MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Health and Human Services

Bulletin Number: MSA 17-30

Distribution: All Providers

Issued: September 1, 2017

Subject: Updates to the Medicaid Provider Manual; Code Updates

Effective: As Indicated

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

Updates to the Medicaid Provider Manual

The Michigan Department of Health and Human Services (MDHHS) has completed the October 2017 update of the online version of the Medicaid Provider Manual. The manual will be available October 1, 2017 at www.michigan.gov/medicaidproviders >> Policy and 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 and Forms to view the attachments that describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change.

Code Updates

- **Retroactive Coverage of Existing Code**

  Effective for dates of service on and after July 1, 2016, MDHHS will cover the following Healthcare Common Procedure Coding System (HCPCS) code for Physicians, Nurse Practitioners and Oral/Maxillofacial Surgeons:

  95806

- **New Coverage of Existing Codes**

  Effective for dates of service on and after July 1, 2017, MDHHS will cover the following HCPCS codes:

  - For Physicians, Nurse Practitioners, Medical Clinics and Urgent Care Centers:
    90682
  - For Physicians, Nurse Practitioners and Medical Clinics:
    76706

- **Coverage of New Codes**

  Effective for dates of service on and after July 1, 2017, MDHHS will cover the following HCPCS codes:

  - For Physicians, Nurse Practitioners, Medical Clinics and Outpatient Hospitals:
    Q9984, Q9985, Q9986, Q9989
  - For Ambulatory Surgical Centers (ASC):
    Q9986, Q9989
  - For Certified Nurse Midwife:
    Q9984, Q9985, Q9986
  - For Family Planning Clinics:
    Q9984

- **Coverage of New Code Requiring Prior Authorization (PA)**

  Effective for dates of service on and after July 1, 2017, MDHHS will cover the following HCPCS code for Ambulatory Surgical Centers (ASC) and Outpatient Hospitals:

  C9498

- **Discontinued Coverage of Codes**

  MDHHS will discontinue coverage of the following codes effective June 30, 2017:

  C9487, J1725, P9072, 90649, 90650, 90748

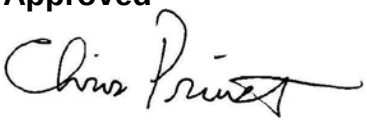
Manual Maintenance

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 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. Providers may phone toll-free 1-800-292-2550.

Approved



Chris Priest, Director
Medical Services Administration

Michigan Department of Health and Human Services

Medicaid Provider Manual
October 2017 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Medicaid Provider Manual Overview	1.1 Organization	The following text was added: Chapter: Non-Emergency Medical Transportation Affected Providers: Non-Emergency Transportation Providers and Authorizing Parties Chapter Content: Coverage policy related to scheduled non-emergency, non-ambulance, medical transportation.	Update.
General Information for Providers	4.1 Provider Domains	Text was revised to read: Providers must register for a ~~Single Sign On (SSO) user identification (ID) and password through the Single Sign On website~~ MILogin account to access the CHAMPS system. (Refer to the Directory Appendix for website information.) All users within a provider's organization who need access to information within CHAMPS (Provider Enrollment, Claims, Prior Authorization, etc.) must obtain a ~~SSO~~ MILogin user ID and password. The CHAMPS Provider Enrollment online system allows providers to easily update their information at any time or submit a new provider enrollment application with an approval process of approximately one to two weeks. The ~~SSO~~ MILogin user who submits the Provider Enrollment application becomes the Provider Domain Administrator for that application. The Provider Domain Administrator has the responsibility of assigning rights for all users within the organization to access the provider's file. Multiple Provider Domain Administrators may be established for a single organization, but a separate application must be completed and approved for each administrator.	Update.
Beneficiary Eligibility	9.7 Excluded Health Plan Services	The last bullet point was deleted. • ~~Maternal Infant Health Program services as defined in the Maternal Infant Health Program chapter of this manual.~~	Clarification.

