MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

Bulletin Number: MSA 19-07

Distribution: All Providers

Issued: March 1, 2019

Subject: Updates to the Medicaid Provider Manual; Healthy Michigan Plan Changes; Retroactive Coverage of Existing Codes; Clarification to Bulletin MSA 19-01

Effective: As Indicated

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

Updates to the Medicaid Provider Manual

The Michigan Department of Health and Human Services (MDHHS) has completed the April 2019 update of the online version of the Medicaid Provider Manual. The manual will be available April 1, 2019 at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Medicaid Policy Manual.

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

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

Healthy Michigan Plan Changes

The Healthy Michigan Plan (HMP) will change beginning in January 2020 as required by Michigan Public Act 208 of 2018.

- HMP beneficiaries must report at least 80 hours per month of work or other community activities to keep their health care coverage.
- Some HMP beneficiaries must also make new HMP premium payments on time and do an HMP health risk assessment (HRA) or complete an MDHHS-approved healthy behavior yearly to keep their health care coverage.

MDHHS began notifying HMP beneficiaries about these upcoming changes in February 2019 via beneficiary letter B 19-01. In addition to providing information about the changes, letter B 19-01 encourages beneficiaries to talk to their doctor about different healthy behavior choices and completing an HRA. Further beneficiary information and updates regarding the January 2020 changes, as well as information about the completion of HRAs, can be found at www.healthymichiganplan.org.

MDHHS will issue Medicaid policies that provide additional provider guidance about the January 2020 changes later this year. Providers are encouraged to continue to assist their HMP patients with choosing healthy behaviors and completing an HRA. The latest version of the Health Risk Assessment (form DCH-1315) can be found on the MDHHS website at www.michigan.gov/healthymichiganplan >> Health Risk Assessment. Providers can also complete the HRA online by adding the Provider HRA Profile to their Community Health Automated Medicaid Processing System (CHAMPS) Profile. With this new profile, providers can view shared beneficiary HRA data, attest online to a beneficiary's HRA, or see historical HRA data in CHAMPS.

Retroactive Coverage of Existing Codes

Effective for dates of service on and after January 1, 2019, MDHHS will cover the following Healthcare Common Procedure Coding System (HCPCS) codes in the following provider categories:

1. Physician, Nurse Practitioner, Podiatry, Oral Maxillofacial Surgeon, Federally Qualified Health Center, Rural Health Clinic, Tribal Health Center

   Q4186 Q4187

2. Federally Qualified Health Center, Rural Health Clinic, Tribal Health Center

   J2062

3. Medicaid Health Plan Carve-Out

   Q2041*

The symbol * will appear with those codes requiring Prior Authorization (PA).

Clarification to Bulletin MSA 19-01

HCPCS Q2042 requires PA.

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, 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

Kathy Stiffler, Acting Director
Medical Services Administration

Michigan Department of Health and Human Services

Medicaid Provider Manual
April 2019 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Medicaid Provider Manual Overview	1.1 Organization	Under "School Based Services – Random Moment Time Study", text for "Affected Providers" was revised to read: Enrolled Intermediate School Districts, ~~and~~ Detroit Public Schools Community District, and Michigan School for the Deaf	Update.
Billing & Reimbursement for Dental Providers	7.2 Billing Requirements	Text was revised to read: ~~MDHHS policy directs~~ Providers ~~to bill~~ must use the date of delivery when billing for dentures and laboratory-processed crowns. However, when a beneficiary has a change in eligibility status and services have been started for root canal therapy, dentures, and laboratory-processed crowns, the provider has 30 days from the ~~loss or~~ change in/loss of eligibility ~~status~~ to complete the services. The date of service on the claim form should be the date of the initial impression for dentures and laboratory-processed crowns, or the first treatment appointment for root canal therapy.	Improve clarity. This is the only reference to billing the date of delivery in policy. Root canal therapy is mentioned in the paragraph, but billing instructions are not included in the last sentence.
Billing & Reimbursement for Institutional Providers	7.23 Radiation ~~Treatments~~ Therapy Services	Change to section title only.	Update language to current terminology.

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	8.11 Ancillary Physical and Occupational Therapy, Speech Pathology	In the 2nd paragraph, the 2nd and 3rd bullet points were revised to read: • Each claim line requires a: ➢ Date of service ➢ Revenue code and a HCPCS code ➢ PA number on the claim ➢ Therapy discipline ~~and nature~~ modifier~~.~~ ➢ Therapy nature modifier (habilitative claims only) • PA number must be on the claim. The 3rd paragraph was revised to read: Therapy services must be reported using the appropriate therapy modifier to distinguish the discipline under which the service is delivered. In addition, when services are habilitative, they must be reported with the appropriate modifier that represents ~~either~~ the ~~habilitative or rehabilitative~~ nature of the therapy. Maintenance therapy visits should also include the MDHHS designated maintenance modifier. Refer to the Therapy Services chapter for additional information related to therapies. ……..	Clarification.
Billing & Reimbursement for Professionals	6.14 Laboratory Services	Text in the chart was revised to read: **Panels** — CPT definitions for panels apply. All services in the panel must be provided and each test must be appropriate to the diagnosis or symptom for which the test was ordered. If a group of tests overlaps two or more panels, report the panel that incorporates the greater number of tests to fulfill the code definition and report the remaining tests as individual tests.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Professionals	7.16 Therapy Services	Text was revised to read: Therapy claims must be submitted using the appropriate procedure code and therapy modifier to distinguish the discipline under which the service is delivered. In addition, habilitative services must be reported with the appropriate modifier that represents the nature of therapy being performed ~~(habilitative vs. rehabilitative)~~. Maintenance therapy visit claims should also include the MDHHS designated maintenance modifier. Therapy services submitted without these modifiers may be denied. …..	Clarification.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.5 Child Therapy	Text was revised to read: Treatment activity designed to prevent deterioration, reduce maladaptive behaviors, maximize skills in behavioral self-control, or restore or maintain normalized psychological functioning, reality orientation and emotional adjustment, thus enabling the child to function more appropriately in interpersonal and social relationships. A child mental health professional may provide child therapy on an individual or group basis with a family-driven, youth-guided approach**.**	Embedding the family-driven youth-guided policy language for services provided to children, youth and families.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.9 Family Therapy	Text was revised to read: Family Therapy is therapy for a beneficiary and family member(s), or other person(s) significant to the beneficiary, for the purpose of improving the beneficiary/family function. For children and youth, a family-driven, youth-guided planning process should be utilized. Family therapy does not include individual psychotherapy or family planning (e.g., birth control) counseling. Family therapy is provided by a mental health professional or limited licensed master's social worker supervised by a fully licensed master's social worker.	Embedding the family-driven youth-guided policy language for services provided to children, youth and families.

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.28 Treatment Planning	The 1st paragraph was revised to read: Activities associated with the development and periodic review of the plan of service, including all aspects of the person-centered planning process, such as pre-meeting activities, and external facilitation of person-centered planning. This includes writing goals, objectives, and outcomes; designing strategies to achieve outcomes (identifying amount, scope, and duration) and ways to measure achievement relative to the outcome methodologies; attending person-centered planning meetings per invitation; and documentation. Monitoring of the individual plan of service, including specific services~~;~~ when not performed by the case manager or supports coordinator, is included in this coverage. For children and youth, a family-driven, youth-guided planning process should be utilized.	Embedding the family-driven youth-guided policy language for services provided to children, youth and families.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	Section 13 - Targeted Case Management	The 1st paragraph was revised to read: Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process. For children and youth, a family driven, youth guided planning process should be utilized. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.	Embedding the family-driven youth-guided policy language for services provided to children, youth and families.
Dental	6.6.A. General Instructions	The 5th paragraph was revised to read: Reimbursement for a complete or partial denture includes all necessary adjustments, relines, repairs, and duplications within six months of insertion. This also includes such services necessary for an immediate ~~upper~~ complete denture when authorized. If any necessary adjustments or repairs are identified within the six-month time period but are not provided until after the six-month time period, no additional reimbursement is allowed for these services.	Replace the word "upper" with "complete" in the second sentence. Adjustments, relines, repairs, and duplications apply to both upper and lower immediate complete dentures.

