MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

Bulletin Number: MSA 18-32

Distribution: All Providers

Issued: August 31, 2018

Subject: Updates to the Medicaid Provider Manual; Clarification to Bulletin MSA 17-21; Code Updates

Effective: October 1, 2018

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 October 2018 update of the online version of the Medicaid Provider Manual. The manual will be available October 1, 2018, 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.

Clarification to Bulletin MSA 17-21

Bulletin MSA 17-21 discussed additional guidance regarding free or reduced fee services that a provider may offer to the general public. The intent of this policy was to clarify that these free or reduced fee services may now be billed to Medicaid using the provider's customary charge. After further consultation, the definition of customary charge is slightly revised. Customary charge means the amount the provider charges another third party payer or the general public (except in cases where the general public receives free or reduced charges) for the same or a similar service. This definition does not include negotiated or contracted payment rates. Exclusions discussed in MSA 17-21 still apply.

Code Updates

- **Coverage of New Codes - Effective July 1, 2018**

  1. Physicians, Nurse Practitioners, Medical Clinics, Ambulatory Surgical Centers, Outpatient Hospitals, Local Health Department, Child and Adolescent Health Center & Programs, Federally Qualified Health Center, Rural Health Clinic, and Tribal Health Center

     Q5105 Q5106

  2. Physicians, Nurse Practitioners, Medical Clinics, Ambulatory Surgical Centers, Outpatient Hospitals, Federally Qualified Health Center, Rural Health Clinic and Tribal Health Center

     Q9993 Q9995

- **Coverage of New Codes Requiring Prior Authorization - Effective October 1, 2018**

  Medical Suppliers

  Q9994

- **Retroactive Coverage of Existing Code Requiring Prior Authorization - Effective August 1, 2018**

  Medical Suppliers

  A9274

- **Retroactive Coverage of Existing Codes - Effective October 1, 2017**

  Tribal Health Center

H0010	H0012	H0014	H0019	H0020	H0022	H0023	H0025	H0032
H0033	H0038	H0043	H0045	H0046	H0050	H2010	H2014	H2016
H2019	H2023	H2035	T1007	T1012	T1016	T1027	T2015	T2037

- **Discontinued HCPCS Procedure Codes For All Applicable Provider Types - Effective June 30, 2018**

  C9469

- **Discontinued HCPCS Procedure Codes For All Applicable Provider Types - Effective December 31, 2017**

  0008M 83992

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

Approved

Kathy Stiffler, Acting Director
Medical Services Administration

Michigan Department of Health and Human Services

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Medicaid Provider Manual Overview	1.1 Organization	Chapter information for *Plan First!* Family Planning Waiver was removed.	Obsolete information. (Program ended 7/1/2016.)
Beneficiary Eligibility	2.1 Benefit Plans	Information for Benefit Plan ID Plan First! was removed.	Obsolete information. (Program ended 7/1/2016.)
Beneficiary Eligibility	2.4 Scope/Coverage Codes	In the last table, information for Coverage Code Y was removed.	Obsolete information.
Billing & Reimbursement for Institutional Providers	7.15 Emergency Department Services	Under "EMTALA Screen", the last sentence was revised to read: (Refer to the General Information for Providers~~,~~ and the Emergency Services Only Medicaid~~, and the Plan First! Family Planning Waiver~~ chapters for additional information.)	Obsolete information. (Program ended 7/1/2016.)
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. Customary charge means the amount the provider charges another third party payer or the general public (except in cases where the general public receives free or reduced charges) for the same or a similar service. This definition does not include negotiated or contracted payment rates. 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.	

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	4.3 Essential Elements	In the table, under "Team Composition and Size", the following bulletin point was added after the 3rd bullet point: • A physician assistant may perform clinical tasks under the terms of a practice agreement with a participating physician. The physician assistant must hold a current physician assistant license and a controlled substance license in Michigan. The physician assistant is not counted in the staff-to-beneficiary ratio. Typically, although not exclusively, physician assistant activities may include team meetings, beneficiary appointments during regular office hours, evaluations, psychiatric meetings/consultations, medication reviews, home visits, telephone consultations and telepractice.	Expands provision of psychiatric services to include physician assistants.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	Section 11 – Personal Care in Licensed Specialized Residential Settings	The 1st paragraph was revised to read: Personal care services are those services provided in accordance with an individual plan of service to assist a beneficiary in performing his own personal daily activities. Services may be provided only in a licensed foster care or child caring institution (CCI) setting with a specialized residential program certified by the state. These personal care services are distinctly different from the state plan Home Help program administered by MDHHS.	Additional clarification for EPSDT children settings that are licensed in the State of Michigan.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	11.2 Provider Qualifications	Text was revised to read: Personal care may be rendered to a Medicaid beneficiary in an Adult Foster Care or a CCI setting licensed and certified by the state under the 1987 Department of ~~Mental Health~~ Health and Human Services Administrative Rule R330.1801-09 (as amended in 1995). For children birth to 21, personal care may be rendered to a Medicaid beneficiary in a Child Caring Institution setting with a specialized residential program facility licensed by the State for individuals with I/DD under Act No. 116 of the Public Acts of 1973, as amended, and Act No. 258 of the Public Acts of 1974, as amended.	Update of Department name. Additional clarification on settings covered for children under the EPSDT benefit.