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

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	8.17 Reporting Medicare on the Medicaid Nursing Facility Claim	The last bullet point was removed: • ~~Claim Examples~~ ➢ ~~Nursing facility claim examples on how to report Medicare and commercial insurance on the Medicaid nursing facility secondary claim can be found on the MDHHS website.~~	Claim examples no longer exist.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.29.B. Qualified Staff	In the 1st paragraph, the 1st sentence was revised to read: Wraparound facilitators ~~shall~~ must: In the 1st paragraph, the following bullet point was added: • Possess a bachelor's degree and be a CMHP or be supervised by a CMHP.	Updated to make provider qualifications uniform with SED-Waiver Wraparound requirements.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	7.2.C. Age Seven Through Seventeen	The following note was added at the beginning of the subsection text: **NOTE:** For EPSDT, this same criteria should be utilized to determine eligibility for home-based services for young adults ages 18-21. In the 1st paragraph, the 2nd sentence was revised to read: For children age ~~seven to seventeen~~ 7 through 17, the Child and Adolescent Functional Assessment Scale (CAFAS) is used to make discriminations within the functional impairment dimension.	Updated to make eligibility criteria consistent with EPSDT requirements.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	17.3.G.3. Youth Peer Support Services	The following text was added to the 3rd paragraph after the 4th sentence: Youth Peer Support is intended to be provided to children and youth who are middle school to 21 years of age. It is not intended to substitute for other services such as respite or community living support services.	Change needed to further clarify target population.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
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 ~~(DCH-3927)~~ (MDHHS-5515) to enroll in and receive the MI Care Team benefit.	Change in form reference number (from DCH-3927 to MDHHS-5515).
Federally Qualified Health Centers	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 ~~[DCH-3927]~~ [MDHHS-5515]).	Change in form reference number (from DCH-3927 to MDHHS-5515).
Hospital	5.8 Nursing Facility	In the 3rd paragraph, 4th bullet point, 1st paragraph, the last sentence was revised to read: The Level I screening is part of the hospital discharge planning process and must be completed by a registered nurse, licensed Bachelor's or Master's Social Worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or physician.	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	2.5 through 2.12.B.	Subsections 2.5 through 2.12.B. were re-formatted to be part of/subsections of 2.4 Medicare Severity Diagnosis Related Grouper Assignment. There were no revisions to text; revisions apply only to subsection numbering. ~~2.5~~ 2.4.A. Inflation ..... 18 ~~2.6~~ 2.4.B. MS-DRG Relative Weights ..... 18 ~~2.7~~ 2.4.C. Episode File ..... 19 ~~2.8~~ 2.4.D. DRG Price ..... 22 ~~2.8.A.~~ 2.4.D.1. Incentive Calculations ..... 23 ~~2.8.B.~~ 2.4.D.2. Updated Cost Adjustor ..... 23 ~~2.8.C.~~ 2.4.D.3. Budget Neutrality Factor ..... 23 ~~2.8.D.~~ 2.4.D.4. Cost-to-Charge Ratio ..... 23 ~~2.8.E.~~ 2.4.D.5. Summary of DRG Price Calculations ..... 24 ~~2.9~~ 2.4.E. Special Circumstances Under DRG Reimbursement ..... 24 ~~2.9.A.~~ 2.4.E.1. High Day Outliers ..... 25 ~~2.9.B.~~ 2.4.E.2. Low Day Outliers ..... 25 ~~2.9.C.~~ 2.4.E.3. Less than Acute Care ..... 25 ~~2.9.D.~~ 2.4.E.4. Cost Outliers ..... 25 ~~2.9.E.~~ 2.4.E.5. Transfers to an Acute Care Inpatient Hospital ..... 26 ~~2.9.F.~~ 2.4.E.6. Transfers from a Hospital ..... 26 ~~2.9.G.~~ 2.4.E.7. Readmissions ..... 26 ~~2.9.H.~~ 2.4.E.8. Percent of Charge Reimbursement ..... 27 ~~2.9.I.~~ 2.4.E.9. Hospitals Outside of Michigan ..... 27 ~~2.9.J.~~ 2.4.E.10. New DRG Hospitals ..... 27 ~~2.10~~ 2.4.F. Hospitals and Units Exempt from DRG Reimbursement ..... 27 ~~2.10.A.~~ 2.4.F.1. Freestanding Rehabilitation Hospitals/Distinct Part Rehabilitation Units ..... 27 ~~2.10.B.~~ 2.4.F.2. Hospitals Outside of Michigan ..... 30 ~~2.10.C.~~ 2.4.F.3. New Freestanding Hospitals and Distinct Part Units ..... 30 ~~2.11~~ 2.4.G. Frequency of Recalibrations ..... 30 ~~2.12~~ 2.4.H. Mergers ..... 31 ~~2.12.A.~~ 2.4.H.1. General Hospitals ..... 31 ~~2.12.B.~~ 2.4.H.2. Freestanding Rehabilitation Hospitals/Distinct Part Rehabilitation Units 31	Formatted the MS-DRG section (2.4) to one section similar to how the APR-DRG (2.3) is formatted so it's clear which language applies to APR-DRG and which applies to MS-DRG.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	7.4 Calculation of DSH Ceiling	The following text was added as a last paragraph: During the Interim DSH Settlement calculation, an upward historical adjustment to the calculated DSH ceiling will be applied to those hospitals that meet certain requirements. To qualify, a hospital would need to be DSH eligible and have a higher audited ceiling calculation compared to the Interim ceiling calculation for each of the last three years of available DSH audits. A percentage increase based on the difference between the audited ceiling and Interim ceiling from the most recent available year will then be applied to the current Interim DSH ceiling calculation. Hospitals may decline this upward adjustment by reducing their ceiling during the Interim DSH Settlement review period.	Clarification.
Maternal Infant Health Program	1.2 Staff Credentials	Under "Infant Mental Health Specialist", text was revised to read: • ~~Licensure by the State of Michigan;~~ • ~~A degree as a Psychologist, Master Social Worker, or professional counselor;~~ • Current Michigan licensure as a psychologist, master social worker, or professional counselor by the Michigan Department of Licensing and Regulatory Affairs; • Infant Mental Health Endorsement by the Michigan Association for Infant Mental Health (MI-AIMH), level 2 or level 3; and • At least one year of experience in an infant health program.	Clarification.
Maternal Infant Health Program	5.3 Operations and Certification Requirements	The 13th bullet point was revised to read: • Respond to referrals received prior to the infant's discharge from the inpatient setting within ~~48 hours~~ two business days of hospital discharge.	Clarification.