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CHAPTER	SECTION	CHANGE	COMMENT
Dental	9.5 Benefit Administration	In the 2nd paragraph, the 1st sentence was revised to read: DHPs ~~will~~ administer covered dental services according to Medicaid policy, contract requirements, and the DHP's standard policies, procedures, prior authorization, and claim submission process.	
Hospital	3.26 Radiology	The 1st paragraph was revised to read: MDHHS covers Medicaid enrolled hospitals for the following medically-necessary radiology services, including diagnostic imaging and radiation therapy ~~and therapeutic radiology, nuclear medicine, CT scan procedures, magnetic resonance imaging services, ultrasound,~~ and other imaging ~~procedures~~ services: • Necessitated by injury or disease, including benign or malignant conditions; • Needed to diagnose a specific condition, illness, or injury; and • Ordered by physicians (MD or DO), podiatrists, dentists, ~~nurse practitioners, or nurse midwives~~ or advance practice registered nurses. The 4th paragraph was revised to read: Reimbursement for outpatient services ~~is billed using the appropriate HCPCS code~~ follows Medicare Outpatient Hospital Prospective Payment System (OPPS) rules and includes the use of the facility, equipment, supplies, and attendant personnel required to provide the service. Prior authorization may be required. Refer to the CHAMPS Code Rate and Reference tool for guidance. The last paragraph was revised to read: MDHHS reimburses for diagnostic imaging and ~~therapeutic x-rays and nuclear medical~~ radiation therapy services, including:	Updating with current terminology. PTCA section removed as procedure is covered when medically necessary.

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Computerized Axial Tomography (CT) Scanning	CT scanning is not covered for routine screening, nonspecific diagnoses, or in situations where less costly diagnostic methods are appropriate. CT scanning procedures must be provided on equipment that has an approved Certificate of Need (CON) on file with MDHHS.
Radiation Therapy	Treatment must be provided on equipment and in locations that meet Federal and State regulatory requirements.
~~**Percutaneous Transluminal Coronary Angioplasty (PTCA)**~~	~~PTCA is covered for those beneficiaries who meet the following criteria: failed maximum medical treatment, intractable angina, and single vessel disease with left ventricular function.~~
Ultrasonography	Ultrasound procedures are reimbursed when there is clinical evidence in the beneficiary's record to substantiate the medical need for such services. Ultrasound procedures are generally not covered when used as screening procedures or on a routine basis. When billing two ultrasound codes, the diagnosis must reflect the medical need for two procedures. Claims for diagnostic ultrasound procedures that are performed more than once must be documented for medical necessity. Documentation with the claim should clearly state the reason for the repeat procedure. Claims are rejected if the documentation does not support the need for the repeat diagnostic procedure.

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Hospital Reimbursement Appendix	2.3.A.6. Special Circumstances	Text for '**Low Day Outliers'** was revised to read: For services where the length of stay is less than the published low day threshold, reimbursement is charges multiplied by the individual hospital's operating cost-to-charge ratio, not to exceed the full DRG payment. Length of stay is calculated using the From and To dates of service. The specific low day outlier threshold for each DRG is listed on the MDHHS website. (Refer to the Directory Appendix for website information.)	Adding language describing length of stay.
Laboratory	5.3 Test Reports	Text for 'Panel Tests' was revised to read: **Panel Tests**: Only AMA-approved organ- or disease-oriented panels may be billed. All tests within the panel must be medically necessary. ~~Unless the~~ When a complete panel is ordered and performed, a panel code should be billed. When some, but not all the tests identified in a panel are performed, bill as individual tests. If a group of tests overlaps two or more panels, report the panel that incorporates the greater number of tests to fulfil the code definition and report the remaining tests as individual tests.	Clarification.
Medical Supplier	1.11 Noncovered Items	The following bullet point was deleted: • ~~Nutritional formula representing only a liquid form of food~~	HCPCS code B4149 is now covered when home blenderized food does not meet the beneficiary's medical need.
MI Health Link	7.3.A. Integrated Care Team Members	The 2nd paragraph was revised to read: ICT membership will include the individual and the individual's chosen allies, ICO Care Coordinator, primary care physician, and LTSS Supports Coordinator or PIHP Supports Coordinator (as applicable). Additional membership on the ICT may vary at each meeting depending on the changing needs of the individual. PCPs may designate a licensed medical professional on their staff who has personal knowledge of the enrollee's condition(s) and health care needs, to attend in place of the PCP. The ICT may also include the following persons as needed and available: ……	To align with 3 Way contract changes effective 1/1/19.

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CHAPTER	SECTION	CHANGE	COMMENT
MI Health Link	7.3.B. Integrated Care Team Responsibilities	The 2nd and 3rd paragraphs were revised to read: The operations of ICTs will vary depending on the needs and preferences of the individual. An individual with extensive service needs may warrant periodic meetings with all ICT members. An individual with less intense needs may warrant fewer meetings with selected members of the ICT. Communication among the ICT members will be maintained by the ICO Care Coordinator and other direct communication with ICT members. The ICO Care Coordinator is responsible for facilitating communication among the ICT members. The ICT will adhere to an individual's determination about the appropriate involvement of his/her medical providers and caregivers at each meeting, according to HIPAA ~~and other laws,~~ and, for individuals in SUD treatment, 42 CFR Part 2.	To align with 3 Way contract changes effective 1/1/19.
MI Health Link	7.4 ICO Care Coordinator	In the 3rd paragraph, the following bullet point was added: • Limited license Bachelor's prepared social worker;	To align with 3 Way contract changes effective 1/1/19.
MI Health Link	7.4 ICO Care Coordinator	Under "ICO Care Coordinator Responsibilities', 2nd paragraph, last bullet point, the last sub-bullet point was revised to read: ➢ If the individual is receiving services that require meeting the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) standards, ensure through required Level I and/or Level II assessments that the individual continues to meet the criteria or transitions to services that do not require LOCD standards. The ICO Care Coordinator ~~is required to conduct the LOCD assessment~~ will ensure appropriate assessments are conducted for individuals with identified long term care needs, and MDHHS will make final eligibility determinations, unless otherwise directed by the State and CMS.	To align with 3 Way contract changes effective 1/1/19.
MI Health Link	7.5.A. LTSS Supports Coordinator	In the 1st paragraph, the following bullet point was added: • Limited license Bachelor's prepared social worker;	To align with 3 Way contract changes effective 1/1/19.

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MI Health Link	7.6.C. Level I Assessments	In the 1st paragraph, 2nd bullet point, the 1st sub-bullet point was revised to read: • The ICO shall attempt to contact the individual at least five times within the first ~~45~~ 60 days of enrollment. Attempts must be on different days of the week and at different times during the day, including times outside of standard work hours.	To align with 3 Way contract changes effective 1/1/19.
MI Health Link	7.6.C. Level I Assessments	Under 'Timing of Level I Assessments', text was revised to read: Level I Assessments will be completed within ~~45~~ 60 calendar days of enrollment. ICOs approved by CMS and MDHHS to conduct early Level I Assessment may start the assessment no earlier than 20 days before the enrollment effective date. Early assessment does not impact the time frames for completing other assessments. Other Assessments cannot be completed before the enrollment effective date. Individuals identified with immediate needs or as having high risk should have Level I Assessments completed earlier than ~~45~~ 60 calendar days from enrollment, as appropriate.	To align with 3 Way contract changes effective 1/1/19.
MI Health Link	7.6.D. Triggers From the Level I Assessment	Under 'Michigan Medicaid Nursing Facility Level of Care Determination (LOCD)', text was revised to read: The Michigan Medicaid Nursing Facility Level of Care Determination tool must be conducted for all individuals according to the Michigan Medicaid Nursing Facility Level of Care Determination requirements in the Medicaid policy (refer to the Nursing Facility Level of Care Determination Chapter of the Medicaid Provider Manual) and additional guidance provided by MDHHS. For the MI Health Link program only, the Nursing Facility Level of Care ~~Exception~~ Frailty Review criteria will be applied at the time the LOCD is conducted for the individual if the individual does not meet LOCD criteria under Doors one through seven.	Current LOCD policy changed exception criteria to frailty criteria.

