MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

Bulletin Number: MSA 19-33

Distribution: All Providers

Issued: November 26, 2019

Subject: Updates to the Medicaid Provider Manual; CROS/BICROS Hearing Aid Prior Authorization Update

Effective: January 1,2020

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 Medicaid Provider Manual

The Michigan Department of Health and Human Services (MDHHS) has completed the January 2020 quarterly update of the Michigan Medicaid Provider Manual. The Manual is maintained on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Medicaid Provider Manual. A compact disc (CD) version of the Manual is available to enrolled providers upon request.

The January 2020 version of the Manual does not highlight changes made in 2019. 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. Subsequent changes made for the April, July, and October 2020 versions of the manual will be highlighted within the text of the on-line manual.

CROS/BICROS Hearing Aid Prior Authorization Update

Prior authorization (PA) is no longer required for monaural or binaural CROS/BICROS hearing aids included in the MDHHS Volume Purchase Contract if all other hearing aid requirements are met and restrictions (i.e., frequency of replacement) are not exceeded.

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 Medicaid Provider Manual, providers should retain all bulletins issued since the version date of the CD. Providers are encouraged to use the Michigan 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 an e-mail, 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
Medical Services Administration

Michigan Department of Health and Human Services

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans	Addition of: **Benefit Plan ID**: BHHMP **Benefit Plan Name**: Medicaid Behavioral Health NOT Enrolled in an MHP **Benefit Plan Description**: This plan covers Medicaid mental health and substance abuse services managed by the PIHP for Healthy Michigan Plan (HMP) recipients who have a specialty level of need and are not enrolled in a Medicaid Health Plan (Fee For Service- FFS). **Type**: Managed Care Organization **Funding Source**: XIX **Covered Services**: AI, MH	Update.
Beneficiary Eligibility	2.1 Benefit Plans	Addition of: **Benefit Plan ID**: BHHMP-MHP **Benefit Plan Name**: Healthy Michigan Plan Behavioral Health Enrolled in an MHP **Benefit Plan Description**: This plan covers Medicaid mental health and substance abuse services managed by the PIHP for Healthy Michigan Plan (HMP) recipients who have a specialty level of need and are enrolled in a Medicaid Health Plan for Managed Care (MC). **Type**: Managed Care Organization **Funding Source**: XIX **Covered Services**: AI, MH	

