MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 09-29

Distribution: All Providers

Issued: June 1, 2009

Subject: Updates to the Medicaid Provider Manual

Effective: July 1, 2009

Programs Affected: Medicaid, Adult Benefits Waiver, Children's Special Health Care Services, Children's Waiver, Maternity Outpatient Medical Services, MIChoice Waiver, Plan First!

The Michigan Department of Community Health (MDCH) has completed the July 2009 update of the online version of the Medicaid Provider Manual.

Attachments to this bulletin describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change.

Attachment II describes changes made to incorporate information from recently issued Medicaid Bulletins. These changes appear in pink in the online version of the 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.

When utilizing the compact disc (CD) version of the manual, refer to this bulletin in addition to the CD to assure you have the most current policy information available.

Public Comment

The Technical Changes Attachment of this bulletin is being issued for public comment of the policy promulgation process concurrently with the implementation of the changes noted in this bulletin. Any interested party wishing to comment on the changes may do so by submitting comments in writing to:

Michigan Department of Community Health
Medical Services Administration
P.O. Box 30479
Lansing, Michigan 48909-7979
Or
E-mail: MSADraftPolicy@michigan.gov

If responding by e-mail, please include "Technical Changes Comment" in the subject line.

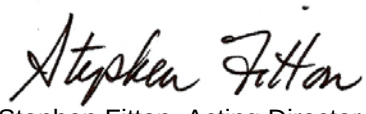
Manual Maintenance

If using the CD version of the Medicaid Provider Manual, retain this bulletin and those referenced in this bulletin. If utilizing the online version of the manual at www.michigan.gov/medicaidproviders >> Policy and Forms, this bulletin and those referenced in this bulletin may be discarded.

Questions

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

Approved



Stephen Fitton, Acting Director
Medical Services Administration

Michigan Department of Community Health

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July 2009 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Throughout the Manual		References to the MDCH Program Investigation Section were changed to MDCH Medicaid Integrity Program Section.	Update
Throughout the Manual		References to the Joint Commission on Accreditation of Healthcare Organizations/JCAHO were changed to Joint Commission.	Update
General Information for Providers	8.3 Prior Authorization (Medicaid Health Plans Only)	The 1st sentence was revised to read: Medicaid Health Plans (MHPs) are responsible for authorizing Medicaid-covered services in ...	Corrective clarification
General Information for Providers	13.7 Clinical Records	In the Clinical Documentation Requirements table, MIHP was added for the category "Begin Time & End Time if Service is Time-Specific ...".	Update
Billing & Reimbursement for Institutional Providers	5.2.A. General Information	The following was added as a first row to the table: **Coding**: All unlisted or not otherwise classified (NOC) codes require an explanation of the service/item provided. The explanation may be entered in the Remarks Section or may be provided as a claim attachment. Do not recode procedure codes submitted to Medicare or other insurers to unlisted or NOC codes when billing Medicaid unless MDCH does not cover the procedure code. When Medicaid covers the procedure code, providers must submit the same procedure code to Medicaid that was submitted to the other payer to ensure proper reimbursement. Claims will be rejected for inappropriate recoding even if PA was issued by MDCH.	Added to align with Billing & Reimbursement for Professionals Chapter for billing clarification of NOC codes

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	6.13 Labor and Delivery	Section language was revised to read: Labor and delivery room charges must only be billed when labor progresses to delivery. • Do not report fetal monitoring, a fetal contraction stress test, or a fetal non-stress test in addition to a labor and delivery or false labor room charge when there is no active labor. False labor charges for a room used by a beneficiary in active labor who does not progress to delivery must be billed using the appropriate revenue code (i.e., RC 0729) and the appropriate HCPCS code. The appropriate diagnosis code must also be used. • A fetal contraction stress test or a fetal non-stress test may be billed in addition to false labor (under the MDCH OPPS) when medically necessary. • No other room charges may be billed with Revenue Code 0729 for the same date of service. Refer to the OPPS Wrap Around Code List on the MDCH website for the appropriate HCPCS/CPT code. (Refer to the Directory Appendix for website information.)	Revised to clarify labor/no active labor/false labor
Billing & Reimbursement for Institutional Providers	6.20 Therapies (Occupational, Physical and Speech-Language)	Under Occupational Therapy (OT), 3rd bullet: the 3rd sentence was deleted. Under Physical Therapy (PT), the last bullet was deleted. Under Speech-Language Therapy (ST), the 4th bullet was deleted.	Obsolete information
Billing & Reimbursement for Institutional Providers	10.2 Adult Home and Community Based Waiver Beneficiaries (MI Choice) [new subsection; following subsections re-numbered]	New subsection text reads as follows: Level of Care (LOC) 22 identifies the beneficiary as receiving services through the Home and Community Based Waiver for the Elderly and Disabled (MI Choice Waiver) and remains on the eligibility file for the beneficiary. LOC 22 must be noted in the Remarks Section of the claim form in order to allow for correct claims processing.	Clarification & uniformity between the Hospice and the Billing & Reimbursement for Institutional Providers chapters. Section added to explain claim completion when hospice beneficiary is in the MI Choice Waiver.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Adult Benefits Waiver	Table of Contents	The textbox with open enrollment information was changed to state an enrollment freeze is in effect.	Update
Adult Benefits Waiver	1.3 Reimbursement	The opening sentence of the 4th paragraph was revised to read: ABW beneficiaries may not be billed for services except in the following situations:	Corrective clarification
Children's Special Health Care Services	Section 1 – General Information (renamed)	The section title was changed to General Information. The last paragraph (NOTE:) was deleted.	Section title was revised for consistency with Manual language. The last paragraph was obsolete information.
Children's Special Health Care Services	Section 3 – Medical Eligibility	The 1st sentence of the 1st paragraph was revised to read: CSHCS covers over 2,600 medical diagnoses that are handicapping in nature and require care by a medical or surgical subspecialist.	Update
Children's Special Health Care Services	Section 8 – Coverage Period	The 2nd sentence of the 2nd paragraph was revised to read: Those with Medicaid, MIChild, or WIC are determined complete in the annual financial review each year those circumstances remain true.	Update
Children's Special Health Care Services	9.7 Insurance Premium Payment Benefit	The 2nd sentence of the 1st paragraph was revised to read: It must be deemed cost effective for CSHCS (i.e., the cost of the insurance premium is less than the projected cost of CSHCS covered services that are paid by other insurance) and the client/family must have a financial hardship that interferes with their ability to pay for the coverage.	To clarify/define what "cost effective" means