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CHAPTER	SECTION	CHANGE	COMMENT
Emergency Services Only	Section 3 - Coverage	In the table in the 2nd paragraph, the following text was revised: ~~**Physician**~~ ~~**Nurse Practitioner (NP)**~~ ~~**Physician Assistant (PA) (added 7/1/18)**~~ ~~**Medical Clinic**~~ **Physician and Non-Physician Practitioner (NPP) Services** Limited to labor and delivery services, and treatment of an emergency condition. Preventative care, follow-up care to emergency treatment, and chronic care are **not** covered. Medically necessary services provided by physician and non-physician practitioners (NPPs) provided in compliance with state law will be considered for reimbursement.	Changes to align with CMS language regarding "non-physician practitioners."
Plan First! Family Planning Waiver		The chapter was removed.	Obsolete information. (Program ended 7/1/2016.)
Federally Qualified Health Centers	2.2 Transportation/ Outreach	Text was revised to read: ~~Outreach services and non-emergency transportation of the Medicaid beneficiary to and from the FQHC is covered.~~ The cost of outreach and non-emergency transportation is part of ~~the~~ an FQHC's encounter rate. These services are not cost settled. The FQHC provides non-emergency transportation to and from the FQHC for Medicaid covered services provided to Medicaid Fee-for-Service beneficiaries. For Medicaid managed care enrollees, the FQHC may provide transportation in certain circumstances. Refer to the Managed Care Programs section of the Non-Emergency Medical Transportation chapter for additional information.	To clarify that readers should refer to the NEMT chapter for more information on how to handle NEMT when serving a managed care beneficiary in an FQHC.

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Home Health	Section 1 – General Information	The 4th paragraph was revised to read: Services solely to prevent an illness, injury or disability are only covered for women/newborns following delivery. For postpartum/newborn follow-up nurse visits, a nursing diagnosis can be used to establish medical necessity. Otherwise, a medical diagnosis is required to establish medical necessity. Medicaid beneficiaries are expected to be an active participant in the planning for their home health care. For beneficiaries enrolled in a Medicaid Health Plan (MHP) or Integrated Care Organization (ICO), the HHA must contact that health plan for authorization to provide services to their members.	Applicable to Integrated Care Organizations.
Home Health	Section 4 – Outcome and Assessment Information Set	In the 1st paragraph, the 3rd sentence was revised to read: This means beneficiaries under Medicaid traditional fee-for service (FFS), MHP, ICO, Children's Waiver, Home and Community Based Services Waiver for the Elderly and Disabled (MI Choice Waiver), Habilitation Supports Waiver, Healthy Michigan Plan, and CSHCS who receive home health services are to have OASIS information collected by the HHA.	Applicable to Integrated Care Organizations.
Home Health	Section 6 – Nursing Services	Text after the 3rd paragraph was revised to read: Intermittent nurse visits are not covered for a beneficiary receiving Private Duty Nursing Services. Intensive care (for cases that require five or more visits per week or beyond 60 days) may be reviewed by MDHHS during post-payment audit to determine if home care was medically appropriate and a cost effective alternative to institutional care. ~~Intermittent nurse visits are not covered for a beneficiary receiving Private Duty Nursing Services.~~	

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CHAPTER	SECTION	CHANGE	COMMENT
Hospitals	1.5.E. Hospital-Based Provider	Text was revised to read: A hospital-based provider (HBP) is defined as a hospital-employed MD, DO, Certified Registered Nurse Anesthetist (CRNA), physician's assistant (PA), nurse practitioner (NP), dentist, podiatrist, optometrist, or nurse-midwife. HBPs must be enrolled separately as Medicaid providers and bill MDHHS directly using their own provider NPI number for any covered professional service(s) that they provide. (Refer to the appropriate provider-specific chapter and the Billing & Reimbursement for Professionals Chapter of this manual for additional information.)	Added to maintain consistency with Medicare.
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. Customary charge means the amount the provider charges another third party payer or the general public (except in cases where the general public receives free or reduced charges) for the same or a similar service. This definition does not include negotiated or contracted payment rates. 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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Nursing Facility Certification, Survey & Enforcement Appendix	Section 2 – Medicaid Certification and De-certification of Nursing Facility Beds and Medicaid Provider Enrollment	The term "licensing officer" was revised to read "Team Manager" in the following sections/subsections: • 2.1 Dual Certification; 1st paragraph • 2.4.A. Bed Certification Process for Medicaid-Enrolled Providers; 1st paragraph • 2.4.B. Bed Certification Process for Nursing Facilities Not Enrolled in Medicaid; 2nd paragraph • 2.4.C. Bed Certification Process During a Change in Ownership (CHOW); 1st paragraph and 4th paragraph • 2.4.D. Bed Certification Process for a New Nursing Facility or Newly Licensed Nursing Facility Beds; 2nd paragraph • 2.5 Medicaid Enrollment as a Ventilator Dependent Care Unit (VDCU) and Additional VDCU Beds	
Nursing Facility Certification, Survey & Enforcement Appendix	3.2 Employee Screening (Criminal Background Checks)	Text was revised to read: Nursing facilities are prohibited from employing, independently contracting with, or granting clinical privileges to any individual making application or being offered privileges who has been convicted of certain crimes. ~~Public Act 303 of 2002~~ Michigan Public Act 28 of 2006 requires nursing facilities to facilitate and bear the cost of criminal background checks, either through the Michigan State Police or the Federal Bureau of Investigation (depending on defined criteria), on all individuals seeking to perform direct services to residents. The law also provides for the sharing of criminal background information with other member agencies of the provider community for the purpose of applicant screening. An overview of ~~Public Act 303 of 2002~~ Michigan Public Act 28 of 2006 and template forms for use by nursing facilities conducting criminal history checks on applicants are available on the MDHHS website. (Refer to the Directory Appendix for website information.)	The referenced Act on background checks was replaced.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix		The term "licensing officer" was revised to read "Team Manager" in the following subsections: • 2.2 Ownership Changes; 1st paragraph • 10.12.F.1. Change of Ownership	
Nursing Facility Cost Reporting & Reimbursement Appendix		Throughout the appendix, the term 'time period' was revised to read 'period'.	Removal of redundant wording.
Nursing Facility Cost Reporting & Reimbursement Appendix		Throughout the subsections, the years in **examples** were revised to read: ~~2016~~ 2017 ~~2017~~ 2018 ~~2018~~ 2019 ~~2019~~ 2020 ~~2020~~ 2021 ~~2021~~ 2022 ~~2024~~ 2025	Years are updated in examples to be more current.
Nursing Facility Cost Reporting & Reimbursement Appendix	8.3.B. Enforcement Actions	The 1st bullet point was revised to read: • The provider prevails and the action is reversed. **Example**: A ~~Denial of Payment for New Admissions~~ DPNA is rescinded and does not go into effect, or when a provider is not in compliance before the effective date of the DPNA but succeeds in disputing the imposition and the DPNA is rescinded with no interruption in payment for the covered service.	Edit wording to use acronym.