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CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans	Addition of: **Benefit Plan ID**: BHMA **Benefit Plan Name**: Medicaid Behavioral Health NOT Enrolled in an MHP **Benefit Plan Description**: This plan covers Medicaid mental health and substance abuse services managed by the PIHP for MA recipients who have a specialty level of need and are not enrolled in a Medicaid Health Plan (Fee For Service - FFS). **Type**: Managed Care Organization **Funding Source**: XIX **Covered Services**: AI, MH	Update.
Beneficiary Eligibility	2.1 Benefit Plans	Addition of: **Benefit Plan ID**: BHMA-MHP **Benefit Plan Name**: Medicaid Behavioral Health Enrolled in an MHP **Benefit Plan Description**: This plan covers Medicaid mental health and substance abuse services managed by the PIHP for MA recipients who have a specialty level of need and are enrolled in a Medicaid Health Plan for Managed Care (MC). **Type**: Managed Care Organization **Funding Source**: XIX **Covered Services**: AI, MH	Update.
Beneficiary Eligibility	2.1 Benefit Plans	**Benefit Plan ID**: CWP The following text was added: This benefit plan is obsolete as of 10/01/2019. Beneficiaries are now assigned to the CWP-MC benefit plan.	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans	Addition of: **Benefit Plan ID**: CWP-MC **Benefit Plan Name**: Children's Waiver Program Managed Care **Benefit Plan Description**: This benefit plan provides services that are enhancements or additions to Medicaid state plan services for children under age 18 with developmental disabilities who are enrolled in the Children's Waiver Program (CWP). The CWP is a statewide managed care program. The CWP enables Medicaid to fund necessary home and community-based services for children with developmental disabilities who have challenging behaviors and/or complex medical needs, meet the criteria for admission to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) and who are at risk for placement without waiver services. **Type**: Managed Care Organization **Funding Source**: XIX **Covered Services**: N/A	Update.
Beneficiary Eligibility	2.1 Benefit Plans	**Benefit Plan ID**: HSW The following text was added: This benefit plan is obsolete as of 10/01/2019. Beneficiaries are now assigned to the HSW-MC benefit plan.	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans	Addition of: **Benefit Plan ID**: HSW-MC **Benefit Plan Name**: HSW Habilitation Supports Waiver Program Managed Care **Benefit Plan Description**: Beneficiaries with intellectual or developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined. HSW beneficiaries may also receive other Medicaid state plan services. **Type**: Managed Care Organization **Funding Source**: XIX **Covered Services**: N/A	Update.
Beneficiary Eligibility	2.1 Benefit Plans	**Benefit Plan ID**: SED The following text was added: This benefit plan is obsolete as of 10/01/2019. Beneficiaries are now assigned to the SED-MC benefit plan.	Update.
Beneficiary Eligibility	2.1 Benefit Plans	Addition of: **Benefit Plan ID**: SED-MC **Benefit Plan Name**: Serious Emotional Disturbances Managed Care **Benefit Plan Description**: The Waiver for Children with Serious Emotional Disturbances (SEDW) provides services that are enhancements or additions to Medicaid state plan services for children under age 21. The SEDW is a statewide managed care program. The SEDW enables Medicaid to fund necessary home and community-based services for eligible children with a serious emotional disturbance who meet admission criteria for psychiatric hospitalization. **Type**: Managed Care Organization **Funding Source**: XIX **Covered Services**: N/A	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	4.2 Target Population	In the 1st paragraph, the 2nd sentence was revised to read: ACT is not an appropriate service for a beneficiary with a primary diagnosis of a personality disorder, a primary diagnosis of a Substance Use Disorder, or a primary diagnosis of intellectual or developmental disability.	Clarification.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	4.3 Essential Elements	Under "Team-Based Service Delivery", the 2nd and 3rd paragraphs were revised to read: All ACT staff must obtain a basic knowledge of ACT programs and principles acquired through participation in MDHHS-approved ACT-specific initial training, and subsequent participation in at least one MDHHS-approved ACT-specific training annually thereafter. All initial training of ACT staff must occur within six months of hire for work in ACT. Physicians/Nurse Practitioners/Physician's Assistants/Clinical Nurse Specialists must participate in the MDHHS-approved Physicians/Nurse Practitioners/Physician's Assistants/Clinical Nurse Specialists training one time, with additional ACT training/participation for Physicians/Nurse Practitioners/Physician's Assistants/Clinical Nurse Specialists encouraged, but not mandatory. Team meetings occur Monday through Friday on business days and are attended by all ACT staff members on duty. Physicians, Nurse Practitioners, Physician's Assistants ~~and/~~or Clinical Nurse Specialists are expected to participate in ACT team meetings at least weekly. Agendas for daily team meetings include the status of all beneficiaries, updates from on-call, clinical and case/care management needs, crisis management, schedule organization, and finalized plans for ACT staff deployment into the community.	Language revised to include physician's assistant which was omitted in previous versions; there is no change in the requirement.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	4.3 Essential Elements	Under "Team Composition and Size", in the 1st column, the 4th paragraph was revised to read: *All telepractice interactions shall occur through real-time interactions between the ACT consumer and the physician/nurse practitioner/physician's assistant/clinical nurse specialist from their respective physical location. Psychiatric services are the only ACT services that are approved to be provided in this manner.*	Language revised to include physician's assistant which was omitted in previous versions; there is no change in the requirement.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	4.3 Essential Elements	Under "Team Composition and Size", the 1st paragraph was revised to read: The ACT team requires a sufficient number of qualified staff to assure the provision of an intensive array of services on a 24-hour basis. ~~Teams must have at least three staff members, but generally are comprised of 4-9 staff members, with the expected team average of 6-7.~~ The minimum ACT staffing requirements are below. ~~ACT teams that need to operate with as few as 3 members or more than 9 members must have MDHHS approval. The scope of services for individual ACT staff members requires that some staff will work in the community more often than others.~~ The scope of services for individual ACT staff members requires that some staff will work in the community more often than others. An ACT team operates minimally with 4 FTE staff and with no more than 9 FTE staff members. Teams average 6-7 FTE staff. If an ACT team believes it is necessary to operate outside of team requirements, consult with MDHHS regarding feasibility. Iif appropriate, a waiver request may be submitted to the PIHP. If approved, the PIHP will submit the request to MDHHS for consideration of approval.	Clarification and revision of language related to ACT team size requirements, reference to 3-person team is omitted; language to clarify process for waiver requests is added. Scope of service sentence moved.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	4.3 Essential Elements	Under "Team Composition and Size", 1st paragraph, the 3rd bullet point was revised to read: • A physician who provides psychiatric coverage for all beneficiaries served by the ACT team is required. The physician is considered a part of the ACT team, but is not counted in the staff-to-beneficiary ratio. The physician participates in the team meeting at least weekly and is assigned to the ACT team at least 15 minutes per beneficiary per week in a capacity that allows for immediate access to the physician so that emergency, urgent or emergent situations may be addressed. The expectation is that some beneficiaries will need more physician time and some beneficiaries will need less time during any given week. The physician may delegate psychiatric activities to a nurse practitioner, physician's assistant or clinical nurse specialist, but the nurse practitioner, physician's assistant or ~~/~~clinical nurse specialist must be supervised by that physician. Typically, although not exclusively, physician activities may include team meetings, beneficiary appointments during regular office hours, psychiatric evaluations, psychiatric meetings/consultations, medication reviews, home visits, telephone consultations and telepractice. The physician (MD or DO) must possess a valid license to practice medicine in Michigan, a Michigan Controlled Substance License, and a Drug Enforcement Administration (DEA) registration.	Language revised to include physician's assistant which was omitted in previous versions; there is no change in the requirement.