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Children's Special Health Care Services	9.7 Insurance Premium Payment Benefit	The following was added as the 3rd paragraph. Following the initial approval, all CSHCS clients receiving the insurance premium payment benefit are re-evaluated for cost effectiveness within six months or when family circumstances change.	Added for clarification/information
Dental	Section 1 – General Information	Information was separated into subsections. Information after the 5th paragraph is now a new subsection titled 1.1 Dental Program Coverage. The 6th paragraph was reformatted to two new subsections reading: 1.1.A. Early and Periodic Screening, Diagnosis, and Treatment Dental benefits are available to beneficiaries under 21 years of age through Medicaid which provides Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Upon completion of a well-child visit (EPSDT), providers must refer beneficiaries to a dental provider for a thorough dental examination. (Refer to the Early and Periodic Screening, Diagnosis and Treatment section of the Practitioner Chapter for additional information.) 1.1.B. Early and Periodic Screening, Diagnosis, and Treatment Dental Periodicity Schedule The 7th paragraph was reformatted as subsection 1.1.C. Adult Dental Program. The 8th paragraph was reformatted as subsection 1.1.D. CSHCS Program.	Formatted categories to better locate information Refer to the Bulletins Incorporated attachment, bulletin MSA 09-23, for additional information for subsection 1.1.B.
Hospice	3.2 Beneficiary Enrollment Process	The following sentence was added at the end of the 1st paragraph: Do not submit the form if the beneficiary is enrolled in the Adult Home and Community Based Waiver (MI Choice).	Clarification

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hospice	5.5 Categories of Care	The 1st sentence of "General Inpatient Care" was revised to read: General Inpatient Care is defined as short-term inpatient care provided in a hospice inpatient unit, …	Clarification
Hospice	5.6.D. Adult Home and Community Based Waiver Beneficiaries (MI Choice)	The 2nd paragraph was deleted. The 3rd paragraph was revised to read: Beneficiaries may receive services from both types of providers concurrently as long as the services are not duplicative. Level of Care (LOC) 22 identifies the beneficiary as receiving services through the Adult Home and Community Based Waiver for the Elderly and Disabled (MI Choice Waiver) and remains on the MDCH eligibility file for the beneficiary. The 1st sentence of the 4th paragraph was revised to read: The hospice should not submit a Hospice Membership Notice (DCH-1074) to MDCH for a beneficiary whose … The textbox after the 4th paragraph was revised to read: LOC 22 must be noted in the Remarks Section of the claim form in order to allow correct claims processing.	For clarification and uniformity between the Hospice and the Billing & Reimbursement for Institutional Providers chapters.
Hospital	3.8 Blood Products	The paragraph was revised to read: MDCH aligns with Medicare OPPS coverage and billing guidelines for Blood Processing/Storage in an outpatient hospital. Providers must follow the Medicare coding and reporting requirements.	OPPS update
Hospital	3.23 Organ Transplants	The last sentence of the 8th paragraph was revised to read: If the donor and beneficiary are both Medicaid-enrolled, providers must bill the services under their respective Medicaid ID numbers.	Correction

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital	3.27.B. Recovery Room	The 1st paragraph was revised to read as follows: MDCH covers routine supplies, anesthesia, and recovery room use. Most drugs are considered to be an integral part of a surgical procedure. Payment for these items is packaged into the APC payment for the surgical procedure.	Clarification
Hospital Reimbursement Appendix	2.8.E. Transfers to an Acute Care Inpatient Hospital (renamed)	The subsection title was changed **from** Transfers to a Hospital **to** Transfers to an Acute Care Inpatient Hospital. The 1st paragraph was revised to read: Payment to an acute care inpatient hospital that receives a patient as a transfer from another acute care inpatient hospital differs ... The 2nd paragraph was revised to read: If the beneficiary is subsequently discharged, the receiving acute care inpatient hospital is paid ... The 4th paragraph was revised to read: If the beneficiary is subsequently transferred again, the acute care inpatient hospital is paid ...	Revised to reflect "acute care inpatient"
Hospital Reimbursement Appendix	2.8.F. Transfers From a Hospital	The 1st sentence was revised to read: ... the transferring acute care inpatient hospital is paid ...	Revised to reflect "acute care inpatient"
Hospital Reimbursement Appendix	4.2.A. Definitions	Under "Certificate of Coverage", "Clean Claims" and "OFIS": Changed Office of Financial and Insurance Services (OFIS) **to** Office of Financial and Insurance Regulation (OFIR). Changed Michigan Department of Labor and Economic Growth (MDLEG) **to** Department of Energy, Labor and Economic Growth (DELEG).	Updates