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CHAPTER	SECTION	CHANGE	COMMENT
MI Health Link	7.6.F.1. Level I Reassessments	In the 1st paragraph, the 4th bullet point was deleted. ~~• Upon any of the following trigger events:~~ ~~➢ A hospital admission;~~ ~~➢ Transition between care settings;~~ ~~➢ Change in functional status;~~ ~~➢ Loss or change in circumstances of a caregiver so that the individual supports or services are affected;~~ ~~➢ Change in diagnosis; and~~ ➢ ~~As requested by a member of the ICT who observes a change that requires further investigation.~~	Deleted to align with 3-way contract revisions effective 1/1/19.
Nursing Facility Coverages	10.17 Laboratory Services	The second paragraph was revised to read: Laboratory tests that are listed as waived tests under CLIA are included in the facility's per diem rate (e.g., Testrip). A list of these tests and the instrumentation needed to perform them can be found on the ~~FDA~~ CMS website. (Refer to Clinical Laboratory Improvement Amendments under Provider Resources in the Directory Appendix for website information.)	To correct where to find the information in the Directory Appendix.
Nursing Facility Cost Reporting & Reimbursement Appendix	4.4 Cost Report Acceptance	The following text was added after the 1st paragraph: Prior to acceptance of the submitted cost report, RARSS may adjust inaccurate data reported on the cost report if correct data is available to RARSS and the adjustment would not impact the computation of the per diem reimbursement rate. For example, RARSS may adjust the Title XIX Routine Nursing Days reported on the cost report if there is large discrepancy between the reported days and actual billed Medicaid days from the reporting period.	Clarification of a long-standing component of the cost report acceptance process.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.7.D. Nursing Facility Quality Measure Initiative (QMI)	The last paragraph was revised to read: Refer to the Nursing Facility Resources section of the Directory Appendix for NHC website information, and for additional QMI resources and contact information.	Technical change to reference NHC website information in the Directory Appendix.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	10.7.D.1. Eligibility for QMI Payment	In the 1st paragraph, the 5th bullet point was revised to read: • The provider must not be designated as a Special Focus Facility (SFF) by CMS. (Refer to the Directory Appendix for SFF list website information.)	Technical change to reference SFF website information in the Directory Appendix.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.14.A. Eligibility Criteria	Under the 4th bullet point, the 5th sub-bullet point was revised to read: Rate relief is needed to prevent closure of a Medicaid-enrolled facility due to a regulatory action by the SSA, where the facility's closure would result in severe hardship for its residents and their families due to the distance to other nursing facilities, and no new provider would operate the facility at its current reimbursement rate. A facility would meet this hardship ~~criteria~~ criterion only if a new owner has agreed to take over its operation and it is either the only nursing facility in the county or the facility has at least 65 percent of the Medicaid nursing facility (Class I, III and V) certified beds in that county.	Technical change to keep singular and plural usage of the words "criteria" and "criterion" consistent.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	10.14.B. Rate Relief Petition Process	The following text was added after the 1st paragraph: It is the provider's responsibility to submit supporting documentation with the rate relief petition. A petition from the provider must include: ▪ Identification of the criterion under which rate relief is requested. ▪ Supporting documentation for the criterion. ▪ Detail of the circumstances causing the need for the rate relief request. ▪ A requested effective date (the actual effective date of the rate relief is based on the date that the petition is received by Medicaid). The earliest effective date would be the first day of the next month (i.e., a petition received on August 31 may be effective as soon as September 1). ▪ The services period that is the basis for which rate relief is requested. ▪ Detail of the expenses that are not in the base period for the current or subsequent fiscal year Medicaid rate and how these expenditures relate to the provision of resident care. **NOTE:** Increases in cost per day due to changes in resident occupancy or changes in the application of rate limitations do not constitute additional expenses. ▪ Plans on how these changes will ensure the required level of resident care.	Technical change to eliminate redundancy. The supporting documentation requirements currently appear in three different subsections, despite the supporting documentation requirements being the same for any rate relief petition, so this technical change would consolidate the supporting documentation requirements into one subsection.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.14.G.2. Rate Relief Documentation	Subsection was eliminated.	Technical change to eliminate redundancy. (See the above explanation.)
Nursing Facility Cost Reporting & Reimbursement Appendix	10.14.H.2. Rate Relief Documentation	Subsection was eliminated.	Technical change to eliminate redundancy. (See the above explanation.)

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	10.14.I.2. Rate Relief Documentation	Subsection was eliminated.	Technical change to eliminate redundancy. (See the above explanation.)
Pharmacy	13.8 Allowable Charges to the Beneficiary	Text was revised to read: A pharmacy may only charge a beneficiary the MDHHS established copayment for covered services. A beneficiary may not be charged for any cost of the prescription above the MDHHS reimbursement level. A pharmacy may only charge a beneficiary its usual and customary charge if the service is a noncovered service~~, or if MDHHS has denied the service based on lack of medical necessity~~ and the beneficiary has indicated a desire to purchase the service privately. Furthermore, a beneficiary may not be charged for a prescription in lieu of the pharmacy accepting the reimbursement paid by MDHHS, or in lieu of obtaining PA when indicated.	Clarifies the policy by removing the redundancy in the sentence.
Practitioner	4.7 Pediatric Multichannel Recordings	The 3rd paragraph was revised to read: Two multichannel recordings may be covered in one year for the same beneficiary. If more than two are medically justified for CSHCS beneficiaries, the physician must obtain PA. ~~from CSHCS. A copy of the PA approval letter must be attached to the claim form to be reimbursed. Physicians are responsible for providing a copy of the PA approval letter to the hospital.~~ The PA number must be included on the claim for payment. (Refer to the General Information for Providers Chapter for additional prior authorization information.)	Update process.

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CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	9.1 Radiology Services	The subsection title was revised to read: Radiology and Diagnostic Imaging Services Text was revised to read: Medically necessary radiological services are covered when ordered by a ~~physician~~ qualified practitioner to diagnose or treat a specific condition based on the beneficiary's signs, symptoms, and past history as documented in the medical record. Radiology services include diagnostic imaging services and therapeutic radiology services such as proton beam therapy, nuclear medicine, computed tomography (CT) ~~scan~~ procedures, magnetic resonance imaging (MRI) services, diagnostic ultrasound, and other ~~imaging procedures~~ diagnostic and therapeutic services. Practitioners are required to perform or interpret radiologic services within their professional expertise and education within the confines of federal and State law. It is the expectation that practitioners conform with professional practice parameters and technical standards to ensure the most efficacious use of radiology and the delivery of safe, quality care. Medical need for all services must be documented in the medical record and ~~are~~ is subject to post-payment review.	Updating language to current terminology.
Practitioner	9.1.B. Multiple Services on Same Day	In the table, under 'CT, MR, PET Scans', the 2nd paragraph was revised to read: ~~Flat films~~ Radiographic images, including ~~and~~ CT or MRI studies of the same anatomical area, are covered on the same day when medically indicated. The provider is responsible for using the most appropriate diagnostic test(s) according to current standards of practice. A CT and a myelogram may be covered on the same day; however, an MRI and a myelogram are not covered separately if done on the same day. Coverage of a CT of the spine is limited to one level per day, and coverage of an MRI is limited to two levels of the spine on the same day. Providers should be directing the study at the area of the suspected problem.	

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CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	9.3 Nuclear Medicine	The 1st paragraph was revised to read: Medicaid covers medically necessary nuclear medicine procedures. Providers are responsible for complying with ~~Nuclear Regulatory Commission (NRC)~~ Federal and State law requirements. Only professional services rendered to hospital patients are covered for the practitioner.	
School Based Services	Section 1 – General Information	The 1st paragraph was revised to read: This chapter applies to enrolled Intermediate School Districts, Detroit Public Schools Community District, and Michigan School for the Deaf. The 6th paragraph was revised to read: Coverage is based on medically necessary, Medicaid-covered services already being provided in the school setting and enables these services provided to Medicaid-eligible beneficiaries to be billed to Medicaid. This ensures federal participation in the funding of these Medicaid covered services. Enrollment as a Michigan Medicaid provider for services delivered in the school setting is limited to the Intermediate School Districts (ISDs), Detroit Public Schools Community District, and Michigan School for the Deaf. For the purpose of this document, the ISDs, Detroit Public Schools Community District, and Michigan School for the Deaf will be referred to as "ISDs" for simplicity. In the last paragraph, the definition for "Enrolled Medicaid Provider" was revised to read: The 56 Michigan Intermediate School Districts, Detroit Public Schools Community District, and Michigan School for the Deaf that have enrolled and revalidated with the MDHHS CHAMPS Provider Enrollment subsystem. In the last paragraph, the definition for "School-Based Services" was revised to read: A program which provides medically necessary Medicaid covered services in the school setting. All Michigan ISDs, Detroit Public Schools Community District, and Michigan School for the Deaf participate in the Direct Medical Services Program.	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
School Based Services	4.1 Enrollment	The 1st sentence was revised to read: The 56 Michigan Intermediate School Districts (ISDs), Detroit Public Schools Community District, and Michigan School for the Deaf are the only providers eligible to bill Medicaid for School Based Services.	Update.
School Based Services Random Moment Time Study	1.3 Staff Pools and Confidence Levels	In the 1st paragraph, the last sentence was revised to read: The Contractor conducts the statewide time studies, produces the implementation plans and reports, and develops and submits the claims on behalf of the 56 ISDs, Detroit Public Schools Community District and Michigan School for the Deaf (hereafter referred to as the ISDs).	Update.
Therapy Services	1.5 Modifiers	The 1st paragraph was revised to read: Therapy claims must be submitted using the appropriate procedure code and therapy modifier to distinguish the discipline under which the service is delivered. To differentiate between habilitative and rehabilitative therapy, when services are habilitative ~~should also be~~ reported with the appropriate modifier that represents the nature of the therapy being performed. Only Medicaid beneficiaries under 21 years of age and Healthy Michigan Plan beneficiaries may be eligible for medically necessary habilitative therapy services. In addition to these modifiers, maintenance therapy services should be billed with the MDHHS identified modifier to categorize the service as maintenance related.	Clarification.
Acronym Appendix		Deletion of: ~~DPS – Detroit Public Schools~~ Addition of: DPSCD - Detroit Public Schools Community District	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Nursing Facility Resources	Under 'MDHHS, LTC Services', addition of: Email: MDHHS-BEDCERTS@MICHIGAN.GOV	Will be using a mailbox for bed certification changes instead of an employee email.
Directory Appendix	Nursing Facility Resources	Under 'Nursing Facility Rate Setting', the mailing address was revised to read: Mailing address: MDHHS/LTC Reimbursement & Rate Setting Section PO Box 30815 Lansing MI 48909-7979 Delivery address: Lewis Cass Building, 4th Floor 320 S. Walnut St. Lansing, MI 48933	Update.
Directory Appendix	Nursing Facility Resources	Addition of: **Contact/Topic:** United States Department of Labor Consumer Price Index **Mailing/Email/Web Address:** https://www.bls.gov/cpi/ **Information Available/Purpose:** United States Department of Labor Consumer Price Index website information to find the cost-of-living changes for the Owner/Administrator compensation limits.	Add website information.
Directory Appendix	Nursing Facility Resources	Addition of: **Contact/Topic:** Nursing Home Compare (NHC) **Mailing/Email/Web Address:** https://www.medicare.gov/nursinghomecompare/search.html **Information Available/Purpose:** NHC website information used for nursing facility QMI payments.	Add website information.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Nursing Facility Resources	Addition of: **Contact/Topic:** Special Focus Facility (SFF) List **Mailing/Email/Web Address:** https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/SFFList.pdf **Information Available/Purpose:** Website information for the SFF list.	Add website information.
Forms Appendix	MSA-1324; Nurse Aide Training and Testing Program Interim Reimbursement Request	On page 1, the form submission address was revised to read: MDHHS/LTC Reimbursement & Rate Setting Section PO Box 30815 Lansing MI 48909-7979	Update to PO Box Number.