MI Choice Waiver	2.2.A. Michigan Medicaid Nursing Facility Level of Care Determination	Text in the 1st paragraph was revised to read: MI Choice applicants are evaluated for functional eligibility via the Michigan Medicaid Nursing Facility Level of Care Determination. The LOCD is available online through ~~Michigan's Single Sign-on~~ ~~System~~ MILogin in CHAMPS. (Refer to the Directory Appendix for website information.)	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Non-Emergency Medical Transportation	4.1 Volunteer Drivers	The last bullet point was revised to read: • Compliant with all provider enrollment background and screening requirements as required by the Medicaid program. (Refer to the General Information for Providers Chapter of this manual for additional information.)	Consistency with wording.
Non-Emergency Medical Transportation	4.2 Individuals With a Vested Interest	The last bullet point was revised to read: • Compliant with all provider enrollment background and screening requirements as required by the Medicaid program. (Refer to the General Information for Providers Chapter of this manual for additional information.)	Consistency with wording.
Non-Emergency Medical Transportation	Section 7 – Prior Authorization (PA)	The following text was added at the end of the 1st paragraph: Prior authorization may be requested for up to six months for prolonged treatment requiring multiple transports. In the 2nd paragraph, the 6th bullet point was deleted. • ~~Prolonged treatment requiring multiple transports (PA may be requested for up to six months);~~	Correction.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	Section 8 – PASARR Process	In the 3rd paragraph, the following bullet point was added: • An individual assessed by adult protective services, requiring protective services, may be granted provisional admission to a nursing facility pending further assessment due to this emergent situation. Placement in a nursing facility is not to exceed seven (7) days. In the 4th paragraph, information in the table for "Transfer Trauma" was revised to read: Borton vs. Califono Transfer Trauma Transfer trauma protections apply to individuals with mental illness or intellectual disability who were determined during a PASARR Level II evaluation to not need nursing facility services. ~~Transfer trauma is evaluated by SSA, with consideration to the opinion of the individual's attending physician. (Refer to the Transfer Trauma subsection of this chapter for additional information.)~~	This is in OBRA Federal Regulations. To differentiate between LOC transfer trauma and Borton vs Califono transfer trauma (OBRA).
Nursing Facility Coverages	8.1 Level I Screening	In the 1st paragraph, the last sentence was revised to read: The DCH-3877 must be completed and signed by a registered nurse, licensed Bachelor's or Master's Social Worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or physician.	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	8.3 Level II Evaluation Exemption	In the 1st paragraph, the 2nd sentence was revised to read: The DCH-3878 may be completed by a registered nurse, licensed Bachelor's or Master's Social Worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner, or physician and must be signed by a physician's assistant, nurse practitioner or a physician. In the 2nd paragraph, 2nd bullet point, the last sentence was revised to read: A physician's assistant, nurse practitioner or physician must certify that the individual meets the clinical criteria for dementia and does not have another primary psychiatric diagnosis, intellectual disability, or a related condition. In the 2nd paragraph, 3rd bullet point, 3rd sub-bullet point, text was revised to read: The attending physician, physician's assistant, or nurse practitioner has certified before admission to the nursing facility that the individual is likely to require less than 30 days nursing facility services.	Update.
Nursing Facility Coverages	8.4 Level II Evaluation Completion	In the 5th paragraph, the 2nd sentence was revised to read: It is the responsibility of the CMHSP to explain the evaluation and determination to the individual and his legal representative ~~within 30 days~~.	The number is being removed as it is referenced as five days further in the section.
Nursing Facility Cost Reporting & Reimbursement Appendix	Throughout the appendix 3, 5, 5.3, 8.18.B., 9.6.C., 10.5.B., 10.5.C., 10.5.D., 10.13.D., 10.13.G.1., 10.13.H.1., 10.13.I.1., 13	Throughout the subsections, the years were revised to read: ~~2015~~ 2016 ~~2016~~ 2017 ~~2017~~ 2018 ~~2018~~ 2019 ~~2019~~ 2020 ~~2020~~ 2021 ~~2023~~ 2024	Years are updated in examples to be more current.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	5.1 Plant Cost Certification Eligibility Criteria	The 1st bullet point was revised to read: • The nursing facility provider is constructing a new building or incurring physical plant improvements with Certificate of Need (CON) approval, or the asset costs are, on average, $1500 or more per licensed bed in capital expenditures in a single cost reporting period.	Clarifying that the intent of the policy is for asset costs to be $1500 or more per licensed bed on average, not exactly $1500.
Pharmacy	7.1 Notification of New Outpatient Drugs	The following text was added: Most drug products are required to be on the market for six months prior to review. Products with a "priority" FDA rating may be reviewed earlier than the six month requirement.	This change incorporates information about our policy from our "FAQ for Drug Manufacturers" document posted on the MDHHS website.
Pharmacy	8.6 Prior Authorization Denials	The following text was added: The PBM reviews the information submitted to determine whether the clinical criteria have been met. If the submitted information does not indicate that the criteria have been met, the PA is then sent to the Office of Medical Affairs in MDHHS for final determination on whether the clinical criteria have been met.	This change provides additional details on the Department's PA review process.
School Based Services	2.1 Individuals with Disabilities Education Act Assessment and IEP/IFSP Development, Review and Revision	In the table for 'Procedure Codes', the 1st paragraph was revised to read: Qualified staff can bill for three distinct types of assessments/evaluations/tests ~~as follows~~. All activities, such as meetings and written reports related to the assessment/evaluation/test, are an integral part or extension of the service and are not separately reimbursable. For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) (Individual procedure codes and descriptions were removed.)	Reference information was added.

