MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 12-43

Distribution: All Providers

Issued: August 31, 2012

Subject: Updates to the Medicaid Provider Manual; Change in MIHP Mileage Reimbursement; HCPCS Code Update; ICD-10 Project Update

Effective: October 1, 2012

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

Updates to the Medicaid Provider Manual

The Michigan Department of Community Health (MDCH) has completed the October 2012 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.

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.

Change in Maternal Infant Health Program (MIHP) Mileage Reimbursement

In order to align with current Department of Human Services (DHS) transportation rates, the mileage reimbursement rate for all Maternal Infant Health Program (MIHP) transportation will be 23 cents per mile effective October 1, 2012. This amount includes any and all administrative costs associated with the travel.

Healthcare Common Procedure Coding System (HCPCS) Code Update for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

The following HCPCS codes will be added to the DMEPOS database effective for dates of service on and after October 1, 2012.

Code	Code Description	Prior Authorization Required
E2312	Mini-prop remote joystick	Yes
E2323	Special joystick handle	Yes
E2324	Chin cup interface	Yes
E2326	Breath tube kit for sip and puff interface	Yes

Refer to the CMS website (www.cms.hhs.gov) for full descriptions of the codes. Information regarding fee screens and coverage parameters is located in the Medical Supplier/DME/Prosthetics and Orthotics Database available on the MDCH website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.

ICD-10 Project Update

The Centers for Medicare & Medicaid Services (CMS) issued a final rule on August 24, 2012 to delay the deadline for ICD-10 implementation to October 1, 2014. Beginning October 1, 2014, ICD-10-CM codes must be used on all HIPAA transactions, including outpatient claims based on dates of service and inpatient claims based on dates of discharge. ICD-10-PCS procedure codes must be used for inpatient services. It is imperative that providers continue transition efforts in order to implement the ICD-10 code sets on all HIPAA transactions. To provide assistance and meaningful resources to ensure implementation by the compliance date, MDCH Provider Outreach activities include:

- ICD-10 Implementation Education as part of the core Medicaid Educational Training sessions and one-on-one Provider Consultations;
- Informative ICD-10 webcasts, such as ICD-10 Implementation: "Get Ready", which is available on the MDCH website at www.michigan.gov/5010icd10. Additional webcasts will be available in the future, including ICD-10 Clinical Documentation; and
- State-wide ICD-10 implementation sessions.

Any questions regarding ICD-10 implementation should be directed to MDCH-ICD-10@michigan.gov. Providers should continue to check the MDCH website at www.michigan.gov/5010icd10 frequently for ICD-10 updates.

Manual Maintenance

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. If using a CD version of the Medicaid Provider Manual, providers should retain all quarterly manual update bulletins, with their attachments, in addition to bulletins issued since the version date of the CD. Providers are encouraged to use the Michigan Medicaid Provider Manual on the MDCH 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 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, Director
Medical Services Administration

Michigan Department of Community Health

Medicaid Provider Manual
October 2012 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	1.3.C. Disclaimer	Addition of new subsection with text reading: The Medicaid Provider Manual serves as the policy reference guide and will supersede any discrepancies regarding rates or coverage on the website or databases.	Clarification.
Beneficiary Eligibility	Section 2 - mihealth Card	In the 1st paragraph, the following bullet point was added: ▪ MOMS	Due to change in residency policy, mihealth cards will be issued to MOMS only beneficiaries who are denied MA or MA/ESO coverage due to residency.
Beneficiary Eligibility	3.1 CHAMPS Eligibility Inquiry	The following text was added to the 4th paragraph: NOTE: Additional search options (use if needed with one of the search options above to obtain a unique member match) include: • Gender • Zip Code	Additional Search Options were added with 5010 implementation.
Billing & Reimbursement for Institutional Providers	7.18.A. Electronic Claims	Subsection text was revised in its entirety to read: The following NDC information is reported in the appropriate segments of the electronic claim format: • N4 (2-digit qualifier) • NDC (11 digits, with 5-4-2 format) • Unit of Measurement Value (2-digit qualifier) • NDC Quantity	