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Nursing Facility Cost Reporting & Reimbursement Appendix	8.18.B. Compensation Limit for Owner and/or Administrator Serving Multiple Nursing Facilities	The dollar values are updated as follows: ~~$211,205~~ $218,646 ~~$140,805~~ $145,766 ~~$117,337~~ $121,471 ~~$70,403~~ $72,883 ~~$38,795~~ $31,354 ~~$21,121~~ $21,865 ~~$36,961~~ $38,263 ~~$52,801~~ $54,662 ~~$100,322~~ $103,857 ~~$61,121~~ $61,865 ~~$121,961~~ $123,263 ~~$147,801~~ $149,662 ~~$215,322~~ $218,857 ~~$4,624~~ $1,792 ~~$6,996~~ $3,896 ~~$4,117~~ $211	Update to example values.
Nursing Facility Cost Reporting & Reimbursement Appendix	Section 10 – Rate Determination	In the 6th paragraph, the 3rd sentence was revised to read: If an acceptable cost report was not filed within this ~~time frame~~ period, Medicaid is not required to set the prospective payment rate in advance of the State's fiscal year.	

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Nursing Facility Cost Reporting & Reimbursement Appendix	10.6 Class V Nursing Facilities – Ventilator Dependent Care (VDC) Units	The following text was added at the end of the 3rd paragraph: If this cost report covers a period that is less than seven months or there was no cost report filed in the prior calendar year, the cost report used for rate setting is the most recent cost report available prior to the previous calendar year that covers a period of at least seven months.	To clarify which cost report is used if there is no cost report ending in the prior calendar year.
Nursing Facility Cost Reporting & Reimbursement Appendix	14.4 Administrative & General	"Employee Background Check Fees ... Support" and "Employee Fingerprinting Fees ... Support" were relocated and placed after "Employment Agency Fees ... Support".	To conform this section with the cost report.
Nursing Facility Cost Reporting & Reimbursement Appendix	14.9 Dietary	The following lines were added after "In-service Training... Support": Salaries & Wages – In-service Training... Support Employee Benefits – In-service Training... Support Payroll Taxes – In-services Training... Support	To conform this section with the cost report.
Nursing Facility Cost Reporting & Reimbursement Appendix	14.10 Nursing Administration	The following lines were added after "Contracted Services – Base/Support ... Base Support": Salaries & Wages – In-service Trainer... Support Employee Benefits – In-service Trainer... Support Payroll Taxes – In-services Trainer... Support	To conform this section with the cost report.
Pharmacy	Section 1 – General Information	The 2nd paragraph was revised to read: Throughout this chapter the terms Medicaid and MDHHS are used to refer to the Michigan Medicaid FFS, Healthy Michigan Plan, CSHCS, and MOMS~~, and *Plan First!*~~ programs unless otherwise noted.	Obsolete information. (Program ended 7/1/2016.)

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CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	1.1 MDHHS Pharmacy Benefits Manager and Other Vendor Contractors	The last paragraph was revised to read: MDHHS contracts with other vendors to perform financial, program or provider audits on behalf of the State of Michigan. (Refer to the ~~Pharmacy~~ Provider Resources portion of the Directory Appendix for additional information.)	Updating reference to audit vendor.
Pharmacy	19.1 Documentation Requirements	The 2nd paragraph was revised to read: The following information serves as a general guide for compliance monitoring during post-payment pharmacy reviews and audits. Additional ~~details pertaining to post-payment pharmacy~~ information regarding audits can be found on the MDHHS post-payment auditor's website. (Refer to the Directory Appendix for website and contact information.) Non-compliance, especially continued non-compliance, may result in payment recovery, sanctions, or referral to the Michigan Attorney General's Office.	
Practitioner	3.13.C. Administration of the Injectable	The 1st paragraph was revised to read: Medicaid covers the injectable drug and the administration of the drug. ~~If another covered service is provided at the same time, the administration of the drug is considered a part of that service and is not covered separately.~~ If the administration of the drug is an integral component of the procedure, the administration is considered a part of that service and is not separately reimbursed.	Clarification.
Rural Health Clinics	4.3 Eligibility Groups Not Subject to PPS Methodology	The 2nd sentence was revised to read: CSHCS ~~and Family Planning Waiver (*Plan First!*)~~ may be paid FFS rates only.	Obsolete information. (Program ended 7/1/2016.)
Directory Appendix	Eligibility Verification	Under "CHAMPS Eligibility Inquiry", the website address for Benefit Plan Information was revised to read: www.Michigan.gov/mdhhs >> Resources >> Beneficiary Eligibility Verification >> Benefit Plans >> Benefit Plan ID table	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Provider Resources	The following information was added: **Contact/Topic:** MDHHS OIG Post-Payment Audits **Phone #:** 614-801-0495 **Mailing Address:** AdvanceMed Midwestern 1530 E. Parham Rd. Henrico, VA 23228 **Web Address:** www.michigan.gov/medicaidproviders >> Resources >> MDHHS OIG Post-Payment Audits **Information Available/Purpose:** Audit resources for providers	Update.
Directory Appendix	Pharmacy Resources	Information regarding "Pharmacy Audits" was removed.	Reader should refer to the Provider Resources Section, "MDHHS OIG Post-Payment Audits"
Directory Appendix	Pharmacy Resources	Under "List of Participating Entities in 340B Program, the website address was revised to read: https://340bopais.hrsa.gov/coveredentitysearch	Update.
Glossary Appendix	U & C Charge	The definition was revised to read: The usual and customary charge to the general public. Customary charge means the amount the provider charges another third party payer or the general public (except in cases where the general public receives free or reduced charges) for the same or a similar service. This definition does not include negotiated or contracted payment rates. 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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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 18-08	5/1/2018	Billing & Reimbursement for Institutional Providers	8.10 Daily Care	The following bullet point was added to the 1st paragraph: • State Veterans' Homes
			8.11 Ancillary Physical and Occupational Therapy, Speech Pathology	The following bullet points were added to the 1st paragraph: • Ventilator Dependent Units • State Veterans' Homes