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CHAPTER	SECTION	CHANGE	COMMENT
School Based Services	2.2.A. Occupational Therapy Services	In the table for 'Procedure Codes', text was revised to read: For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) (Individual procedure codes and descriptions were removed.)	Reference information was added.
School Based Services	2.2.B. Orientation and Mobility Services	In the table for 'Procedure Codes', text was revised to read: For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) (Individual procedure codes and descriptions were removed.)	Reference information was added.
School Based Services	2.2.C. Assistive Technology Device Services	In the table for 'Procedure Codes', text was revised to read: For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) (Individual procedure codes and descriptions were removed.)	Reference information was added.
School Based Services	2.3.A. Physical Therapy Services	In the table for 'Procedure Codes', text was revised to read: For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) (Individual procedure codes and descriptions were removed.)	Reference information was added.
School Based Services	2.3.B. Assistive Technology Device Services	In the table for 'Procedure Codes', text was revised to read: For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) (Individual procedure codes and descriptions were removed.)	Reference information was added.

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CHAPTER	SECTION	CHANGE	COMMENT
School Based Services	2.4.A. Speech, Language and Hearing Therapy	In the table for 'Procedure Codes', text was revised to read: For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) (Individual procedure codes and descriptions were removed.)	Reference information was added.
School Based Services	2.4.B. Assistive Technology Device Services	In the table for 'Procedure Codes', text was revised to read: For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) (Individual procedure codes and descriptions were removed.)	Reference information was added.
School Based Services	2.5 Psychological, Counseling and Social Work Services	In the table for 'Procedure Codes', text was revised to read: For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) (Individual procedure codes and descriptions were removed.)	Reference information was added.
School Based Services	2.6 Developmental Testing	Under 'Provider Qualifications', the 1st and 2nd bullet points were revised to read: • A fully-licensed psychologist ~~(Doctoral level)~~ in the State of Michigan; • A limited-licensed psychologist ~~(Doctoral level)~~ under the supervision of a licensed psychologist; In the table for 'Procedure Codes', text was revised to read: For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) (Individual procedure codes and descriptions were removed.)	Correction. Reference information was added.

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CHAPTER	SECTION	CHANGE	COMMENT
School Based Services	2.7 Nursing Services	In the table for 'Procedure Codes', text was revised to read: For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) (Individual procedure codes and descriptions were removed.)	Reference information was added
School Based Services	2.8 Physician and Psychiatrist Services	In the table for 'Procedure Codes', text was revised to read: For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) ~~The procedure codes listed below may be used to bill for physician or psychiatrist services.~~ Procedure codes ~~99367 and G9008~~ that replicate the services of other billed codes, either in part or in total, will not be reimbursed for the same date of service. If a physician order/referral is written as a result of a physician medical conference, the order/referral is considered to be a part of that service and is not separately reimbursable. (Individual procedure codes and descriptions were removed.)	Reference information was added
School Based Services	2.9 Personal Care Services	In the table for 'Procedure Codes', text was revised to read: For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) (Individual procedure codes and descriptions were removed.)	Reference information was added
School Based Services	2.10 Targeted Case Management Services	In the table for 'Procedure Code', text was revised to read: For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) (The individual procedure code and description was removed.)	Reference information was added