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CHAPTER	SECTION	CHANGE	COMMENT
		To report the NDC information in an 837 HIPAA-compliant format with the correct information in the 2410 Loop: • Repeat the HCPCS code on multiple service line loops, allowing one NDC to be reported within each LIN segment. • Within the LIN segment, report the 2-digit qualifier along with the 11-digit NDC. • Within the CTP segment, report the quantity and unit of measurement. • For the REF segment, the prescription number or Compound Drug Association Number must be reported on each service line to link this service together.	Update; clarification.
Children's Special Health Care Services	9.1 Specialty Dental Benefits	In the 1st paragraph, the first and second sentences were revised to read: Specialty dentistry refers to services that are not covered under the Medicaid dental benefit but may be covered for CSHCS enrollees who have a qualifying diagnosis that includes specialty dental services. Examples include, but are not limited to, orthodontia and specialty crown and bridge. In the 2nd paragraph, the 1st sentence was revised to read: To request approval as a CSHCS Specialty provider, dentists must contact MDCH.	Clarification.
Children's Special Health Care Services	9.2 General Dental Benefits	In the 1st paragraph, the 1st sentence was revised to read: General dentistry refers to services covered under the Medicaid dental benefit that may be covered for CSHCS enrollees who have a qualifying diagnosis that includes general dental services. Examples include, but are not limited to, diagnostic, preventive, restorative, endodontia, prosthodontia, and oral surgery. In the 2nd paragraph, the 1st sentence was revised to read: To request approval as a CSHCS General Dentistry provider, dentists must contact MDCH.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Children's Special Health Care Services	11.3 Travel Reimbursement Process	In the chart under "Transportation," the 2nd bullet point was revised to read: • Car rentals, parking costs, and highway, bridge, and tunnel tolls require original receipts In the chart under "Air Travel", bullet points were revised to read: • The family cannot be reimbursed for airline tickets unless prior approval to purchase the tickets was obtained from MDCH/CSHCS. Original receipts are required for reimbursement. • Penalties, oxygen charges, baggage charges, etc. require original receipts.	Clarification.
Children's Special Health Care Services	Section 12 – Interaction with Other Programs	Section title was changed to read: CSHCS Coordination with Other Health Care Coverage	Title change to better describe content of section.
Hospice	6.7.D. Adult Home and Community Based Waiver Beneficiaries (MI Choice)	In the 1st paragraph, the following text was added after the 2nd sentence: The hospice is the primary provider and manages the joint POC. The POC must clearly identify the services the beneficiary receives, which entity is responsible for providing the services, and the frequency of the services to be provided. Each waiver service included in the POC should be accompanied by documentation stating why the service is not covered under hospice.	

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CHAPTER	SECTION	CHANGE	COMMENT
		The following paragraph was inserted after the 2nd paragraph: If the beneficiary is receiving hospice and becomes eligible to receive waiver services, the waiver agency contacts the hospice to establish the first date of service for the waiver services. The hospice then submits a Hospice Membership Notice (DCH-1074) to MDCH noting the hospice "disenrollment" date. The waiver services begin date is the day following the hospice "disenrollment" date. The hospice must document in the "Remarks" section of the form the effective date of the beneficiary's enrollment into the MI Choice waiver program. The beneficiary should **not** sign the disenrollment portion of the form. The textbox after the 3rd paragraph was removed, and text was re-located/added at the end of the 3rd paragraph.	Clarification.
MI Choice Waiver	4.3 Hospice	The following text was added at the end of the 1st paragraph: If the beneficiary is receiving hospice and becomes eligible to receive waiver services, the waiver agency contacts the hospice to establish the first date of service for the waiver services.	Clarification.
Nursing Facility Cost Reporting & Reimbursement Appendix	9.9.C. Nurse Aide Reimbursement	In the 3rd paragraph, the 1st sentence was revised to read: The CNA must request reimbursement by submitting to the nursing facility the Nurse Aide Training and Competency Evaluation Program, Certified Nurse Aide Training Reimbursement form (MSA-1326), available in the Forms Appendix and on the MDCH website.	Language revised to clarify which form should be submitted for the NATCEP process.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.11.B. Nurse Aide Training and Competency Evaluation Program (NATCEP) Add-On	In the 2nd paragraph, the 1st sentence was revised to read: The interim rate add-on amount is limited to a maximum per diem of $1.00 per resident day; …	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Practitioner Reimbursement Appendix	1.1 Practitioner Fee Screens	A second paragraph was added and reads: Any rate discrepancies will be resolved by using the policy language describing reimbursement methodology for the established fee schedules.	Clarification.
Practitioner Reimbursement Appendix	Section 2 –Enhanced Practitioner Payments	Section text was separated into subsections to provide easier reference to specific information. General section text now reads: MDCH makes payment adjustments for practitioner services payable under Medicaid Fee for Service (FFS) through the following public entities: • University of Michigan Health System • Wayne State University • Hurley Hospital • Michigan State University • Oakland University	Clarification; removal of obsolete information.
Practitioner Reimbursement Appendix	2.1 Qualifying Practitioners	New subsection was developed to provide easier reference to specific information. Subsection text reads: Adjustments apply to both public and private practitioners and practitioner groups who are either employees of one or more of the above public entities, or are under contract with one or more of the above public entities, and include the following: • University medical and dental faculty, employed practitioners, and private practice groups with contractual arrangements with one or more of the above universities and provide services to Medicaid beneficiaries in a variety of settings. • Hurley Hospital-employed or –contracted physicians, dentists, and other practitioners who provide services to Medicaid beneficiaries in a variety of settings. Services eligible for the payment adjustments are billed under the federal employer identification number of the public entity or under the federal employer identification number of the practitioner/practitioner group.	Clarification; removal of obsolete information.