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BULLETINS INCORPORATED*

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			8.20 State Veterans' Homes (new subsection)	New subsection text reads: In addition to customary billing requirements, a State Veterans' Home must report: ▪ revenue code 0022, ▪ the five-digit Health Insurance Prospective Payment System (HIPPS) code, ▪ the Assessment Reference Date (ARD), ▪ the number of covered days for each HIPPS code, and ▪ occurrence code 50. Revenue code 0022 must be reported on the same service line as each HIPPS code. The HIPPS code consists of the three-digit Resource Utilization Group (RUG) category followed by the two-digit Assessment Indicator (AI). The service units on the service line must contain the number of covered days for each HIPPS code. RUG categories and AIs are determined by the MDS 3.0 and can be found in the MDS 3.0 Resident Assessment Instrument (RAI) Manual. (Refer to the Directory Appendix for RAI Manual information.) The federally required Omnibus Budget Reconciliation Act (OBRA) Minimum Data Set (MDS) assessments listed in A0310A of the MDS 3.0 RAI Manual are the only assessments that may be used for billing RUGs. There must be an occurrence code 50 for each assessment period represented on the claim. The date of service with occurrence code 50 must contain the ARD associated with the applicable MDS assessment. Occurrence code 50 is not required with the default HIPPS code. Providers must report the HIPPS code(s) and ARD(s) based on the applicable MDS assessment(s) to the billing period. Example: The provider is billing for April 1 through April 30, and MDS assessments occurred on March 15 and May 15. The HIPPS code and ARD would be based on the March 15 assessment since that was the assessment in effect when services were rendered.

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				Submitted claims will reject in the Community Health Automated Medicaid Processing System (CHAMPS). MDHHS will review the rejected claims and make periodic gross adjustments to the provider based on the claims data. MDHHS will adjust the gross adjustments as necessary to correct for past payments that do not conform to MDHHS billing and reimbursement policies. Non-routine occupational therapy (OT), physical therapy (PT) and speech-language pathology (SLP) services are included in the RUG rates paid to State Veterans' Homes. These providers are to bill for non-routine therapies on the same claims as daily care, and they are required to obtain prior authorization. These billing requirements apply to State Veterans' Homes billing for NF services and hospice providers billing for room and board in a State Veterans' Home.
		Hospice	7.3.H. Room and Board to Nursing Facilities	In the 1st paragraph, the 3rd sentence was revised to read: Except for State Veterans' Homes, MDHHS pays the hospice 95 percent of the individual or specific facility's Medicaid rate for room and board plus 100 percent of the nursing facility's Quality Assurance Supplement (QAS) rate. The following was added as a sixth bullet point: • **State Veterans' Homes.** MDHHS pays the hospice 100 percent of the beneficiary-specific Resource Utilization Group (RUG) Medicaid rate for room and board in a State Veterans' Home, and payments will be made through gross adjustments. In addition to standard billing practices, hospice providers must follow the State Veterans' Homes billing policy found in the Billing & Reimbursement for Institutional Providers chapter. The hospice must submit a separate claim from other services for the room and board provided in a State Veterans' Home. Hospice reimbursement for room and board must be outlined in the contract established between the hospice and the State Veterans' Home.
		Medicaid Health Plans	1.2 Services Excluded from MHP Coverage but Covered by Medicaid	The following bullet point was added: • Services provided to an individual with Medicaid who resides in a State Veterans' Home.

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		Medical Supplier	2.48.A. Definitions	The definition for Institutional Residential Setting was revised to read: An institutional residential setting refers to a nursing facility, State Veterans' Home, hospital long-term care unit, or county medical care facility.
		MI Health Link	Section 2 – Eligibility and Service Areas	The following bullet point was added to the 2nd paragraph: • Individuals with Medicaid who reside in a State Veterans' Home.
		Non-Emergency Medical Transportation	Section 2 - Common Terms	The definition for Long-Term Care Resident was revised to read: A beneficiary who resides in a Medicaid-certified nursing facility, State Veterans' Home, county medical care facility, or hospital long-term care unit.
		Nursing Facility Coverages	Section 1 – General Information	In the 4th paragraph, the 1st sentence was revised to read: A Medicaid-certified nursing facility is defined as a nursing home, State Veterans' Home, county medical care facility, or hospital long-term care unit with Medicaid certification.
			5.1.D.1. Michigan Medicaid Nursing Facility Level of Care Determination	In the 1st paragraph, the 2nd sentence was revised to read: To verify medical/functional eligibility, the nursing facility (i.e., hospital long term care unit, county medical care facility, ventilator dependent unit, hospital swing bed, State Veterans' Home) must complete the online LOCD under the provider's NPI prior to the start of Medicaid reimbursable services.
			10.36 Therapies	The following text was added after the 11th paragraph: Non-routine occupational therapy (OT), physical therapy (PT) and speech-language pathology (SLP) services are included in the RUG rates paid to State Veterans' Homes. These providers are to bill for non-routine therapies on the same claims as daily care, and they are required to obtain prior authorization.