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CHAPTER	SECTION	CHANGE	COMMENT
School Based Services	2.11 Special Education Transportation	In the table for 'Procedure Codes', text was revised to read: For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) (Individual procedure codes and descriptions were removed.)	Reference information was added
School Based Services	6.1.D. Cost Reconciliation and Settlement	In the 3rd paragraph, the last two sentences were revised to read: Providers must register and have access to the secure ~~Single Sign On (SSO)~~ MILogin in order to utilize the MMF summary software. ~~SSO~~ MILogin registration instructions are also available on the School Based Services Provider Specific webpage.	Update.
Acronym Appendix		Addition of: RARSS – Reimbursement and Rate Setting Section	
Directory Appendix	Provider Assistance – MI Care Team	Under "Information Available/Purpose", text was revised to read: • ~~DCH-3927~~ MDHHS-5515 *(2 instances)*	Change in form reference number (from DCH-3927 to MDHHS-5515).
Directory Appendix	Eligibility Verification – CHAMPS Eligibility Inquiry	Text for Web Address was revised to read: Website: Log into CHAMPS using ~~https://sso.state.mi.us~~ MILogin at https://milogintp.michigan.gov. Go to the Eligibility Inquiry hyperlink located on the 'Provider Portal' page under the 'Member' section.	Update.
Directory Appendix	Billing Resources – Medicaid Code and Rate Reference Tool	Text for Web Address was revised to read: Log into CHAMPS using: ~~https://sso.state.mi.us~~ MILogin at https://milogintp.michigan.gov. Go to the External Links menu located on the 'Provider Portal' page. Select 'Medicaid Code and Rate Reference' from the dropdown list.	Update.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Other Health Care Resources/Programs -- Habilitation Supports Waiver for Persons with Developmental Disabilities	The phone number was revised to read: ~~517-335-4419~~ 517-335-1134	Correction.
Forms Appendix	DCH-3878; Mental Illness/Intellectual Disability/Related Condition Exemption Criteria Certification (For Use in Claiming Exemption Only) – Level II Screening	Form was revised to reflect Nurse Practitioners have authorization to complete and/or sign form; miscellaneous editing.	Update.
Forms Appendix	DCH-3877; Preadmission Screening (PAS)/ Annual Resident Review (ARR) (Mental Illness/ Intellectual Disability/Related Conditions Identification – Level 1 Screening)	Form was revised to reflect Nurse Practitioners have authorization to complete and/or sign form; miscellaneous editing.	Update.
Forms Appendix	Sample 3 – Care Coordination Agreement	Under article 'E', 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 Purposed form ~~[DCH-3927]~~ [MDHHS-5515]) to disclose medical information protected under the Mental Health Code or substance use disorder information under 42CFR Part 2.	Change in form reference number (from DCH-3927 to MDHHS-5515).
Forms Appendix	DCH-1401; Electronic Signature Agreement	Revision to Field Name: Individual ~~Single Sign-on~~ MILogin User ID	Update.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Forms Appendix	DCH-3890; Electronic Signature Verification Statement	Instructions for the Field Name 'User ID' were revised to read: User identification for the ~~State Single Sign-on~~ MILogin portal or software user identification.	Update.
Forms Appendix	MDHHS-5405; Provider Electronic Signature Agreement Cover Sheet	Revision to Field Name: ~~Single Sign-On (SSO)~~ MILogin User ID	Update.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 16-34	11/1/2016	Home Health	Section 3 – Plan of Care	The 1st paragraph was revised to read: The plan of care (POC) must include the following: • Date of most recent hospitalization. • All pertinent medical diagnoses, prognosis, ~~and impact of~~ functional limitations and rehabilitation potential. • Detailed documentation of mental status. • Detailed documentation of nutritional requirements, medications, and treatments. • Activities permitted and special ~~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 the HHA's first visit for this admission. • The start of care date for which the HHA began providing home care and 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, ~~to be provided,~~ 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. • 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 resources used by the beneficiary (e.g., Area Agency on Aging, Protective Services, Home Help Services).

*Bulletin inclusion updates are color-coded to the quarter in which the update was made (April 1 = Blue; July 1 = Pink; October 1 = Green; January 1 = Orange)

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				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. **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.
		Home Health	Section 6 – Nursing Services	The 1st paragraph was revised to read: Nursing services are covered on an intermittent (separated intervals of time) basis when provided by, or under the direct supervision of, a registered nurse (RN). Nursing care provided by a licensed practical nurse (LPN) must be under the supervision of an RN, and the RN must co-sign the LPN's documentation.