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	4.3 Essential Elements	Under "Staff-to-Beneficiary Ratio", text was revised to read: The ACT team's staff-to-beneficiary ratio shall be ~~no less than 1:10, i.e., a maximum of 10 beneficiaries to each ACT staff.~~ at least one FTE ACT staff to a maximum of 10 ACT beneficiaries, a 1:10 staff-to-beneficiary ratio. Teams serving large service areas, highly complex beneficiaries, or very high acuity beneficiaries may find a lower staff-to-beneficiary ratio better meets beneficiary needs and retains team capacity to quickly address emerging or acute treatment needs and adjust service contacts. With the exceptions of the limitations on paraprofessionals and peer support specialists described above, the ratio includes all ACT team members, excluding the clerical support staff and physicians, nurse practitioners, and clinical nurse specialists.	Language revised to clarify staff-to-beneficiary ratio; there is no change in the requirement.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	4.3 Essential Elements	Under "Availability of Services", the 1st bullet point was revised to read: • 24-hour/7-day crisis response coverage (including psychiatric availability) that is handled directly by members of the ACT team. ~~For 3-member teams, 'on call' services may be a part of the larger organization's on-call system if approved by MDHHS.~~	Language revised to clarify staff-to-beneficiary ratio; references to 3-member teams is omitted.
Federally Qualified Health Centers	3.1 Definition	The 1st paragraph was revised to read: An allowable FQHC encounter means a face-to-face medical visit between a patient and the provider of health care services who exercises independent judgment in the provision of health care services. Encounters may be classified as medical, dental, or behavioral health.	Clarification to add context on definition of encounter.

