MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

Bulletin Number: MSA 18-16

Distribution: All Providers

Issued: June 1, 2018

Subject: Updates to the Medicaid Provider Manual; Clarification for Services Provided to Beneficiaries Receiving Hospice Services; Code Updates

Effective: July 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 July 2018 update of the online version of the Medicaid Provider Manual. The manual will be available July 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 for Services Provided to Beneficiaries Receiving Hospice Services

MDHHS does not separately reimburse providers for services related to the beneficiary's terminal illness when the beneficiary is enrolled in a hospice program. All provider services related to the beneficiary's terminal illness are either arranged for (via contract agreement) and reimbursed by, or provided by, the hospice program. Refer to the Hospice chapter of the Medicaid Provider Manual for additional information about hospice services.

Code Updates

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

  Physicians, Nurse Practitioners, Medical Clinics, Ambulatory Surgical Centers and Outpatient Hospitals

  Q5103 Q5104

- **New Coverage of Existing Codes - Effective April 1, 2018**

  1. Physicians, Nurse Practitioners, Medical Clinics, Local Health Department, Child and Adolescent Health Center & Programs, Federally Qualified Health Center, Rural Health Clinic, Tribal Health Center and Urgent Care Center

     90739

  2. Physicians, Nurse Practitioners, Medical Clinics, Federally Qualified Health Center, Rural Health Clinic and Tribal Health Center

     96377

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

  Physicians, Nurse Practitioners, Medical Clinics, Local Health Department, Federally Qualified Health Center, Rural Health Clinic and Tribal Health Center

  Q9991 Q9992

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

  Medical Suppliers

  B4100 E0242 E0745

- **Retroactive Coverage of Existing Codes**

  1. Nurse Practitioners -- Effective April 1, 2017

     90791 90792

  2. Local Health Department - Effective January 1, 2018

     D1575 D5511 D5512 D5611 D5612 D5621 D5622 D6081

- **Discontinue Coverage of Existing Codes - Effective March 31, 2018**

  Local Health Department, Child and Adolescent Health Center & Programs, Federally Qualified Health Center, Rural Health Clinic and Tribal Health Center

  R0070 R0075

- **Discontinued HCPCS Procedure Codes For All Applicable Provider Types - Effective March 31, 2018**

  Q5102

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

  0004U 0015U

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

Medicaid Provider Manual
July 2018 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	11.2 Beneficiary Copayment Requirements	In the 1st paragraph, the 1st bullet point was revised to read: • Physician office visits (including those provided by ~~podiatrists and~~ nurse practitioners, physician assistants, and podiatrists)	Update.
Coordination of Benefits	2.6.B. Medicare Part A	In the 5th paragraph, the 2nd bullet point was revised to read: • Medicare Beneficiary Identifier (MBI) or Health insurance claim number (HICN);	Update.
Billing & Reimbursement for Dental Providers	Section 2 – General Information/Prior Authorization	In the 1st paragraph, the 1st sentence was revised to read: The Dental Prior Approval Authorization Request (MSA-1680-B) is a form designed to obtain authorization for those services that require prior authorization (PA), as indicated in the Dental Chapter. In the 2nd paragraph, the 1st bullet point was revised to read: • ~~X rays~~ Radiographs must be sent along with the PA form.	Consistency in language.
Billing & Reimbursement for Institutional Providers	7.25 Self-Care Dialysis Training	In the 3rd paragraph, the last bullet point (appears as a separate paragraph) was removed: • ~~A quantity of "1" must be entered, not to exceed a maximum of nine sessions per course.~~	Duplicate information
Billing & Reimbursement for Institutional Providers	Section 8 – Nursing Facility Claim Completion	The following text was added as a burst box: For Room and Board, the service line from and to date (if reported) must match that of the claim header from and through dates and be reflected in the units billed. The room and board revenue code billed must be for the appropriate room type. Both Revenue Codes 0110 and 0120 must not be billed on two separate claims for the same beneficiary and same/overlapping service dates. These claims will be denied or recouped if paid incorrectly.	Clarification.

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

Medicaid Provider Manual
July 2018 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Professionals	7.13 School Based Services	The description for modifier TM was revised to read: Individualized Educational ~~al~~ Program (IEP)	Consistency in terminology.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	2.3 Location of Service	In the 5th paragraph, the 2nd bullet point was revised to read: • Wraparound planning, ~~or~~ case management or supports coordination. This should occur up to 180 days prior to discharge from a CCI or Hawthorn Center.	The statutory references for this decision are the Supplemental Appropriations Act, 2008, Pub. L. 110-252, which was signed into law on June 30, 2008 and a July 25, 2000 State Medicaid Director letter which summarizes CMS policy clarifications designed to support State efforts to transition individuals from institutions and expand availability of home and community-based services. In summary, Wraparound, which is the equivalent of targeted case management or supports coordination, can be provided for a child transitioning out of a CCI and Hawthorn Center to the community for a period of 180 days prior to discharge.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	2.4 Staff Provider Qualifications	In the table in the 2nd paragraph, text for Physician's Assistant was revised to read: Physician~~'~~s Assistant An individual licensed by the State of Michigan as a physician~~'~~s assistant. Practice as a physician~~'~~s assistant means the practice of medicine ~~or osteopathic medicine and surgery performed under the supervision of a physician(s) license~~ with a participating physician under a practice agreement.	State law change (PA 379 of 2016).

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	9.2.D. Qualified Staff	Text was revised to read: Intensive crisis stabilization services must be provided by a mobile intensive crisis stabilization team consisting of at least two staff who travel to the child or youth in crisis. One team member must be a Master's prepared Child Mental Health Professional (or Master's prepared Qualified Intellectual Disabilities Professional [QIDP], if applicable) and the second team member may be another professional or paraprofessional under appropriate supervision. Paraprofessionals must have at least one year of satisfactory work experience providing services to children with serious emotional disturbance and/or intellectual/developmental disabilities, as applicable. Team members must have access to an on-call psychiatrist by telephone, as needed. At minimum, all team members must be trained in crisis intervention and de-escalation techniques.	
Behavioral Health and Intellectual and Developmental Disability Supports and Services	15.1 Waiver Supports and Services	Individual Education Plan was revised to read: Individualized Education Plan Individualized Educational Plan was revised to read: Individualized Educational ~~al~~ Plan	Consistency in terminology.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	17.3.H. Prevention-Direct Service Models	In the table in the 2nd paragraph, text for "Child Care Expulsion Prevention (CCEP)" was revised to read: CCEP, an infant and early childhood mental health consultation model, provides consultation to child care providers and parents who care for children under the age of six who are experiencing behavioral and emotional challenges in their child care settings. Sometimes these challenges may put children at risk of expulsion from the child care setting. CCEP aims to reduce expulsion and increase the number of families and child care providers who successfully nurture the social and emotional development of children 0-5 in ~~licensed~~ child care ~~programs~~ settings. CCEP programs provide short-term child/family-centered mental health consultation for children with challenging behaviors which includes: • Observation and functional assessment at home and at child care.	Additional wording is provided to highlight what the focus of the model is and to ensure that providers are trained in the evaluated model and its use with young children, families and child care providers.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
		• Individualized plan of service developed by a team comprised of the family, child care provider, other identified support person(s) that the family identifies. • Intervention (e.g., coaching and support for parents and providers to build their reflective capacity, learning new ways to interact with the child to build their social-emotional skills and resilience, providing educational resources for parents and providers, modifying the physical environment, connecting family to community resources, providing counseling for families in crisis, and referral for ongoing mental health services, if needed). Provider qualifications: • Master's prepared early childhood mental health professional plus specific training in the evaluated model as approved by MDHHS. Effective October 1, 2009, training requirement must, at a minimum, include ~~minimally have~~ Endorsement, at Level 2, by the Michigan Association of Infant Mental Health; Level 3 preferred.	
Behavioral Health and Intellectual and Developmental Disability Supports and Services	18.5 Determination of Eligibility for BHT	In the 2nd paragraph, 5th bullet point, text was revised to read: ... (i.e., Individualized Education Plan/Individualized Family Service Plan [IEP/IFSP], Individual Plan of Service [IPOS], etc.).	Consistency in terminology.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	18.9.D. Telepractice for BHT Services	The 1st paragraph was revised to read: All telepractice services must be prior authorized (i.e., IPOS indicates telepractice as an identified treatment modality for the beneficiary) by the Michigan Department of Health and Human Services (MDHHS). Telepractice is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of services (e.g., access or travel to needed medical services may be prohibitive). Telepractice must be obtained through real-time interaction between the child's physical location (patient site) and the provider's physical location (provider site). Telepractice services are provided to patients through hardwire or internet connection. It is the expectation that providers, facilitators, and staff involved in telepractice are trained in the use of equipment and software prior to servicing patients, and services provided via telepractice are provided as part of an array of comprehensive services that include in-person visits and assessments with the primary supervising BHT provider. Qualified providers of behavioral health services are able to arrange telepractice services for the purposes of teaching the parents/guardians to provide individualized interventions to their child and to engage in behavioral health clinical observation and direction (i.e. increase oversight of the provision of services to the beneficiary to support the outcomes of the behavioral plan of care developed by the primary supervising BHT provider). Qualified providers of ...	Additional clarification on authorization requirements and use of telepractice for BHT services.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	18.12.A. BHT Supervisors	Under "Limited License Psychologist (LLP)", the 3rd bullet point was revised to read: • License/Certification: LLP means a doctoral or master level psychologist licensed by the State of Michigan. Master's Limited Psychologist ~~master's limited~~ license is good for one two (2)-year period. Must complete all coursework and experience requirements.	Clarification/consistency in use of terminology in Manual.

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

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	18.12.A. BHT Supervisors	Under "Qualified Behavioral Health Professional (QBHP)", 4th bullet point, the 2nd sub-bullet point was revised to read: ➢ Minimum of a master's degree in a mental health-related field or BACB approved degree category from an accredited institution with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD. Works within their scope of practice, works under the supervision of the BCBA, and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented coursework at the graduate level (i.e. completion of three BACB evaluated graduate courses or BACB verified course sequences meeting specific standards toward certification) from an accredited university in at least three of the six following areas:	Additional clarification to assist in interpretation of "extensive knowledge and training in behavior analysis" consistent with ASD practice guidelines, best practice and professional standards from the national certification board (BACB) and feedback from PIHPs/CMHSPs responsible for credentialing QBHP providers.
Children's Special Health Care Services	Section 10 – Out-of-State Medical Care	The last paragraph was revised to read: The LHD CSHCS offices authorize and assist families with travel for care received in borderland areas in the same manner as for travel in state. Refer to the ~~Travel~~ Non-Emergency Medical Transportation (NEMT) Assistance section of this chapter for specific information.	Changes in terminology used to improve consistency within Medicaid Provider Manual.
Children's Special Health Care Services	Section 11 – Travel Assistance	The section title was revised to read: ~~Travel~~ Non-Emergency Medical Transportation (NEMT) Assistance Text was revised to read: CSHCS may reimburse~~s~~ for travel to assist beneficiaries in accessing and obtaining authorized specialty medical care and treatment (in-state and out-of-state, as appropriate) when the family's resources for the necessary travel pose a barrier to receiving care. ~~Travel~~ NEMT assistance is allowed for the beneficiary and one adult to accompany the beneficiary when the beneficiary: • Is a minor, or • Has a court-appointed guardian, and/or • Has a medical condition that supports the need for a caregiver.	Changes in terminology used to improve consistency within Medicaid Provider Manual.

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

CHAPTER	SECTION	CHANGE	COMMENT
		The treatment must be related to the qualifying medical ~~diagnosis~~ condition and provided by a CSHCS approved provider. The ~~travel~~ NEMT benefit is not intended to assume the entire cost for the expenses incurred.	
Children's Special Health Care Services	11.1 In-State Travel	The subsection title was revised to read: In-and Out-of-State Travel Subsection text was revised to read: Requests for ~~transportation~~ NEMT assistance must be made as follows: • Beneficiaries who are not covered by Medicaid must request ~~travel~~ NEMT assistance ~~from~~ through the LHD. • Beneficiaries who have Fee-For-Service Medicaid and live in Wayne, Oakland or Macomb County must request NEMT assistance from the contracted transportation broker. ~~coverage can request travel assistance from the LHD when travel assistance from MDHHS is unavailable. Travel must be related to the CSHCS qualifying diagnosis. If the request for travel is not related to the CSHCS qualifying diagnosis, but is a Medicaid covered service, the LHD will refer the family to the local MDHHS office for assistance.~~ • Beneficiaries who have Fee-For-Service Medicaid and live outside of Wayne, Oakland or Macomb County must request NEMT assistance from their local MDHHS office. When NEMT assistance from the local MDHHS office is unavailable, beneficiaries can request NEMT assistance through the LHD. • Beneficiaries who are Medicaid Health Plan (MHP) members must request NEMT from their health plan. MHPs may have different prior authorization and documentation requirements from those described in this chapter.	Criterion for in-state and out-of-state travel are combined for purposes of clarity. Process for NEMT request is updated to reflect process used specific to Medicaid beneficiaries.

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

CHAPTER	SECTION	CHANGE	COMMENT
		To be eligible and authorized for CSHCS ~~in-state~~ NEMT ~~travel~~ assistance, the beneficiary must be determined by MDHHS to meet the following criteria: • The beneficiary has CSHCS coverage at the time of the travel~~*~~; ➢ NEMT assistance may be authorized for individuals who do not have CSHCS but need NEMT assistance to participate in a diagnostic evaluation that is performed for the purpose of determining CSHCS eligibility. ➢ There must be verification that no other resources are available and the individual is otherwise unable to access the site of the diagnostic evaluation. • The ~~travel~~ NEMT assistance is for obtaining CSHCS specialty medical care and treatment from a CSHCS approved provider for the CSHCS medically-eligible ~~diagnosis~~ condition; • The family/beneficiary lacks the financial resources to pay for all or part of the travel expenses; • Other travel/financial resources are unavailable or insufficient; • The mode of travel to be used is the least expensive and most appropriate mode available; and • Prior approval for ~~travel~~ NEMT assistance has been obtained. The following are additional criteria for out-of-state NEMT assistance: • Comparable medical care is not available to the beneficiary within the state of Michigan or borderland areas. • Prior approval for the out-of-state medical care and treatment was obtained from MDHHS before NEMT assistance was requested. Travel to borderland providers is considered the same as travel to in-state providers and follows the same requirements and rules. ~~Travel assistance is authorized on the Client Transportation Authorization and Invoice form (MSA-0636). Authorization is given for up to one month per form. Reimbursement is made according to the allowable amount established by MDHHS. Rates are reviewed~~	

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
		~~at least annually and published on the MDHHS website. (Refer to the Directory Appendix for website information.)~~ ~~Reimbursement for beneficiaries with Medicaid coverage who request in-state travel assistance from their local MDHHS office is provided in accordance with the Medicaid/MDHHS transportation policy.~~ ~~*Travel assistance may be authorized for individuals who do not have CSHCS but need travel assistance to participate in a diagnostic evaluation that is performed for the purpose of determining CSHCS eligibility. There must be verification that no other resources are available and the individual is otherwise unable to access the site of the diagnostic evaluation.~~	
Children's Special Health Care Services	11.2 Out-of-State Travel	This subsection was deleted as information was incorporated into subsection 11.1. The following subsections were re-numbered.	