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		Home Health	7.1 Occupational Therapy	The 3rd paragraph was revised to read: Medicaid covers OT services when provided by: • A licensed occupational therapist (OT). • A licensed occupational therapy assistant (OTA) under the supervision of an OT (i.e., the OTA's services must follow the evaluation and treatment plan developed by the OT, and the OT must supervise and monitor the OTA's performance, with continuous assessment of the beneficiary's progress). All documentation must be reviewed and co-signed by the supervising OT. Evidence of supervision must be documented in the beneficiary's medical record by the licensed OT. • A student completing his clinical affiliation under the direct supervision of (i.e., in the presence of) an OT. All documentation must be reviewed and co-signed by the supervising OT. Evidence of supervision must be documented in the beneficiary's medical record by the licensed OT.
		Home Health	7.2 Physical Therapy	The 5th paragraph was revised to read: PT services must be provided by a licensed Physical Therapist (PT) or an appropriately supervised, licensed Physical Therapy Assistant (PTA) (i.e., the PT supervises and monitors the PTA's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and co-signed by the supervising PT. Evidence of supervision must be documented in the beneficiary's medical record by the licensed PT. The Code of Ethics, Standards of Practice, and Practice Guidelines provided by the American Physical Therapy Association (APTA) should serve as the basis of appropriate standards of practice.

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		Home Health	7.3 Speech-Language Therapy	The 4th paragraph was revised to read: MDHHS reimburses services for ST when provided by: • A licensed speech-language pathologist (SLP). • An appropriately supervised SLP candidate (i.e., in their clinical fellowship year [CFY] or having completed all requirements but has not obtained a license). All documentation must be reviewed and co-signed by the appropriately credentialed supervising SLP. Evidence of supervision by the appropriately credentialed supervising SLP must be documented in the beneficiary's medical record. • A student completing his clinical affiliation under direct supervision of (i.e., in the presence of) a licensed SLP. All documentation must be reviewed and co-signed by the appropriately credentialed supervising SLP. Evidence of supervision by the appropriately credentialed supervising SLP must be documented in the beneficiary's medical record.
		Home Health	8.1 Supervisory Visit	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.

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MSA 17-11	3/31/2017	Hospital Reimbursement Appendix	8.8 GME Innovations Grants	The subsection title was revised to read: GME Innovations ~~Grants~~ Agreements The 1st paragraph was revised to read: ~~The~~ GME Innovation~~s~~ ~~Pool~~ Agreements ~~is to~~ support innovative GME programs that emphasize the importance of coordinated care, health promotions and psychiatric care in integrated systems. The purpose of this training is to develop the skills and experience necessary to provide psychiatric services utilized by Michigan Medicaid patient groups. ~~Pool size is $10,947,878 per fiscal year.~~ Current single state agency agreements with innovative hospital GME programs include: • Detroit Receiving Hospital for $8,929,800 annually; • Edward W. Sparrow Hospital for $2,018,078 annually; • Pine Rest Christian Mental Health Services for $3,960,00 in FY17, $6,336,000 in FY 18, and $7,603,200 in FY 19 and future years.

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MSA 17-14	5/1/2017	Billing & Reimbursement for Institutional Providers	6.2.B. Changes in Facility Ownership Split Billing	The subsection title was revised to read: Changes in Facility Ownership ~~Split Billing~~ During a Beneficiary's Inpatient Stay Text was revised to read: When a change in facility ownership occurs during a beneficiary's inpatient stay, ~~two claims must be submitted (one by each provider). The first owner is entitled to payment for the day of transfer.~~ • ~~The first claim must show the appropriate patient status code and a "through" date equal to the last day of original ownership.~~ • ~~The second claim must show the "from" date as the first day of the new ownership.~~ • ~~The same admission date must be used on both claims.~~ • ~~If a PACER number was required for the admission, both claims must use the same PACER number.~~ • ~~"Change in ownership" must be stated in the remarks section on the second claim.~~, the owner on the date of admission should submit a claim for all inpatient hospital services for the beneficiary regardless of when the admission began and ended. The National Provider Identifier (NPI) of the hospital facility on the date of admission is the applicable billing NPI for claims to Medicaid. Claims must include necessary information for Medicaid to compute the payment amount, whether or not some of the services occurred during a period when a different party legally owned the hospital. Payments are not prorated between the buyer and seller.

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MSA 17-15	5/1/2017	Billing & Reimbursement for Institutional Providers	7.3.D. Mileage	Text was revised to read: ~~When billing the mileage code, enter the appropriate number of whole miles the beneficiary was transported in the Service Units field. Do not use decimals.~~ When billing a mileage code for trips totaling: • Less than 100 miles, ambulance providers must report mileage units rounded up to the nearest tenth of a mile (e.g., 15.5 miles). For trips totaling less than one mile, ambulance providers must report a "0" prior to the decimal (e.g., 0.5 miles). For claims submitted with mileage units greater than one decimal place, Medicaid will truncate to accommodate its fractional billing policy (e.g., 15.99 reported miles will become 15.9 miles). • 100 miles or more, ambulance providers must report mileage rounded up to the nearest whole mile. For claims submitted totaling 100 miles or more and that are reported using fractional mileage, Medicaid will truncate to accommodate this policy (e.g., 115.99 reported miles will become 115 miles). Medicaid will not round up to the nearest whole mile for ambulance runs totaling 100 miles or more that are truncated as a result of this policy. NOTE: Because the National Uniform Billing Committee (NUBC) UB-04 paper claim form cannot accommodate fractional billing, hard copy ambulance billers submitting the UB-04 should report mileage units rounded up to the nearest whole mile.