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		Nursing Facility Certification, Survey & Enforcement Appendix	Section 1 – Introduction	In the 1st paragraph, the 1st sentence was revised to read: Michigan Department of Health and Human Services (MDHHS), under an approved State Plan as required by the Social Security Act, is responsible for annual Medicaid certification of all nursing facilities (other than State-owned facilities, such as a State Veterans' Home).
		Nursing Facility Cost Reporting & Reimbursement Appendix	Section 3 – Definitions	The definition for Nursing Facility or Nursing Home was revised to read: A facility (or distinct part of a facility) that is licensed and certified by the State of Michigan or certified by CMS to provide nursing care and related medical services for residents who require such care above the level of room and board. The following definitions were added: **Class VII Facilities** – State-owned and-operated veterans' homes as established under Michigan Public Act 152 of 1885. **Minimum Data Set (MDS) Assessment** – Clinical assessment tool required for all Medicaid-or-Medicare certified long-term care facilities. The federally required Omnibus Budget Reconciliation Act (OBRA) MDS assessments listed in A0310A of the MDS 3.0 Resident Assessment Instrument (RAI) Manual are the only assessments that may be used to determine rates for Class VII facilities. **Resource Utilization Group (RUG)** – Classifications which NF residents may be placed into based on their clinical needs as determined by the MDS. RUG classifications are used in the rate setting of Class VII facilities.

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			4.1.C. State Veterans' Homes (new subsection)	New subsection text reads: A State Veterans' Home is not required to submit a Medicaid NF cost report. The Medicare SNF cost report is used in place of the Medicaid cost report. The Medicare cost report is to be submitted electronically to the MDHHS Reimbursement and Rate Setting Section (RARSS) through the MDHHS File Transfer application. The Medicare Principles of Reimbursement apply for cost reporting purposes rather than the allowable cost principles described in the Allowable and Non-Allowable Costs section of this Appendix. The cost reporting requirements in the Less Than Complete Cost Report, Cost Report Due Date, New Facility/Owner Requirements, Changing a Cost Reporting Period, and Cost Report Delinquency subsections of this Appendix are still applicable.
			Section 6 – Audit	The following text was added as a 2nd paragraph: The audit process described in this section is not applicable to State Veterans' Homes.

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			10.11 Class VII Nursing Facilities – State Veterans' Homes (new subsection; the following subsections were re-numbered)	New subsection text reads: Reimbursement rates to State Veterans' Homes will be prospective, per patient day, and based on the RUG classification of each resident. MDHHS will utilize the Resource Utilization Group RUG-IV 66 group classifications as calculated by the MDS 3.0. Each RUG category will reflect a resident's needs and correspond to a specific payment rate. The rate associated with an individual RUG category will be set as a percentage of the rate paid by the Medicare skilled nursing facility (SNF) Prospective Payment System (PPS). The percentage used to set rates will not exceed 100% of the corresponding Medicare PPS rate. MDHHS will notify the State Veterans' Homes of the percentage and specific payment rates by October 1 of each year. The RUG category used for payments will be based on the applicable MDS assessment(s) to the billing period. **Example:** Services were rendered from April 1 through April 30, and MDS assessments were conducted on January 15 and April 15. The payment to the provider would be based on the January 15 assessment for dates of services from April 1 through April 14, and would be based on the April 15 assessment for dates of services April 15 through April 30. State Veterans' Homes are excluded from the reimbursement policy that requires Medicaid to pay the lower of the customary charge to the general public or the prospective rate determined by Medicaid. In conformance with the Veterans' Health Programs Improvement Act of 2004, per diem payments received by State Veterans' Homes from the federal Department of Veterans Affairs will not be considered a third-party liability or otherwise used to directly reduce Medicaid payments to these providers. State Veterans' Homes are excluded from the NF Quality Assurance Assessment Program (QAAP) and all supplemental payments funded by the QAAP. State Veterans' Homes will receive payment for services through gross adjustments.

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		Acronym Appendix		Addition of: AI - Assessment Indicator ARD - Assessment Reference Date HIPPS - Health Insurance Prospective Payment System RUG - Resource Utilization Group SNF - skilled nursing facility
		Directory Appendix	Nursing Facility Resources	Addition of: Contact/Topic: MDS RAI Manual Web Address: www.cms.gov >> Medicare >> Nursing Home Quality Initiative >> MDS 3.0 RAI Manual Information Available/Purpose: Instruction manual for the MDS
		Glossary Appendix		The definition for Nursing Facility was revised to read: A nursing home, county medical care facility, State Veterans' Home, or hospital long-term care unit, with Medicaid certification.
MSA 18-10	6/1/2018	Medicaid Health Plans	1.2 Services Excluded from MHP Coverage but Covered by Medicaid	The following bullet point was added: • Pediatric Outpatient Intensive Feeding Program services
		Practitioner	1.9.A. To Obtain Prior Authorization	In the 1st paragraph, the 1st sentence was revised to read: Requests for PA for practitioner services such as surgeries, procedures, office-administered pharmaceuticals, biologicals, and out-of-state-care must be submitted utilizing the Practitioner Special Services Prior Approval – Request/Authorization form (MSA-6544-B).