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CHAPTER	SECTION	CHANGE	COMMENT
		Inpatient and outpatient services provided by the following practitioners, when not included in facility payments to the public entity, are included: • Physicians (MD and DO) • Ophthalmologists • Oral-Maxillofacial Surgeons • Dentists • Podiatrists • Physician Assistants • Nurse Practitioners • Certified Nurse Midwives • Certified Registered Nurse Anesthetists • Anesthesiologist Assistants • Optometrists	
Practitioner Reimbursement Appendix	2.2 Payment Adjustment Amount	New subsection was developed to provide easier reference to specific information. Subsection text reads: The payment adjustment amount for services provided to Medicaid beneficiaries who do not have other insurance coverage will be the lesser of: • The difference between the practitioner Medicaid fee-for-service fee screen and the practitioner's customary charge; or • 95.7% of the Average Commercial Rate for the service rendered. The payment adjustment amount for services provided to Medicaid beneficiaries with other insurance coverage will be the lesser of: • The difference between the total of the Medicaid, Medicare, and commercial insurance payments and the practitioner's customary charge; or • The difference between the total of the Medicaid, Medicare, and commercial insurance payments and 95.7% of the Average Commercial Rate.	Clarification; removal of obsolete information.

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Practitioner Reimbursement Appendix	2.3 Financing the Payment Adjustments	New subsection was developed to provide easier reference to specific information. Subsection text reads: The public entities must certify to MDCH that they will provide the non-federal share of the payment adjustments established by this policy. These public entities must also certify to MDCH that the financial arrangements used to offset the non-federal share of these Medicaid payment adjustments do not violate Title XIX of the Social Security Act, §1903 Payment to States, Subsection (W) Prohibition on Use of Voluntary Contributions, and Limitation on Use of Provider-Specific Taxes to Obtain Federal Financial Participation Under Medicaid. No additional state funds are available beyond the amount needed to pay designated providers up to the standard Medicaid fee screens for these services. The non-federal share of the Medicaid payment adjustments is supplied by the public entity through an intergovernmental transfer (IGT) to MDCH.	Clarification; removal of obsolete information.
Practitioner Reimbursement Appendix	2.4 Payment Adjustment Process	New subsection was developed to provide easier reference to specific information. Subsection text reads: Upon receipt of the provider information from the public entity, MDCH will generate a report which will include the federal employer identification numbers and utilization data for the providers affected by this policy for each covered period. The public entity must review the report and acknowledge the completeness and accuracy of the report. After receipt of this confirmation, MDCH will make the payment adjustment. The payment adjustments will be made for the federal employer identification number used to bill Medicaid under the FFS program. The payment adjustments will be processed quarterly. Each quarterly payment adjustment will include a reconciliation that takes into account all claims submitted to MDCH and paid after the prior Physician Adjuster payment quarter cut-off date.	Clarification; removal of obsolete information.
Acronym Appendix		Addition of: IGT - intergovernmental transfer	General information.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Claim Submission/ Payment	Information for "Claim Attachment Submission (Hospitals only)" was removed.	Obsolete information.
Forms Appendix	MSA-1326	References to Nurse Assistant were changed to read Nurse Aide; includes name change of form.	Clarification.

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Michigan Department of Community Health