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	4.4 Disputed Claims	The 2nd sentence was revised to read: The process is included with the Hospital Access Agreement.	Update
Medicaid Health Plans	4.4 Data Sources	In the 1st paragraph, 4th bullet, Office of Financial and Insurance Services was changed **to** Office of Financial and Insurance Regulation (OFIR).	Update.
Mental Health/Substance Abuse	1.7 Definition of Terms	The 1st bullet for "Substance Abuse Treatment Specialist" was revised to read: An individual who has licensure in one of the following areas, and is working within their scope of practice: The 10th sub-bullet was revised to read: Limited Licensed Professional Counselor (LLPC) The following was added after the sub-bullets for the 1st bullet: and who has a registered development plan leading to certification and is timely in its implementation; or who is functioning under a time-limited exception plan approved by the substance abuse coordinating agency; or The 2nd bullet was revised to read: An individual who has one of the following Michigan Certification Board of Addiction Professionals (MCBAP) or International Certification and Reciprocity Consortium (IC & RC) credentials: ➢ Certified Addictions Counselor – Michigan (CAC-M) ➢ Certified Addictions Counselor – IC & RC – Reciprocal (CAC-R) ➢ Certified Advanced Addictions Counselor – IC & RC (CAAC) ➢ Certified Criminal Justice Professional – IC & RC - Reciprocal (CCJP-R) or ...	Update

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CHAPTER	SECTION	CHANGE	COMMENT
		The following was added as a 3rd bullet: an individual who has one of the following approved alternative certifications: ➢ for medical doctors: American Society of Addiction Medicine (ASAM) ➢ for psychologists: American Psychological Association (APA) ➢ certification through the Upper Midwest Indian Council on Addiction Disorders (UMICAD) The following was added as a final paragraph: A physician (MD, DO), physician assistant, nurse practitioner, registered nurse or licensed practical nurse who provides substance use disorder treatment services within the scope of their practice is considered to be specifically-focused treatment staff and is not required to obtain MCBAP credentials. If one of these professionals provides substance use disorder treatment services outside their scope of practice, the MCBAP applies. Language for "Substance Abuse Treatment Practitioner" was revised to read as follows: An individual who has a registered MCBAP certification development plan, is timely in its implementation, and is supervised by a Certified Clinical Supervisor – Michigan (CCS-M) or Certified Clinical Supervisor – IC & RC - Reciprocal (CCS-R); or who has a registered development plan to obtain the supervisory credential while completing the requirements of the plan (6000 hours).	
Mental Health/Substance Abuse	4.3 Essential Elements	Under Team Composition and Size, 6th bullet, the first three sub-bullets were revised to read: ➢ Certified Addictions Counselor – Michigan (CAC-M) ➢ Certified Addictions Counselor – IC & RC – Reciprocal (CAC-R) ➢ Certified Advanced Addictions Counselor – IC & RC (CAAC)	For consistency with language used in other areas of the chapter.

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CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/Substance Abuse	Section 18 – Additional Substance Abuse Services (B3s)	The 1st bullet of the 2nd paragraph was revised to read: Meets medical necessity criteria for the beneficiary (refer to the Medical Necessity Criteria section); and	Update
Nursing Facility Coverages	4.1.A. Verification of Financial Medicaid Eligibility	The 1st paragraph was revised to read: ... When a Medicaid financially-eligible beneficiary is admitted to a nursing facility, or when a resident becomes Medicaid financially-eligible while in a facility, the nursing facility must submit the Facility Admission Notice (MSA-2565-C) to the local DHS office to establish/confirm the individual's eligibility for Medicaid benefits. The facility should also submit the MSA-2565-C for residents who are potentially financially eligible. The 2nd paragraph was revised to read: DHS will return a copy of the MSA-2565-C to the facility noting an individual's Medicaid financial eligibility status and patient-pay amount (do not wait for DHS to return a copy of the MSA-2565-C; the online Michigan Medicaid Nursing Facility Level of Care Determination must be conducted within the required timeframe for Medicaid or Medicaid-pending beneficiaries). A copy of the MSA-2565-C is available on the MDCH website and in the Forms Appendix of this manual. The textbox after the 2nd paragraph was revised to read: In order for Medicaid to reimburse for nursing facility services from the date of admission of a Medicaid-eligible beneficiary, the Medicaid beneficiary must be in a Medicaid-certified bed, and the Michigan Medicaid Nursing Facility Level of Care Determination must be completed online within 14 calendar days of admission.	Clarification
Nursing Facility Coverages	4.1.D.1. Michigan Medicaid Nursing Facility Level of Care Determination	The 3rd paragraph was revised to read: Services will only be reimbursed when the beneficiary is determined medically/functionally eligible through the web-based version of the Michigan Medicaid Nursing Facility LOC Determination and the Michigan Medicaid Nursing Facility LOC determination was completed online within policy guidelines, or when the beneficiary is determined eligible through the Nursing Facility LOC Exception Process criteria.	Clarification

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CHAPTER	SECTION	CHANGE	COMMENT
		The 1st sentence of the 6th paragraph was revised to read: The **web-based** Michigan Medicaid Nursing Facility LOC Determination must be completed as follows: The bullet list for the 6th paragraph was revised to read: • Within 14 calendar days from the date of a new admission of a Medicaid-eligible applicant, regardless of primary payer source ... • Within 14 calendar days from the date of a non-emergency transfer of a Medicaid-eligible resident to another nursing facility, including ... • Within 14 calendar days from the date of disenrollment of a beneficiary from a Medicaid Health Plan ... • Within 14 calendar days from the date a Medicaid financial application was registered with the Department of Human Services by a current private-pay nursing facility resident requesting Medicaid as the payer for nursing facility services. • Within 14 calendar days from the date a dually eligible beneficiary chooses to return to their Medicaid nursing facility bed, refusing their Medicare SNF benefit following a qualified Medicare hospital stay. • Within 14 calendar days from the date of a Medicaid-eligible resident's transfer into a new nursing facility from a nursing facility that is undergoing an involuntary facility closure due to federal or state regulatory enforcement action. ... ... • Within 14 calendar days from the date of a Medicaid-eligible resident's emergency transfer into a new nursing facility from a nursing facility experiencing a hazardous condition ...	