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		Special Programs	Section 8 – Pediatric Outpatient Intensive Feeding Program Services (new section)	New section text reads: Pediatric Outpatient Intensive Feeding Program services are for beneficiaries with significant feeding and swallowing difficulties and are part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. (Refer to the Early and Periodic Screening, Diagnosis and Treatment Chapter for additional information.) Pediatric Outpatient Intensive Feeding Program services may be reimbursed through Medicaid Fee-for-Service (FFS). Covered services that are carved out of the Medicaid Health Plan (MHP) delivery system will be reimbursed through FFS consistent with applicable Medicaid policy.
			8.1 General Information (new subsection)	New subsection text reads: Pediatric feeding disorders are a complex set of feeding and swallowing problems that disrupt the acquisition of functional age-appropriate feeding habits. To resolve complex pediatric feeding issues, clinical evidence indicates that both medical and behavioral interventions are needed. Failure to address feeding issues in young children can be severe and include growth failure, susceptibility to chronic illness, and/or death. A Pediatric Outpatient Intensive Feeding Program is an onsite day program that is delivered by a team of medical, behavioral health and other professionals who address complex feeding issues through integrated, individualized care.

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			8.2 Program Services (new subsection)	New subsection text reads: Medicaid covers medically necessary Pediatric Outpatient Intensive Feeding Program services for eligible beneficiaries. Pediatric Outpatient Intensive Feeding Program services primarily focus on children who have been diagnosed by a medical professional to have significant feeding difficulties that have not been resolved or treated adequately through less intensive therapies. Pediatric Outpatient Intensive Feeding Program services utilize a multi-disciplinary team to assist the beneficiary and his/her parents/guardians in improving the beneficiary's ability to eat and swallow and improve nutritional outcomes. Pediatric Outpatient Intensive Feeding Program services include an initial comprehensive assessment, individualized plan of care (POC), on-going monitoring, and incorporate appropriate behavioral modification techniques and parent/guardian education/training. Pediatric Outpatient Intensive Feeding Program services offer an intensive focus on oral-motor skill development with attention to nutritional markers for the most therapeutic outcome. Medicaid covers medically necessary Pediatric Outpatient Intensive Feeding Program services for eligible beneficiaries. Pediatric Outpatient Intensive Feeding Program services: • Primarily focus on children who have been diagnosed by a medical professional to have significant feeding difficulties that have not been resolved or treated adequately through less intensive therapies; • Utilize a multi-disciplinary team to assist the beneficiary and his/her parents/guardians in improving the beneficiary's ability to eat and swallow and improve nutritional outcomes; • Include an initial comprehensive assessment, individualized POC, ongoing monitoring, and incorporate appropriate behavioral modification techniques and parent/guardian education/training; and • Offer an intensive focus on oral-motor skill development with attention to nutritional markers for the most therapeutic outcome.

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				Pediatric Outpatient Intensive Feeding Program services are designed to evaluate, diagnose and treat beneficiaries with significant feeding and swallowing difficulties. The initial comprehensive evaluation is performed by a multi-disciplinary team who meets with the beneficiary and his/her parents/guardians to assess the beneficiary's current status and potential for improvement. The initial comprehensive evaluation should include: • Assessment of medical history and physical exam; • Nutritional history and evaluation of growth and nutritional parameters; • Psychological assessment of developmental, cognitive, emotional and behavioral function; • Psychosocial evaluation; • Evaluation of oral-motor function (may include videofluoroscopy swallow study, Fiberoptic Endoscopic Evaluation of Swallowing (FEES), clinical swallowing evaluation, and sensory evaluation); • Standardized tests and/or objective functional baseline measures to assist with planning short- and long-term goals and to document progress; • Observation of a simulated meal/snack time; and • Development of an individualized POC. Following the initial comprehensive evaluation, the beneficiary and his/her parents/guardians commit to an outpatient program which may typically be held five days per week, six to eight hours per day, for a period up to six weeks. The goals of Pediatric Outpatient Intensive Feeding Program services are to: • Promote consistent mealtime acceptance; • Promote good nutrition; • Increase the variety of foods the beneficiary will eat;

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				• Promote development of oral-motor skills for feeding; • Promote developmental feeding skills, such as cup drinking and self-feeding; • Transition from tube to oral feeding; and • Assist the beneficiary and/or parents/guardians in acquiring feeding skills through education/training. Beneficiaries should be routinely monitored, and one-on-one consultations and/or conferences with team members should be routinely scheduled to discuss progress. Supportive services provided during this time may include speech therapy, occupational therapy, physical therapy and/or social work. Progress is assessed regularly and the POC is updated, if continuation is necessary.

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			8.3 Indications for Services (new subsection)	New subsection text reads: Pediatric Outpatient Intensive Feeding Program services may be considered medically necessary for individuals with anatomical, physiological, congenital, or cognitive conditions and/or complications of severe illness who experience significant feeding difficulties. Eligible beneficiaries must meet all the following criteria: • Significant oral-motor problems and/or chronic medical condition exist; • Normal feeding milestones have not been met through previous therapies and treatment; • Suboptimal nutritional status has been determined; and • Inadequate responsiveness to less intensive treatment has been clinically documented. Examples of feeding disorders treated in these programs include, but are not limited to: • Oral-motor dysfunction (including swallowing, oral and/or pharyngeal dysphagia); • Severe pathology in the perception of, or response to, sensory input to the extent that it significantly limits the ability to function; • • Gastrointestinal disorders; and • Feeding tube dependency. Pediatric Outpatient Intensive Feeding Program services are not covered for individuals with specific eating disorders (e.g., binge eating, bulimia, anorexia or obesity-related disorders).

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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></td><td></td><td></td><td>8.4 Provider Qualifications
(new subsection)</td><td>New subsection text reads:

Pediatric Outpatient Intensive Feeding Programs are provided under the delegation and supervision of a Medical Director and delivered by a multi-disciplinary team of medical, behavioral health and other professionals who are licensed, certified and/or registered to provide health-related services within the scope of practice for their discipline. The multi-disciplinary team should integrate and coordinate an individualized, comprehensive POC to address complex feeding issues. Each Pediatric Outpatient Intensive Feeding Program must have the following staff actively involved in the assessment process and/or development/implementation of the POC.