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Medicaid Provider Manual
April 2019 Updates

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 18-27	8/31/2018	Behavioral Health and Intellectual and Developmental Disability Supports and Services	Section 19 – Opioid Health Home (new section)	New section developed. Includes: 19.1 General Information 19.2 Beneficiary Eligibility 19.3 Beneficiary Enrollment 19.3.A. Enrollment Processes 19.3.B. Beneficiary Consent 19.3.C. OHH Benefit Plan Assignment 19.3.D. Beneficiary Disenrollment 19.3.E. Beneficiary Changing OHH Providers 19.4 Covered Services 19.5 Provider Eligibility Requirements 19.5.A. Geographic Area 19.5.B. Provider Types 19.5.C. Provider Requirements 19.5.D. Provider Infrastructure Requirements 19.6 Provider Enrollment and OHH Designation 19.6.A. Training and Technical Assistance 19.6.B. Use of Applicable Health Information Technology (HIT) 19.7 Provider Disenrollment 19.8 OHH Payment 19.8.A. General Provisions for OHH Payment 19.8.A.1. MDHHS to Regional PIHP 19.8.A.2. Regional PIHP to OHH Providers 19.8.B. Recoupment of Payment

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 18-40	11/1/2018	Hospital Reimbursement Appendix	8.8.A. GME Innovations Hospital Program	In the 1st paragraph, the bullet list was revised to read: • Detroit Receiving Hospital for $8,929,800 annually; • ~~Edward W. Sparrow Hospital for $2,018,078 annually;~~ • Hurley Medical Center for $2,018,078 in FY 2018 and $4,381,078 in FY 2019 and future years; • Pine Rest Christian Mental Health Services for $3,960,000 in FY17, $6,336,000 in FY 2018, and $7,603,200 in FY 2019 and future years.
MSA 18-41	11/30/2018	Local Health Departments	3.1.A. Medicaid Outreach and Public Awareness	Subsection language was replaced in its entirety; new language reads: Informing Medicaid eligible and potentially Medicaid eligible children and families about the benefits and availability of services provided by Medicaid. This category of outreach also includes coordinating and presenting information about Medicaid through media resources, health fairs and other community forums. Examples of activities in this category include, but are not limited to: • Developing, compiling, and/or distributing materials that inform individuals about the Medicaid program, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, and how and where to obtain benefits. • Contacting pregnant and parenting women about the availability of Medicaid services, including referral to family planning and well-baby care programs and services. Examples of activities that are **not appropriate** for this category include, but are not limited to, Women, Infants, and Children (WIC) and Maternal Infant Health Program (MIHP) staff providing referral information about available health and community services. The State of Michigan mandates that these services be provided as a condition of operating the program.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			3.1.B. Facilitating Medicaid Eligibility Determination	Subsection language was replaced in its entirety; new language reads: Activities related to assisting potentially Medicaid-eligible individuals in applying for Medicaid benefits. This includes explaining the Medicaid program to individuals or families, providing a Medicaid application form, assisting an individual in completing a Medicaid application, and/or referring individuals to the local MDHHS office for determination of benefits. Community health workers may act as client advocates when additional assistance is needed to complete the application process. Community health workers can also help clients overcome other barriers such as linguistic, cultural, and cognitive challenges to the application and enrollment process. Examples of activities in this category include, but are not limited to: • Verifying an individual's current Medicaid eligibility status for purposes of the Medicaid eligibility process. • Assisting the individual or family in collecting/gathering required information and documents for the Medicaid application. Examples of activities that are **not appropriate** for this category include, but are not limited to: • Verifying an individual's current Medicaid eligibility status for a direct service or billing of medical appointment. • Explaining the eligibility process for non-Medicaid programs.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			3.1.C. Program Planning, Policy Development and Interagency Coordination Related to Medical Services	Subsection language was replaced in its entirety; new language reads: Development of health programs and services targeted to the Medicaid population and collaboration between the LHD and other agencies to ensure the delivery of Medicaid-covered services. Activities in this category only apply to LHD staff whose position descriptions include program planning, policy development and interagency coordination, and/or those staff specifically appointed to appropriate committees/programs performing required activities. This includes planning and developing procedures to track requests for referrals and coordinating services with the Medicaid Health Plans. Examples of activities in this category include, but are not limited to: • Working with other agencies and/or providers that provide medical/dental/mental health services to improve the coordination and delivery of services, to expand access to additional Medicaid populations, increase provider participation, and improve provider relations. • Enhancing, improving, or streamlining health care service delivery systems in the community. • Representing the LHD on a committee or task force that is intended to improve access to Medicaid programs and services. Examples of activities that are **not appropriate** for this category include, but are not limited to: • Developing procedures for tracking families' requests for assistance with non-Medicaid services and the providers of such services. • Creating a collaborative of health professionals to provide consultation and advice on the delivery of health care services to the non-Medicaid population.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			3.1.D. Referral, Coordination, and Monitoring of Medicaid Services	Subsection language was replaced in its entirety; new language reads: Making referrals for, coordinating access to, and/or monitoring the delivery of Medicaid services. Working with Medicaid providers to improve the coordination and delivery of clinical health care services, expand access to specific Medicaid populations, and improve collaboration around early identification of medical/dental problems. Examples of activities in this category include, but are not limited to: • Making referrals for and/or scheduling appropriate Medicaid-covered services for Medicaid-enrolled individuals. • Developing referral sources for the LHD, such as a list or brochure of the physicians, dentists or Health Maintenance Organizations (HMOs) in the area who accept Medicaid patients for evaluation or treatment, or a list of other health agencies providing Medicaid services. • Monitoring or coordinating the completion of the prescribed services, the termination of services, and the referral of the individual to other Medicaid services as necessary. Examples of activities that are **not appropriate** for this category include, but are not limited to: • Conducting quality assurance reviews when MDHHS requires the reviews as a condition of operating the program. • Making referrals for, and coordinating access to, non-Medicaid services, such as child care, employment, job training, food assistance, and housing. • Activities that are an integral part of or an extension of a direct medical service.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			3.1.E. Medicaid-Specific Training on Outreach Eligibility and Services	Subsection language was replaced in its entirety; new language reads: Outreach activities that focus on coordinating, conducting, or participating in training and seminars for staff and/or contractors regarding the Medicaid program and available services, the benefits of the program, and how to assist families in accessing Medicaid services. These include trainings that enhance early identification, screening, and referral of children and adolescents for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. This category also includes development and presentation of training modules regarding Medicaid eligibility and benefits to LHD staff. Examples of activities in this category include, but are not limited to: • Participating in or coordinating training that improves the delivery of Medicaid services. • Attending or participating in a Medicaid Outreach inservice or webinar. • Developing, participating in, or presenting training that addresses the clinical importance of pediatric or other clinical standards for preventive care offered through the Medicaid program. Examples of activities that are **not appropriate** for this category include, but are not limited to: • Participating in or coordinating training that improves the delivery of general LHD services. • The time spent determining if a specific task can be considered Medicaid outreach.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			3.1.F. Arranging for Medicaid-Related Transportation	Subsection language was replaced in its entirety; new language reads: Assisting an individual in obtaining transportation for Medicaid-related services. NOTE: This does **not** include activities that contribute to the actual billing of transportation as a medical service. Examples of activities in this category include, but are not limited to: • Scheduling or arranging transportation to and from Medicaid-covered services for a Medicaid-enrolled individual. • Assisting or arranging for transportation for the parent/guardian of a Medicaid-enrolled individual in support of the referral and evaluation activities. Examples of activities that are **not appropriate** for this category include, but are not limited to: • Transporting or accompanying a Medicaid-enrolled individual to a medical appointment. • Assisting an individual in obtaining transportation for non-Medicaid services.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			3.1.G. Arranging for Provision of Medicaid-Related Translation Services	The subsection title was revised to read: Arranging for ~~Provision of~~ or Providing Medicaid-Related Translation Services Subsection language was replaced in its entirety; new language reads: Arranging for or providing translation services related to a Medicaid-covered service when translation services are not included and/or paid for as part of a direct medical assistance service. Examples of activities in this category include, but are not limited to: • Arranging for or providing translation services (oral or signing services) to assist an individual with completing a Medicaid application. • Arranging translation services that assist an individual in understanding the Medicaid services available. Examples of activities that are **not appropriate** for this category include, but are not limited to: • Developing translation materials that assist individuals in accessing and understanding non-Medicaid programs and services. • Arranging for or providing translation services (oral or signing services) that assist the individual in accessing non-Medicaid services. • Providing translation services to assist a Medicaid-enrolled individual in communicating as part of a direct medical service.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			3.2 Reporting Requirements	The subsection title was revised to read: Documentation and Reporting Requirements Text was revised to read: Documentation maintained in support of administrative claims must be sufficiently detailed to allow determination of whether the activities were necessary for the proper and efficient administration of the Medicaid State Plan. The LHD is responsible for all claiming determinations. LHDs that bill for Medicaid Outreach Activities ~~must~~ are expected to provide a quarterly summary report of Medicaid outreach activities. Guidelines and reporting requirements are described in the ~~CPBC Grant Agreement~~ Comprehensive Agreement.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 18-43	11/1/2018	Home Health	Section 3 – Plan of Care	The 1st paragraph was revised to read: The plan of care (POC) must include the mandatory elements required under Medicare CoP regulations at 42 CFR §484.60. The Medicare CoP POC elements represent the minimum information that must be included in each home health beneficiary's POC. ~~following:~~ MDHHS requires home health providers must also include the following: • ~~Date of most recent hospitalization.~~ • ~~All pertinent medical diagnoses, prognosis, functional limitations and rehabilitation potential.~~ • ~~Detailed documentation of mental status.~~ • ~~Detailed documentation of nutritional requirements, medications, and treatments.~~ • ~~Activities permitted and special circumstances, conditions, or situations that require services to be provided in the home and not in a physician's office or outpatient clinic.~~ • Date of the ~~HHA's~~ first visit the HHA made for ~~this~~ the new admission. • ~~The~~ Start date of care ~~date for which~~ when the HHA began providing home care and the certification period. (This date remains the same on subsequent POCs until the beneficiary is discharged from home health care services.) • ~~Detailed description of each service, supplies, and equipment required, including frequency of visits and duration of services.~~ • ~~Documentation of orders for therapy services, which include the specific procedures and modalities to be used, the amount, frequency, and duration.~~ • ~~Detailed description of current goals as related to the services provided and the goal for referral or discharge planning.~~