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	4.1.D.1. Michigan Medicaid Nursing Facility Level of Care Determination	The last paragraph was revised to read: The admitting provider must complete the web-based Michigan Medicaid Nursing Facility LOC Determination only one time for each Medicaid or Medicaid-pending beneficiary. However, if the beneficiary has a significant change in condition as noted in the provider's nursing notes or Minimum Data Set and that significant change in condition may affect the beneficiary's current medical/functional eligibility status, the provider must conduct a subsequent web-based Michigan Medicaid ...	Clarification
Nursing Facility Coverages	4.1.D.6. Adverse Action Notice	The 2nd sentence of the 2nd paragraph was revised to read: The State Office of Administrative Hearings and Rules (SOAHR) Administrative Hearings Pamphlet explains the process ... The last sentence of the 2nd paragraph was revised to read: ... for contact information for SOAHR.) The 1st sentence of the 3rd paragraph was revised to read: ... notice to SOAHR, ... Under Immediate Review-Adverse Action Notices, the 2nd bullet was revised to read: ... obtain information from the Medicaid-eligible/Medicaid-pending beneficiary and/or their representative ...	Update and clarification
Nursing Facility Coverages	4.2.B. Provider Appeals	The 1st sentence was revised to read: ... based on a review of the Michigan Medicaid Nursing Facility Level of Care Determination is an adverse action for a nursing facility when MDCH proposes ...	Clarification

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	9.13 Hospice Services	The 1st sentence of the 4th paragraph was revised to read: For nursing facilities that elect to contract with hospice providers, a written contract is required between the hospice provider and …	Clarification [reference 418.12(c)]
Practitioner	Section 3 - Early and Periodic Screening, Diagnosis and Treatment	The 1st sentence of the 1st bullet of the 2nd paragraph was revised to read: … at specified intervals as defined in the current American Academy of Pediatrics (AAP) Periodicity Schedule.	Update
Private Duty Nursing	Section 1 – General Information	The 2nd sentence of the 3rd paragraph was revised to read: … that program authorizes the PDN services. The 1st bullet of the 3rd paragraph was deleted. The 5th paragraph was revised to read: … (i.e., MI Choice Waiver, Children's Waiver, Habilitation Supports Waiver).	References to CSHCS no longer applicable
Private Duty Nursing	1.1 Enrollment Requirements	Under Private Duty Nursing Agency, the 1st bullet was revised to read: Be accredited by the Joint Commission, the Community Health Accreditation Program (CHAP), or the Accreditation Commission for Health Care (ACHC) as a PDN agency; or be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) as a Home and Community-Based Rehabilitation Program.	Clarification

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CHAPTER	SECTION	CHANGE	COMMENT
Private Duty Nursing	1.3 Prior Authorization	The 1st sentence of the 1st paragraph was revised to read: PDN services must be authorized by the Program Review Division, the MI Choice Waiver, the Children's Waiver, or the Habilitation Supports Waiver before services can be provided. The 1st sentence of the 2nd paragraph was revised to read: ... when requesting PDN services for persons with Medicaid coverage. The following was added to the end of the 2nd paragraph: Private Duty Nursing is not a benefit under CSHCS. Individuals with CSHCS coverage may be eligible for PDN under Medicaid.	Clarification
School Based Services	3.3.A. Sanctions	The 1st sentence of the 2nd paragraph was revised to read: The following are examples of causes for sanctions.	Clarification
School Based Services Random Moment Time Study	3.3 Time Study Participants	Language was revised to read as follows: Time study participants are staff who are eligible to participate in the quarterly time study for one of the four staff pools: • AOP only • AOP & FFS/Direct Medical Services • Personal Care Services • Targeted Case Management Services	Clarification
School Based Services Random Moment Time Study	8.2. AOP Summer Quarter Formula and Random Moment Time Study	The following was added as a last paragraph: The sums of Part I and Part II are utilized to calculate the claim submitted to Medicaid for reimbursement.	Relocation of information

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
School Based Services Random Moment Time Study	8.2.B. Part II – Date the 9-Month Staff Return to Work Through September 30	The last paragraph was deleted.	Information relocated to Section 8.2 of the chapter
Acronym Appendix		Added: APA – American Psychological Association CHAMPS – Community Health Automated Medicaid Processing System CHAP - Community Health Accreditation Program OFIR - Office of Financial and Insurance Regulation DELEG – Department of Energy, Labor and Economic Growth MCBAP – Michigan Certification Board of Addiction Professionals MPHI – Michigan Public Health Institute PTAN – Provider Transaction Access Number SOAHR – State Office of Administrative Hearings and Rules UMICAD – Upper Midwest Indian Council on Addiction Disorders	Update
Forms Appendix	MSA-115	The Occupational Therapy – Physical Therapy – Speech Therapy Prior Approval Request/Authorization form (MSA-115) was revised with a version date of 07/01/09. Due to CHAMPS implementation, the form was revised to require the ICD-9-CM diagnosis code(s) [including the description(s)] for the condition that will be evaluated and/or treated.	Update

