COVID-19. Examples of diagnoses, conditions or procedures not covered include, but are not limited to:
		Pharmacy	14.15 Vaccines	The 2nd paragraph was revised to read: Pharmacies may submit a claim for COVID-19 and seasonal influenza vaccines and ~~its~~ their administration for CSHCS beneficiaries. For beneficiaries 19 years and older who are enrolled in a Medicaid Health Plan, the pharmacy provider must confirm coverage of pharmacist-administered vaccines with the plan.
MSA 21-11	6/1/2021	Medicaid Provider Manual Overview	1.1 Organization	The following information was added: **Chapter Title:** Community Transition Services **Affected Providers:** Area Agencies on Aging, Centers for Independent Living, and other qualified community-based organizations **Chapter Content:** Policy requirements for operations and billing for Community Transition Services
		Community Transition Services		Addition of new chapter.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Acronym Appendix		Addition of: IADL - instrumental activities of daily living LBSW - Licensed Bachelor of Social Work LLBSW - Limited License Bachelor of Social Work LLMSW - Limited License Master of Social Work LMSW - Licensed Master of Social Work NFT - Nursing Facility Transition NMNET - non-medical (non-emergency) transportation PCSP - person-centered service plan PCTP - person-centered transition plan TN – transition navigator
		Directory Appendix	Community Transition Services (new section)	Addition of: **Contact/Topic:** Community Transition Services **Web Address:** https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42551-481963--,00.html **Information Available/Purpose:** Webpage specific to Community Transition Services where program information is posted.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				Addition of: **Contact/Topic:** Critical Incident Reporting System **Phone # Fax #:** Phone: 517-241-8474 Fax: 517-241-7816 **Mailing Address:** MDHHS Home and Community-Based Services Section 400 S. Pine St. Lansing, MI 48913 **Web Address:** https://webapp.ciminc.com/CompassMI **Information Available/Purpose:** Resource for gaining access to and using the Critical Incident Reporting System to enter critical incidents as required by policy.
MSA 21-13	6/15/2021	Program of All Inclusive Care for the Elderly	Section 4 – Encounters (new section)	New section text reads: PACE providers are required to submit encounter data to MDHHS. On a monthly basis, PACE providers will submit encounters for all services provided/paid for in the month prior. PACE organizations must pass testing for 837 Professional, Dental, and Institutional encounter files and National Council for Prescription Drug Programs (NCPDP) Post-Adjudicated v4.2 pharmacy encounter files in order to submit production files.

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			4.1 Provider Enrollment (new subsection)	New subsection text reads: As part of the encounter process, PACE providers are required to enroll as a provider through CHAMPS. PACE providers will still maintain their Managed Care Organization (MCO) enrollment. To enroll as a Medicaid provider, the PACE provider must complete an online application in CHAMPS. PACE providers should enroll as a Facility/Agency/Organization (FAO) with an organization (Type 2) National Provider Identifier (NPI). (Refer to the Directory Appendix for Provider Enrollment information.)
			4.2 National Provider Identification (new subsection)	New subsection text reads: A Type 2 (Organization) NPI is required for organizations such as centers, group practices and incorporated individuals who provide health care services and receive payment. PACE providers and typical servicing providers must be enrolled in CHAMPS and have a valid NPI. PACE provider encounters must also include the appropriate Type 1 (Individual) NPI of the specific provider performing the services as "Rendering Provider". All Type 1 (Individual) providers must be associated to their affiliated PACE provider in CHAMPS.
			Section 4 – PACE Organization Evaluation Criteria	Section was re-numbered as Section 5.
			Section 5 – Becoming a PACE Organization	Section was re-numbered as Section 6.
		Acronym Appendix		Addition of: FAO – Facility/Agency/Organization