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Children's Special Health Care Services	11.3 Travel Reimbursement Process	Subsection was re-numbered as 11.2. The subsection title was revised to read: ~~Travel~~ NEMT Reimbursement Process Subsection text was revised to read: In-state NEMT assistance is prior authorized by the LHD using the process designated by CSHCS. Out-of-state NEMT assistance requests may be initiated by the LHD and must be authorized by the CSHCS state office. Prior authorization may be issued up to one calendar month for recurring visits. Reimbursement is made according to the allowable amount established by MDHHS. Rates are reviewed at least annually and published on the MDHHS website. (Refer to the Directory Appendix for website information.) Reimbursement for beneficiaries with Medicaid coverage who request NEMT assistance from their local MDHHS office is provided in accordance with the Medicaid/MDHHS Non-Emergency Medical Transportation policy. Beneficiaries who are authorized for ~~travel~~ CSHCS NEMT assistance must request reimbursement by submitting the completed Client Transportation Authorization and Invoice form (MSA-0636) and Addendum according to the General Instructions ~~described on the form~~. Receipts are required for all reimbursable expenditures except mileage. Meal expenditures are not reimbursable. Requests for ~~travel~~ NEMT reimbursement must be received by MDHHS within 90 days following the authorized month ~~authorized on the MSA-0636~~ of travel to be considered for payment. New enrollees may be reimbursed retroactive to the date of CSHCS enrollment when applicable.	Formatting changes and clarification updates.

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

CHAPTER	SECTION	CHANGE	COMMENT
		Ground Transportation • ~~Actual~~ Mileage by private car to and from the health care service. Mileage is reimbursed according to the rate established by MDHHS. • Car rentals, parking costs, and highway, bridge, and tunnel tolls require ~~original~~ receipts. • Bus, taxi, ferry or train fare, when it is the least expensive, most appropriate mode of transportation available and supported by ~~original~~ receipts. **Air Travel** • The family cannot be reimbursed for airline tickets unless prior approval to purchase the tickets was obtained from MDHHS/CSHCS. ~~Original~~ Receipts are required for reimbursement. • ~~Penalties, oxygen charges,~~ Baggage charges, etc. require ~~original~~ receipts. **Lodging** • The beneficiary must be required to stay overnight to obtain in-patient or out-patient treatment related to the CSHCS covered ~~diagnosis~~ condition, performed by a CSHCS approved provider and at a CSHCS approved medical facility, in order for the family to be reimbursed for lodging. • Inpatient Requirements: Reimbursement is for the accompanying adult as needed. • Outpatient Requirements: Reimbursement is for the beneficiary and the accompanying adult as needed. • MDHHS reimburses lodging up to the allowable amount established by MDHHS, regardless of cost. ~~Original~~ Receipts are required.	

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

CHAPTER	SECTION	CHANGE	COMMENT
Children's Special Health Care Services	11.4 Non-Emergency Medical Transportation	Subsection was re-numbered as 11.3. The subsection title was revised to read: ~~Non-Emergency Medical~~ Commercial or Non-profit Transportation Provider (Non-ambulance) Subsection text was revised to read: Beneficiaries may be eligible for ~~non-emergency medical transportation~~ NEMT through a commercial or non-profit provider (e.g., Ambu-Cab, Medi-Van, vans operated by medical facilities or public entities, ~~taxis,~~ etc.) when at least one of the following conditions is met. Beneficiary is: • Wheelchair dependent; or • Bed bound; or • Medically dependent on life-sustaining equipment which cannot be accommodated by standard transportation; or • Unable to access public or private transportation for the purpose of obtaining medical care. ~~Non-emergency medical transportation~~ CSHCS NEMT provided by a commercial or non-profit transportation provider must be prior approved by the ~~local health department (~~LHD~~)~~ on the Non-Emergent Medical Transportation Authorization and Verification form (MSA-0709). Payment is made directly to the commercial or non-profit transportation provider by MDHHS. The family/beneficiary should not pay the provider directly since the family/beneficiary cannot be reimbursed.	Clarification regarding processes for commercial and non-profit transportation providers.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Children's Special Health Care Services	11.5 Emergency and Special Transportation Coverage	Subsection was re-numbered as 11.4. The 1st paragraph was revised to read: CSHCS follows the same policies and procedures regarding emergency and special medical transportation coverage as the Medicaid Program. Coverage must be related to the CSHCS qualifying ~~diagnosis~~ condition. (Refer to the Ambulance Chapter of this manual for additional information.) The burst box was revised to read: **An additional person, such as a donor related to the medical care of the beneficiary, may be considered for ~~travel~~ NEMT assistance when approved by a MDHHS medical consultant. The treating specialist must provide CSHCS with documentation of the relationship between the beneficiary and the additional person.**	Terminology changed for consistency purposes.
Dental	1.1.A. Early and Periodic Screening, Diagnosis and Treatment	Text was revised to read: The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is available to all Medicaid beneficiaries under 21 years of age. This program was established to detect and correct or ameliorate defects and physical and mental illnesses and conditions discovered in children. Under EPSDT, dental services are to be provided at intervals which meet reasonable standards of dental practice. Primary care providers (PCPs) should provide an oral health screening and caries risk assessment for beneficiaries ~~under 21 years of age~~ at each well child visit as recommended by the AAP periodicity schedule. Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter for additional information.	Consistency in terminology.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Dental	2.2 Completion Instructions	Text was revised to read: The Dental Prior Approval Authorization Request form (MSA-1680-B) is used to obtain authorization. (Refer to the Forms Appendix for instructions for completing the form.) When requesting authorization for certain procedures, dentists may be required to send specific additional information and materials. Based on the MSA-1680-B and the documentation attached, staff ~~approves or disapproves the request and sends a letter of status to the dentist~~ reviews and makes an authorization determination. Approved requests are assigned a PA number and notification is sent to the provider. For billing purposes, the PA number must be entered in the appropriate field on the claim form. An electronic copy of the MSA-1680-B is available on the MDHHS website. (Refer to the Directory Appendix for website information.)	Update.
Dental	2.3 CHAMPS Website	The 1st sentence was revised to read: Information on specific coverage and reimbursement policies can be accessed using the Medicaid Code and Rate Reference tool in the Community Health Automated Medicaid Processing System (CHAMPS).	
Dental	2.4 Approved Prior Authorization Requests	The 6th paragraph was revised to read: If a change in the treatment plan is necessary, dentists should submit a new MSA-1680-B with appropriate ~~images~~ radiographs and information to the Dental Prior Authorization Unit.	Consistency in terminology.
Dental	Section 3 – Copayment	In the 1st paragraph, the 1st bullet point was revised to read: • When more than one reimbursable service is provided during a visit, only one copayment may be charged.	Correction.
Dental	5.1 Pharmacy Services	The 1st paragraph was revised to read: Medicaid has a list of covered drugs that include selected legend and over-the-counter drugs. The intent is to maintain coverage of economical products for most drugs. Medicaid does not reimburse dentists for drugs dispensed in the office setting. For those beneficiaries enrolled in a Medicaid Health Plan (MHP), dentists should refer to the MHP's formulary for the list of approved drugs.	

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Dental	6.1.G.1. Technical Considerations and Additional Requirements	The subsection was re-located and re-numbered as 6.1.G.7. The following subsections were re-numbered: 6.1.G.2. through 6.1.G.7. were re-numbered as 6.1.G.1. through 6.1.G.6.	Improve clarity of sections.
Dental	6.1.G.~~7~~6. Radiograph Submission Requirements for Prior Authorization	Text was revised to read: When requesting prior authorization (PA) for procedures, the dentist may be required to send radiographs along with the request. (Information regarding the completion of the PA request and the submission of radiographs is contained in the Billing & Reimbursement for Dental Providers Chapter of this manual.) In some cases, pre-op radiographs are necessary to document the presence and/or absence of teeth, related tooth structure, or related chronic pathology within the alveolar process(es). A full mouth radiograph series must be submitted with PA requests for complete dentures in cases where beneficiaries are receiving their first denture. A full mouth radiograph series is optional for PA requests for replacement of existing complete dentures (i.e., the beneficiary is edentulous, has worn dentures for years, and needs replacement dentures). In this case, the dentist may submit radiographs if they deem them necessary in the evaluation of the beneficiary's oral condition. A full mouth radiograph series must be submitted with all PA requests for partial dentures. A periapical radiograph is required when submitting PA requests for crown coverage. ~~When requesting PA for procedures, the dentist may be required to send radiographs along with the request. (Information regarding the completion of the PA request and the submission of radiographs is contained in the Billing & Reimbursement for Dental Providers Chapter of this manual.)~~	Improve clarity.

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

<table>
<tr><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th><th>COMMENT</th></tr>
<tr><td>Dental</td><td>6.1.G.7. Technical Considerations and Additional Requirements

(re-numbered from 6.1.G.1.)</td><td>Text was revised to read:
All radiographs submitted must be diagnostically acceptable and meet the following technical considerations and additional requirements.

<table>
<tr><td>Technical Considerations</td><td>• All teeth or areas of concern must be visible on the radiographs.
• Density and clarity of the radiograph must be such that radiographic interpretation can be made without difficulty.
• On a periapical view, the apex of the tooth must be demonstrated clearly, as well as a minimum of one-eighth of an inch of surrounding bone.
• Where pathologic change is in question, healthy bone must be seen surrounding the questionable area.
• Interproximal bone must be visible without the overlapping of interproximal surfaces of teeth under consideration.
• Posterior teeth areas (e.g., demonstrated impactions, developing third molars) must be completely visible.</td></tr>
<tr><td>Additional Requirements</td><td>• All film radiographs submitted must be mounted in an x-ray mount, with the exception of a single film which may be submitted in an envelope. Only actual films or diagnostically acceptable duplicates will be accepted.
• Digital radiographs submitted must be regulation film size and ~~printed on diagnostic quality paper~~ diagnostically acceptable.
• All radiographs must be identified with the beneficiary's name and Medicaid ID number.
• All radiographs must have the date the radiograph was taken.
• All full-mouth radiographs and panoramic radiographs must have "right" and "left" identification.</td></tr>
</table>
</td><td>Improve clarity of sections and update language.</td></tr>
</table>

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
		• All radiographs must include the ~~dentist's~~ provider's name and address. Technically unacceptable radiographs are returned to the dentist for replacement with no additional reimbursement provided. Radiographs are returned to the dentist with a letter of status of the PA.	
Dental	6.1.G.8. Returned Radiographs	The subsection was deleted. Text was relocated to the Technical Considerations and Additional Requirements subsection. ~~Technically unacceptable radiographs are returned to the dentist for replacement with no additional reimbursement provided.~~ ~~Radiographs are returned to the dentist with a letter of status of the PA.~~ The following subsection (6.1.G.9.) was re-numbered to 6.1.G.8..	Improve clarity of sections and update language.
Dental	6.2.A. Prophylaxis	Text was revised to read: Oral prophylaxis is a covered benefit once every six months for all beneficiaries. It includes routine scaling and debridement, as well as stain removal and polishing of the tooth surface. ~~Prophylaxis is a covered benefit once every six months.~~ ~~If prophylaxis is provided, it must be billed only once, regardless of the number of visits necessary to complete it.~~ If more than one visit is necessary to complete the ~~service,~~ prophylaxis, it must be billed only once and the date of service used on the claim must be the date of the final visit.	Improve clarity.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Dental	6.3.C. Indirect Restorations	The 1st paragraph was revised to read: Limited crown coverage is a covered benefit for beneficiaries under age 21. ~~Crowns are covered only once per five years by any provider.~~ Limited crown coverage includes: **Provisional Crowns** • Stainless steel crown – for primary teeth and permanent molars. • Stainless steel crown with resin window – for anterior primary teeth. • Crowns are covered only once per two years by any provider. **Crowns** • Laboratory-processed resin crown and ¾ resin crowns (indirect) – for anterior permanent teeth only; prior authorization (PA) is required. • Crowns are covered only once per five years by any provider.	Laboratory-processed crowns are covered once per five years. Stainless steel (provisional) crowns are covered once per two years.
Dental	6.4.C. Pulpectomy	Text was revised to read: ~~Endodontic therapy on primary teeth~~ Pulpal therapy is a benefit for beneficiaries under age ~~eight~~ 8 on anterior primary teeth and under age 13 on posterior primary teeth when the tooth is non-vital or hemostasis cannot be established by conventional pulpotomy.	Coverage parameters are different for endodontic therapy on anterior and posterior primary teeth.
Dental	6.4.E. Apexification	Text was revised to read: ~~This service is covered~~ Apexification is a benefit for beneficiaries under age 13 and is limited to permanent teeth when the apex has not completely closed.	Improve clarity. Consistent language.
Dental	6.4.F. Apexogenesis	Text was revised to read: ~~This service is covered~~ Apexogenesis is a benefit for beneficiaries under age 21~~. It~~ and is limited to permanent teeth.~~, and it~~ This service is not considered the first stage of root canal therapy.	Improve clarity. Consistent language.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Early and Periodic Screening, Diagnosis and Treatment	Section 2 – AAP Periodicity Schedule and Components	In the 2nd paragraph, the last sentence was revised to read: ~~If providers receive authorization, results of well child visits may be shared with Head Start agencies.~~ Providers are strongly encouraged to share the results with the Head Start agency if that agency was the referral source, and if the provider receives authorization.	
Early and Periodic Screening, Diagnosis and Treatment	5.1.A. Preschool	The last sentence was revised to read: ~~If the LHD receives authorization, the results may be shared with the Head Start agency if that agency was the referral source.~~ Providers are strongly encouraged to share the results with the Head Start agency if that agency was the referral source, and if the provider receives authorization.	
Early and Periodic Screening, Diagnosis and Treatment	5.2.B. Preschool	The last sentence was revised to read: ~~If the LHD receives authorization, the results may be shared with the Head Start agency if that agency was the referral source.~~ Providers are strongly encouraged to share the results with the Head Start agency if that agency was the referral source, and if the provider receives authorization.	
Emergency Services Only Medicaid	Section 3 – Coverage	In the table in the 2nd paragraph, text was revised to read: Physician Nurse Practitioner (NP) Physician Assistant (PA) Medical Clinic	Update language to include PA.
Family Planning Clinics	1.1 Explanation of Services	The 1st paragraph was revised to read: A family planning clinic or a primary care provider (i.e., MD, DO) or other Medicaid-approved provider (i.e., certified nurse midwife [CNM], nurse practitioner [NP], physician assistant [PA]) can provide family planning services. Family planning clinics are limited to providing only family planning services.	Change for consistency in manual.