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 09-24	5/15/09	Hospital	6.5 Home and Community Based Waiver for the Elderly and Disabled (MI Choice Waiver Program)	The textbox after the 2nd paragraph was deleted.
			6.8 Nursing Facility	The textbox after the 5th bullet of the 3rd paragraph was deleted.
		Nursing Facility Coverages	4.1.D.1. Michigan Medicaid Nursing Facility Level of Care Determination	The textbox after the 1st paragraph was deleted.
MSA 09-23	5/1/09	Dental	1.1.B. Early and Periodic Screening, Diagnosis, and Treatment Dental Periodicity Schedule (new subsection)	New subsection added to read as follows: Federal regulations require state Medicaid programs to provide dental services at intervals that meet reasonable standards of dental practice. The dental periodicity schedule is as follows: • An examination is recommended by age one. • An examination by a dentist is required by age three. • It is then recommended that dental visits be repeated every six months. It is recommended that a dental appointment be made every six months and that it include a complete dental examination, appropriate x-rays, and preventive care such as a prophylaxis and fluoride treatment. If additional treatment is needed, follow-up dental visits are to be scheduled at the end of the examination so dental treatment can be completed. Additional information on pediatric oral health is available from the American Academy of Pediatrics (AAP) and the American Academy of Pediatric Dentistry (AAPD). (Refer to the Directory Appendix for website information.)

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Practitioner	3.6 Inspections	The following bullet points were added: • It is recommended that at age one a child is seen by a dentist for an examination. • A separate periodicity schedule for dentists is established.
			3.6.B. Periodicity Schedule for Dentists (new subsection)	A new subsection was added to read as follows: The dental periodicity schedule is as follows: • An examination is recommended by age one. • An examination by a dentist is required by age three. • It is then recommended that dental visits be repeated every six months.
		Directory Appendix/Provider Resources	American Academy of Pediatrics (AAP) Bright Futures Practice Guides (new category)	Language added: Web address: http://brightfutures.aap.org >> Materials >> Practice Guides on Oral Health, Mental Health, Nutrition and Physical Activity Information Available/Purpose: Practice guides on oral health, mental health, nutrition and physical activity
			American Academy of Pediatric Dentistry (AAPD) (new category)	Language added: Web address: http://www.aapd.org >> Policies and Guidelines >> Infant Oral Health Care (under Clinical Guidelines) Information Available/Purpose: Guidelines on periodicity of examination, preventive dental services, anticipatory guidance and oral treatment

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 09-22	5/1/09	Billing & Reimbursement for Dental Providers	3.1.B. Electronic Claims with Attachments	The following was added after the 2nd sentence of the 1st paragraph: Within Documentation EZ Link, the appropriate documentation category must be chosen along with completing specified information to successfully enter the document.
		Billing & Reimbursement for Institutional Providers	2.1.B. Electronic Claims with Attachments	The following was added after the 2nd sentence of the 1st paragraph: Within Documentation EZ Link, the appropriate documentation category must be chosen along with completing specified information to successfully enter the document. The following was added as the 2nd paragraph: Consent forms (Informed Consent to Sterilization [MSA-1959] and Acknowledgement of Receipt of Hysterectomy Information [MSA-2218]) must also be submitted through Documentation EZ Link. If submitted via facsimile, consent forms must be sent accompanied by the appropriate fax cover sheet (MSA-0003-EZ). (Refer to the Forms Appendix for copies of the forms.) MDCH will notify the submitter of the status of their consent review within seven business days. Once the consent forms are approved and entered, it is not necessary to submit additional copies when billing for sterilization or hysterectomy services. The 1st sentence of the 1st bullet was revised to read: Include the notation "Required documentation was sent via EZ Link" for claim attachments or "Consent form sent via EZ Link" for consent forms in the Claim Note area … The first sentence of the last paragraph was revised to read: … MSA-0001-EZ (Professional/Dental Claim Documentation Review Area Fax Cover), MSA-0002-EZ (Institutional Claim Documentation Review Area Fax Cover) or MSA-0003-EZ (Consent Forms Approval Area). …

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			2.2.B. Providing Attachments with Paper Claim Forms	The following was added after the 2nd paragraph: Unlike claim attachments, consent forms (Informed Consent to Sterilization [MSA-1959] and Acknowledgement of Receipt of Hysterectomy Information [MSA-2218]) are the only type of documentation that may be associated to paper claims through the Documentation EZ Link web portal. If submitted via facsimile, the consent forms must be accompanied with the fax cover sheet (MSA-0003-EZ). (Refer to the Forms Appendix for copies of the forms.) Once the consent forms are approved and entered into Documentation EZ Link, it is not necessary to submit additional copies when billing for sterilization or hysterectomy services. The notation "Consent form sent via EZ Link" must be included in the Remarks section of the paper claim. Refer to the MDCH website for Documentation EZ Link instructions. (Refer to the Directory Appendix for website information.)
		Billing & Reimbursement for Professionals	2.1.B. Electronic Claims with Attachments	The following was added after the 2nd sentence of the 1st paragraph: Within Documentation EZ Link, the appropriate documentation category must be chosen along with completing specified information to successfully enter the document. The following was added as the 2nd paragraph: Consent forms (Informed Consent to Sterilization [MSA-1959] and Acknowledgement of Receipt of Hysterectomy Information [MSA-2218]) must also be submitted through Documentation EZ Link. If submitted via facsimile, consent forms must be sent accompanied by the appropriate fax cover sheet (MSA-0003-EZ). (Refer to the Forms Appendix for copies of the forms.) MDCH will notify the submitter of the status of their consent review within seven business days. Once the consent forms are approved and entered, it is not necessary to submit additional copies when billing for sterilization or hysterectomy services.