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CHAPTER	SECTION	CHANGE	COMMENT
Federally Qualified Health Centers	3.5 Allowable Encounters Per Day	Text was revised to read: ~~An individual provider may be credited with no more than one encounter per patient during a single day, except when the patient, after the first visit, suffers illness or injury requiring additional diagnosis or treatment. For example, a patient sees a physician for flu symptoms early in the day, and then later the same day sees the same physician for a broken leg. These visits may be classified as two encounters.~~ ~~An FQHC is entitled to two encounters for different types of visits on the same day. For example, a patient first sees a physician at the FQHC and then later sees a dentist. These visits may be classified as two encounters.~~ An FQHC may be credited with one encounter for each different type of visit provided to a beneficiary during a single day, regardless of the number of services provided at the visit. A maximum of three encounters are allowed per beneficiary per day (one medical, one dental, and one behavioral health). In cases where the beneficiary, after the first visit, suffers illness or injury requiring additional diagnosis or treatment, these visits may be classified as two encounters. • Example 1: A beneficiary sees a dentist for an exam and three restorations and sees the dental hygienist for a prophylaxis on the same day. These visits count as one encounter (dental). • Example 2: A beneficiary sees a physician at the FQHC, and then later sees a dentist and a social worker on the same day. These visits may be classified as three encounters (one medical, one dental, and one behavioral health). • Example 3: A beneficiary sees a physician for flu symptoms early in the day, and then later the same day sees the same physician for a broken leg. These visits may be counted as two encounters (both medical – subsequent injury).	Clarification to add context and examples of allowable encounters per day.
Hearing Aid Dealers	1.12 Prior Authorization	In the 2nd paragraph, the 3rd bullet point was removed. • ~~CROS or BICROS hearing aids.~~	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Hearing Aid Dealers	2.3.B. Documentation	The 5th and 6th bullet points were removed. ~~• A letter of medical necessity that identifies the specific medical reason or reasons why a non-contract hearing aid is required that cannot be met by a contracted hearing aid.~~ • ~~CROS and BICROS continue to require prior authorization. In addition to the published documentation required, the letter of medical necessity must identify why a wired versus a non-wired hearing aid is needed.~~	Clarification.
Hearing Aid Dealers	2.3.C. Prior Authorization Requirements	The 1st paragraph was revised to read: PA is required for ~~all~~ monaural or binaural CROS hearing aids~~.~~ not included in the MDHHS volume purchase contract. When PA is needed, the following documentation must be submitted with the MSA-1653-B:	Clarification.
Hearing Aid Dealers	2.4.B. Documentation	The 6th and 7th bullet points were removed. ~~• A letter of medical necessity that identifies the specific medical reason or reasons why a non-contract hearing aid is required that cannot be met by a contracted hearing aid.~~ • ~~CROS and BICROS continue to require prior authorization. In addition to the published documentation required, the letter of medical necessity must identify why a wired versus a non-wired hearing aid is needed.~~	Clarification.
Hearing Aid Dealers	2.4.C. Prior Authorization Requirements	The 1st paragraph was revised to read: PA is required for ~~all~~ monaural or binaural BICROS hearing aids~~.~~ not included in the MDHHS volume purchase contract. When PA is needed, the following documentation must be submitted with the MSA-1653-B:	Clarification.