<table>
<tr><th>Provider Type</th><th>Required Qualifications</th></tr>
<tr><td>Pediatrician</td><td>A Medicaid-enrolled and CSHCS-approved physician who possesses or is eligible for Pediatric Specialty Board Certification. Physicians are expected to remain familiar with current developments and standards of treatment in their respective fields. May serve in the required role as Medical Director.</td></tr>
<tr><td>Subspecialist</td><td>A Medicaid-enrolled and CSHCS-approved physician who possesses or is eligible for Pediatric Subspecialty Board Certification, including physicians with special training and demonstrated clinical experience related to pediatric feeding clinic issues. Physicians are expected to remain familiar with current developments and standards of treatment in their respective fields. May serve in the required role as Medical Director.</td></tr>
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Provider Type	Required Qualifications
Licensed Behavioral Health Professional	A Licensed Behavioral Health Professional, such as a licensed psychologist or licensed Master's Social Worker, with at least two years of professional experience in providing services to children/youth and their families.
Occupational Therapist	A Licensed Occupational Therapist with at least one year of professional pediatric experience.
Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN)	An RD or RDN in possession of a Master's degree in human nutrition, public health, or a health-related field with an emphasis on nutrition, and one year of pediatric nutrition experience in providing nutrition assessment, education and counseling.
Speech-Language Pathologist	A Licensed Speech-Language Pathologist in possession of a Master's degree, and at least one year of professional pediatric experience.
Other staff	Other staff may include registered nurses, physical therapists, etc.
Parent/Guardian and/or Beneficiary	The parent/guardian and/or the beneficiary must be an active, participating team member in the development of the beneficiary's comprehensive POC.

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			8.5 Service Provider Enrollment (new subsection)	New subsection text reads: CSHCS-approved, Medicaid-enrolled program sites must be certified by the Michigan Department of Health and Human Services (MDHHS). MDHHS certification will be based upon adherence to the following requirements: • Existence of a program schedule of services and supports. • Assessment and POC services must be delivered by professional staff, as identified. • If an aide under professional supervision delivers direct services, that supervision must be documented in the beneficiary's medical record. Certification of new program sites will be contingent upon submission of acceptable enrollment information to MDHHS or upon a site visit by MDHHS.

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			8.6 Prior Authorization (new subsection)	New subsection text reads: Pediatric Outpatient Intensive Feeding Program services require prior authorization. Requests for prior authorization must be submitted utilizing form MSA-6544-B (Practitioner Special Services Prior Approval – Request/Authorization) and include documentation to support medical necessity such as height/weight measurements and previously attempted therapeutic interventions. (Refer to the Prior Authorization subsection of the Practitioner Chapter for additional information.) Medicaid forms can be accessed on the MDHHS website. (Refer to the Directory Appendix for website information.) A copy of the prior authorization must be retained in the beneficiary's medical record. Pediatric Outpatient Intensive Feeding Program services must request prior authorization to continue intensive treatment services beyond the current authorization period, even if a beneficiary changes providers. A copy of the latest re-evaluation must be submitted with the prior authorization request. Requests for continued treatment must be supported by all of the following: • Summary of previous treatment period (not to exceed 90 days prior to that time period for which prior authorization is being requested), including measurable progress on each short- and long-term goal, rate of progress, statement of the beneficiary's response to treatment, and any factors that have affected progress during the therapy period. Do not send daily treatment notes. • Revised goals and justification for any change in the treatment plan for the requested period of treatment. • Statement detailing any parent/guardian education and training.

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			8.7 Billing and Reimbursement (new subsection)	New subsection text reads: Reimbursement for Pediatric Outpatient Intensive Feeding Program services is a bundled payment rate based on the covered services provided by a multi-disciplinary team. This service is reimbursed as a daily rate comprised of all costs associated with the services provided within the day program, including: facility-related costs; medical care services provided by the physician and other licensed practitioners; services provided by clinical staff working under the delegation and supervision of a licensed medical practitioner; and diagnostic, screening and rehabilitative services. Services are billed as FFS claims through the Community Health Automated Medicaid Processing System (CHAMPS) regardless of beneficiary health plan status. Providers are to bill using Healthcare Common Procedure Coding System (HCPCS) code S0317 (disease management; per diem).
MSA 18-11	6/1/2018	Laboratory	Section 2 – Billing Information	Text was revised to read: When billing Medicaid for services rendered, the date of service (DOS) indicated on the claim must be the date the specimen is collected. Refer to the Billing & Reimbursement for Professionals Chapter of this manual for additional information about billing.

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			2.2.C. Independent Laboratory	The 2nd and 3rd paragraphs were revised to read: The physician-owned independent laboratory is subject to the following policies: • The laboratory must not accept referrals from the physician owner or his immediate family members. • Laboratory claims are billed using the independent laboratory NPI number. • ~~Laboratory claims are subject to the independent laboratory daily reimbursement limit.~~ The non-physician owned independent laboratory is subject to the following policies: • The laboratory must not accept referrals from the owner or his immediate family members. • Laboratory claims are billed using the independent laboratory NPI number. • ~~Laboratory claims are subject to the independent laboratory daily reimbursement limit.~~