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

CHAPTER	SECTION	CHANGE	COMMENT
Federally Qualified Health Centers	7.1 General Information	Text was revised to read: Effective July 1, 2016, MDHHS implemented a new care management and care coordination primary care Health Home benefit called the MI Care Team. The goals of the program are to ensure seamless transitions of care and to connect eligible beneficiaries with needed clinical and social services. MDHHS expects the benefit will enhance patient outcomes and quality of care, while simultaneously shifting people from emergency departments and hospitals to a primary care setting. The MI Care Team has an operations guide for providers called the MI Care Team Handbook. In addition, the MI Care Team has a website with provider resources. (Refer to the Directory Appendix for website information.) **Note: ~~Continuation of the MI Care Team policy/benefit after eight (8) quarters of the effective date is subject to MDHHS review and approval.~~ The benefit will continue as program evaluations are completed.**	
Hearing Services	2.1.D. Newborn Hearing Services	The 2nd paragraph was revised to read: If the birthing hospital is not equipped for ABR or EOAE, the child's ~~physician,~~ certified nurse midwife (CNM), ~~or~~ nurse practitioner (NP), physician, or physician assistant must refer the newborn to a Medicaid enrolled hearing center where screening must be completed prior to one month of age.	Update language to include PA.
Hospital	1.5.I. Services That Must be Billed by Other Providers	The following text was added to the bullet list: • Physician Assistant*	Update language to include PA.
Hospital	3.15 Hearing Services	In the 5th paragraph, the 2nd bullet point was revised to read: • Hospitals with less than 15 Medicaid deliveries per year may provide the service or advise the ~~physician,~~ nurse-midwife, ~~or~~ nurse practitioner, physician or physician assistant to refer the newborn for the hearing screening prior to age one month.	Update language to include PA.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hospital	3.20 Laboratory	In the 2nd paragraph, the last bullet point was revised to read: MDHHS policy covers hospitals for medically necessary laboratory tests when: • Ordered by physicians (MD or DO), physician assistants, podiatrists, dentists, nurse practitioners, or nurse-midwives.	Update language to include PA.
Local Health Departments	2.3 Additional Information on Objective Hearing & Vision Screening	In the 2nd paragraph, the last sentence was revised to read: ~~The results must also be shared with the Head Start agency if that agency was the referral source.~~ Providers are strongly encouraged to share the results with the Head Start agency if that agency was the referral source, and if the provider receives authorization.	
Medical Supplier	1.3 Place of Service	The following text was added as the last paragraph: MDHHS does not separately reimburse DMEPOS providers for services related to the beneficiary's terminal illness when the beneficiary is enrolled in a hospice program. All DMEPOS services related to the beneficiary's terminal illness are either arranged for (via contract agreement) and reimbursed by, or provided by, the hospice program. Refer to the Hospice chapter for additional information about hospice services.	Incorporating from the Hospice chapter for clarification purposes.
Medical Supplier	1.10 Noncovered Items	The following item was removed from the bullet list: • ~~Ultrasonic osteogenesis stimulators~~	Update.
Nursing Facility Cost Reporting & Reimbursement Appendix	4.7 New Facility/Owner Requirements	In the 3rd paragraph, the 1st bullet point was revised to read: • Medicaid operations begin date.	To clarify this bullet refers to the begin date of Medicaid participation.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	10.4.B. Facility Plant Cost Limit Per Resident Day	The 4th paragraph was revised to read: The individual facility updated Plant Cost Limit effective with the completion of the capital asset project is a weighted average of the historic individual facility Plant Cost Limit for the portion of the facility prior to the new construction, addition or renovation project and the current Class Plant Cost Limit applicable to the new capital asset project. The weighting factors used are the respective ratios of the allowable historic asset costs of the facility prior to the new construction addition or renovation project, and the allowable asset costs of the new ~~construction~~ capital asset project, to the combined allowable old and new asset costs of the nursing facility after ~~construction~~ completion of the capital asset project. The current Class Plant Cost Limit used in the weighted calculation applicable to the new capital cost portion will be the class limit in effect for the year corresponding to the new asset acquisitions being placed into service.	To conform policy language to the language in the Medicaid State Plan.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.6 Class V Nursing Facilities – Ventilator Dependent Care (VDC) Units	The 3rd paragraph was revised to read: Factors used in the determination of the per diem rate include audited costs of facilities providing similar services, the inflationary factor for the effective period of the prospective rate, the supply response of providers, and the number of residents for whom beds are needed. The prospective rate does not exceed 85 percent, nor fall below 15 percent, of an estimated average inpatient hospital rate for currently placed acute care Medicaid residents who are ventilator-dependent. The prospective rate is periodically re-evaluated to ensure reasonableness of supply and demand for special care. A new VDC nursing unit that has not previously participated in Medicaid for VDC services will have a reimbursement rate in the initial two years (24 months) of Medicaid operations based upon the statewide average VDC unit reimbursement rate for the current year. The reimbursement rate period beginning on the October 1 after the initial two years of Medicaid operations will utilize the most recent Medicaid cost report ending in the prior calendar year.	To clarify how a new VDC nursing unit's rate is determined.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.12.A. New Facility and Provider	The 1st bullet point was revised to read: • A newly constructed (non-replacement) facility.	To clarify that a replacement facility is not considered a new facility.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	10.12.A.2. New Provider Nursing Facility Variable Cost Component	The following text was added as a 3rd paragraph: This section does not apply to Class V providers.	To clarify that this section does not apply to Class V providers.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.13.G.2. Rate Relief Documentation	The 6th bullet point was revised to read: • ~~Specific details reflecting how the additional funds will be spent (i.e., staffing, consultants, medical supplies, etc.).~~ Detail of the expenses that are not in the base period for the current or subsequent fiscal year Medicaid rate and how these expenditures relate to the provision of resident care. NOTE: Increases in cost per day due to changes in resident occupancy or changes in the application of rate limitations do not constitute additional expenses.	To conform the language in this rate relief documentation section to the other sections. Clarifying that increases in cost per day do not constitute new expenses.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.13.H.2. Rate Relief Documentation	The 6th bullet point was revised to read: • Detail of the expenses that are not in the base period for the current or subsequent fiscal year Medicaid rate and how these expenditures relate to the provision of resident care. NOTE: Increases in cost per day due to changes in resident occupancy or changes in the application of rate limitations do not constitute additional expenses.	Clarifying that increases in cost per day do not constitute new expenses.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.13.I.2. Rate Relief Documentation	The 6th bullet point was revised to read: • Detail of the expenses that are not in the base period for the current or subsequent fiscal year Medicaid rate and how these expenditures relate to the provision of resident care. NOTE: Increases in cost per day due to changes in resident occupancy or changes in the application of rate limitations do not constitute additional expenses.	Clarifying that increases in cost per day do not constitute new expenses.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	13.4 Product Cost Payment Limits	The 2nd paragraph was revised to read: Entities that ~~participate in~~ dispense drugs purchased through the Federal 340B program to beneficiaries must bill the 340B price as the actual acquisition cost.	The intent of the policy is to require entities that dispense drug products purchased through the Federal 340B program to pass on the discount to MDHHS. This change clarifies that MDHHS recognizes that entities participating in the Federal 340B program do not always have 340B products available or dispense those 340B products to Fee-For-Service Medicaid beneficiaries.
Practitioner	1.5 Hospital-Based Provider	The 2nd paragraph was revised to read: For purposes of Medicaid, a HBP includes physicians (MD, DO, DPM). Some nonphysician practitioners, such as certified registered nurse anesthetists (CRNAs), nurse practitioners (NPs), ~~and~~ certified nurse midwives (CNMs), and physician assistants (PAs) can also be considered HBPs under certain circumstances.	Update language to include PA.
Practitioner	3.3.B. Local Health Department Screenings	In the 1st paragraph, the last sentence was revised to read: ~~The results must also be shared with the Head Start agency if that agency was the referral source.~~ Providers are strongly encouraged to share the results with the Head Start agency if that agency was the referral source, and if the provider receives authorization.	
Practitioner	3.8 Diagnostic Tests	Text was revised to read: Medicaid covers tests to diagnose a disease or a medical condition. Diagnostic testing must be directly related to the presenting condition of the beneficiary. The ordering or referring of specific diagnostic tests may be restricted to physicians (MD or DO) by program policy.	Clarification.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	3.14 Laboratory	Text was revised to read: The program covers medically necessary laboratory ~~tests~~ services, including the specimen collection, analysis, and report, 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, physician assistant, nurse practitioner, clinical nurse specialist, dentist, or CNM must order laboratory services according to their scope of practice. The ordering ~~physician or CNM~~ practitioner must document required laboratory testing in the beneficiary's medical chart regardless of where the tests are performed. The ordering ~~physician~~ practitioner is held responsible ~~if he orders~~ for the ordering of excessive or unnecessary laboratory tests regardless of who actually renders the services. ~~He may be subject to any corrective action related to these services, including recovery of funds.~~ MDHHS performs pre- and/ or post-payment reviews to monitor laboratory procedures for medical necessity and appropriate practitioner orders. Questionable ordering patterns may result in a prepayment review of each laboratory procedure billed or other corrective measures, including recovery of funds. A beneficiary cannot be charged for any covered laboratory procedure, including those that are determined to be not medically necessary. ~~Ordering or rendering of "profiles", "batteries" or "panels" of tests that include tests not necessary for the diagnosis or treatment of the beneficiary's specific condition is considered random screening and is not covered. Multiple laboratory tests carried out as a part of the initial evaluation of the beneficiary, when the results of the history and physical examination do not suggest the need for the tests, are considered screening and are not covered.~~	

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	3.14.A. Medical Necessity	Text was revised to read: The documentation of medical necessity must include a description of the beneficiary's symptomatology and other findings that have led the ~~physician~~ practitioner to order the test(s). An explanation of the laboratory testing method or the results of diagnostic tests, whether normal or abnormal, is not considered documentation of medical necessity.	
Practitioner	3.14.B. Referred Services	Text was revised to read: If a ~~physician~~ practitioner refers a beneficiary to an outside laboratory (independent lab, hospital lab, clinic lab, or physician office lab) for testing, the ~~physician~~ practitioner must indicate his NPI number on the referral. **A physician cannot refer a beneficiary to an outside laboratory where he or an immediate family member has a financial relationship. Noncompliance may result in corrective action by MDHHS or other agencies.** ~~Physician laboratory services are covered when performed by the physician or by his employees under his direct supervision. Coverage for laboratory services includes the collection of the specimen(s), the analysis, and the report(s). MDHHS performs pre- and/ or post payment reviews to monitor laboratory procedures for medical necessity and appropriate practitioner orders. Questionable ordering patterns may result in a prepayment review of each laboratory procedure billed or other corrective measures as a result of that provider's orders.~~ A beneficiary cannot be charged for any covered laboratory procedure, including those that are determined to be not medically necessary.	

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

CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	3.14.C. Non-covered Services (new subsection; following subsection was re-numbered)	New subsection text reads: Ordering or rendering of "profiles", "batteries" or "panels" of tests that include tests not necessary for the diagnosis or treatment of the beneficiary's specific condition is considered random screening and is not covered. Multiple laboratory tests carried out as a part of the initial evaluation of the beneficiary, when the results of the history and physical examination do not suggest the need for the tests, are considered screening and are not covered. The collection of the lab specimen(s), analysis, and test results are included in the reimbursement for laboratory services and are not covered separately unless otherwise indicated. Refer to the Laboratory chapter for additional information regarding coverage parameters, ordering limitations, and prior authorization requirements.	
Practitioner	4.5 Hospice	Text was revised to read: Medicaid covers hospice services which include palliative and supportive services to meet physical, psychological, social, and spiritual needs of terminally ill beneficiaries and their families in the home, adult foster care facility, home for the aged, nursing facility, or an inpatient hospice setting. Medicaid enrolled Hospice programs are responsible for providing all physician services related to a beneficiary's terminal illness as part of its core services. To enroll in hospice, the beneficiary must have a life expectancy of six months or less, have knowledge of the illness and life expectancy, and elect to receive hospice services rather than active treatment for the illness. Both the referring physician and the hospice medical director must certify the life expectancy. ~~(Refer to the Hospice Chapter of this manual for specific requirements related to the provision of hospice services.)~~ If the physician is not familiar with Medicaid-enrolled hospices in his area, hospice names, addresses, and telephone numbers may be obtained from MDHHS Provider Inquiry. (Refer to the Directory Appendix for contact information.) Refer to the Billing & Reimbursement for Institutional Providers and the Hospice chapters of this manual for specific requirements related to the provision of hospice services.	Clarification.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	17.5 Authorized Providers	The following text was added as the 1st paragraph: In compliance with the Michigan Insurance Code of 1956 (Act 218 of 1956), telemedicine services must be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in his or her health care profession in the state where the patient is located.	Clarification.
Practitioner Reimbursement Appendix	2.1 Qualifying Practitioners	The 1st paragraph was revised to read: Adjustments apply to both public and private practitioners and practitioner groups who are either employees of ~~one or more of the above~~ the public entities identified in the state plan, or are under contract with one or more of the ~~above~~ public entities, and include the following:	Clarification.
School Based Services	6.2.A. Reimbursement	Individualized Educational Program was revised to read: Individualized Education~~al~~ Program	Consistency in terminology.
School Based Services	6.2.B. Specialized Transportation Reconciliation and Settlement	Individualized Family Service Program (IFSP) was revised to read Individualized Family Service Plan (IFSP)	Consistency in terminology.
Tribal Health Centers	Section 7 – Billing	The 2nd paragraph was revised to read: The NPI (Type 1 – Individual) number ~~of the physician (MD or DO) overseeing the beneficiary's care must be entered as the attending provider~~ is the individual who has overall responsibility for the patient's medical care and treatment reported in the claim or encounter. The attending provider field is mandatory to complete. Additionally, the NPI (Type 1 – Individual) number of the practitioner who performed the service should be entered as the rendering provider. Do not enter a Group (Type 2) NPI number as the attending or rendering provider.	