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Hospital	3.22 Organ Transplants	The following text was added after the 2nd paragraph: Refer to the Hospital Reimbursement Appendix for information about MDHHS reimbursement for Transplant Services. The 3rd, 4th, and 5th paragraphs were removed: ~~MDHHS reimbursement for the following transplants is at the hospital's Medicaid cost to charge ratio:~~ • ~~Heart~~ • ~~Bone marrow~~ • ~~Liver~~ • ~~Lung~~ • ~~Simultaneous pancreas/kidney~~ • ~~Pancreas transplants~~ ~~Organ acquisition costs are reimbursed at 100% of charges when billed using the appropriate revenue code. (Refer to the Transplants subsection of the Billing & Reimbursement for Institutional Providers Chapter for revenue code information.) This applies to:~~ • ~~Heart~~ • ~~Kidney~~ • ~~Liver~~ • ~~Lung~~ • ~~Simultaneous pancreas/kidney~~ • ~~Pancreas transplants~~ ~~All bone marrow transplant charges are reimbursed at the hospital's cost to charge ratio.~~	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	4.1 Medicaid Health Plan Payments to Out of Network Hospitals	The 2nd paragraph was revised to read: The hospital's Medicaid operating cost to charge ratios in effect for the date of service are to be used in the calculation of low day outliers, cost outliers, and organ transplants. ~~(with the exception of kidney transplants which are paid under relative weights). Organ acquisition costs are reimbursed at 100% of charges. This applies to heart, kidney, liver, lung, simultaneous pancreas/kidney, or pancreas transplants. This does not apply to bone marrow transplants. All bone marrow transplant charges are reimbursed at the hospital's cost-to-charge ratio.~~ Refer to the Special Circumstances subsection of this Appendix for information about MDHHS reimbursement for Transplant Services.	Update.
Medical Supplier	2.30 Oxygen, Oxygen Equipment and Accessories	Under "PA Requirements", 1st paragraph, the following bullet point was removed: • ~~Obstructive Sleep Apnea (adult) (pediatric)~~ The last paragraph was revised to read: PA is not required for gaseous stationary or concentrators for the condition of obstructive sleep apnea (adult) (pediatric).	Correcting conflicting information.
Non-Emergency Medical Transportation	Section 5 – Covered Services	In the 1st paragraph, the 1st bullet point was revised to read: • Treatment eligible for Medicaid ~~covers~~ coverage (one-time or ongoing);	Clarifying that treatment does not need to be paid for by Medicaid -- just that it needs to be a service that Medicaid can cover and is not prohibited by Medicaid.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Rural Health Clinics	4.1 Definition	The 2nd paragraph was revised to read: An encounter is a face-to-face visit between a patient and the provider of health care services who exercises independent judgment in the provision of health care services. For a health service to be defined as an encounter, the provision of the health service must be recorded in the patient's medical record. Encounters may be classified as medical or behavioral health. The following text was added after the 2nd paragraph: An RHC may be credited with one encounter for each different type of visit provided to a beneficiary during a single day, regardless of the number of services provided at the visit. A maximum of two encounters are allowed per beneficiary per day (one medical and one behavioral health). In cases where the beneficiary, after the first visit, suffers illness or injury requiring additional diagnosis or treatment, these visits may be classified as two encounters. • Example 1: A beneficiary sees a physician at the RHC to treat bronchitis and then sees an optometrist on the same day for an eye exam. These visits count as one encounter (medical). • Example 2: A beneficiary sees a physician at the RHC, and then later sees a social worker on the same day. These visits may be classified as two encounters (one medical and one behavioral health). • Example 3: A beneficiary sees a physician for flu symptoms early in the day, and then later the same day sees the same physician for a broken leg. These visits may be counted as two encounters (both medical – subsequent injury).	Clarification to add context on definition of encounter.

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CHAPTER	SECTION	CHANGE	COMMENT
School Based Services Administrative Outreach Program Claims Development	2.11 Claim Certification	Text was revised to read: The accuracy of the submitted claims must be certified by the chief financial officer, the superintendent of the district, or the consortium's lead ISD/DPSCD designee. Such certification is ~~to be documented on an MDHHS-approved certification form, and conform to the certification~~ accomplished when the annual cost report is submitted in CHAMPS and meets the requirements of 42 CFR 433.51. Detailed claim analyses and supporting documentation will be maintained by the ISD/DPSCD for audit or future reference purposes according to the terms identified in the interagency agreement between the district and MDHHS. ~~The Electronic Signature Verification Statement (DCH-3890) form must be completed by each provider and submitted to MDHHS to certify costs electronically. A copy of the completed DCH-3890 must be kept on file by the provider until the individual signing the certification changes. (Refer to the Forms Appendix for a copy of the form.)~~ Reimbursement will be paid after the claim has been submitted to, reviewed by, and determined to be acceptable and accurate by MDHHS and CMS.	Update.
Special Programs	3.3.A. Eligible Beneficiaries	The 1st paragraph was revised to read: Medicaid-eligible disabled adults aged 16 through 64 years old with earned income may be eligible. ~~A beneficiary must move into this Medicaid category from another Medicaid category.~~ SSI beneficiaries whose SSI eligibility may end due to financial factors are among those eligible to be considered for this program. The 3rd paragraph was revised to read: For a married beneficiary, the spouse's income and assets are not considered when determining eligibility for this Medicaid category. The beneficiary's total countable unearned income cannot exceed ~~100~~ 250 percent of the Federal Poverty Level (FPL) for ongoing eligibility. The beneficiary's countable assets are limited to $75,000. In addition, the beneficiary is allowed to have IRS-recognized retirement accounts (including IRAs and 401Ks) of unlimited value.	Updates.