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				The 1st sentence of the 1st bullet was revised to read: Include the notation "Required documentation was sent via EZ Link" for claim attachments or "Consent form sent via EZ Link" for consent forms in the Claim Note area ... The first sentence of the last paragraph was revised to read: ... MSA-0001-EZ (Professional/Dental Claim Documentation Review Area Fax Cover), MSA-0002-EZ (Institutional Claim Documentation Review Area Fax Cover) or MSA-0003-EZ (Consent Forms Approval Area). ...
			2.2.B. Providing Attachments with Paper Claims	The following was added after the 2nd paragraph: Unlike claim attachments, consent forms (Informed Consent to Sterilization [MSA-1959] and Acknowledgement of Receipt of Hysterectomy Information [MSA-2218]) are the only type of documentation that may be associated to paper claims through the Documentation EZ Link web portal. If submitted via facsimile, the consent forms must be accompanied with the fax cover sheet (MSA-0003-EZ). (Refer to the Forms Appendix for copies of the forms.) Once the consent forms are approved and entered into Documentation EZ Link, it is not necessary to submit additional copies when billing for sterilization or hysterectomy services. The notation "Consent form sent via EZ Link" must be included in the Remarks section of the paper claim. Refer to the MDCH website for Documentation EZ Link instructions. (Refer to the Directory Appendix for website information.)

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		Directory Appendix	Claim Submission Payment/Sterilization & Hysterectomy Forms Submission	Under Phone #/Fax #, the fax number was changed to: 866-229-6675 Under Information Available/Purpose, the first sentence was revised to read: Fax completed form to MDCH through the Documentation EZ Link web portal.
		Forms Appendix		MSA-0001-EZ (Professional/Dental Claim Documentation Review Area Fax Cover) was revised. MSA-0002-EZ (Institutional Claim Documentation Review Area Fax Cover) was revised. MSA-0003-EZ (Consent Forms Approval Area) is new.
MSA 09-21	5/1/09	School Based Services	2.1 Individuals with Disabilities Education Act Assessment and IEP/IFSP Development, Review and Revision	The following procedure codes and descriptions were added: 96101 – Psychological testing (Used by the psychologist when billing for the IDEA evaluation (HT) when the psychological testing is performed as part of the assessment/evaluation process.) 96116 – Neurobehavioral status exam (Used by the psychologist when billing for the IDEA evaluation (HT) when the neurobehavioral status exam is performed as part of the assessment/evaluation process.) 96118 – Neuropsychological testing (Used by the psychologist when billing for the IDEA evaluation (HT) when the neuropsychological testing is performed as part of the assessment/evaluation process.)

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			2.2.B. Orientation and Mobility Services	Under "Prescription", the paragraph is revised to read: Orientation and mobility services must be prescribed by a physician (MD, DO, or OD). If services are prescribed by a Doctor of Optometry (OD), the OD must have either low vision experience or certification. The prescription must be updated at least annually. A stamped signature is not acceptable.
			3.3.A. Sanctions	The following is added to the bullet list in the 2nd paragraph: • Failure to comply with the federal mandate to submit procedure-specific claims through the Medicaid Management Information System (MMIS).
			6.2.B. Specialized Transportation Reconciliation and Settlement	Text in this subsection is replaced in its entirety with the following: On an annual basis, the cost per trip is calculated by dividing the total Medicaid allowable costs (including indirect cost) by the total ISD-reported special education (specialized) one-way transportation trips. The cost per trip is multiplied by the quantity of Medicaid "allowable" one-way trips gleaned from the Medicaid Invoice Processing (IP) system to arrive at the Medicaid allowable cost. An "allowable" one-way trip is one that is provided to a Medicaid beneficiary and fulfills all of the following requirements: • Documentation of ridership is on file; • The need for the specialized transportation service is identified in the Individualized Education Program/Individualized Family Service Program; and • A Medicaid-covered service (other than transportation) is provided on the same date of service.

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				The cost settlement is accomplished by comparing the interim monthly payment totals to the annual Medicaid allowable specialized transportation cost. The cost settlement amount for the specialized transportation is combined with the cost settlement amounts for the fee-for-service (FFS) Direct Medical, Targeted Case Management, and Personal Care Services; any over/under adjustments are processed as one transaction.
		School Based Services Random Moment Time Study	3.3 Time Study Staff Pools (re-named)	The subsection title was re-named. The following was added as the 1st and 2nd paragraphs: To preserve the integrity of the RMTS process and to allow for timely process flow, ISD coordinators are given four weeks to review and return the staff pool lists and financials to the Contractor for those staff eligible to participate in each time study group. The staff pool lists must be returned as a complete file with all updates reflected. No partial staff pool list files will be accepted by the Contractor. If staff pool lists and/or financials are not returned to the Contractor on or before the published deadline, the staff pool lists and correlating financials will be removed from the time study and claim calculation for the affected quarter.
			3.3.A. AOP Only Staff Pool	The following positions were added to the staff pool list: • School Psychologists (certified by the Michigan Department of Education but without Michigan licensure) • Teachers of Speech and Language Impairments (without their American Speech-Language-Hearing Association Certificate of Clinical Competence) • School Social Workers (certified by the Michigan Department of Education but without Michigan licensure)