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

CHAPTER	SECTION	CHANGE	COMMENT
Acronym Appendix		Addition of: MBI - Medicare Beneficiary Identifier Revision: IEP - Individualized Educational Program was revised to read: Individualized Educational Program IFSP - Individualized Family Service Program (IFSP) was revised to read Individualized Family Service Plan	Update.
Directory Appendix	Billing Resources – Medicaid National Correct Coding Initiative (NCCI)	The web address was revised to read: https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html	Update.
Directory Appendix	Appeals – Appeals (Beneficiary)	Phone numbers were revised to read: 877-833-0870 or ~~517-373-0722~~ (517) 335-7519 Fax ~~517-373-4147~~ (517) 763-0146	Update..
Directory Appendix	Provider Resources – Clinical Laboratory Improvement Amendments (CLIA)	The web address was revised to read: ~~http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/testswaived.cfm~~ https://www.cms.gov/Regulations-and-guidance/Legislation/CLIA/Downloads/waivetbl.pdf Information Available/Purpose was revised to read: List of CLIA-waived lab tests ~~waived under CLIA~~.	

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Provider Resources – Mental Health Screening and Assessment Tools for Primary Care	The website was revised to read: www.aap.org >> Advocacy & Policy >> AAP Health Initiatives >> Clinical Resources >> Mental Health >> Key Resources >> Primary Care Tools >> Mental Health Screening and Assessment Tools for Primary Care	
Directory Appendix	Provider Resources – State Survey Agency (Non-Long Term Care Facilities)	The mailing address was revised to read: Department of Licensing and Regulatory Affairs ~~Licensing & Certification Division~~ Bureau of Community and Health Systems Federal Survey and Certification Division 611 W. Ottawa Street PO Box 30664 Lansing, MI 48909 ~~Delivery: 611 W. Ottawa, 1st Floor~~ ~~Lansing, MI 48933~~ Information Available/Purpose was revised to read: Hospital, ESRD, OPT/CORF~~, Rural Health Clinic licensing, hospice and home health agencies,~~ RHC, Hospice, Home Health Agencies, Clinical Labs, FSOF/ASC, Psychiatric hospitals ~~licensing and Laboratory Improvement Section.~~	Update.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Nursing Facility Resources – Complaints	Phone and Fax numbers were revised to read: Hotline: 800-882-6006 517-~~241-4061~~ 284-9798 Fax 517-~~241-0093~~ 335-7167 The mailing address was revised to read: Department of Licensing and Regulatory Affairs Bureau of Community and Health Systems ~~Long-Term Care Division~~ Facility Complaint ~~and Investigation~~ Intake Section PO Box 30664 Lansing, MI 48909 Delivery: 611 W. Ottawa, 1st Floor Lansing, MI 48933 Information Available/Purpose was revised to read: To file a complaint against a health care facility. Complaints on quality of care by nursing facilities, hospitals, home health agencies.	
Directory Appendix	Nursing Facility Resources – Nurse Aide Registry	Phone and Fax numbers were revised to read: ~~800-748-0252~~ Phone: 517-284-8961 Fax: 517-241-3354 The website was revised to read: ~~www.michigan.gov/lara >> Professional Licensing >> Resources >> Other Programs >> Nurse Aide Registry Program~~ www.michigan.gov/bchs >> Nurse Aide Registry	

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Nursing Facility Resources – RAI Coordinator	Phone # was revised to read: ~~877-247-0330~~ 517-335-2086 Fax # was revised to read: ~~517-241-2629~~ 517-241-2635 Mailing Address information was revised to read: Department of Licensing and Regulatory Affairs ~~RAI Coordinator~~ Bureau of Community and Health Systems Federal Survey and Certification Division RAI Coordinator 611 W. Ottawa St. PO Box 30664 Lansing, MI ~~48933~~ 48909 Addition of e-mail address: najafih@michigan.gov	Update.

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Nursing Facility Resources – State Survey Agency (Nursing Facilities)	The fax number was revised to read: ~~517-241-2629~~ 517-241-2635 The mailing address was revised to read: Department of Licensing and Regulatory Affairs Bureau of Community and Health Systems Federal Survey and Certification Division ~~Long-Term Care Division~~ 611 W. Ottawa PO Box 30664 Lansing, MI 48909 ~~Delivery: 611 W. Ottawa, 1st Floor~~ ~~Lansing, MI 48933~~ Information Available/Purpose was revised to read: ~~Nursing facility licensing,~~ NH/SNF federal survey~~,~~ and certification	

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Nursing Facility Resources – Informal Deficiency Dispute Resolution	The fax number was revised to read: Fax 517-~~241-2635~~ 241-0093 The mailing address was revised to read: Department of Licensing and Regulatory Affairs Bureau of Community and Health Systems ~~Health Professions Division~~ ~~Enforcement Unit~~ Enforcement and Compliance Section PO Box 30664 Lansing, MI 48909 Delivery: 611 W. Ottawa, 1st Floor Lansing, MI 48933 The website was revised to read: www.michigan.gov/bchs >> Covered Providers >> Nursing Homes >> Dispute Resolution (IDR/IIDR)	
Directory Appendix	Reporting Fraud, Abuse, or Misuse of Services – Health Facility Complaint Line	Information was removed in its entirety. Phone: ~~800-882-6006~~ Information Available/Purpose: ~~Complaints on quality of care by nursing facilities, hospitals, home health agencies~~	Information can be found under Nursing Facility Resources – Complaints

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

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Reporting Fraud, Abuse, or Misuse of Services – Bureau of Community and Health Systems, Allegation Unit	Contact/Topic was revised to read: Bureau of Community and Health Systems, Allegation Unit (MI Dept. of Licensing and Regulatory Affairs) The following website was added: www.michigan.gov/bpl >> File a Complaint	

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 17-20	6/30/2017	Nursing Facility Cost Reporting & Reimbursement Appendix	4.11 Home Office, Chain Organization, or Related Party Cost Reporting	The last paragraph was deleted. ~~If the facility does not provide the above-referenced supporting documentation to support home office or related party organization costs, the facility must remove the costs from the nursing facility's cost report. The nursing facility's cost report will not be accepted if the provider does not remove the unsupported costs.~~
			4.11.B. Related Party Business Transactions	The 2nd and 3rd paragraphs were revised to read: The related party organization cost reporting is required for the specific related party organization business entity in the following cases: • If the dollar amount of routine nursing care costs to the individual nursing facility exceeds ~~$10,000~~ $25,000 in aggregate, regardless of the number or type of services provided. • If the sum (total dollar amount) of routine nursing care costs to multiple nursing facilities exceeds ~~$50,000~~ $125,000 in aggregate, regardless of the number or type of services provided and number of nursing facilities served. These dollar limits apply to related party business transactions whether they are routine or ancillary nursing services. The dollar thresholds will only apply to costs allocated to a Medicaid routine care unit, either directly or through the stepdown process (i.e., if $25,000 in costs are allocated to a nursing facility from a related party, but none of the costs are allocated to the Medicaid routine care unit, then no home office cost report would be required). Beginning October 1, 2018 and biennially thereafter, these amounts will be updated based on the Centers for Medicare & Medicaid Services (CMS) Skilled Nursing Facility (SNF) Market Basket. The updated amounts will be posted to the Long-Term Care Reimbursement and Rate Setting Section (RARSS) website. (Refer to the Directory Appendix for website information.) The following text was added as a 5th paragraph: Related party expenses must remain on the individual nursing facility cost report for the proper allocation of overhead costs regardless of whether they are ancillary or routine. This provision applies even if a home office cost report is not required.

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			4.11.B.1. Exception Process (new subsection)	New subsection text reads: An exception to the related party home office cost reporting requirements may be granted if all or part of the expenses are directly allocated to the nursing facility or facilities. If only part of the expenses are directly allocated, the sum of all other expenses allocated to a facility or facilities must be less than the dollar thresholds established in policy. Exceptions must be approved by RARSS prior to or on the due date of the home office cost report. Examples of expenses that would qualify for an exception include, but are not limited to, health insurance benefits, administrator and other staff salaries, retirement benefits, payroll taxes, other fringe benefits, contracted health services, medical supplies, office supplies, utilities, legal fees, etc.
		Directory Appendix	Nursing Facility Resources	Under 'Nursing Facility Rate Setting', the following website was added: www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Nursing Facilities
MSA 17-27	9/1/2017	Beneficiary Eligibility	9.7 Excluded Health Plan Services	The 3rd bullet point was deleted. • ~~Mental health services in excess of 20 outpatient mental health visits each contract year. (Refer to the Medicaid Health Plans and the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapters for additional information.)~~
		Beneficiary Eligibility	10.1 Coverage	The last paragraph was revised to read: CSHCS does not cover substance abuse treatment services. A beneficiary who has both CSHCS and FFS Medicaid or CSHCS and MIChild benefits receives his Medicaid or MIChild covered substance abuse treatment services from the regional PIHP. A beneficiary who has CSHCS and is enrolled in a Medicaid Health Plan may receive ~~20~~ outpatient mental health visits through the Medicaid Health Plan. Provision of outpatient mental health services through the Medicaid Health Plan is available pursuant to the Beneficiary Eligibility subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter.

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Federally Qualified Health Centers	1.4 Nonenrolled Provider Services	The last paragraph was revised to read: Services provided by clinical psychologists and clinical social workers are included in the ~~20~~ outpatient visits for MHP members. FQHCs must participate as part of a MHP provider panel in order to bill for services provided to members, and all services must be prior authorized by the respective MHP.
		Medicaid Health Plans	1.1 Services Covered by Medicaid Health Plans (MHPs)	The 23rd bullet point was revised to read: The following services must be covered by MHPs: • Mental health care ~~(up to 20 outpatient visits per calendar year)~~
MSA 17-46	12/1/2017	General Information for Providers	12.3 Timely Filing Billing Limitation	In the 5th paragraph, 1st bullet point, the 2nd sub-bullet point was revised to read: ➢ MDHHS staff failed to enter (or entered erroneous) authorization~~, level of care,~~ or restriction in the system;
		Beneficiary Eligibility	1.1 Local Michigan Department of Health and Human Services Office Determination	In the 2nd paragraph, the last sentence was revised to read: (Refer to the Medicaid Deductible Beneficiaries (Spenddowns) Section of this chapter for additional information.)
		Beneficiary Eligibility	1.2 Eligibility Begin Date	In the 2nd paragraph, the last sentence was revised to read: (Refer to the Medicaid Deductible Beneficiaries (Spenddowns) Section of this chapter for additional information.)

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Beneficiary Eligibility	2.1 Benefit Plans	The following Benefit Plan was added: Benefit Plan ID: LTC-EXEMPT Benefit Plan Name: Long Term Care Exempt Benefit Plan Description: Beneficiaries that are excluded from Long Term Care and Support Services because of Divestment, not meeting LOCD or PASARR requirements, or not returning asset verification. Type: No Benefits Funding Source: XIX Covered Services: N/A
		Beneficiary Eligibility	2.1 Benefit Plans	The following text was added to the "Benefit Plan Description" for Benefit Plan ID MI Choice: **This benefit plan is obsolete as of 12/31/17 with the implementation of MCC. Beneficiaries were re-assigned to the Hospice Benefit Plan.**
		Beneficiary Eligibility	2.2 Patient-Pay Information	Text was revised to read: Patient pay is the beneficiary's financial liability. It is shown in whole dollars only and is provided in the CHAMPS eligibility response if the amount is on file for the DOS ~~under the LOC Authorization segment "Patient Pay" field~~ (e.g., 00050 is $50.00, not 50 cents; 1285 is $1,285.00; or 0 (zero) indicates no patient pay amount). This amount applies to inpatient hospitals, nursing facilities (including ICF/IIDs), and hospice while in a nursing facility. (Refer to the Patient Pay Amount Section of this chapter for more information.)
		Beneficiary Eligibility	2.3 Level of Care Codes	The subsection was deleted.

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Beneficiary Eligibility	2.3 LOC to PET Crosswalk Table (new subsection)	The 'LOC to PET Crosswalk Table' included in bulletin MSA 17-40 was inserted.
		Beneficiary Eligibility	2.4 Scope/Coverage Codes	In the table in the 2nd paragraph, 'Qualifying Information' for Coverage Code 0 (zero) was revised to read: No Medicaid eligibility/coverage (refer to the Medicaid Deductible Beneficiaries (Spenddowns) Section of this chapter for additional information)
		Beneficiary Eligibility	3.1 CHAMPS Eligibility Inquiry	In the 2nd paragraph, the 3rd bullet point was revised to read: • ~~LOC~~ PET information (including the ~~LOC~~ PET code), Source Provider ID (supplied through MDHHS), National Provider Identifier (NPI), provider name, telephone number, address, and the patient pay amount, if applicable.
		Beneficiary Eligibility	Section 4 – Medicaid Deductible Beneficiaries	The section title was revised to read: Medicaid Deductible Beneficiaries (Spenddowns)
		Beneficiary Eligibility	6.2 Medicaid Deductible Beneficiaries and MSP	The subsection title was revised to read: Medicaid Deductible Beneficiaries (Spenddowns) and MSP

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Beneficiary Eligibility	7.1 Facility Admission Notice	The subsection title was revised to read: ~~Facility Admission Notice~~ Hospital Newborn Notice The 1st and 2nd paragraphs were revised to read: In the few cases where this process may be delayed, the hospital's submission of the newborn birth though the State's Electronic Birth Certificate (EBC) system will add the Medicaid coverage and assign a MHP to the newborn. This process is the most efficient way for hospitals to obtain a Medicaid ID for newborns. If the facility is unable to submit the newborn birth through the EBC, the hospital may submit a Hospital Newborn Notice (form MSA-2565-C) to the local MDHHS office for Medicaid eligibility to be established and to obtain a Medicaid ID number. If the MSA-2565-C form is used, ~~any provider may notify the local MDHHS office of the newborn's birth by submitting a Facility Admission Notice form (MSA-2565-C). (Refer to the Forms Appendix for a sample.)~~ the local MDHHS office will open~~s~~ the newborn's MA case and return~~s~~ the ~~MSA-2565-C~~ form to the provider with the necessary billing information.
		Beneficiary Eligibility	9.1 Enrollment	In the table, under "Excluded Enrollment", the 7th bullet point was revised to read: • People being served under the MI Choice Waiver ~~(LOC Code 22)~~. The 9th bullet point was revised to read: • Medicaid Deductible beneficiaries. (Refer to Medicaid Deductible Beneficiaries (Spenddowns) Section of this chapter for additional information.)