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				• ~~A full description of the reason(s) that initial and/or continued home care is needed (e.g., pertinent laboratory values, medications, wounds, abnormal vital signs).~~ • ~~Safety measures to protect against injury (e.g., fall safety measures, medication management, infection control)~~. • ~~Identification of~~ Other identified resources used by the beneficiary (e.g., Area Agency on Aging, Protective Services, Home Help services, MI Choice Waiver). • Name, address and provider NPI number of the HHA, and beneficiary's name, date of birth, and Medicaid ID number. • The attending physician's signature and date of signature. The POC must be signed and dated by the beneficiary's attending physician before the HHA submits a claim to MDHHS for payment. • Specific circumstances, conditions, or situations that require services to be provided in the home and not in a physician's office or outpatient clinic. • Date of most recent hospitalization, if applicable. If the physician orders Home Health aide services and the beneficiary is also receiving personal care through another entity (Home Help Program, MI Choice Waiver), there must be a coordination between the two entities and documentation in the POC to verify there is no duplication of services. (Refer to the Personal Care Section of this chapter for additional information.) • ~~Date of physician's last contact.~~ • Role of family or support person.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				If Home Health aide services are ordered, an assessment of the family's ability and willingness to perform the services must be made and included in the POC. If the family is unable to perform the services, the reason must be stated on the POC. • ~~HHA's name, address and provider NPI number, and beneficiary's name, date of birth, and Medicaid ID number.~~ • ~~The attending physician's signature and date he signed the POC. The POC must be signed and dated by the beneficiary's attending physician before the HHA submits a claim to MDHHS for payment.~~ • Any additional items the home health agency or physician chooses to include.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			Section 4 – Transfers and Discharge Planning (new section; following sections/ subsections were re-numbered)	New section text reads: The HHA must develop a transfer or discharge plan at the time of admission to home health services. As identified in the Medicare CoP (42 CFR §484.50), the beneficiary shall be discharged from the Home Health program by the admitting HHA under the following conditions: • The beneficiary acuity exceeds the HHA's capabilities; • The beneficiary or payer will no longer pay for home health services; • The beneficiary no longer meets the criteria for medical necessity because the measurable outcomes and goals identified in the POC have been achieved; • The beneficiary refuses services or elects to be transferred or discharged; OR • The HHA provider cannot safely service the beneficiary in accordance with 42 CFR §484.50(d)(5). It is the responsibility of the HHA to ensure continuity of care during transition or discharge to another HHA or entity (e.g., Home Help, MI Choice Waiver). The HHA's strategies for a safe transition or discharge must be documented in the beneficiary's medical record. The beneficiary's medical record must also identify the HHA or other entity from which the transition or discharge occurred. In some cases, the beneficiary may receive home health aide services and start receiving services concurrently from other entities (e.g., Home Help, MI Choice Waiver). In such instances, the HHA must document in the medical record other resources used by the beneficiary in the POC.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			Section 5 – Coordination of Services (new section; following sections/ subsections were re-numbered)	New section text reads: The HHA must ensure coordination in the delivery of services through an integrated process across all aspects of home health services. Integrated services encompass communication from all physicians and disciplines (e.g., skilled nursing and therapy services) as well as other entities (e.g., Home Help, MI Choice Waiver). The HHA must also provide ongoing training and education for the beneficiary and caregiver with respect to the care and services identified in the POC, as well as for the safe transfer into or discharge from the community services. Throughout the care planning process, it is the responsibility of the HHA to ensure coordination of care and to avoid duplication of services (e.g., Home Help. MI Choice Waiver).