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CHAPTER	SECTION	CHANGE	COMMENT
Special Programs	3.3.C. Premiums	Text was revised to read: If the beneficiary's ~~earned~~ MAGI income is below ~~250~~ 138 percent of the FPL, there is no premium required for coverage. If the beneficiary's ~~earned~~ MAGI income is between ~~250~~ 138 percent of the FPL and $75,000 per year, the premium is ~~based on the sliding fee scale~~ 2.5 percent of MAGI income. If the total countable earned income exceeds $75,000 per year, the beneficiary must pay a premium equal to 100 percent of the cost of Medicaid coverage.	Update.
Directory Appendix	Nursing Facility Resources	Under "LTC Ombudsman", the phone number was revised to read: ~~800-292-7852~~ 866-485-9393	Update.
Forms Appendix	DCH-3890	Removal of: DCH-3890; Electronic Signature Verification Statement	Form is obsolete.

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Michigan Department of Health and Human Services

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 19-19	8/2/2019	Medicaid Provider Manual Overview	1.1 Organization	Addition of the following: Chapter Title: Independent Diagnostic Testing Facilities and Portable X-ray Suppliers Affected Providers: Independent Diagnostic Testing Facilities and Portable X-ray Suppliers Chapter Content: Information regarding enrollment, billing, coverage and reimbursement for Independent Diagnostic Testing Facilities and Portable X-ray Suppliers.
		General Information for Providers	Section 2 – Provider Enrollment	In the 9th paragraph, the 1st sentence was revised to read: Providers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) and Independent Diagnostic Testing Facilities and Portable X-ray Suppliers must be enrolled as a Medicare provider.
		Billing & Reimbursement for Professionals	Section 1 – General Information	In the 2nd paragraph, the following bullet points were added: • Independent Diagnostic Testing Facilities • Portable X-ray Suppliers In the last paragraph, the following bullet points were added: • Independent Diagnostic Testing Facilities • Portable X-ray Suppliers
		Independent Diagnostic Testing Facilities and Portable X-ray Suppliers (new chapter)		Addition of new chapter.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Practitioner	9.4 Transportation and Set-up of Portable X-ray Equipment	In the 1st paragraph, the last sentence was revised to read: (Refer to the Nursing Facility and the Independent Diagnostic Testing Facilities and Portable X-ray Suppliers chapters of this manual for additional information.)
MSA 19-20	8/2/2019	Pharmacy	2.2 Prescriber Identification	Text was revised to read: Pharmacy providers must provide the individual prescriber's National Provider Identifier (NPI) on the submitted claim. MDHHS will deny pharmacy claims where the prescriber is not enrolled in CHAMPS. Refer to the General Information for Providers chapter and the Practitioner chapter for additional information.
MSA 19-21	8/30/2019	Behavioral Health and Intellectual and Developmental Disability Supports and Services	18.9.D. Telepractice for BHT Services	At the end of the 1st paragraph, text was revised to read: … Providers of telepractice services must be currently certified by the Behavior Analyst Certification Board (BACB), be a QBHP ~~enrolled in a BACB degree program~~, be licensed in the State of Michigan as a fully licensed psychologist, or be a practitioner who holds a limited license and is under the direction of a fully licensed psychologist. Providers must ensure the privacy of the child and secure any information shared via telemedicine.