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Beneficiary Eligibility	9.7 Excluded Health Plan Services	The 2nd bullet point was revised to read: • Nursing facility (NF) custodial services. The health plan is responsible for restorative or rehabilitative care in a nursing facility up to 45 days in a rolling 12-month period. In order for a provider to receive Medicaid reimbursement for nursing care, the nursing facility beds must be Medicaid certified by the SMA and the provider must be enrolled with Medicaid. The SSA is responsible for conducting any required certification surveys for the SMA. If nursing facility services will exceed this coverage, the health plan may initiate the disenrollment process by submitting the Request for Disenrollment Long Term Care form (MSA-2007). The provider may bill Medicaid after the disenrollment is processed. Beneficiaries who reside in a nursing facility are excluded from subsequent enrollment in a MHP. ~~However, a beneficiary may occasionally be enrolled in a MHP due to administrative error. When this happens, disenrollment may be requested by either the nursing facility or MHP. For a nursing facility to request disenrollment, the facility must submit a Nursing Facility Request to Disenroll from Medicaid Health Plan form (DCH-1185) along with a copy of the Facility Admission Notice form (MSA-2565-C). The completed forms must be mailed or faxed to the MDHHS Enrollment Services Section as indicated on the DCH-1185. A MHP uses the Request for Administrative Disenrollment form (MSA-2008) for disenrollment.~~ If a beneficiary is in a facility prior to enrollment in a MHP and the nursing facility does the admission record in CHAMPS correctly, CHAMPS will automatically remove the MHP and set the nursing facility PET. ~~The nursing facility or MHP must submit a disenrollment to MDHHS within six months of the administrative error occurrence. Disenrollment requests that exceed six months from the date of occurrence will be retroactive to six months from receipt of the request.~~

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Beneficiary Eligibility	11.2 Initial Assessment of Assets	The 1st paragraph was revised to read: ~~The local MDHHS office must make an initial assessment of an institutionalized or MIChoice waiver patient's assets upon request from that patient. The assessment should be requested even if the patient is not currently applying for Medicaid benefits. The assessment must be made from the date of admission to the facility.~~ The local MDHHS office must make an Initial Asset Assessment for a married resident in a nursing facility (even if not currently applying to Medicaid) or for a married individual who is applying for the MI Choice Waiver or the PACE program. The assessment must be made from the first day of continuous care received by the applicant/individual.

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Beneficiary Eligibility	Section 12 – Eligibility Determination of Institutional Care	The following text was added: Nursing facilities, hospitals, state-owned and –operated facilities, CMHSP facilities, hospice, MI Choice Waiver, and MI Health Link agencies must enter beneficiary admissions, transfers, and discharges directly in CHAMPS. A completed admission will assign a PET code and benefit plan. Alternatively, when a discharge is completed in CHAMPS, the beneficiary's PET code and benefit plan will end date to reflect the discharge date. The admission or discharge should be submitted even if Medicare or other insurance covers the person's stay. When completing an admission via CHAMPS, the facility must print the admission/enrollment form generated by CHAMPS and continue to obtain the potential beneficiary (or his/her authorized representative) signature on the form. The signature of the facility personnel completing the admission form must also be obtained. This signed form must be retained in the beneficiary's record. If the facility has a signature on file, that should be noted in the signature box. In the event a beneficiary is admitted to a subsequent facility and the previous facility did not discharge the beneficiary, the new admission created in CHAMPS by the second facility will automatically discharge the beneficiary from the previous facility one day before the new facility admission date. The previous facility will receive an alert in CHAMPS that the beneficiary was discharged so they can modify the discharge date if needed (for example, if the beneficiary was discharged a week earlier before going to the second facility). When a beneficiary is discharged, the facility must discharge the beneficiary via CHAMPS to avoid any access to care problems for the beneficiary in the community (e.g., durable medical equipment, medical supplies).

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				Hospice note: For Medicaid beneficiaries residing in a nursing facility and receiving hospice services when the beneficiary is discharged from hospice (involuntary or voluntary), the NF must complete an admission in CHAMPS to assign the nursing facility PET code and benefit plan. The nursing facility will receive a manual gross adjustment for the date of the admission. Alternatively, if the facility completes the admission in CHAMPS prior to the hospice discharging the beneficiary, the new admission created in CHAMPS will automatically discharge the beneficiary from hospice and the associated PET code one day before the nursing facility admission date.
		Beneficiary Eligibility	12.1 Facility Admission Notice (following subsections were re-numbered)	Subsection was deleted. ~~In addition to the Application for Health Coverage & Help Paying Costs form (DCH-1426), the Facility Admission Notice (MSA-2565-C) is used by institutional providers to notify the local MDHHS office of the admission of a beneficiary or potentially eligible Medicaid beneficiary. It should be submitted even if Medicare or other insurance covers the person's stay. (Refer to the Forms Appendix of this manual for a copy of the form.)~~

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Beneficiary Eligibility	12.1.A. Hospitals and Nursing Facilities (following subsections were re-numbered)	Subsection was deleted. ~~The MSA-2565-C must be completed by facility personnel and signed by the beneficiary or his authorized representative. If the facility has a signature on file, that should be noted in the signature box.~~ ~~The facility must retain the original of the MSA-2565-C in the beneficiary's file. A copy must be sent to the local MDHHS office. MDHHS returns a copy of the MSA-2565-C to the facility noting the eligibility status and the beneficiary's patient pay amount.~~ ~~A nursing facility must notify the local MDHHS office if there is a change in the facility's NPI/Medicaid Provider ID number. Notification to the local MDHHS office must be made via a revised Facility Admission Notice (form MSA-2565-C) for all current Medicaid beneficiaries and newly admitted Medicaid beneficiaries. Notification applies to a facility enrolling in the Medicaid program or an enrolled facility that has a change of ownership where the NPI/Medicaid Provider ID number changes, including an enrolled ventilator dependent unit. When completing the MSA-2565-C, the NPI field must also contain the effective date of the NPI.~~ ~~An MSA-2565-C is not submitted for beneficiaries receiving hospice services in a nursing facility.~~

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Beneficiary Eligibility	12.1.B. State-Owned and -Operated Facilities and CMHSP Facilities (following subsections were re-numbered)	Subsection was deleted. ~~If no authorized beneficiary representative is available, an authorized representative of the facility's Reimbursement Office may sign the MSA-2565-C on behalf of the beneficiary. The representative must use his personal signature and position title.~~ ~~A copy of the MSA-2565-C (and the completed DCH-1426, if necessary) must be forwarded to the local MDHHS office as soon as possible following admission.~~ ~~The MSA-2565-C is generally self-explanatory. The facility should contact the local MDHHS office with any questions regarding completion of this form.~~ ~~Medicaid does not pay the facility services rendered if:~~ • ~~The returned copy of the MSA-2565-C indicates the person is not eligible for Medicaid.~~ • ~~The person has a divestment penalty (LOC Code 56).~~

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Beneficiary Eligibility	12.2.A. Nursing Facility Determinations	The 1st, 2nd, and 3rd paragraphs were revised to read: After the Medicaid application ~~and MSA-2565-C have~~ has been submitted, the local MDHHS office determines eligibility for medical assistance. All allowable expenses and income are calculated, and any remaining income ~~is considered excess income. Such excess income~~ is then considered in determining the amount the beneficiary must pay toward his medical expenses each month. This monthly contribution by the beneficiary toward his care is called the Patient Pay Amount (PPA). Nursing facilities have the following options to obtain the PPA and eligibility information: • DHS-3227 – If the local MDHHS office is unable to determine final eligibility status within five working days of receipt of the application for medical assistance, the Tentative Patient Pay Amount Notice (DHS-3227) is sent to the facility as notification of the person's tentative PPA. ~~When the final determination is made, a copy of the MSA-2565-C is returned to the facility.~~ • Nursing facility's determination of potential PPA – A timely collection of the PPA is vital for nursing facilities as it helps eliminate the need to claim adjust Medicaid and the need to retroactively collect the PPA from the beneficiary. To help alleviate unneeded claim adjusting and to collect a PPA more timely, nursing facilities are encouraged to determine what a potential beneficiary's PPA will be and collect that PPA prior to receiving the DHS-3227. Subsequently, the facility would bill Medicaid showing that potential PPA as determined by the facility. • CHAMPS Eligibility Inquiry and/or other available eligibility options to obtain the Benefit Plan ID, ~~LOC~~ PET code authorization, facility information and PPA. (Refer to the Directory Appendix for contact and website information.) ~~The identity of residents in each facility is determined from the Medicaid Provider ID number and the NPI number entered on the MSA-2565-C submitted at admission or readmission. It is very important that providers ensure that their provider numbers are valid.~~

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Billing & Reimbursement for Institutional Providers	4.1 MDHHS Admission Notification – Hospitals (new subsection; the following subsections were re-numbered)	New subsection text reads: It is vital that hospital providers complete admission/enrollment and discharge/disenrollment information in a timely manner in CHAMPS in order to maintain an accurate roster, as well as to ensure that beneficiaries have the correct PET and benefit plans assigned for correct payments. Hospitals must submit facility admissions via CHAMPS for the following beneficiaries: • Medicaid deductible beneficiaries (regardless of the length of stay). • Medicaid eligible beneficiaries if their stay is expected to be 30 days or greater. • Private Pay admission if applying for Medicaid (regardless of length of stay). Refer to the Beneficiary Eligibility Chapter for additional information about the admission process through CHAMPS.

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Billing & Reimbursement for Institutional Providers	6.2.I. Newborn Eligibility	The 1st paragraph was revised to read: All newborn services must be billed under the newborn's ID number. The hospital must not bill under the mother's ID number. If an ID number has not been assigned prior to or at the time of delivery, the ~~hospital must submit a Facility Admission Notice (MSA-2565-C) form to the local MDHHS office~~ State's Electronic Birth Certificate (EBC) system is the preferred method of adding Medicaid coverage and assigning a MHP to newborns with mothers who are Medicaid beneficiaries. This process is the most efficient way for hospitals to obtain a Medicaid ID for newborns. If the facility is unable to submit the newborn birth through the EBC, the hospital may submit a Hospital Newborn Notice (form MSA-2565-C) to the local MDHHS office for Medicaid eligibility to be established and to obtain a Medicaid ID number. (Refer to the Forms Appendix for additional information.) If the MSA-2565-C form is used, the local MDHHS office will open the newborn's MA case and return the form to the provider with the necessary billing information. ~~The local MDHHS office then returns the MSA-2565-C to the hospital.~~ Providers must not bill until the eligibility response shows the newborn's ID number, date of birth, and the sex. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information regarding verifying beneficiary eligibility. Refer to the General Information for Providers Chapter of this manual for PACER requirements for newborns.)
		Billing & Reimbursement for Institutional Providers	6.2.K. Patient-Pay Amount	The 5th and 6th bullet points were revised to read: • When an admission spans two or more months, the nursing facility must collect the patient-pay amount for each month the beneficiary is in the nursing facility ~~(for Level of Care (LOC) Code 02 and LOC Code 16)~~ (for PETs LTC-NFAC and LTC-CMCF) and in hospice (PET HOS-NFAC). • When an admission spans two or more months, the facility only collects one spend-down amount for the entire hospital admission ~~(for LOC Code 10)~~.

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Billing & Reimbursement for Institutional Providers	11.1 Billing Instructions for Hospice Claim Completion	The 6th bullet point was revised to read: • To bill for room and board in a nursing facility, licensed hospice long-term care unit, or Ventilator Dependent Care Unit (VDCU), use Revenue Code 0658. Providers must bill their customary room and board rate and Medicaid pays the usual and customary rate or the Medicaid fee screen, whichever is less. Room and board is reimbursable on the day of discharge if the discharge is due to resident death or the resident is discharged from hospice but remains in the NF. NOTE: ~~To ensure proper payment for a beneficiary in a VDCU, the VDCU provider identification number must be on the Hospice Membership Notice (DCH-1074).~~ In order for the hospice provider to complete the hospice beneficiary's admission, the type of facility for the VDCU must be identified as a nursing facility in the Admission Information Section in CHAMPS and include the VDCU's NPI. When a beneficiary resides in a VDCU/Dialysis Unit under which the VDCU has a special agreement with Medicaid and elects hospice, a prior authorization (PA) number for hospice is not required.
		Billing & Reimbursement for Institutional Providers	11.2 Adult Home and Community Based Waiver Beneficiaries (MI Choice) (following subsections were re-numbered)	The subsection was deleted. ~~The Benefit Plan ID of MI Choice identifies the beneficiary as receiving services through the Home and Community Based Waiver for the Elderly and Disabled (MI Choice Waiver) and remains on the eligibility file for the beneficiary. The Benefit Plan ID of MI Choice must be noted in the Remarks Section of the claim form in order to allow for correct claims processing.~~