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 21-22	7/1/2021	Laboratory	5.5.C. Multi-Gene Panel Billing (new subsection)	New subsection text reads: Medicaid defines multi-gene panels as any assay that simultaneously tests for more than one gene associated with a condition or symptom. The term "gene", when used throughout this section, will be used to indicate a gene, region of a gene, and/or variant(s) of a gene. Genes assayed on the same date of service will be considered assayed in parallel if the result of one assay does not affect the decision to complete the assay on another gene, and the genes are being tested for the same indication. If a laboratory assays multiple genes simultaneously in parallel, then those genes will be considered part of the same panel. As a panel constitutes a single procedural service, one procedure code must be submitted for the panel. The laboratory should not report multiple individual procedure codes describing the gene component test results. If a procedure code is available for the multi-gene panel test, this procedure code should be utilized. If no procedure code accurately describes the panel performed, an unlisted molecular pathology or unlisted molecular multi-analyte assay with algorithmic analysis procedure code (as applicable) may be used. When an unlisted procedure code is reported, providers should include the name of the panel test in box 21 of the Genetic and Molecular Laboratory Test Authorization Request form (MSA-2081). The test name should also be reported in the Procedure Code Comment field in the MDHHS Community Health Automated Medicaid Processing System (CHAMPS) authorization form. Genes assayed on the same date of service will be considered assayed serially when the results of one or more gene analyses determines whether additional analyses are reasonable and necessary. When genes are serially assayed, the laboratory should submit claims with the genes reported individually.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 21-23	7/1/2021	Medical Supplier	2.46 Wearable Cardioverter-Defibrillators	Under "Documentation", the following text was added: In addition to the above documentation requirements, for continued need beyond the initial 60-day approval period, compliance download data for the previous 60-day initial authorization period, or if submitting a prior authorization request 15 days prior to the end of the initial approval period; there must be a minimum of 45 days wear time download data. Under "PA Requirements", text was revised to read: Food and Drug Administration (FDA)-registered WCDs are covered under the Medicaid and CSHCS programs with prior authorization (PA). Requests for PA (form MSA-1653-B) may only be submitted by the beneficiary's managing cardiologist and must include a current treatment plan and updated recommendations. PAs are approved for ~~30~~ 60 days at a time for a maximum of ~~three~~ four months. For continued medical need beyond ~~30~~ the initial 60 days, a new PA request must be submitted documenting all of the following: • The beneficiary's response to and continued need for the WCD; • The anticipated date of the ICD procedure; and • Documentation of the beneficiary's compliance with wearing the WCD. The compliance report should demonstrate a compliance rate of at least 92% for the previous ~~30-~~60-day period. The provider may submit an authorization request 15 days prior to the end of the initial approval period; however, there must be a minimum of 45 days wear time download data submitted with the authorization request. Requests for continued PA beyond the maximum of ~~three~~ four months will be considered on a case-by-case basis. Subsequent approvals will be for month-to-month periods.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 21-20	7/16/2021	Behavioral Health and Intellectual and Developmental Disability Supports and Services	18.4 Medical Necessity Criteria	The 1st paragraph was revised to read: Medical necessity and recommendation for BHT services ~~is~~ are determined by a physician or other licensed practitioner working within their scope of practice under state law. Comprehensive diagnostic re-evaluations are required no more than once every three years, unless determined medically necessary more frequently by a physician or other licensed practitioner working within their scope of practice. The recommended frequency should be based on the child's age and developmental level, the presence of comorbid disorders or complex medical conditions, the severity level of the child's ASD symptoms, and adaptive behavior deficits through a person-centered, family-driven youth-guided process involving the child, family, and treating behavioral health care providers. The child must demonstrate substantial functional impairment in social communication, patterns of behavior, and social interaction as evidenced by meeting criteria A and B (listed below); and require BHT services to address the following areas:

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			18.5 Determination of Eligibility for BHT	The 2nd paragraph was revised to read: To be eligible for BHT, the following ~~requirements~~ criteria must be met: • ***(4th bullet point)*** Treatment outcomes are expected to ~~result in a generalization of adaptive behaviors across different settings to maintain the BHT interventions and that they can be demonstrated beyond the treatment sessions~~ develop, maintain, or restore, to the maximum extent practicable, the functioning of a child with ASD. Measurable variables may include increased social-communication skills, increased interactive play/age-appropriate leisure skills, increased reciprocal and functional communication, etc. • ***(9th bullet point)*** Medical necessity and recommendation for BHT services are determined by a qualified licensed practitioner ~~recommends BHT services and the services are medically necessary for the child~~.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			18.8 Discharge Criteria	The subsection title was revised to read: Transition and Discharge Criteria Text was revised to read: The desired BHT goals and outcomes for discharge should be specified at the initiation of services, monitored throughout the duration of service implementation, and refined through the behavioral service level evaluation process. Transition and discharge from all BHT services should generally involve a gradual step-down model and require careful planning. Transition and discharge planning from BHT services should include transition goal(s) within the behavioral plan of care or plan, or written plan, that specifies details of monitoring and follow-up as is appropriate for the individual and the family or authorized representative(s) utilizing the PCP process. Discharge from BHT services ~~is determined~~ should be reviewed and evaluated by a qualified BHT professional for children who meet any of the following criteria: • The ~~child~~ individual has achieved treatment goals, and less intensive modes of services are medically necessary and/or appropriate. • The ~~child~~ individual is either no longer eligible for Medicaid or is no longer a State of Michigan resident. • The individual, family, or authorized representative(s) is interested in discontinuing services. • The ~~child~~ individual has not demonstrated measureable improvement and progress toward goals, and the predicted outcomes, as evidenced by a lack of generalization of adaptive behaviors across different settings where the benefits of the BHT interventions are not able to be maintained or they are not replicable beyond the BHT treatment sessions through ~~a period of six months~~ the successive authorization periods.