Medicaid Provider Manual
October 2012 Updates

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 12-33	8/1/2012	Nursing Facility Cost Reporting & Reimbursement Appendix	9.13.F. Penalty for Use of Non-Available Beds	Subsection text was revised to read: Admitting residents to any beds in the area designated non-available for occupancy, regardless of payer source, before the end of the plan negates the non-available bed agreement. All beds covered by a non-available bed agreement that is negated during the initial period of the plan will be considered available for patient care for the plan's entire initial period. All beds covered by a non-available bed agreement that is negated during a plan's extension period will be considered available for patient care beginning with the first day of that cost reporting period of the extension.
MSA 12-32	8/1/2012	School Based Services Random Moment Time Study	3.3.A. AOP Only Staff Pool	Program Specialists was removed from the Staff Pool list.
MSA 12-31	8/1/2012	Medical Supplier	1.3 Place of Service	In the 2nd paragraph, the 5th sentence was revised to read: The following items are exempt from the per diem rate and must be billed by the medical supplier:
MSA 12-28	6/29/2012	Children's Special Health Care Services	9.9 Telemedicine (new subsection)	Text reads: CSHCS allows and reimburses for telemedicine services according to Medicaid policy; however, there are no requirements or limitations regarding the distance between the originating and distant sites for any beneficiary with CSHCS coverage.
MSA 12-25	6/29/2012	General Information for Providers	7.3 Out of State/Beyond Borderland Providers	The following text was added after the 1st paragraph: **Note for Hospice Providers:** An out-of-state/borderland hospice provider cannot cross over the border into Michigan to provide services to a Medicaid beneficiary unless: • The agency is licensed and Medicare-certified as a hospice in Michigan; or

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				• The state in which the provider is licensed and certified has a reciprocal licensing agreement with the State of Michigan. If one of these conditions is met and the hospice provides services across state lines, its personnel must be qualified (e.g., licensed) to practice in Michigan. Medicaid will not cover services for a beneficiary who enters a hospice-owned residence outside of Michigan. The Community Health Automated Medicaid Processing System (CHAMPS) will not recognize the core-based statistical area (CBSA) code of another state. Additionally, when a Michigan Medicaid beneficiary voluntarily enters a hospice-owned residence in another state to receive routine hospice care, they are no longer considered a Michigan resident and, therefore, are not eligible for hospice benefits under Michigan Medicaid. **Note for Home Health Providers:** An out-of-state/borderland home health provider cannot cross over the border into Michigan to provide services to a Medicaid beneficiary unless they are Medicare certified as a home health agency in Michigan. If this condition is met, and the home health agency provides services across state lines, its personnel must be qualified (e.g., licensed) to practice in Michigan.
MSA 12-22	6/1/2012	Nursing Facility Cost Reporting & Reimbursement Appendix	10.7.C. Annual Reconciliation (new subsection)	New subsection text reads: The reconciliation of approved Medicaid days, changes to the variable rate from filed to audited cost report data, and QAS payments is completed on an annual basis within 90 calendar days after the end of the State's fiscal year. The Reimbursement and Rate Setting Section (RARSS) will reconcile the QAS payments to the provider against the provider's approved Medicaid days and filed and audited cost report data. If RARSS determines that an underpayment has been made, the provider will receive a gross adjustment payment. If RARSS determines that an overpayment has been made, recovery will be made by gross adjustment recovery against future payments. The gross adjustment process follows the Initial Settlement and Final Settlement practices described in the Cost Report Reimbursement Settlements section of this chapter. A provider may submit a written request to RARSS for an extended repayment schedule to repay the Program. The request must include a written justification of the need for extended payment.

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				The provider will be given advance notice of the actions taken on QAS payments and has 30 calendar days from the date of the advance notice to request a review of the determination with RARSS. The provider's request for a review must cite specific concerns with the determination.
MSA 12-20	6/1/2012	Children's Special Health Care Services	9.8 Health Insurance Program (HIP) Enrollment (new subsection)	Subsection text reads: Clients who are covered by CSHCS specifically for hemophilia or cystic fibrosis, are age 18 or older, and with no other health insurance are required to apply for enrollment in the Health Insurance Program (HIP) of Michigan. This high-risk pool option was created by the federal Affordable Care Act (ACA) for individuals who are denied access to insurance due to a pre-existing condition. A CSHCS Temporary Eligibility Period (TEP) of 90 days is activated at the initial CSHCS enrollment or renewal of CSHCS enrollment to allow the client time to complete the HIP application. Upon CSHCS receipt of a completed HIP application, CSHCS coverage is extended to complete the full 12-month enrollment period from the initial coverage date. CSHCS coverage terminates at the end of the 90-day TEP if the client fails to submit the application to CSHCS.
		Acronym Appendix		Addition of: ACA – Affordable Care Act HIP – Health Insurance Program
MSA 12-19	6/1/2012	Hospice	5.4 Face-to-Face Encounter	In the 1st paragraph, the 1st sentence was revised to read: A hospice physician, hospice-employed nurse practitioner (NP), or hospice-employed physician assistant (PA) must have a … In the 2nd paragraph, the 1st sentence was revised to read: The hospice physician, NP, or PA must attest … In the 2nd paragraph, the 2nd sentence was revised to read:

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				A NP or PA is allowed to perform …
MSA 12-18	6/1/2012	Mental Health/ Substance Abuse	17.3.N. Wraparound Services for Children and Adolescents	The subsection was re-written in its entirety; includes addition of the following subsections: • 17.3.N.1. Organizational Structure • 17.3.N.2. Qualified Staff • 17.3.N.3. Plans of Service • 17.3.N.4. Amount and Scope of Service • 17.3.N.5. Evaluation and Outcomes Measurement • 17.3.N.6. 1915(c) Children's Serious Emotional Disturbance Home and Community-Based Services Waiver (SEDW)
		Mental Health/ Substance Abuse Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix	2.9 Wraparound Services	Text was revised and added to address Wraparound Services.
MSA 12-16	6/1/2012	Practitioner	3.6.A Oral Health Screen and Fluoride Varnish	In the 1st paragraph, the 3rd sentence was revised to read: ... medical providers can apply fluoride varnish to children ages 0-35 months up to four times in a 12-month time period.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				The 2nd paragraph was revised to read: Physicians and nurse practitioners must complete an online oral health training program and obtain certification prior to providing fluoride varnish applications. Providers who complete the specified certification requirements are allowed to bill Medicaid for these services. The Certificate of Completion (obtained through the training website) and the Contact Information Form (available on the MDCH Oral Health website) must be submitted to the MDCH Oral Health Program upon completion of the training program. Upon receipt and verification of the required information, the MDCH Oral Health Program will issue a certificate to the provider. (Refer to the Directory Appendix for website and contact information.)
MSA 11-52	12/1/2011	Hospital Reimbursement Appendix	2.8.H. Percent of Charge Reimbursement	Text was revised to read: The payment amount for claims that fall into DRGs 1, 2, 5, 6, 7, 8, 10, 14, 16, and 17 is hospital charges …

Michigan Department of Community Health

Supplemental Bulletin List

July - September 2012

The following is a list of Medicaid policy bulletins that supplement the online version of the Medicaid Provider Manual. The list is updated as additional policy bulletins are issued. NOTE: As stated in MSA Bulletin 09-60 issued December 1, 2009, this list includes only those bulletins which have not been formally incorporated into the Medicaid Provider Manual maintained on the MDCH website. The updated list showing all bulletins for the current calendar year is 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 using a CD version of the Medicaid Provider Manual should retain all quarterly manual update bulletins, with their attachments, in addition to bulletins issued since the version date of the CD.

DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	COMMENTS
8/15/2012	MSA 12-35	Graduate Medical Education (GME)	Hospitals, Medicaid Health Plans	
8/1/2012	MSA 12-34	Sanctioned Providers Update	All Providers	A complete list of sanctioned providers is available on the Michigan Department of Community Health (MDCH) website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> List of Sanctioned Providers
7/1/2012	MSA 12-27	Sanctioned Providers Update	All Providers	A complete list of sanctioned providers is available on the Michigan Department of Community Health (MDCH) website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> List of Sanctioned Providers
6/29/2012	MSA 12-26	Non-Emergency Medical Transportation (NEMT) Reimbursement Rates	Bridges Eligibility Manual Holders, Bridges Administrative Manual Holders	Bulletin content incorporated into Bridges Eligibility Manual and Bridges Administrative Manual; not applicable to MDCH Medicaid Provider Manual.

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Supplemental Bulletin List

July - September 2012

DATE ISSUED	BULLETIN NUMBER	TOPIC	AFFECTED PROVIDERS	COMMENTS
6/29/2012	MSA 12-29	July 2012 Healthcare Common Procedure Coding System (HCPCS) Code Updates	Practitioners, Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers, Hospitals, Ambulatory Surgical Centers, Local Health Departments, Medicaid Health Plans, County Health Plans, Mental Health and Substance Abuse	Information regarding fee screens and coverage parameters is located in the appropriate databases available on the MDCH website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information
6/1/2012	MSA 12-24	Sanctioned Providers Update	All Providers	A complete list of sanctioned providers is available on the Michigan Department of Community Health (MDCH) website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> List of Sanctioned Providers
6/1/2012	MSA 12-23	Inpatient Hospital Payment Reduction	Hospitals	Bulletin provides dated information applicable to subject matter detailed in the Hospital Reimbursement Appendix, Special Payment Adjustments subsection.; not applicable for inclusion in the MDCH Medicaid Provider Manual.
5/10/2012	MSA 12-17	Sanctioned Providers Update	All Providers	A complete list of sanctioned providers is available on the Michigan Department of Community Health (MDCH) website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> List of Sanctioned Providers