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			Section 3 - Reimbursement Limitations	The section title was revised to read: Reimbursement ~~Limitations~~ Text was revised to read: Reimbursement rates for clinical laboratories, physician's offices, and clinics are established by MDHHS as a fee screen for each procedure. MDHHS uses the Medicare Clinical Laboratory Fee Schedule (MCLFS) prevailing fees as a guideline or reference in determining the maximum fee screens for individual procedures. Services are reimbursed at a maximum rate of 90% of the MCLFS. The Medicaid Clinical Laboratory fee schedule is updated following the January release of the MCLFS. Reimbursement for laboratory services includes the collection of the specimen(s), the analysis, and the lab test results. Medicaid performs pre- and/or post-payment reviews to monitor laboratory procedures for medical necessity and appropriate practitioner orders. A beneficiary cannot be charged for any covered laboratory procedures, including those that are determined to be non-medically necessary. Laboratory services provided by outpatient hospitals or ESRD facilities are reimbursed through the Medicaid Outpatient Prospective Payment System (OPPS) and not subject to the reimbursement methodology described in this section. ~~When billing Medicaid for services rendered, the DOS indicated on the claim must be the date the specimen is collected.~~
		Acronym Appendix		Addition of: MCLFS - Medicare Clinical Laboratory Fee Schedule

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MSA 18-14	6/29/2018	Hospital Reimbursement Appendix	11.3 Final Settlement(s)	The following text was added at the end of the subsection: For the purpose of the hospital final settlement process only, hospitals that participate in the Medicaid FFS 340B program will have the option to have their 340B drug costs adjusted from actual acquisition cost to a hospital's normal and customary charge. Participation in the 340B final settlement adjustment process is contingent on the provision of sufficient documentation to confirm the reasonableness of reported charges. This adjustment will not apply to drug reimbursement, and participating providers are required to continue to bill 340B actual acquisition cost and all applicable modifiers. This policy does not impact or require any additional action for providers that do not participate in the Medicaid FFS 340B program. This policy is effective for final settlements with fiscal year ends on and after October 1, 2015, and does not apply to prior settlements or settlements reopened prior to this effective date.
MSA 18-15	6/1/2018	Program of All-Inclusive Care for the Elderly	3.6 Deeming Process (new subsection; following subsections were re-numbered)	New subsection text reads: MDHHS may deem a participant who no longer meets the State Medicaid nursing facility level of care requirements to continue to be eligible for the PACE program if, in the absence of continued coverage under the program, MDHHS determines the participant reasonably would be expected to meet the nursing facility level of care requirement in the next six months. To be eligible for deeming, a participant must meet the following requirements: • Participant must have been receiving PACE services for at least the past six months and no longer than one year. • Participant no longer meets nursing facility level of care requirements. • In the absence of continued coverage under PACE, the participant reasonably would be expected to meet the nursing facility level of care requirement in the next six months. When a deemed PACE participant has been in the program for one year, the PACE organization must conduct an in-person annual reassessment to determine if the participant meets nursing facility level of care.

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MSA 18-20	6/29/2018	Non-Emergency Medical Transportation	Section 3 – Transportation Authorization	The following text was added after the 4th paragraph: In situations when a completed, original DHS-5330 cannot be secured prior to a beneficiary's scheduled Medicaid-covered appointment, authorizing parties may approve and reimburse all necessary NEMT services if the DHS-5330 is completed and returned to the authorizing party within 10 business days of the appointment. Allowable circumstances include, but are not limited to, the beneficiary's first trip to their primary care physician or medical appointment, or an inability by the beneficiary's physician's office to complete the form and secure the necessary signatures in a timely manner. The 5th (6th) paragraph was revised to read: Authorizing parties must retain the completed, original DHS-5330 in the beneficiary's file and make it available upon request. Authorizing parties are ~~The authorizing party is~~ responsible for verifying Medicaid eligibility, maintaining a network of transportation subcontractors, and scheduling the least-costly mode of appropriate transportation to medical appointments/services.
			5.2 Meals	The last paragraph was revised to read: Meal reimbursement requires original, itemized, unaltered receipts which must include the business name, address, date, time, itemized list of items purchased with cost of each item. However, if the restaurant or place of business omits any necessary items from their receipt, the information may be hand-written by the individual incurring that expense. Bulk purchases of groceries and shared meals are not reimbursable. Meals must be purchased and consumed on the day and within the time of travel. Reimbursement for alcoholic beverages is not permitted. If a lodging reservation or other travel includes a complimentary breakfast or other meals, Medicaid does not provide any additional reimbursement for that meal.

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			5.3 Fees and Tolls	Text was revised to read: Travel-related fees and tolls (e.g., parking, toll road, and bridge fare) are reimbursed at actual cost and require original, unaltered receipts. In situations when it is necessary for a Medicaid beneficiary to traverse the Mackinac Bridge and the original, unaltered receipt(s) is unavailable, the authorizing party may still approve reimbursement for the toll when supported by documentation on the MSA-4674. Documentation must include the origin and destination points, and a notation regarding the reason an original receipt is unavailable. Per leg reimbursement for passenger vehicles crossing the Mackinac Bridge will be consistent with rates included on the Mackinac Bridge Authority website. Bridge fare is only reimbursable when the beneficiary is in the vehicle. This exception is not intended to eliminate the requirement that necessary Mackinac Bridge tolls require original, unaltered receipts and may be subject to post-payment review.
			5.6 Hospital Facility Meal and Lodging Reimbursement (new subsection)	New subsection text reads: Some hospital facilities (e.g., University of Michigan Health System [Michigan Medicine]) provide advance expenses for meals or lodging on a per diem basis to Medicaid beneficiaries securing inpatient or outpatient treatment at their facility, and these facilities seek reimbursement directly from an authorizing party or local MDHHS office after the treatment's end. For these facilities to receive reimbursement of their advance expenses, they must provide to the local MDHHS office, or authorizing party, an invoice or general authorization of services documenting the name of the facility, the name of the Medicaid beneficiary, the date(s) of service, the service(s) requesting reimbursement (i.e., meals or lodging), and the cost of each service. Requests made by the facilities for reimbursement must be received by the local MDHHS office, or authorizing party, within 90 calendar days of the last date-of-service. The current maximum per-day rates for these services are indicated on the MDHHS NEMT Database.

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