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		Billing & Reimbursement for Professionals	6.3 Ambulance	Under 'Mileage', text was revised to read: ~~When billing a mileage code, enter the number of whole miles the beneficiary was transported in the Quantity field. When billing for mileage greater than 100 miles, enter the origin and destination addresses in the Remarks section. Do not use decimals.~~ When billing a mileage code for trips totaling: • Less than 100 miles, ambulance providers must report mileage units rounded up to the nearest tenth of a mile (e.g., 15.5 miles). For trips totaling less than one mile, ambulance providers must report a "0" prior to the decimal (e.g., 0.5 miles). For claims submitted with mileage units greater than one decimal place, Medicaid will truncate to accommodate its fractional billing policy (e.g., 15.99 reported miles will become 15.9 miles). • 100 miles or more, ambulance providers must report mileage rounded up to the nearest whole mile. For claims submitted totaling 100 miles or more and that are reported using fractional mileage, Medicaid will truncate to accommodate this policy (e.g., 115.99 reported miles will become 115 miles). Medicaid will not round up to the nearest whole mile for ambulance runs totaling 100 miles or more that are truncated as a result of this policy.
		Ambulance	3.3 Continuous or Round Trip Transport	The 1st paragraph was revised to read: This type of transport is considered to be one run. The base rate code for the highest level of service performed during transport should be billed on one claim line. ~~Loaded~~ Mileage is also billed on one claim line with the total number of ~~whole (~~loaded~~)~~ miles ~~indicated as the quantity~~ reported.

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		Ambulance	3.9 Pronouncement of Death	Text was revised to read: ~~There are three rules that apply to ambulance services and the pronouncement of~~ In situations where a Medicaid beneficiary dies, reimbursement to a Medicaid ambulance provider depends upon when the beneficiary's death occurs. If a beneficiary is pronounced dead by an individual legally authorized to pronounce death: • ~~If the beneficiary was pronounced dead by an individual who is licensed to pronounce death (coroner/physician)~~ Prior to the time that the ambulance is called, no payment is made. • ~~If the beneficiary is pronounced dead~~ After the ambulance is called, ~~but~~ either before or after the ambulance arrives at the scene, payment for an ambulance trip is made at the BLS rate, but no mileage is paid. • ~~If the beneficiary is pronounced dead after being loaded into the ambulance~~ On arrival to the receiving hospital after getting medically necessary care during the ambulance transport from the scene to the receiving facility, payment is made ~~following the established program policies (that is, the same level of payment is made as if the beneficiary had not died)~~ at the medically necessary level of service furnished.
MSA 17-13	6/1/2017	General Information for Providers	11.2 Beneficiary Copayment Requirements	The following text was added as a 3rd paragraph: Preventive medicine evaluation and management services are not subject to beneficiary cost sharing.
		Beneficiary Eligibility	9.9 Copayments	The following text was added at the end of the 1st paragraph: Preventive medicine evaluation and management services are not subject to beneficiary cost sharing.

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<table>
<tr><th>BULLETIN NUMBER</th><th>DATE ISSUED</th><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th></tr>
<tr><td rowspan="3"></td><td rowspan="3"></td><td>Billing & Reimbursement for Professionals</td><td>7.10 Preventive Services

(new subsection; following subsections were re-numbered)</td><td>New subsection text reads:

<table><tr><th>Modifier</th><th>Description</th><th>Special Instructions</th></tr><tr><td>33</td><td>Preventive Services</td><td>When the primary purpose of the service is delivery of an evidence-based service in accordance with a United States Preventive Services Task Force (USPSTF) A or B rating in effect and other preventive services mandates (legislative or regulatory), the service may be identified by adding modifier 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.</td></tr></table></td></tr>
<tr><td>Healthy Michigan Plan</td><td>5.5 Preventive Services</td><td>The following text was added after the 4th paragraph:

Providers submitting claims for services in accordance with the United States Preventive Services Task Force (USPSTF) grade A and B recommendations are to identify the service with the appropriate International Classification of Diseases (ICD) diagnosis code(s). Providers are encouraged to include HCPCS Modifier 33, Preventive Services. (Refer to the Billing & Reimbursement for Professionals Chapter for specific information.)</td></tr>
<tr><td>Practitioner</td><td>3.14 Laboratory</td><td>The 1st paragraph was revised to read:

~~Medicaid covers medically necessary laboratory tests needed to diagnose or treat a specific condition, illness, or injury. Medicaid also covers screenings such as Pap smears, PSA, TB, etc.~~ The program covers medically necessary laboratory tests to diagnose or treat a specific condition, illness, or injury and laboratory tests associated with preventive services assigned a grade A or B by the United States Preventive Services Task Force (USPSTF). A physician, podiatrist, dentist, or CNM must order laboratory services according to their scope of practice.</td></tr>
</table>