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Billing & Reimbursement for Institutional Providers	11.3 Application of the Patient-Pay Amount	The 1st paragraph was revised to read: CHAMPS handles the Patient-Pay Amount (PPA) in the following manner: When a beneficiary has a monthly PPA and a ~~level of care (LOC) for nursing facility (02) and hospice (16) on file,~~ corresponding nursing facility and hospice PET (i.e., HOS-NFAC), the PPA will be deducted from the first claim received in CHAMPS. ~~This will occur regardless of whether the PPA is located on the eligibility segment for LOC 02 or LOC 16, and the higher PPA amount will be deducted.~~ The PPA will be deducted from the first claim received in CHAMPS resulting in deduction of the higher PPA amount. If the PPA is greater than the amount of the first submitted claim, the difference will be applied to subsequent claims until the total PPA for that month is met. The PPA must be exhausted each month before any Medicaid payment will be made. The nursing facility and hospice must bill in sequence according to the ~~level of care~~ location of the beneficiary ~~was~~ at ~~on~~ the first of the month. This will prevent the PPA from being deducted from the wrong claim. The following text was added as a 2nd paragraph: Providers have the ability to verify the PPA on the Member Eligibility Detail page in CHAMPS.
		Home Health	9.2 Home and Community Based Services Waiver for the Elderly and Disabled	The 2nd paragraph was revised to read: MI Choice beneficiaries are identified in the eligibility response with the Benefit Plan ID of MI Choice-MC. (Refer to the Beneficiary Eligibility chapter for additional information.) When the physician orders home health services, and the beneficiary is enrolled in the waiver program, the HHA should contact the waiver agent in order to assure coordination and verify there is no duplication of care provided.
		Hospice	Section 3 – Beneficiary Enrollment	The section title was revised to read: Beneficiary ~~Enrollment~~ Admission

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Hospice	3.1 Beneficiary Enrollment Determination	The subsection title was revised to read: Beneficiary ~~Enrollment~~ Admission Determination Subsection text was revised to read: A terminally ill Medicaid beneficiary who lives in a hospice service area and whose life expectancy is six months or less (if the illness runs its normal course), as determined by a licensed physician and the Hospice Medical Director, has the option ~~to enroll in~~ for admission into a hospice program. A representative, such as a spouse, parent, legal guardian, or other authorized adult, may act on behalf of the beneficiary. Medicaid does not cover Hospice services if the following conditions exist: • The individual is not eligible for the Medicaid benefit. • The beneficiary does not meet the hospice's ~~enrollment~~ admission criteria. • If the beneficiary is currently enrolled in a Medicaid Health Plan (MHP), the hospice services must be arranged and reimbursed by the MHP. All Hospice ~~enrollment~~ admission activities must be conducted according to MDHHS policies and in such a manner as to maximize the beneficiary's ability to make a choice between ~~enrollment in~~ admission into hospice or maintaining current active treatment with Medicaid coverage. Such activities must assure that the beneficiary fully understands how to use hospice services and that all care must be received from or through the hospice (except those services not related to the terminal illness or services provided by his attending physician). It is imperative that the Hospice provider review the Conditions of Admission with the beneficiary and answer any questions raised by the beneficiary and/or authorized representative. ~~read the Conditions of Enrollment on the Hospice Membership Notice form (DCH-1074) to the beneficiary and answer any questions raised by the beneficiary. (Refer to the Forms Appendix for an example of the DCH-1074 and instructions for its completion.)~~

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Hospice	3.2 Beneficiary Enrollment Process	The subsection title was revised to read: Beneficiary ~~Enrollment~~ Admission Process Subsection text was revised to read: Hospice providers are responsible for ~~enrolling~~ admitting beneficiaries for hospice services in the Admission Information Section in CHAMPS.~~ A DCH-1074 must be completed, including the signature of the beneficiary or his legally appointed representative. Fax the completed form to the MDHHS Enrollment Services Section. (Providers are not required to submit the form by US mail.) A copy of the form must be given to the beneficiary, and the original filed in the beneficiary's record. Do not submit the form if the beneficiary is enrolled in the Adult Home and Community Based Waiver (MI Choice).~~ The admission process must be electronically completed in CHAMPS. A downloaded copy of the beneficiary's admission must be signed by the beneficiary and/or authorized representative, with a copy given to the beneficiary and/or authorized representative and the original copy retained in the beneficiary's record. Completion of the hospice beneficiary's admission in CHAMPS will result in real-time changes to the National Provider Identification (NPI) and the beneficiary's Program Enrollment Type (PET). ~~**Do not submit forms in batches.**~~ Hospice providers have the ability to track their current beneficiaries in CHAMPS via the Member Enrollment/Admission List screen. This roster screen will allow the provider to view beneficiary admission information and Medicaid status. Hospice providers must complete the hospice admission in a timely manner in CHAMPS in order to maintain an accurate roster, and to ensure the beneficiary has the correct PET and benefit plan assigned for correct payment.

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				A copy of the following information must be retained in the beneficiary's record: • ~~Hospice Membership Notice form (DCH-1074).~~ • ~~Effective date of enrollment. (If the date entered on the DCH-1074 is changed, the hospice must contact the beneficiary to notify him of the new effective date.)~~ • The original, signed copy of the Admission Certification. • Hospice ~~enrollment~~ identification card (if the hospice chooses to issue one to their beneficiaries).
		Hospice	3.3 Beneficiary Notification	Text was revised to read: Hospice providers must provide Medicaid beneficiaries with the following materials and written information within ten days of the effective date of ~~enrollment in~~ admission into hospice: • Conditions of ~~enrollment~~ admission, including: ➢ Scope, content, and duration of coverage; ➢ ~~Enrollee~~ Beneficiary grievance procedure; and ➢ Beneficiary responsibility for reporting coverage by any other insurance. • Procedures for obtaining health care, including: ➢ Address, telephone number, and service hours of the health care providers; ➢ Emergency medical care (other than for the treatment of the terminal illness); and ➢ Health care provision outside of the hospice.

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Hospice	3.4.B. Nursing Facility	The 3rd and 4th paragraphs were revised to read: ~~The DCH-1074 is used as the benefit election form for Medicaid eligible beneficiaries.~~ The CHAMPS application process is used to complete the beneficiary's election for hospice and create the correct PET (e.g., HOS-NFAC) for Medicaid eligible beneficiaries. This does not mean that the beneficiary has revoked the Medicare benefit for services not related to their terminal illness. The beneficiary remains eligible for Medicare, but has elected to use only the hospice portion of the Medicare benefit. If the NF contracts to make hospice services available, the hospice must ~~provide DCH-1074 forms to~~ complete the admission in CHAMPS for all Medicaid, Medicare and dually eligible beneficiaries. The facility must provide room and board for the beneficiary, and the hospice must provide its normal services.
		Hospice	3.5 Duration of Coverage	Text was revised to read: Based on hospice eligibility criteria, the duration of hospice services is generally six months or less. There is no minimum period of hospice ~~enrollment~~ admission. A change in the beneficiary's prognosis could eliminate the need for hospice care. A beneficiary may cancel his ~~enrollment~~ admission in the hospice at any time and without cause. Beneficiaries who become ineligible for Medicaid while ~~enrolled~~ admitted in a hospice also become ineligible for Medicaid reimbursement for hospice 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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Hospice	Section 4 – Beneficiary Disenrollment	The section title was revised to read: Beneficiary ~~Disenrollment~~ Discharge Text was revised to read: A beneficiary may ~~disenroll or~~ be discharged from hospice as noted below. ~~A DCH-1074 indicating the reason for the disenrollment or discharge must be signed and dated by the beneficiary and/or authorized representative as proof of notification (unless the beneficiary has expired). The hospice must submit a copy of the disenrollment notice to the MDHHS Enrollment Services Section. (Refer to the Directory Appendix for contact information.)~~ The provider must complete the Discharge webpage in CHAMPS. The discharge must indicate the type of discharge, date of the discharge, reason, and details of the beneficiary's residence after discharge. A downloaded copy of the beneficiary's discharge (voluntary or involuntary) must be signed by the beneficiary and/or authorized representative as proof of notification (unless the beneficiary has expired). A copy must be given to the beneficiary and/or authorized representative after he/she signs it. **Terminations generated by the hospice are subject to the appeal procedures, as required by licensure requirements.** Completion of the hospice beneficiary's discharge in CHAMPS will result in real-time changes to the National Provider Identification (NPI) and the beneficiary's PET. Hospice providers must complete the hospice discharge (voluntary or involuntary) in a timely manner in CHAMPS in order to maintain an accurate roster, and to ensure the beneficiary has the correct PET and benefit plan assigned for correct payment.

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Hospice	4.1 Beneficiary Dies	Text was revised to read: When a ~~hospice-enrolled~~ beneficiary dies while admitted in hospice, the hospice must complete the ~~DCH-1074~~ discharge in CHAMPS indicating the date the beneficiary expired ~~and submit it to MDHHS~~.
		Hospice	4.2 Beneficiary Elects to Disenroll/Revoke Their Hospice Benefit	The subsection title was revised to read: Beneficiary Elects ~~to Disenroll~~ Voluntary Discharge/Revokes Their Hospice Benefit Text was revised to read: A beneficiary may ~~choose to disenroll~~ elect voluntary discharge from, or revoke their election of, hospice care at any time during an election period. The hospice must obtain written documentation, signed and dated by the beneficiary or their authorized representative, stating they are revoking the hospice benefit for the remainder of that election period. The ~~disenrollment~~ voluntary discharge or revocation is effective with the date of the beneficiary's/representative's signature. The hospice must ~~give a copy of the disenrollment notice to the beneficiary when he~~ complete the discharge in CHAMPS, give a copy of the discharge notice to the beneficiary or authorized representative after he/she signs it, and retain ~~another~~ the original copy in the beneficiary's record.

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Hospice	4.3 Hospice Revocation, Disenrollment, or Discharge When Beneficiary Is Hospitalized	The subsection title was revised to read: Hospice Revocation~~, Disenrollment,~~ or Discharge When Beneficiary Is Hospitalized Text was revised to read: A beneficiary should **not** revoke~~, disenroll,~~ or be discharged from hospice for the purpose of admission to the hospital for care related to the hospice diagnosis. Medicaid does not reimburse the hospital separately unless the hospitalization is **not** related to the terminal illness. When this is the case, the hospice may continue to provide care to the beneficiary under the routine hospice care benefit.
		Hospice	4.4 Beneficiary No Longer Meets Enrollment Criteria	The subsection title was revised to read: Beneficiary No Longer Meets ~~Enrollment~~ Admission Criteria Text was revised to read: ~~An enrolled~~ A beneficiary may have a change in condition and no longer qualify for hospice services. If the beneficiary is discharged for this reason, the hospice must ~~send a copy of the DCH-1074 (indicating the disenrollment) to the beneficiary along with a letter explaining the reason and effective date for the disenrollment.~~ complete the discharge in CHAMPS, provide the date of the discharge, and indicate the reason in the Remarks section of the webpage for the discharge. A copy of the discharge must be downloaded, printed, and provided to the beneficiary and/or their authorized representative.

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Hospice	4.5 Beneficiary Becomes Ineligible for Medicaid	Text was revised to read: The hospice is responsible for verifying the beneficiary's continued Medicaid eligibility once he is enrolled. Medicaid does not reimburse hospice services rendered to a Medicaid ineligible beneficiary. Once the beneficiary is deemed no longer eligible for hospice services, the hospice must complete the discharge in CHAMPS and indicate in the Remarks section the reason why the beneficiary is no longer eligible for hospice services. A copy of the discharge must be downloaded, printed, and provided to the beneficiary and/or their authorized representative.
		Hospice	4.6 Beneficiary Moves Outside the Hospice Service Area	Text was revised to read: At the time of ~~enrollment~~ the hospice admission, beneficiaries must be told to notify the hospice and their local MDHHS worker if their place of residence changes. If the new residence is located in the hospice's normal service area, or if the hospice agrees to continue to provide services to the beneficiary, the move creates no changes except an address change. ~~However,~~ If the move is too far for the hospice to continue services for the beneficiary, the hospice must arrange a transfer of care for the beneficiary to another Medicaid enrolled hospice. The two hospices must work together to assure that no lapse occurs in services to the beneficiary. The first hospice must complete the discharge webpage and indicate the planned date of admission for the second hospice in the Remarks section. It is then the responsibility of the second hospice to complete the admission application in CHAMPS. Each hospice must place an explanation in the Remarks section stating the reason for the transition. ~~The effective date of disenrollment for a beneficiary who has moved is the day that the beneficiary moves. It is preferable that the DCH-1074 indicating the disenrollment from the first hospice, and the DCH-1074 indicating enrollment for the second hospice be sent to MDHHS together. If the notices are sent separately, each hospice must place an explanation in the Remarks box on the DCH-1074 indicating the reason for the transition to the new hospice.~~

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Hospice	4.7 Hospice Elects to Terminate the Beneficiary's Enrollment	The subsection title was revised to read: Hospice Elects to Terminate the Beneficiary's ~~Enrollment~~ Admission In the 2nd paragraph, the 1st sentence was revised to read: The hospice may request ~~disenrollment~~ discharge of a beneficiary for any of the following reasons:
		Hospice	5.4 Face-to-Face Encounters	The 3rd and 4th paragraphs were revised to read: Failure to meet the face-to-face encounter requirements results in a failure by the hospice to meet the recertification of the terminal illness requirement. This results in the beneficiary no longer being eligible for the hospice benefit. If this should ~~happen~~ occur, the hospice must complete ~~a Hospice Membership Notice (form DCH-1074)~~ the admission in CHAMPS, with the last date of the benefit period as the effective ~~disenrollment~~ discharge date. A comment in the Remarks Section ~~of the form~~ on the Discharge webpage is required to explain the reason for the ~~disenrollment~~ discharge. ~~There may be an occasional case when a hospice admits a beneficiary who received services from another hospice provider, and the beneficiary chose to revoke or was discharged from that provider. When this occurs, the admitting hospice may begin their care with the beneficiary's first benefit period unless the beneficiary is a direct transfer from the other hospice. When this is the case, the beneficiary's benefit period remains the same, and the transferring hospice should provide the receiving hospice with all required documentation. A hospice resuming care for a beneficiary formerly served by their hospice must restart care in the next or subsequent benefit period.~~