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			3.3.B. AOP & FFS/Direct Medical Services Staff Pool	The bullet reading "Psychologists" is revised to read: • Psychologists (not School Psychologists)
			Section 4 – Administrative Outreach and Direct Medical Activity Code Summary	Code 17(D) was added to the table in the 3rd paragraph.
			4.1.S. Code 17(D) – Non-Returned Moments (new subsection; following subsection re-numbered)	New subsection text added as follows: U – Fee for Service U – Administrative Outreach This code is used for moments that are not returned by the published deadline. As long as the compliance rate remains above 85%, these moments will not be used as a negative factor in the RMTS calculation.
			Section 7 – Summary of Time Study Steps	The 8th bullet was revised to read: • Produce quarterly reports summarizing the results of the random moment time studies and RMTS compliance reporting. (Both reports are forwarded to the MDCH Program Policy Division for posting on the MDCH website. Refer to the Directory Appendix for website information.)
			8.4 Financial Reporting Compliance Requirements (new subsection)	New subsection text was added as follows: The financial data reported (salaries, benefits, supplies, purchased services, and other expenditures) must be based on actual detailed expenditures from local educational agency payroll and financial systems. Payroll and financial system data must be applied using generally accepted governmental accounting standards and principles or applicable administrative rules. The expenditures accumulated must correlate to the claiming period.

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Medicaid Provider Manual
July 2009 Updates

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 09-20	5/1/09	General Information for Providers	Section 2 – Provider Enrollment	The following was added as the 6th 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 Community Health Automated Medicaid Processing System (CHAMPS) Provider Enrollment Subsystem.
		Medical Supplier	Section 1 – Program Overview	The following was added as the 2nd paragraph: Providers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) must be enrolled as a Medicare provider effective September 30, 2009. (Refer to the General Information for Providers chapter for additional information.)
MSA 09-18	4/1/09	Mental Health/Substance Abuse	14.3 Covered Waiver Services	A paragraph was added to the "Environmental Accessibility Adaptations" portion of the table to provide additional information on 'fencing'. The "Specialized Medical Equipment and Supplies" portion of the table was re-written in its entirety to address Local Authorization and Prior Authorization.
			14.4 Children's Waiver Program (CWP) Prior Authorization (new subsection; following subsections re-numbered)	This subsection was added to incorporate language taken from the "Children's Waiver Program Technical Assistance Manual".
		Directory Appendix	MH/SA Resources	Mailing address information was added for the Children's Waiver Program.

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MSA 09-17	4/1/09	Directory Appendix	Eligibility Verification	Addition of the following: Contact/Topic: Michigan Public Health Institute (MPHI) Mailing/E-Mail/Web Address: • E-Mail: MedicaidEligibility@mphi.org • Web Address: https://healthplanbenefits.mihealth.org Information Available/Purpose: Pharmacy beneficiary eligibility verification; also X12 270/271 Transaction Companion Guide available at http://mihealth.org >> Trading Partners >> Medicaid Healthplan 270/271 Companion Guide v3.0
MSA 09-15	3/1/09	Billing & Reimbursement for Professionals	7.6.I. Miscellaneous Supplies	Special Instructions was revised to read: Use with HCPCS codes listed on the MDCH Medical Supplier Database that list the U4 modifier for pediatric pricing only. (Refer to the Directory Appendix for website information.)

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Supplemental Bulletin List

The following is a list of Medicaid policy bulletins that supplement the *January 2009* electronic Medicaid Provider Manual. The list will be updated as additional policy bulletins are issued. The updated list will be posted on the MDCH website along with the Medicaid Provider Manual.

Providers affected by a bulletin should retain it until it is incorporated into the quarterly update of the online version of the manual unless instructed otherwise. Providers utilizing the CD version of the manual should retain bulletins until the next CD version is issued.

DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	DATE IN ONLINE MANUAL/COMMENTS
5/09	MSA 09-31	Sanctioned Providers Update	All Providers	Information incorporated into the Sanctioned Providers List maintained on the MDCH website.
6/1/09	MSA 09-30	Community Health Automated Medicaid Processing System (CHAMPS) Implementation Update	All Providers	
6/1/09	MSA 09-29	Updates to the Medicaid Provider Manual	All Providers	
6/1/09	MSA 09-28	Eliminating Certain Medicaid Benefits for Medicaid Beneficiaries age 21 and older, and Medicaid Provider Fee Reductions	All Providers	
6/1/09	MSA 09-27	New Healthcare Common Procedure Coding System (HCPCS) Procedure Code Coverage and an Adjustment to the Fee Screen for Essure Hysteroscopic Sterilization provided in the Office Setting	Practitioners, Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers, Hospitals, Local Health Departments, Medicaid Health Plans, and Mental Health and Substance Abuse	

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6/10/09	MSA 09-26	Medicaid Processing and Payment of Nursing Facility Claims for Co-Insurance Days for Beneficiaries with Medicare Advantage Plan Coverage	Nursing Facilities, County Medical Care Facilities, Hospital Long-Term Care Units, Hospital Swing Beds, Ventilator Dependent Units	
5/15/09	MSA 09-24	Executive Order 2009-22 Eliminating Funding for the Single Point of Entry (Long-Term Care Connection) Demonstration Project	Hospice, Hospitals, Medicaid Health Plans, Mental Health/Substance Abuse (Prepaid Inpatient Health Plans and Coordinating Agencies), Nursing Facilities, Program of All Inclusive Care for the Elderly (PACE), MI Choice Waiver, Local Health Departments, Area Agencies on Aging	7/1/09 Information incorporated into the Hospital and the Nursing Facility Coverages Chapters.
5/1/09	MSA 09-23	Dental Periodicity Schedule	Dentists and Dental Clinics	7/1/09 Information incorporated into the Dental and Practitioner Chapters and the Directory Appendix.
5/1/09	MSA 09-22	Establishment of Consent Form Submission and New Documentation Categories through Claim Documentation EZ Link	Practitioners, Mental Health and Substance Abuse, Community Mental Health Services Program, Chiropractors, Dentists, Ambulance, Independent Labs, Medical Suppliers, Orthotists/Prosthetists, Vision, Hearing and Speech Centers, Hearing Aid Dealers, Family Planning Clinics, Maternal Infant Health Program, Private Duty Nursing, School Based Services, Hospitals, Home Health, Hospice, Nursing Facilities, Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers, and Local Health Departments	7/1/09 Information incorporated into the Billing & Reimbursement for Dental Providers, the Billing & Reimbursement for Institutional Providers, and the Billing & Reimbursement for Professionals Chapters, the Directory Appendix and the Forms Appendix.