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		Practitioner	3.22 Tuberculosis Testing	Text was revised to read: Medicaid covers TB testing according to the guidelines ~~of~~ established by the AAP and USPSTF which ~~is~~ are based on risk. A risk assessment ~~is~~ may be completed at each visit. Coverage for the TB test includes any return visit to read the results of the TB test. For assistance in determining high risk, providers may contact the MDHHS Division of Communicable Diseases ~~and Immunization Division~~, ~~or~~ the AAP, or the USPSTF. (Refer to the Directory Appendix for contact information.)
		Practitioner	4.8 Preventive Services (new subsection)	New subsection text reads: The program covers preventive services assigned a grade A or B by the USPSTF and all adult vaccines and their administration recommended by ACIP for beneficiaries age 21 years and older. (Refer to the Directory Appendix for USPSTF and ACIP website information.) Preventive services for beneficiaries under 21 years of age are covered as part of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. (Refer to the Early and Periodic Screening, Diagnosis, and Treatment Chapter for specific information.) Providers submitting claims for services in accordance with the USPSTF grade A and B recommendations are to identify the service with the appropriate International Classification of Diseases (ICD) diagnosis code(s). To identify the service as a preventive service, providers are encouraged to include HCPCS Modifier 33, Preventive Services. (Refer to the Billing & Reimbursement for Professionals Chapter for specific information.)

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		Practitioner	5.1 Preventive Medicine Services	The 1st paragraph was revised to read: ~~One preventive medicine E/M service is covered for all beneficiaries annually.~~ The program covers one preventive visit annually. For beneficiaries under 21 years of age, EPSDT screening services are covered according to the AAP periodicity schedule and CMS requirements. (Refer to the Early and Periodic Screening, Diagnosis, and Treatment Chapter for specific information.)
		Acronym Appendix		Addition of: USPSTF - United States Preventive Services Task Force
		Directory Appendix	Provider Resources	Addition of new category: Contact/Topic: United States Preventive Services Task Force (USPSTF) Mailing/Email/Web Address: www.uspreventiveservicestaskforce.org Information Available/Purpose: Information regarding preventive service recommendations.
MSA 17-17	6/1/2017	Non-Emergency Medical Transportation	5.1 Mileage	The following text was added: As applicable, NEMT mileage reimbursement will align with standard mileage rates maintained by the Internal Revenue Service (IRS). Individuals with a vested interest or Medicaid beneficiaries providing their own NEMT will be reimbursed at the IRS rate for "medical or moving purposes", while volunteer drivers and foster care parents will be reimbursed at the IRS rate for "business miles driven".

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MSA 17-21	6/30/2017	Ambulance	1.6 Usual and Customary Charges	The 1st paragraph was revised to read: Providers must bill MDHHS the usual and customary (U&C) fee charged to the public. ~~If the public receives a service without charge, an ambulance provider cannot bill MDHHS for the same service.~~ If the provider renders a covered service to a beneficiary that the provider offers for free or for a reduced fee to the general public, the provider may only bill Medicaid up to that customary charge as long as all other Medicaid requirements are met. If one charge is made to tax-paying residents in a given township, and a higher charge is made to nonresidents, the same charge formula should be applied for Medicaid beneficiaries.
		Non-Emergency Medical Transportation	Section 5 – Covered Services	The last paragraph was revised to read: In order to assure appropriate reimbursement for NEMT, MDHHS maintains a database of provider rates which is available on the MDHHS website. The database is reviewed and updated as applicable. (Refer to the Directory Appendix for website information.) NEMT providers must bill MDHHS the usual and customary fee charged to the public. ~~If the public receives a service without charge, an NEMT provider cannot bill MDHHS for the same service.~~ If the provider renders a covered service to a beneficiary that the provider offers for free or for a reduced fee to the general public, the provider may only bill Medicaid up to that customary charge as long as all other Medicaid requirements are met.
		Pharmacy	13.1 Usual and Customary Charge	The 2nd paragraph was revised to read: U&C charge is defined as a pharmacy's charge to the general public. If the provider renders a covered service to a beneficiary that the provider offers for free or for a reduced fee to the general public, the provider may only bill Medicaid up to that customary charge as long as all other Medicaid requirements are met. The sum of charges for both the product cost and dispensing fee must not exceed a pharmacy's U&C charge for the same or similar service. The U&C charge must reflect all advertised discounts, special promotions, or other programs initiated to reduce prices for product costs available to the general public or to a special population.

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		Glossary Appendix		The definition for 'U & C Charge' was revised to read: The usual and customary charge to the general public. If the provider renders a covered service to a beneficiary that the provider offers for free or for a reduced fee to the general public, the provider may only bill Medicaid up to that customary charge as long as all other Medicaid requirements are met.

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