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				It is the responsibility of the first hospice to complete the discharge in CHAMPS before the second hospice can complete the admission in CHAMPS when: • the beneficiary discharges from one provider for admission to a new provider; • the beneficiary revokes the services of a provider; or • the provider discharges the beneficiary. The new hospice provider may begin their care within the beneficiary's first benefit period. In the event a hospice provider is resuming care for a beneficiary formerly served by their hospice, the resuming hospice provider must have previously completed the discharge in CHAMPS at the time hospice services originally ended. To resume care, the hospice must complete a new admission in CHAMPS. The resumption of care starts in the next or subsequent benefit period.
		Hospice	6.7 Plan of Care	Text was revised to read: After ~~enrollment~~ admission in the hospice, a person-centered plan of care (POC) must be developed before the beneficiary can receive services. It is also the responsibility of the hospice provider to determine if the beneficiary is receiving services from another program such as Home Help, MI Choice Waiver, or Private Duty Nursing (PDN). If another program is identified, the hospice provider must contact the other program(s) and develop a joint POC to coordinate services. The beneficiary and/or authorized representative or primary caregiver and the Interdisciplinary Group (IDG), as defined by federal regulations, must also participate in the development of the plan. The beneficiary's attending physician should be encouraged to attend as well. The hospice is responsible for implementing the POC for hospice 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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Hospice	6.7.D. Adult Home and Community Based Waiver Beneficiaries (MI Choice)	The 2nd and 3rd paragraphs were revised to read: Beneficiaries may receive services from both types of providers concurrently as long as the services are not duplicative. ~~The Benefit Plan ID of MI Choice identifies the beneficiary as receiving services through the Adult Home and Community Based Waiver for the Elderly and Disabled (MI Choice Waiver) and remains on the MDHHS eligibility file for the beneficiary.~~ If the beneficiary is receiving hospice and becomes eligible to receive waiver services, the waiver agency contacts the hospice to establish the first date of service for the waiver services. It is the responsibility of the waiver agent to complete the beneficiary's MI Choice waiver enrollment in CHAMPS. However, if the beneficiary is receiving waiver services and becomes eligible for hospice, it is the responsibility of the hospice to complete the hospice admission in CHAMPS. The appropriate Program Enrollment Type (PET) identifies a beneficiary receiving hospice services and Adult Home and Community Based Waiver for the Elderly and Disabled (MI Choice Waiver) services concurrently (e.g., MIC-HOSP or MIC-HSSP). The waiver agency and the hospice provider must discuss and coordinate services in order to prevent delays in access of care. ~~The hospice then submits a Hospice Membership Notice (DCH-1074) to MDHHS noting the hospice "disenrollment" date. The waiver services begin date is the day following the hospice "disenrollment" date. The hospice must document in the "Remarks" section of the form the effective date of the beneficiary's enrollment into the MI Choice waiver program. The beneficiary should not sign the disenrollment portion of the form.~~ The 4th paragraph was deleted. ~~The hospice should not submit a Hospice Membership Notice (DCH-1074) to MDHHS if the eligibility response indicates the Benefit Plan ID of MI Choice for the date of service. The hospice contacts the waiver coordinator to discuss and coordinate the services required. (Refer to the Beneficiary Eligibility chapter for additional information.) The Benefit Plan ID of MI Choice must be noted in the Remarks Section of the claim form in order to allow correct claims processing.~~

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Hospice	6.9.D. MI Health Link	Text was revised to read: Beneficiaries enrolled in MI Health Link are dually eligible for both Medicare and Medicaid. While hospice is not a benefit offered by MI Health Link, beneficiaries in the program may still elect hospice and begin receiving hospice services at any time. Effective November 1, 2016, individuals enrolled in the MI Health Link program who elect hospice services may remain enrolled in the MI Health Link program if they choose. (Refer to the MI Health Link Chapter for additional details regarding hospice services under the MI Health Link program.) ~~When a MI Health Link beneficiary elects hospice services, the hospice agency must notify the beneficiary's Integrated Care Organization (ICO) for initiation of care management and authorization of nursing facility room and board, if indicated. The hospice agency will bill Medicare for hospice services and other Medicare Part A and Part B services not related to the terminal illness and bill the ICO for room and board when hospice is rendered in a nursing home setting.~~ ~~If the beneficiary is receiving hospice services while residing in a nursing facility, the hospice provider must provide to the beneficiary's ICO the Hospice Membership Notice (form DCH-1074) indicating the nursing facility information and when hospice services started. If hospice services end, or the beneficiary moves to a community setting to receive hospice services, the hospice provider must provide the ICO with an updated DCH-1074 indicating the beneficiary is no longer receiving hospice services, or is no longer residing in the nursing facility, as applicable.~~

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				~~The hospice agency does not submit a DCH-1074 to the MDHHS Enrollment Services Section because the beneficiary will remain in MI Health Link at the current level of care (LOC) of 03, 05, 07, or 15. When the individual is enrolled in MI Health Link and receiving hospice services, the LOC code 16 will not be reflected in the Community Health Automated Medicaid Processing System (CHAMPS).~~ ~~A beneficiary has the option of disenrolling from MI Health Link at any time by contacting Michigan's contracted enrollment broker. During the month when disenrollment occurs, the beneficiary will remain with MI Health Link until the first day of the following month, at which time Fee-for-Service (FFS) Medicaid will become effective. Hospice agencies will need to monitor MI Health Link beneficiary enrollment status. If a beneficiary receiving hospice is disenrolled from MI Health Link, a DCH-1074 will need to be submitted by the hospice agency to the MDHHS Enrollment Services Section. The last date of a beneficiary's participation in MI Health Link (the last day of the month) and the start date of FFS Medicaid (the first day of the following month) must be included within the DCH-1074 Remarks section. This will allow the LOC of 16 (hospice) to be placed on the beneficiary's file once the disenrollment is reflected in CHAMPS.~~

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Hospice	7.1 Medicare/Medicaid Beneficiaries	Text was revised to read: If a beneficiary is dually enrolled in Medicare and Medicaid, he must receive hospice coverage under the Medicare benefit. (Medicaid is the payer of last resort.) If the beneficiary resides in a NF, Medicare may pay hospice services, with NF room and board paid for by Medicaid. When a beneficiary is receiving services through the Medicare hospice benefit, Medicaid does not pay for curative or duplicative services. ~~The hospice provider must complete the DCH-1074 whenever Medicaid is billed (i.e., coinsurance, deductibles, and room and board in the NF or hospice-owned NF).~~ The hospice provider must complete the admission in CHAMPS prior to submission of a Medicaid claim (i.e., coinsurance, deductibles, and room and board in the NF or hospice-owned NF). The hospice provider must also complete the beneficiary's discharge (voluntary or involuntary) or upon notification of the beneficiary's demise. (Refer to other applicable Sections for details regarding admission and discharge guidelines.) If the hospice benefit is revoked under Medicare, the beneficiary cannot use the Medicaid hospice benefit as a replacement. Hospices should carefully explain this situation to the dually eligible beneficiary, especially during the fourth Medicare benefit period. However, if the dually eligible beneficiary is no longer appropriate for hospice care and is ~~disenrolled~~ discharged as a hospice beneficiary, that beneficiary is ~~able to re-enroll~~ eligible for re-admittance with the hospice for the Medicaid benefit period if he becomes eligible for hospice again.

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Hospice	7.2 Medicaid Health Plan Enrollees	The 2nd and 3rd paragraphs were revised to read: If a Fee-for-Service (FFS) Medicaid beneficiary is automatically enrolled in a MHP while receiving hospice care, the beneficiary or his representative should contact the MDHHS Hospice Enrollment Coordinator if he wishes to continue receiving services from his current hospice provider. (Refer to the Directory Appendix for contact information.) The Hospice Enrollment Coordinator initiates the process of disenrollment from the MHP. It is not the intent of MDHHS to disrupt a hospice beneficiary's care through automatic enrollment in a MHP. If the beneficiary is subsequently ~~disenrolls or is~~ discharged from hospice care, the beneficiary may be offered the opportunity to join a MHP. If the MHP enrollee requires hospice services in a NF or hospice-owned NF, the MHP pays a negotiated rate for room and board in addition to the payment for the hospice services. The hospice must contact the MHP prior to ~~enrolling~~ admitting the beneficiary for hospice services to request authorization by the MHP.
		Hospice	7.3.E. Patient-Pay Amount	The 3rd paragraph was revised to read: CHAMPS handles the PPA in the following manner: When a beneficiary has a monthly PPA and a ~~level of care (LOC) for nursing facility (02) and hospice (16) on file~~ corresponding nursing facility and hospice PET (i.e., HOS-NFAC), the PPA will be deducted from the first claim received in CHAMPS, ~~This will occur regardless of whether the PPA is located on the eligibility segment for LOC 02 or LOC 16, and the higher PPA amount will be deducted.~~ resulting in deduction of the higher PPA amount. If the PPA is greater than the amount of the first submitted claim, the difference will be applied to subsequent claims until the total PPA for that month is met. The PPA must be exhausted each month before any Medicaid payment will be made. The nursing facility and hospice must bill in sequence according to the ~~level of care~~ location of the beneficiary ~~was~~ at ~~on~~ the first of the month. This will prevent the PPA from being deducted from the wrong claim. Providers have the ability to verify the PPA on the Member Eligibility Detail page in CHAMPS.

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Hospital	5.8 Nursing Facility	The 1st paragraph was revised to read: If the beneficiary requires less than acute, continuous medical care, a nursing facility (NF) may be appropriate. This includes a nursing home, medical care facility, or hospital long-term care unit. The Beneficiary Eligibility Chapter of this manual contains information ~~on the Facility Admission Notice~~ about the facility admission and discharge process. (Any other alternatives for care (e.g., Home Help) may not be provided to the beneficiary while he is in the nursing facility.)
		MI Choice Waiver	2.1 Financial Eligibility	The 2nd paragraph was revised to read: To initiate financial eligibility determination, waiver agencies must ~~use the MI Choice Waiver Enrollment Notification form (MSA-0814) to notify MDHHS of individuals who have applied for MI Choice. The MI Choice Waiver Disenrollment Notification form (MSA-0815) must be used by waiver agencies to notify MDHHS of participants who no longer qualify for MI Choice enrollment. (Refer to the Forms Appendix for additional information.)~~ enter enrollment notifications electronically in CHAMPS. Once the electronic enrollment is completed in CHAMPS, the participant will be assigned an associated MI Choice Program Enrollment Type (PET) code. Waiver agencies must enter disenrollment notifications electronically in CHAMPS to notify MDHHS of participants who are no longer enrolled in MI Choice. Once an electronic disenrollment is completed in CHAMPS, the participant's PET code will end date to reflect a disenrollment date. Proper recordkeeping requirements must be followed and reflected in the applicant's or participant's case record.

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		MI Health Link	Section 4 – Level of Care Codes	The section title was revised to read: ~~Level of Care Codes~~ Program Enrollment Types Text was revised to read: For individuals enrolled with an ICO and who are residing in a NF or County Medical Care Facility (CMCF), the ICO-NFAC or ICO-CMCF PET codes will be updated in CHAMPS when the NF or CMCF completes the Nursing Facility Admission in CHAMPS. The ICO-NFAC or ICO-CMCF PET code will be removed upon the facility completing the NF discharge information in CHAMPS when the individual is discharged from the facility. Similarly, when a MI Health Link enrollee elects hospice services, the ICO-HOSC, ICO-HOSW, ICO-HOSN, ICO-HOSR or ICO-HOSH PET codes will be updated in CHAMPS when the hospice provider completes the Hospice Admission in CHAMPS. When the individual expires or otherwise is discharged from hospice services, the hospice provider must complete the Hospice Discharge in CHAMPS, which then removes the hospice-related PET codes. When the MI Health Link enrollee receives hospice services while residing in a NF or CMCF, the hospice provider must indicate the facility of residence on the Hospice Admission in CHAMPS so the ICO can receive the appropriate capitation rate.

*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)

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				~~Level of care (LOC) codes specific to the MI Health Link program are as follows:~~ ~~**Level of Care Code**~~ / ~~**Description**~~ ~~03~~ — ~~Individual meets nursing facility level of care based on the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD), lives in the community, and participates in the MI Health Link HCBS waiver program.~~ ~~05~~ — ~~Resident of any nursing facility or hospital long term care unit (private or county owned) that is not a County Medical Care Facility.~~ ~~07~~ — ~~General population in the community.~~ ~~15~~ — ~~Resident of a County Medical Care Facility.~~
		MI Health Link	5.4 Hospice	Text was revised to read: Effective November 1, 2016, individuals enrolled in the MI Health Link program who elect hospice services may remain enrolled in the MI Health Link program if they choose. When a MI Health Link beneficiary elects hospice services, the hospice agency must notify the beneficiary's Integrated Care Organization (ICO) for initiation of care management and authorization of nursing facility room and board, if indicated. The hospice agency will bill Medicare for hospice service and other Medicare Part A and Part B services not related to the terminal illness and bill the ICO for room and board when hospice is rendered in a nursing home setting. ~~If the beneficiary is receiving hospice services while residing in a nursing facility, the hospice provider must provide to the beneficiary's ICO the Hospice Membership Notice (form DCH-1074) indicating the nursing facility information and when hospice services started. If hospice services end, or the beneficiary moves to a community setting to receive hospice services, the hospice provider must provide the ICO with an updated DCH-1074 indicating the beneficiary is no longer receiving hospice services, or is no longer residing in the nursing facility, as applicable.~~

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				~~The hospice agency does not submit a DCH-1074 to the MDHHS Enrollment Services Section because the beneficiary will remain in MI Health Link at the current level of care (LOC) of 03, 05, 07, or 15. When the individual is enrolled in MI Health Link and receiving hospice services, the LOC code 16 will not be reflected in the Community Health Automated Medicaid Processing System (CHAMPS).~~ A beneficiary has the option of disenrolling from MI Health Link at any time by contacting Michigan's contracted enrollment broker. During the month when disenrollment occurs, the beneficiary will remain with MI Health Link until the first day of the following month, at which time Fee-for-Service (FFS) Medicaid will become effective. Hospice agencies will need to monitor MI Health Link beneficiary enrollment status. ~~If a beneficiary receiving hospice is disenrolled from MI Health Link, a DCH-1074 will need to be submitted by the hospice agency to the MDHHS Enrollment Services Section. The last date of a beneficiary's participation in MI Health Link (the last day of the month) and the start date of FFS Medicaid (the first day of the following month) must be included within the DCH-1074 Remarks section. This will allow the LOC of 16 (hospice) to be placed on the beneficiary's file once the disenrollment is reflected in CHAMPS.~~