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			18.12.A. BHT Supervisors	Under "Licensed Psychologist (LP)", the 1st bullet point was revised to read: • Must be certified as a BCBA by September 30, ~~2020~~ 2025. Under "Limited License Psychologist (LLP)", the 1st bullet point was revised to read: • Must be certified as a BCBA by September 30, ~~2020~~ 2025. Under "Qualified Behavioral Health Professional (QBHP)", the 1st bullet point was revised to read: • Must be certified as a BCBA by September 30, ~~2020~~ 2025. Under "Qualified Behavioral Health Professional (QBHP)", the 3rd bullet point was revised to read: • License/Certification: ~~A license or certification is not required but is optional.~~ Must be certified as a BCBA within two years of successfully completing ABA graduate coursework.

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 19-22	8/30/2019	Healthy Michigan Plan	5.6.B.4. Crisis Services	Under "Crisis Residential Services", the 3rd bullet point was revised to read: • **Provider Criteria:** The PIHP must seek and maintain MDHHS approval for the crisis residential program in order to use Healthy Michigan Plan funds for program services. Healthy Michigan Plan crisis residential programs may choose to provide a program for serious mental illness, intellectual/developmental disabilities, substance use disorders or a combined program. A program offering services for substance use disorders must be licensed for residential substance use disorder treatment services per the Administrative Rules for Substance Use Disorder Programs and appropriately accredited through one of the organizations identified in the Substance Abuse Services subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter. A combined program, one offering services for serious mental illness/intellectual and developmental disabilities and substance use disorders, must also be approved by MDHHS as a "co-occurring enhanced crisis residential program" (consistent with PA 338 of 2018). A co-occurring enhanced crisis residential program must be able to demonstrate that it can address the mental health needs, substance use disorder needs, or both of an individual through enhanced programming and staffing patterns. Established mental health residential programs that purport to offer this service for individuals with substance use disorders will be required to seek re-approval of the program by MDHHS when appropriate licensing and accreditation has been obtained. Programs currently approved to provide services for mental health and/or intellectual/developmental disabilities by MDHHS through the delivery of Medicaid State Plan, Habilitation Supports Waiver (HSW), or additional/B3 services do not require re-approval.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 19-23	8/30/2019	Therapy Services	Section 3 – Prior Authorization Requests	The 2nd paragraph was revised to read: Prior authorization is not required for the ~~first 60 days~~ initiation of home health therapy for up to a maximum of 24 visits within the first 60 consecutive days if: • the beneficiary has not received home health therapy services within the ~~last~~ calendar year ~~(365 consecutive days from the date of service)~~, and • services do not exceed the visit maximum. If a beneficiary has previously received home health therapy and services were provided more than 60 days ago ~~but less than 365 days~~ within the calendar year, authorization is needed.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 19-25	8/30/2019	Medical Supplier	2.25 Orthotics (Lower Extremity)	"Standards of Coverage" was revised to read: ~~Lower extremity orthotics are covered to:~~ • ~~Facilitate healing following surgery of a lower extremity.~~ • ~~Support weak muscles due to neurological conditions.~~ • ~~Improve function due to a congenital paralytic syndrome (i.e., Muscular Dystrophy).~~ Lower extremity orthotics (including night splints), regardless of diagnosis, are covered for the following manifestations: • To promote healing and/or proper alignment/positioning following injury, procedure (e.g. serial casting), or surgery of the lower extremity. • To support lower extremities due to muscle weakness or abnormal muscle tone (e.g. high/low fluctuating tone) of permanent or long-standing duration (six months or longer). • To support, correct or improve: ➢ Biomechanical alignment (e.g. pronation, supination, varus or valgus). ➢ Static or dynamic contractures. ➢ Congenital or acquired deformities of the lower extremities.