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			10.2 Supervisory Visit (previously numbered as 8.2)	Subsection text was revised to read: ~~HHA registered nurses (RNs) must assign a Home Health aide to a particular beneficiary, prepare written instructions for the beneficiary's care, and supervise home health aide visits. It is the responsibility of the supervising RN to co-sign all documentation completed by the Home Health aide. Also, RNs must make a supervisory visit to the beneficiary's home at least once every two weeks and document the supervisory visit in the beneficiary's medical record.~~ The supervisory visit of the home health aide must be completed every 14 days to provide a more reliable and frequent supervision schedule with documentation of the supervisory visit in the beneficiary's medical record. The HHA RN must assign a home health aide to each beneficiary. It is the responsibility of the RN or other appropriate skilled professional (e.g., physical therapist, [PT], occupational therapist [OT], speech therapist [ST]) to prepare written instructions for the beneficiary's care and to conduct home health aide supervisory visits every 14 days as follows: • If the beneficiary is receiving skilled nursing services, the RN must complete the supervisory visit; OR • If the beneficiary is receiving only therapy services, the supervisory visit must be completed by the appropriate skilled professional (e.g., PT, OT, ST). In some cases, the beneficiary may not be receiving skilled nursing or therapy services. In such cases, the RN must complete the supervisory visit of the home health aide no less than every 60 days. It is the responsibility of the supervising RN to co-sign all documentation completed by the Home Health aide. Each supervisory visit by the RN or other appropriate skilled professional must be documented in the beneficiary's medical record. In accordance with 42 CFR §484.80, the HHA must ensure that the qualifications and training of the home health aide are sufficient to meet the individual needs of the beneficiary.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 18-44	11/30/2018	General Information for Providers	15.5.A. Standard Consent Form (new subsection)	New subsection text reads: The Consent to Share Behavioral Health Information (form MDHHS-5515) must be used for all providers requesting release of information for behavioral health and/or substance use disorder related information. The consent is required to be accepted, honored and used for all Fee for Service (FFS), Managed Care and Prepaid Inpatient Health Plan (PIHP) beneficiaries both from and to any of those providers or entities. The MDHHS-5515 is maintained and updated on the MDHHS website. (Refer to the Directory Appendix for website information.) An interpreter must be provided to assist the individual if the individual does not understand the language used on the consent form or the language used by the person obtaining the consent. Services of an interpreter cannot be billed as separate services or billed to the beneficiary. Providers receiving federal funding under the Victims of Crime Act, Violence Against Women Act, and/or Family Violence Prevention and Services Act should not use the MDHHS-5515 because they are subject to stringent consent requirements under these federal laws that are not satisfied by the form. These requirements are in place to address the heightened safety and privacy concerns that victims of domestic violence, sexual assault, stalking, or other crimes may have. These individuals may need additional safeguards for their behavioral health information. For guidance on addressing issues related to consent and the provision of services for domestic violence, sexual assault, stalking, or other crimes, refer to the MDHHS website.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Behavioral Health and Intellectual and Developmental Disability Supports and Services	1.8 Confidentiality (new subsection)	New subsection text reads: MDHHS complies with Health Insurance Portability and Accountability Act (HIPAA) privacy requirements and recognizes the concern for the confidential relationship between the provider and the beneficiary, and protects this relationship using the minimum amount of information necessary for purposes directly related to the administration of Medicaid. All records are of a confidential nature and should not be released, other than to a beneficiary or their representative, unless the provider has a signed release from the beneficiary/parent/guardian/legal representative or the disclosure is for a permitted purpose under all applicable confidentiality laws. If the provider questions the appropriateness of releasing beneficiary records, the provider is encouraged to seek legal counsel before doing so.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			1.8.A. Standard Consent Form (new subsection)	New subsection text reads: The Consent to Share Behavioral Health Information (form MDHHS-5515) must be used for all providers requesting release of information for behavioral health and/or substance use disorder related information. The consent is required to be accepted, honored and used for all Fee for Service (FFS), Managed Care and Prepaid Inpatient Health Plan (PIHP) beneficiaries both from and to any of those providers or entities. The MDHHS-5515 is maintained and updated on the MDHHS website. (Refer to the Directory Appendix for website information.) An interpreter must be provided to assist the individual if the individual does not understand the language used on the consent form or the language used by the person obtaining the consent. Services of an interpreter cannot be billed as separate services or billed to the beneficiary. Providers receiving federal funding under the Victims of Crime Act, Violence Against Women Act, and/or Family Violence Prevention and Services Act should not use the MDHHS-5515 because they are subject to stringent consent requirements under these federal laws that are not satisfied by the form. These requirements are in place to address the heightened safety and privacy concerns that victims of domestic violence, sexual assault, stalking, or other crimes may have. These individuals may need additional safeguards for their behavioral health information. For guidance on addressing issues related to consent and the provision of services for domestic violence, sexual assault, stalking, or other crimes, refer to the MDHHS website.

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Federally Qualified Health Centers	7.3.B. Beneficiary Consent	The 1st sentence was revised to read: Beneficiaries must provide a signed MI Care Team Beneficiary Enrollment/Disenrollment form (MSA-1030) and a signed Consent to Share Behavioral Health Information ~~for Care Coordination Purposes~~ form (MDHHS-5515) to enroll in and receive the MI Care Team benefit. The following text was added: The Consent to Share Behavioral Health Information (form MDHHS-5515) must be used for all providers requesting release of information for behavioral health and/or substance use disorder related information. The consent is required to be accepted, honored and used for all Fee for Service (FFS), Managed Care and Prepaid Inpatient Health Plan (PIHP) beneficiaries both from and to any of those providers or entities. The MDHHS-5515 is maintained and updated on the MDHHS website. (Refer to the Directory Appendix for website information.) An interpreter must be provided to assist the individual if the individual does not understand the language used on the consent form or the language used by the person obtaining the consent. Services of an interpreter cannot be billed as separate services or billed to the beneficiary. Providers receiving federal funding under the Victims of Crime Act, Violence Against Women Act, and/or Family Violence Prevention and Services Act should not use the MDHHS-5515 because they are subject to stringent consent requirements under these federal laws that are not satisfied by the form. These requirements are in place to address the heightened safety and privacy concerns that victims of domestic violence, sexual assault, stalking, or other crimes may have. These individuals may need additional safeguards for their behavioral health information. For guidance on addressing issues related to consent and the provision of services for domestic violence, sexual assault, stalking, or other crimes, refer to the MDHHS website.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			7.3.E. Beneficiary Changing MI Care Team Providers	The 4th sentence was revised to read: Additionally, the beneficiary must complete new enrollment and consent forms (MI Care Team Beneficiary Enrollment/Disenrollment form [MSA-1030] and a signed Consent to Share Behavioral Health Information ~~for Care Coordination Purposes~~ form [MDHHS-5515]).
		Directory Appendix	Provider Resources	Addition of: **Contact/Topic:** Consent to Share Behavioral Health Information form (MDHHS-5515) **Mailing/Email/Web Address:** email address: MDHHS-BHConsent@michigan.gov website: www.michigan.gov/bhconsent **Information Available/Purpose:** form MDHHS-5515 and supporting resources, including FAQ
		Forms Appendix	Maternal Infant Health Program Provider and Medicaid Health Plan Care Coordination Agreement (Sample)	Under "E. Medical Coordination", the 2nd paragraph was revised to read: The MIHP and MHP will accept and use the MDHHS behavioral health consent form (Consent to Share Behavioral Health Information ~~for Care Coordination Purposes~~ form [MDHHS-5515]) to disclose medical information protected under the Mental Health Code or substance use disorder information under 42 CFR Part 2.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 18-46	11/30/2018	Hearing Services	2.4 Auditory Osseointegrated Devices	The subsection title was revised to read: ~~Auditory Osseointegrated Devices~~ Bone Anchored Hearing Devices Text was revised to read: ~~The auditory osseointegrated system has both implanted and external components. The implanted component is a small post that is surgically attached to the skull bone behind the ear. The external component is a speech processor which converts sound into vibrations; it connects to the implanted post and transmits sound vibrations directly to the inner ear through the skull, by passing the middle ear.~~ Some beneficiaries may have physical or medical conditions that prevent them from wearing traditional hearing aids. A bone anchored hearing aid or device (BAHD) is an alternative hearing instrument for those who can benefit when there is no other suitable aid. A BAHD, also known as an auditory osseointegrated device, is a bone conduction hearing device that allows direct bone conduction of sound through an implant or external sound processor. The BAHD transmits sound vibrations through the skull bone, bypassing the middle ear.
			2.4.A. Bone Anchored Hearing Devices: Implantable (new subsection; following subsections were re-numbered)	New subsection text reads: An implantable BAHD has both implanted and external components. The implanted component is a small post that is surgically attached to the skull bone behind the ear. The external component is a speech processor which converts sound into vibrations; it connects to the implanted post and transmits sound vibrations directly to the inner ear through the skull. The surgically-implanted components and external speech processor are covered as a bundled procedure at the hospital benefit level. All device repairs and replacements, including the processor and batteries, are covered as specified on the Medicaid Hearing Services fee screens.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			2.4.B. Bone Anchored Hearing Devices: Non-Implantable (new subsection; following subsections were re-numbered)	New subsection text reads: BAHD sound processors can be used with a soft or hard headband device. With this application, there is no implantation surgery. The sound processor is connected directly to a headband. A headband system is an option for beneficiaries who meet BAHD standards of coverage and audiological criteria but are not appropriate surgical candidates.
			2.4.C. Standards of Coverage (re-numbered from 2.4.A.)	The 2nd and 3rd paragraphs were removed: ~~The surgically-implanted components and external speech processor are covered as a bundled procedure at the hospital benefit level. All repairs and replacements, including the processor and batteries, are covered at the Prosthetics and Orthotics benefit level.~~ ~~The implantation of the auditory osseointegrated device is covered without prior authorization. One (unilateral) auditory osseointegrated device is covered per beneficiary. A second (bilateral) auditory osseointegrated device is not a covered benefit.~~ The 4th paragraph was revised to read: Medicaid and CSHCS cover ~~auditory osseointegrated devices with a~~ medically necessary unilateral or bilateral implantable and non-implantable BAHDs. Beneficiaries must have a unilateral or bilateral conductive or mixed conductive hearing loss or a unilateral profound ~~and~~ sensorineural hearing loss (single-sided deafness). An air conduction hearing aid must be contraindicated, failed, or not appropriate for the beneficiary's medical condition and ~~where the condition prevents restoration of hearing using a conventional air-conduction hearing aid when~~ the following criteria ~~are~~ met:

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				• Use of an FDA-approved device in accordance with its recommended use. • Beneficiary must be five years of age or older to qualify for surgically-implanted components. • Beneficiary must have one of the following conditions: ➢ Congenital malformation(s) of the middle/external ear or microtia. ➢ Severe chronic otitis externa and/or chronic suppurative otitis media with chronic drainage preventing use of conventional air-conduction hearing aids. ➢ Conductive hearing loss due to ossicular disease and is not appropriate for surgical correction. ➢ Tumors of the external ear canal and/or tympanic cavity. ➢ Unilateral sensorineural hearing loss (single-sided deafness). ➢ Condition that contraindicates an air conduction hearing aid.
			2.4.D. Audiological Criteria (re-numbered from 2.4.B.)	Subsection was reformatted; text was relocated to new subsection (2.4.D.1. Unilateral Implantation and Devices).

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			2.4.D.1. Unilateral Implantation and Devices (new subsection)	Text was relocated from 2.4.B. and revised to read: • Unilateral or bilateral conductive or mixed hearing loss: ➢ Puretone average bone conduction thresholds ~~better~~ greater than or equal to 65 dB HL in ear to be implanted. ➢ A speech recognition score ~~better~~ greater than or equal to 60 percent using appropriate speech recognition testing. • Unilateral profound sensorineural hearing loss: ➢ Confirmed profound hearing loss (greater than or equal to 90 dB HL) in one ear, with confirmed bone conduction thresholds ~~in the opposite ear~~ greater than or equal to 40 dB HL ~~or better~~ in the opposite ear.
			2.4.D.2. Bilateral Implantation and Devices (new subsection)	New subsection text reads: • Bilateral symmetrical conductive or mixed hearing loss with a pure-tone average bone conduction threshold of greater than or equal to 65 dB HL in both ears. • Pure-tone average bone conduction threshold average difference of less than 15 dB HL between ears.

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			2.4.C. Auditory Osseointegrated Device, External Sound Processor, Used Without Osseointegration (Soft Band Device Without Surgically-Implanted Components)	Subsection was removed. ~~This device is covered for beneficiaries who meet the above criteria but have either not reached the age of five years or are not appropriate surgical candidates. Prior authorization **is** required. The soft band device is not covered for unilateral sensorineural hearing loss (single-sided deafness).~~ ~~The following documentation is required for a soft band device without surgical components:~~ • ~~Complete audiology studies that define the type and degree of hearing loss in each ear.~~ • ~~Audiology report with history of hearing aid use and documentation of inability to use an air-conduction hearing aid.~~ • ~~Letter from treating otolaryngologist stating medical need.~~ • ~~A copy of the manufacturer's actual invoice showing the processor make and model, serial number, invoice price, applicable discounts, and shipping and handling charges. If the manufacturer's actual invoice is not included, medical review staff will assign a rate to the code until the invoice is received.~~

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			2.4.E. Bone Anchored Hearing Device Prior Authorization (new subsection)	New subsection text reads: PA is **not** required for the surgical implantation of a unilateral BAHD when the standards of coverage and audiological criteria are met. PA **is** required for bilateral BAHD implantation and all non-surgical BAHDs. When PA is needed, the following documentation, dated within six months prior to the surgical implantation or dispensing of the non-surgical aid, must be submitted with the Special Services Prior Approval-Request/Authorization form (MSA-1653-B): • Complete audiology report (i.e., pure-tone audiogram) that defines the type and degree of hearing loss in each ear; • History of hearing aid use or documentation supporting the inability to use an air-conduction hearing aid; • Letter from the beneficiary's treating otolaryngologist stating medical need.
			2.4.F. Replacement of Auditory Osseointegrated Devices (re-numbered from 2.4.D.)	The subsection title was revised to read: ~~Replacement of Auditory Osseointegrated~~ Bone Anchored Hearing Device~~s~~ Replacement Text was revised to read: Replacement of BAHD devices and external processors ~~for surgically-placed auditory osseointegrated devices~~ requires prior authorization and is not covered more frequently than once every four years. Replacements are not covered during the warranty period. ~~Processor repairs exceeding the published maximums require prior authorization.~~

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			2.4.G. Bone Anchored Hearing Device Repair (new subsection)	New subsection text reads: Medicaid covers BAHD repairs and replacement parts when the device is out of warranty. PA is **not** required if: • The sum of all charges for parts and repairs equals $200 or less on one date of service. • The sum of all charges for parts and repairs within the past 365 days is $400 or less. PA **is** required if: • The sum of all charges for parts and repairs exceeds $200 on one date of service. • The sum of all charges for parts and repairs within the past 365 days exceeds $400. • Items requested exceed the maximums as indicated on the Cochlear Implant and Bone Anchored Hearing Device Parts and Accessories list located on the MDHHS website. (Refer to the Directory Appendix for website information.) When PA is needed, the following documentation, dated within six months prior to the dispensing of the part or repair, must be submitted with the MSA-1653-B: • Documentation from the licensed audiologist and/or other authorized medical professional to substantiate the need for the part(s) and/or repair. • Itemization of materials used to repair the device and the rationale for any related labor costs.
			2.4.H.. Non-Covered Items	Re-numbered from 2.4.E.; no changes to text.

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			2.4.F. Prior Authorization Requirements for Replacement of Auditory Osseointegrated Device Parts	Subsection was removed. ~~PA is **not** required for auditory osseointegrated device parts replacement if:~~ ~~• The sum of all charges for parts and repairs equals $200 or less on one date of service.~~ ~~• The sum of all charges for parts and repairs within the past 365 days is $400 or less.~~ ~~PA **is** required for auditory osseointegrated device parts replacement if:~~ ~~• The sum of all charges for parts and repairs exceeds $200 on one date of service.~~ ~~• The sum of all charges for parts and repairs within the past 365 days exceeds $400.~~ ~~• Items requested exceed the maximums as indicated on the Cochlear Implant and Auditory Osseointegrated Implant Replacement Parts and Accessories list located on the MDHHS website. (Refer to the Directory Appendix for website information.)~~ ~~The following documentation must be submitted with the MSA-1653-B:~~ ~~• Documentation from the licensed audiologist and/or other medical professional on the team to substantiate the need for the part(s) and/or repair.~~ • ~~Itemization of materials used to repair the device and the rationale for any related labor costs.~~
			2.4.G. Auditory Osseointegrated Device Replacement Part Maximums	The subsection was re-numbered as 2.4.I. The subsection title was revised to read: ~~Auditory Osseointegrated~~ Bone Anchored Hearing Device Replacement Part Maximums
		Acronym Appendix		Addition of: BAHD – Bone Anchored Hearing Device

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MSA 18-47	11/30/2018	General Information for Providers	7.3 Out of State/Beyond Borderland Providers	The 2nd paragraph was revised to read: Managed Care Plans follow their own Prior Authorization criteria for out of network/out of state services. Providers participating in Medicaid Health Plan and Dental Health Plan networks should refer to the Dental chapter (Healthy Kids Dental section) and the Medicaid Health Plans chapter of this manual for additional prior authorization information.
		Dental	9.6 Dental Health Plan Provider Enrollment (new subsection)	New subsection text reads: DHPs are prohibited from making payments to all typical network and out-of-network Michigan providers who appear on a claim and are not enrolled in CHAMPS. Typical providers are professional health care providers that provide health care services to beneficiaries. Typical providers must meet education and state licensure requirements and have assigned National Provider Identifiers (NPIs). Examples of typical provider types include, but are not limited to, dentists, pediatric dentists, and oral surgeons. A list of currently allowed typical provider enrollment information is available on the MDHHS Provider Enrollment website. Providers not included on the allowed list are not required to enroll. The Provider Enrollment website is updated periodically. Any updates to the MDHHS Provider Allowed Enrollment lists will be subject to provider enrollment requirements. (Refer to the Directory Appendix for website information.) MDHHS does not prohibit payment to out-of-state, out-of-network pharmacies and providers who provide Medicaid beneficiaries with emergency medical services. Payment for out-of-state, out-of-network dental services is subject to Medicaid policy and applicable health policies and procedures. Refer to the General Information for Providers Chapter, Provider Enrollment section of this manual for additional provider enrollment information.