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				• Targeted behaviors and symptoms are becoming persistently worse with BHT treatment over time or with successive authorizations. • ~~The child no longer meets the eligibility criteria~~ The services are no longer medically necessary, as evidenced by use of valid evaluation tools administered by a qualified licensed practitioner. • ~~The child and/or parent/guardian is not able to meaningfully participate in the BHT services, and does not follow through with treatment recommendations~~ The provider and/or individual/family/authorized representative(s) are unable to reconcile important issues in treatment planning and service delivery to a degree that compromises the potential effectiveness and outcome of the BHT service.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			18.9.A. Behavioral Assessment	Text was revised to read: ~~Behavioral assessments must use a validated instrument and can include direct observational assessment, observation, record review, data collection, and analysis by a qualified provider. Examples of behavior assessments include function analysis and functional behavior assessments. The behavioral assessment must include the current level of functioning of the child using a validated data collection method. Behavioral assessments and ongoing measurements of improvement must include behavioral outcome tools. Examples of behavioral outcome tools include Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), Assessment of Basic Language and Learning Skills -Revised (ABLLS-R), and Assessment of Functional Living Skills (AFLS).~~ A developmentally appropriate applied behavior analysis (ABA) assessment process must identify strengths and weaknesses across domains and potential barriers to progress. The information from this process is the basis for developing the individualized behavioral plan of care with the individual, family, and treatment planning team. Behavioral assessments can include direct observational assessment, record review, rating scales, data collection, functional or adaptive assessments, structured interviews, and analysis by a qualified behavioral health professional (QBHP). Behavioral assessment tools must describe specific levels of behavior at baseline to inform the individual's response to treatment through ongoing collection, quantification, and analysis of the individual's data on all goals as monitored by a QBHP.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			18.10 BHT Service Level	Text was revised to read: BHT services are available for Medicaid beneficiaries diagnosed with ASD and are provided for all levels of severity of ASD. The behavioral intervention should be provided at an appropriate level of intensity in an appropriate setting(s) within ~~their~~ the individual's community for an appropriate period of time, depending on the needs of the ~~child~~ individual and their ~~parents/guardians~~ family or authorized representative(s). Clinical determinations of service intensity, setting(s), and duration are designed to facilitate the ~~child's~~ individual's goal attainment. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings, but are not intended to supplant ~~services provided in school or other settings, or to be provided when the child would typically be in school but for the parent's/guardian's choice to home-school their child~~ responsibilities of educational or other authorities. Each ~~child's~~ individual's IPOS must ~~document that these services~~ specify how identified supports and services will be provided as part of an overall, comprehensive set of supports and services that does not duplicate services that are the responsibility of another entity, such as a private insurance or other funding authority, and do not include special education and related services defined in the Individuals with Disabilities Education Act (IDEA) that are available to the ~~child~~ individual through a local education agency . The recommended service level, setting(s), and duration will be included in the ~~child's~~ individual's IPOS, with the planning team and the ~~parent(s)/guardian(s)~~ family or authorized representative(s) reviewing the IPOS ~~at regular intervals (minimally every three months)~~ no less than annually and, if indicated, adjusting the service level and setting(s) to meet

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				the ~~child's~~ individual's changing needs. The service level includes the number of hours of intervention provided to the ~~child~~ individual. The service level determination will be based on research-based interventions integrated into the behavioral plan of care with input from the planning team. Service intensity will vary with each ~~child~~ individual and should reflect the goals of treatment, specific needs of the ~~child~~ individual, and response to treatment. The PIHP's Utilization Management will authorize the level of services prior to the delivery of services. • **Focused Behavioral Intervention:** Focused behavioral intervention is provided an average of 5-15 hours per week (actual hours needed are determined by the behavioral plan of care and interventions required). • **Comprehensive Behavioral Intervention:** Comprehensive behavioral intervention is provided an average of 16-25 hours per week (actual hours needed are determined by the behavioral plan of care and interventions required).
			18.11 BHT Service Evaluation	Text was revised to read: As part of the IPOS, there is a comprehensive, individualized behavioral plan of care that includes specific targeted behaviors, along with measurable, achievable, and realistic goals for improvement. BCBAs and other qualified providers develop, monitor, and implement the behavioral plan of care. These providers are responsible for effectively evaluating the child's response to treatment and skill acquisition. Ongoing determination of the level of service (minimally every six months) requires evidence of measurable and ongoing improvement in targeted behaviors that are demonstrated with the use of reliable and valid assessment instruments ~~(i.e., VB-MAPP, ABLLS-R, AFLS)~~ and other appropriate documentation of analysis (i.e., graphs, assessment reports, records of service, progress reports, etc.).

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