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MSA 19-31	10/1/2019	Non-Emergency Medical Transportation	5.2 Meals	The 1st paragraph was revised to read: Authorized meals for beneficiaries, volunteer drivers, or individuals with a vested interest are reimbursed at cost or at the maximum allowable amount, whichever is less. To be entitled to meal reimbursement, meals must meet one of the following ~~must be met~~: • For breakfast: The vehicle ~~with the beneficiary~~ must depart ~~at, or~~ before~~,~~ 6:00 AM and must return ~~at, or~~ after~~,~~ 8:30 AM. • For lunch: The vehicle ~~with the beneficiary~~ must depart ~~at, or~~ before~~,~~ 11:30 AM and must return ~~at, or~~ after~~,~~ 2:00 PM. • For dinner: The vehicle ~~with the beneficiary~~ must depart ~~at, or~~ before~~, 6:30~~ 5:30 PM and must return ~~at, or~~ after~~,~~ 8:00 PM. The following text was added after the 1st paragraph: A vehicle's departure and return times cannot include non-medically related travel including, but not limited to, personal errands or business. Meals are not eligible for reimbursement if they are purchased within the requester's official city of residence.

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		Non-Emergency Medical Transportation	5.4 Lodging	Text was revised to read: Medically necessary overnight stays ~~which~~ that include meals and lodging may be authorized for a beneficiary~~, a~~ and transportation provider~~, and if documented by the beneficiary's PCP on the DHS-5330,~~ for up to 14 consecutive nights. In addition, one medically necessary attendant (or individual with a vested interest) ~~for no more than five consecutive nights~~ may be authorized if documented by the beneficiary's provider on the DHS-5330. Medically necessary overnight stays beyond ~~five~~ 14 nights require prior authorization (PA) from the MDHHS Program Review Division (PRD). (Refer to the Directory Appendix for contact information.) Medically necessary overnight stays which include meals and lodging at a Level IV Neonatal Intensive Care Unit (NICU) may be authorized for a beneficiary, a transportation provider, and if documented by the beneficiary's ~~PCP~~ provider on the DHS-5330, one medically necessary attendant (or individual with a vested interest) for no more than 14 nights. Necessary overnight stays at a Level IV NICU beyond 14 nights require PA from PRD. ~~Overnight stays which include meals and lodging ordered by a physician or required due to travel distance may be authorized for a beneficiary, a transportation provider, and if documented by the beneficiary's PCP on the DHS-5330, one medically necessary attendant (or individual with a vested interest).~~ The least expensive, sufficiently maintained lodging available must be utilized. The availability of nonprofit accommodations (i.e., Ronald McDonald House or accommodations available through the visiting medical facility) must be explored before commercial lodging is considered. Lodging expenses are reimbursed at cost or the maximum allowable amount, whichever is less. Original, itemized, unaltered receipts are required. Reimbursement beyond an accommodation's suggested donation amount or per night rate as charged to the public will not be made.

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		Non-Emergency Medical Transportation	5.6 Hospital Facility Meal and Lodging Reimbursement	The end of the paragraph was revised to read: …… Requests made by the facilities for reimbursement must be received by the local MDHHS office, or authorizing party, within ~~90 calendar days of the last date of service~~ 12 months of the incurred expense. The current maximum per-day rates for these services are indicated on the MDHHS NEMT Database.
		Non-Emergency Medical Transportation	Section 7 – Prior Authorization (PA)	The 2nd paragraph was revised to read: Reimbursement for travel expenses related to the following situations requires PA: • All travel to and from out-of-state/beyond borderland medical providers. (Refer to the Out of State/Beyond Borderland Providers subsection of the General Information for Providers chapter of this manual for additional information.); • Transportation reimbursement requests for medical care outside a beneficiary's community when comparable care is available locally; • Meals and lodging for overnight stays if the medical facility is within 50 miles of the beneficiary's residence; • ~~Meals and lodging for overnight stays beyond five nights unless the beneficiary is admitted to an approved children's hospital. (Refer to the MDHHS NEMT Database for additional information.);~~ • Necessary meals and lodging for overnight stays beyond 14 consecutive nights; ~~for a beneficiary who is admitted to an approved children's hospital;~~ • Requests for advance payment of travel costs; and • Travel expenses for two or more individuals with a vested interest or medically necessary attendants.

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