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		Medicaid Health Plans	Section 5 – Medicaid Health Plan Provider Enrollment (new section)	New section text reads: MHPs are prohibited from making payments to all typical network and out-of-network Michigan providers who appear on a claim and are not enrolled in CHAMPS. Typical providers are professional health care providers who provide health care services to beneficiaries. Typical providers must meet education and state licensure requirements and have assigned National Provider Identifiers (NPIs). Examples of typical provider types include, but are not limited to, physicians, physician assistants, certified nurse practitioners, dentists and chiropractors. A list of currently allowed typical provider enrollment information is available on the MDHHS Provider Enrollment website. Providers not included on the allowed list are not required to enroll. The Provider Enrollment website is updated periodically. Any updates to the MDHHS Provider Allowed Enrollment lists will be subject to provider enrollment requirements. (Refer to the Directory Appendix for website information.) MDHHS does not prohibit payment to out-of-state, out-of-network pharmacies and providers who provide Medicaid beneficiaries with emergency medical services. Payment for out-of-state, out-of-network medical services are subject to Medicaid policy and applicable health policies and procedures. (Refer to the Out-of-Network Services subsection of this chapter for additional information.) Refer to the General Information for Providers Chapter, Provider Enrollment section of this manual for additional provider enrollment information.
		Directory Appendix	Provider Assistance	Under "Provider Enrollment Unit", the following website was added: www.michigan.gov/medicaidproviders >> Provider Enrollment
MSA 18-48 and MSA 18-39	11/30/2018 10/1/2018	Nursing Facility Level of Care Determination (new chapter)		Addition of of new chapter: Nursing Facility Level of Care Determination.

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		Directory Appendix		Addition of new section: Nursing Facility Level of Care Determination
MSA 18-49	11/30/2018	Behavioral Health and Intellectual and Developmental Disability Supports and Services	1.2.A. Network Adequacy Standards for the Specialty Behavioral Health System (new subsection)	New subsection text reads: The Code of Federal Regulations at 42 CFR Parts 438.68 and 457.1218 charges states holding managed care contracts with the development and implementation of Network Adequacy Standards, including behavioral health and substance use disorder services for both adults and children. As such, MDHHS developed Network Adequacy Standards for the Prepaid Inpatient Health Plan system of care, including an authorizing policy and a companion procedural document that will be updated as necessary. The policy and procedural document can be found on the MDHHS website. (Refer to the Directory Appendix; Mental Health/Substance Abuse Resources section, for website information.)
		Directory Appendix	Mental Health/ Substance Abuse Resources	Addition of: **Contact/Topic:** Network Adequacy Standards **Phone # Fax #:** **Mailing/Email/Web Address:** website: https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765---,00.html **Information Available/Purpose:** policy and procedural document
MSA 18-50	11/30/2018	General Information for Providers	11.1 General Information	In the 1st paragraph, the following bullet point was removed: • ~~The beneficiary refuses Medicare Part A or B.~~

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		Coordination of Benefits	2.6.A. Medicare Eligibility	The 2nd paragraph was revised to read: ~~If a Medicaid beneficiary is eligible for Medicare but has not applied for Medicare coverage, Medicaid does not make any reimbursement for services until Medicare coverage is obtained. The beneficiary must apply for Medicare coverage at a Social Security Office. Once they have obtained Medicare coverage, services may be billed to Medicaid as long as all program policies (such as time limit for claim submission) have been met.~~ Medicaid beneficiaries who are eligible for Medicare due to age, but not enrolled in Medicare Part A or Part B, will have claims paid by Medicaid for Medicaid covered services. Medicaid will only pay claims for services that fall under the Medicare Part for which the beneficiary is eligible, but not enrolled. The provider must bill Medicare for covered services when the beneficiary only has Part A or Part B. After the beneficiary obtains Medicare, affected claims will be voided and the provider must bill Medicare. After Medicare's payment is received, Medicaid should be billed for any coinsurance and/or deductible amounts. For Medicare Part A and Part B/Medicaid claims, Medicaid's liability never exceeds that of the beneficiary.
			2.6.B. Medicare Part A	The 3rd paragraph was deleted. ~~When a beneficiary has incurred Medicare Part A charges and is eligible for, but does not have, Medicare Part A buy-in, the claim is rejected. Providers must wait for the beneficiary to obtain Medicare coverage, then bill Medicare for services rendered. After Medicare's payment is received, Medicaid should be billed for any coinsurance and/or deductible amounts. For Medicare Part A and Part B/Medicaid claims, Medicaid's liability never exceeds that of the beneficiary.~~

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			2.6.E. Medicare Buy-In/Medicare Savings Program	The 1st paragraph was revised to read: If a beneficiary is eligible for Medicare but has not enrolled, he can do so at any time throughout the year by applying with SSA. If the beneficiary is unable to pay the Medicare premiums, Medicaid may pay the premiums through a contractual agreement (called the Medicare Buy-In Agreement) with the ~~SSA~~ federal government. However, Medicaid cannot buy-in for the beneficiary until he applies for Medicare and the SSA is aware that he is Medicaid eligible, and the beneficiary has applied for the Medicare Savings Program through his local MDHHS office. Beneficiaries eligible for Buy-In but who have not enrolled in Medicare can enroll at any time throughout the year by applying with SSA. Medicaid beneficiaries who did not receive automatic enrollment into Medicare Part A and/or Part B or declined coverage should also seek enrollment. Beneficiaries who need to enroll in Medicare can visit their nearest Social Security office for assistance or contact the Michigan Medicare/Medicaid Assistance Program (MMAP) for health benefit information and counseling. (Refer to the Directory Appendix for contact information.)
			2.6.F. Medicaid Liability	The 10th paragraph was revised to read: When a Medicaid beneficiary is eligible for, but not enrolled in, Medicare Part B and/or Part D, MDHHS ~~rejects any~~ will pay claims for Medicare Part B or Part D services. ~~Providers should instruct the beneficiary to pursue Medicare through the SSA.~~ Medicaid beneficiaries who did not receive automatic enrollment into Medicare Part A and/or Part B or declined coverage should also seek enrollment.
		Directory Appendix	Other Health Care Resources/ Programs	Text was revised to read: **Contact/Topic:** Medicare ~~Part D~~ **Information Available/Purpose:** Questions regarding a beneficiary's eligibility for Medicare ~~Part D~~, specific Medicare Part D drug coverage, or retroactive enrollment in Medicare Part D.

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MSA 18-52	12/28/2018	Early and Periodic Screening, Diagnosis and Treatment	9.6 Blood Lead Screening	In the 9th paragraph, the 2nd sentence was revised to read: All clinical laboratories in Michigan that analyze blood samples for lead shall report all blood lead results~~, rounded to the nearest whole number,~~ to the MDHHS Childhood Lead Poisoning Prevention Program/Community Public Health Agency (CLPPP/CPHA). The following text was added after the 9th paragraph: There is no established safe level of lead for children. While the below recommendations indicate that certain actions should begin at a blood lead level of 5 µg/dL, providers may use their own clinical judgement in determining the appropriate actions in the medical management of children potentially exposed to lead whose blood lead levels are below this level. These activities may include, but are not limited to, repeat testing, follow-up evaluations, treatment services, referral for nurse case management services through the local health department, and referral for environmental investigation.
MSA 19-01	1/15/2019	Billing & Reimbursement for Dental Providers	5.7 Interim Caries Arresting Medicament	Text was revised to read: CDT D1354 - Interim Caries Arresting Medicament Application ~~(D1354)~~ is billable once per date of service~~.~~ regardless of the number of teeth treated up to a maximum of five (5) teeth ~~may be treated~~ per visit. Providers are required to enter the tooth number(s)/letter(s) of all teeth treated in the comments section of the claim. There is a maximum of six applications per lifetime. Silver Diamine Fluoride can be billed on the same date of service as other fluoride applications.
		Dental	6..2.B.1. Interim Caries Arresting Medicament	The 2nd paragraph was revised to read: SDF is billable once per date of service regardless of the number of teeth treated up to a maximum of 5 teeth per visit. ~~There is a maximum of six applications per lifetime.~~ Direct application to the tooth is required to arrest active carious lesions; however, application to sound teeth is not necessary for the additional anti-caries benefit. Application of SDF has an antimicrobial effect on the entire oral cavity in addition to the teeth being treated for caries arrest. (Refer to the Billing and Reimbursement for Dental Providers chapter for additional billing information.)

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