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5/1/09	MSA 09-21	Revisions to the School Based Services and School Based Services Random Moment Time Study Medicaid Provider Manual Chapters	School Based Services providers	7/1/09 Information incorporated into the School Based Services and the School Based Services Random Moment Time Study Chapters.
5/1/09	MSA 09-20	Medicare Enrollment for Providers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies Reminder	Medical Suppliers, Cochlear Implant Manufacturers	7/1/09 Information incorporated into the General Information for Providers and the Medical Supplier Chapters.
4/21/09	MSA 09-19	$5 Million Disproportionate Share Hospital (DSH) Pool	Hospitals	
4/1/09	MSA 09-18	Prior Authorization of Children's Waiver Services – Environmental Accessibility Adaptations and Specialized Medical Equipment and Supplies	Prepaid Inpatient Health Plans/Community Mental Health Services Programs	7/1/09 Information incorporated into the Mental Health/Substance Abuse Chapter and the Directory Appendix.
4/1/09	MSA 09-17	Pharmacy Beneficiary Eligibility Verification	Pharmacies	7/1/09 Information incorporated into the Directory Appendix.
2/09	MSA 09-16	Sanctioned Providers Update	All Providers	Information incorporated into the Sanctioned Providers List maintained on the MDCH website.

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3/1/09	MSA 09-15	Healthcare Common Procedure Coding System (HCPCS) U4 Modifier for Certain Durable Medical Equipment for Beneficiaries Under the Age of 21; Coverage of New HCPCS Procedure Code – K0739	Medical Suppliers	7/1/09 Information incorporated into the Billing & Reimbursement for Professionals Chapter. Information added to databases at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Medical Suppliers/Orthotists/Prosthetists, DME Dealers
3/1/09	MSA 09-13	Updates to Medicaid Provider Manual	All Providers	4/1/09 Information incorporated throughout the Manual, as appropriate. MDCH website updated, as appropriate.
3/1/09	MSA 09-12	Change in Standard Dispensing Fee Reimbursement	Pharmacy	MDCH Pharmacy Drug Dispensing Fees updated to the website. www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Pharmacy
3/1/09	MSA 09-11	Correction to Bulletin MSA 09-03	Hearing Aid Dealers, Audiologists/Hearing Centers, Outpatient Hospitals, Practitioners, Medicaid Health Plans	4/1/09 Information incorporated into the Hearing Aid Dealers Chapter.
3/1/09	MSA 09-10	Adult Benefits Waiver Enrollment	All Providers	Bulletin transmit open enrollment 3/1/09 - 5/31/09
3/1/09	MSA 09-09	Change in Billing and Reimbursement Policy for Occupational Therapy, Physical Therapy, and Speech-Language Therapy	Practitioners (MDs, DOs, Nurse Practitioners, Physical Therapists), Outpatient Hospitals, Outpatient Rehabilitative Facilities, Mental Health and Substance Abuse	4/1/09 Information incorporated into the Billing & Reimbursement for Institutional Providers Chapter.
2/11/09	MSA 09-08	Fiscal Year 2009 Outpatient Uncompensated Care Disproportionate Share Hospital (DSH) Pool	Hospitals	4/1/09 Information incorporated into the Hospital Chapter (Hospital Reimbursement Appendix).

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2/1/09	MSA 09-07	Clarifications, Revisions, and Provider Reinstatement	School Based Services	4/1/09 Information incorporated into the School Based Services Chapter.
2/1/09	MSA 09-06	Medicaid Access to Care Initiative (MACI) Payment Schedule	Hospitals, Medicaid Health Plans	Bulletin issued to retract bulletin MSA 08-16; no changes to manual required.
1/1/09	MSA 09-05	MIHP and MHP Care Coordination Agreement	Maternal Infant Health Program, Medicaid Health Plans	4/1/09 Information incorporated into the Maternal Infant Health Program Chapter, the Medicaid Health Plans Chapter, the Acronym Appendix, and the Forms Appendix.
1/1/09	MSA 09-04	Eligibility Verification System (EVS) – Automated Voice Response System (AVRS) Fee	All Providers	4/1/09 Information incorporated into the Beneficiary Eligibility Chapter and the Directory Appendix.
1/1/09	MSA 09-03	Volume Purchase Contract for Hearing Aids	Hearing Aid Dealers, Audiologists/Hearing Centers, Outpatient Hospitals, Practitioners, Medicaid Health Plans	4/1/09 Information incorporated into the Hearing Aid Dealers Chapter and the Hearing Services Chapter. Information added to the MDCH website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Hearing Aid Services
1/09	MSA 09-02	Sanctioned Providers Update	All Providers	Information incorporated into the Sanctioned Providers List maintained on the MDCH website.
12/1/08	MSA 08-57	Diagnosis Related Group (DRG) Grouper Update, DRG Rate Update, and Per Diem Rate Update	Hospitals, Medicaid Health Plans	4/1/09 Information incorporated into the Hospital Chapter (Hospital Reimbursement Appendix).