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Nursing Facility Coverages	Section 2 – Medicaid Health Plans	Text was revised to read: The Medicaid Health Plan (MHP) is responsible for restorative or rehabilitative care in a nursing facility up to 45 days in a rolling 12-month period. If nursing facility services will exceed this coverage, the health plan may initiate the disenrollment process by submitting the Request for Disenrollment Long Term Care form (MSA-2007). The nursing facility may bill Medicaid after the disenrollment is processed. Beneficiaries who reside in a nursing facility are excluded from subsequent enrollment in a MHP. ~~However, due to administrative error, a beneficiary may occasionally be enrolled in a MHP. Disenrollment of the beneficiary from the MHP due to an administrative error may be requested by either the nursing facility or MHP. For a nursing facility to request disenrollment, the facility must submit a Nursing Facility Request to Disenroll From Medicaid Health Plan form (DCH-1185) along with a copy of the Facility Admission Notice form (MSA-2565-C). The completed forms must be mailed or faxed to the Michigan Department of Health and Human Services (MDHHS) Enrollment Services Section as indicated on the DCH-1185. A MHP uses the Request for Administrative Disenrollment form (MSA-2008) for disenrollment.~~ If a beneficiary is in a facility prior to enrollment in a health plan and the nursing facility does the admission record in CHAMPS correctly, CHAMPS will automatically remove the health plan and set the NH benefit plan. ~~The nursing facility or MHP must submit a disenrollment request to MDHHS within six months of the administrative error occurrence. Disenrollment requests that exceed six months from the date of occurrence will be retroactive to six months from receipt of the request.~~

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Nursing Facility Coverages	5.1.A. Verification of Financial Medicaid Eligibility	The subsection title was revised to read: Verification of ~~Financial~~ Medicaid Financial Eligibility The 1st and 2nd paragraphs were revised to read: Medicaid reimbursement for nursing facility services for an individual requires a determination of Medicaid financial eligibility for that individual by MDHHS. ~~When a Medicaid financially-eligible beneficiary is admitted to a nursing facility, or when a resident becomes Medicaid financially eligible while in a facility, the nursing facility must submit the Facility Admission Notice (MSA-2565-C) to the local MDHHS office to establish/confirm the individual's eligibility for Medicaid benefits. The facility should also submit the MSA-2565-C for residents who are potentially financially eligible.~~ When a nursing facility enters admission information for an individual who does not have active or pending Medicaid eligibility, a Medicaid Application for Health Care Coverage Patient of Nursing Facility (DHS-4574) will be automatically mailed to the individual. ~~MDHHS will return a copy of the MSA-2565-C to the facility noting an individual's Medicaid financial eligibility status and patient-pay amount (do not wait for MDHHS to return a copy of the MSA-2565-C;~~ The online Michigan Medicaid Nursing Facility Level of Care Determination must be conducted within the required timeframe for Medicaid or Medicaid-pending beneficiaries~~)~~. ~~A copy of the MSA-2565-C is available on the MDHHS website and in the Forms Appendix of this manual.~~

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Nursing Facility Coverages	10.13.A. Nursing Facility Responsibilities	The 2nd paragraph was revised to read: If a beneficiary is already receiving hospice services and elects admission to a nursing facility, ~~the nursing facility should note that the beneficiary has elected hospice on the Facility Admission Notice (MSA-2565-C) sent to the local MDHHS office. The eligibility response should indicate the Benefit Plan ID of Hospice after MDHHS processes the MSA-2565-C. (Refer to the Beneficiary Eligibility chapter for additional information.) The beneficiary (or their designated representative) should contact the local MDHHS office if the eligibility response does not indicate the Benefit Plan ID of Hospice.~~ it is the responsibility of the hospice provider to update the beneficiary's location of service in CHAMPS. To update the beneficiary's location of service in CHAMPS, the hospice provider must discharge the beneficiary and complete an admission with the updated location of service in CHAMPS. (Refer to the Beneficiary Admission and the Beneficiary Discharge sections of the Hospice chapter for additional information.) The new admission will result in real-time changes to the beneficiary's Program Enrollment Type (e.g., HOS-NFAC) and the National Provider Identification (NPI).
		Nursing Facility Coverages	10.13.B. Hospice Responsibilities	The 2nd paragraph was revised to read: If a beneficiary already living in a nursing facility elects the hospice benefit, it is the responsibility of the hospice to ~~submit to MDHHS, Enrollment Services Section, a Hospice Membership Notice form (DCH-1074). The eligibility response will indicate a Benefit Plan ID of Hospice after MDHHS processes the DCH-1074.~~ admit the beneficiary for hospice services, indicating the nursing facility NPI in the Admission Information Section in CHAMPS. A completed admission will result in real-time changes to the National Provider Identification (NPI) and the beneficiary's PET code. (Refer to the Beneficiary Eligibility chapter for additional information.)

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Nursing Facility Certification, Survey, & Enforcement Appendix	2.4.C Bed Certification Process During a Change in Ownership (CHOW)	The following text was added (as a burst box) at the end of the subsection: Under a change of ownership (CHOW), a nursing facility must not notify the local MDHHS office if there is a change in the facility's NPI/Medicaid Provider ID number. Rather, the change of ownership submission completed by the facility in the CHAMPS Provider Enrollment subsystem will automatically update the admission or discharge data for these beneficiaries in CHAMPS by moving them to the new NPI once the change of ownership is approved by MDHHS staff. Nursing facilities will not be required to update the admission or discharge data in CHAMPS for these beneficiaries when a change in ownership occurs.
		Pharmacy	13.6.A. Medicaid Copayments	In the Copayment Exemptions table, under "Over Age 21 Exclusions", the 2nd bullet point was revised to read: • The beneficiary is in a nursing facility (Benefit Plan ID of NH ~~or Level of Care code 55 or 56~~). (Refer to the Nursing Facility section of this chapter for additional information.)
		Pharmacy	15.1 Benefit Plans	The 2nd paragraph was deleted. ~~NOTE: Beneficiaries with LOC 55 or 56 indicated in the eligibility response for the DOS are not eligible for NF services and will not have the Benefit Plan ID of NH assigned.~~
		Program of All Inclusive Care for the Elderly	3.6 Enrollment and Disenrollment (new subsection; following sub-sections were re-numbered)	New subsection text reads: PACE provider staff must submit PACE enrollment and disenrollment forms electronically within CHAMPS by the end of card cut-off.

*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)

BULLETINS INCORPORATED*

<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>Program of All Inclusive Care for the Elderly</td><td>3.6.A. Enrollments

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

PACE providers must upload and submit the following signed enrollment materials with the electronic enrollment.
Enrollment Agreement Benefits and Coverages
Nursing Facility Level of Care Freedom of Choice Form
If necessary, Durable Power of Attorney (DPOA) or guardianship documents
Once completed and all eligibility requirements have been checked, CHAMPS will assign the participant a PET code and enrollment start date.</td></tr>
<tr><td></td><td></td><td>Program of All Inclusive Care for the Elderly</td><td>3.6.B. Disenrollments

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

<table><tr><td>Voluntary</td><td>A signed disenrollment form must be uploaded to CHAMPS.</td></tr><tr><td>Involuntary</td><td>Once the electronic form has been completed, PACE providers will submit appropriate supporting documentation to their MDHHS contract manager. MDHHS will review and approve or deny the electronic disenrollment in CHAMPS and determine the appropriate date of disenrollment.</td></tr><tr><td>Death</td><td>Providers will enter the date of death with the electronic disenrollment.
A completed disenrollment will end-date the corresponding PET code.</td></tr></table></td></tr>
<tr><td></td><td></td><td>Acronym Appendix</td><td></td><td>Addition of:

DPOA – Durable Power of Attorney

PET – Program Enrollment Type</td></tr>
<tr><td></td><td></td><td>Directory Appendix</td><td>Hospice Resources</td><td>Information for “MDHHS Enrollment Services Section (hospice)” was removed.</td></tr>
</table>

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Forms Appendix		Revision of MSA-2565-C; ~~Facility Admission Notice~~ Hospital Newborn Notice Removal of DCH-1074; Hospice Membership Notice Removal of MSA-0815; MI Choice Waiver Disenrollment Notification Removal of MSA-0814; MI Choice Waiver Enrollment Notification Removal of DCH-1185; Nursing Facility Request to Disenroll from Medicaid Health Plan
MSA 17-49	1/2/2018	Maternal Infant Health Program	2.10.B. Transportation for MIHP Fee for Service Beneficiaries	The 4th paragraph was revised to read: The MIHP provider must maintain documentation of transportation for each beneficiary for each trip billed. The record must specify: • The name and address of the beneficiary; • The date of service (DOS); • The trip's starting point and destination (address, city); • The purpose of the trip; • The number of tokens or miles required for the trip; ~~and~~ • The amount that the beneficiary or transportation vendor was reimbursed;~~.~~ • The provider identification information for the individual or business providing transportation; and • Verification of transportation provider enrollment in CHAMPS.

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Non-Emergency Medical Transportation	Section 4 – Transportation Provider Qualifications	The following text was added: NEMT individual and agency providers must consent to required screenings to determine eligibility in order to receive Medicaid reimbursement for providing NEMT services. Individual providers are those persons who provide transportation to a Medicaid beneficiary they are not related to and include, but may not be limited to, volunteer drivers or friends, colleagues, or neighbors of a Medicaid beneficiary. Provider screening is conducted through the CHAMPS provider enrollment process. (Refer to the General Information for Providers chapter of this manual for additional information.) Beneficiaries who transport themselves or individuals providing NEMT services to a Medicaid-enrolled family member will not be required to enroll in CHAMPS and will be exempted from mandated provider screening requirements. Self-attestation is sufficient when determining the familial relationship between the driver and the Medicaid beneficiary. Foster parents who transport their foster children are not required to enroll in CHAMPS and are exempt from mandated provider screening requirements. Demand-responsive public transit services and commercially hailed or street taxicabs are also exempt from CHAMPS enrollment and screening requirements.
			Section 5 – Covered Services	The following text was added to the 4th paragraph: Transportation providers must be enrolled in CHAMPS on the date of service to receive Medicaid NEMT reimbursement unless the provider is exempt from enrollment.
MSA 18-01	1/30/2018	Billing & Reimbursement for Dental Providers	5.7 Interim Caries Arresting Medicament (new subsection)	New subsection text reads: Interim Caries Arresting Medicament Application (D1354) is billable once per date of service. A maximum of five (5) teeth may be treated per visit. Providers are required to enter the tooth number(s)/letter(s) of all teeth treated in the comments section of the claim.

*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)

BULLETINS INCORPORATED*

<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>Billing & Reimbursement for Institutional Providers</td><td>7.18 Injections</td><td>The 7th paragraph was revised to read:

If an injectable or non-injectable drug is obtained at a lower than normal cost (e.g., through 340B program), the lower than normal cost (actual acquisition cost) must be reported on the claim in place of the cost of charge. In addition, drugs purchased through the 340B program must be indicated on the institutional claim using the MDHHS modifier U6 and CMS modifiers for OPPS 340B acquired drugs.</td></tr>
<tr><td></td><td></td><td>Billing & Reimbursement for Professionals</td><td>7.1 General Billing</td><td>The subsection title was revised to read:

General Billing Guidelines

The following text was added:

<table>
<tr><th>Modifier</th><th>Description</th><th>Special Instructions</th></tr>
<tr><td>UN</td><td>Two patients served.</td><td>Identifies the number of patients served to allow for adjustment to the reimbursement.</td></tr>
<tr><td>UP</td><td>Three patients served.</td><td>Identifies the number of patients served to allow for adjustment to the reimbursement.</td></tr>
<tr><td>UQ</td><td>Four patients served.</td><td>Identifies the number of patients served to allow for adjustment to the reimbursement.</td></tr>
<tr><td>UR</td><td>Five patients served.</td><td>Identifies the number of patients served to allow for adjustment to the reimbursement.</td></tr>
<tr><td>US</td><td>Six or more patients served.</td><td>Identifies the number of patients served to allow for adjustment to the reimbursement.</td></tr>
</table>
</td></tr>
</table>

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Practitioner	9.4 Transportation and Set-Up of Portable X-Ray Equipment (new subsection)	New subsection text reads: The transportation of portable x-ray equipment, set-up, and personnel is covered when furnished in a place or residence used as the patient's home as reported by the corresponding HCPCS code. These services must be provided under the order and general supervision of a physician. No transportation charge is payable unless the portable x-ray equipment was actually transported to the location where the x-ray was taken. For patients residing in a nursing facility, the transportation, set-up and personnel costs are included in the nursing facility's per diem rate and not separately reimbursable. (Refer to the Nursing Facility Chapter of this manual for additional information.) If only one patient is served, report the appropriate HCPCS code. When more than one patient is served during a single trip to the same location, report the appropriate HCPCS code with the appropriate Level II HCPCS modifier (UN, UP, UQ, UR, US) relative to the number of patients served, irrespective of their insurance. Total payment for services will be adjusted by the number of patients.
MSA 18-02	1/30/2018	Billing & Reimbursement for Institutional Providers	7.18.D. Drugs and Biological Products Not Covered by Medicaid Health Plans (new subsection)	New subsection text reads: When multiple OPH or ASC services are provided in conjunction with a carved-out physician-administered drug, claims with the PA number, all services, the appropriate billing codes, and the appropriate National Drug Code (NDC) must be submitted to Medicaid Fee For Service (FFS). Medicaid FFS will process payment of the carved-out drug service line only. All other claim lines will be denied with Claim Adjustment Reason Code (CARC) 24. Providers are to bill the FFS denied associated services to the beneficiary's health plan.

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Billing & Reimbursement for Professionals	6.4 Ancillary Medical Services	The following text was added: **Injectable Drugs and Biological Products Not Covered by Medicaid Health Plans** When multiple medical services are provided in conjunction with a carved-out physician-administered drug, FFS claims will process for payment of the carved-out drug service line only; all other claim lines will be denied with Claim Adjustment Reason Code (CARC) 24 – Charges are covered under a capitation agreement/managed care plan. The associated services that are denied by FFS are to be billed to the beneficiary's health plan for payment.
		Ambulatory Surgical Centers	3.8 Injections/Intravenous Infusions (new subsection)	New subsection text reads: MDHHS covers intramuscular, subcutaneous or intravenous injections, and intravenous (IV) infusions when medically necessary. A list of outpatient physician-administered drugs and biological products carved out from the Michigan Medicaid Health Plans (MHPs) is maintained on the MDHHS website. (Refer to the Directory Appendix for website information.) Refer to the Injectable Drugs and Biological Products section of the Practitioner chapter of this manual for additional information regarding prior authorization (PA) requirements. Refer to the Drugs and Biological Products Not Covered by Medicaid Health Plans section of the Billing & Reimbursement for Institutional Providers chapter of this manual for additional information regarding billing instructions.

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Hospital	3.18 Injections/Intravenous Infusions	Text was revised to read: MDHHS covers intramuscular, subcutaneous or intravenous injections and intravenous (IV) infusions when medically necessary. In the inpatient hospital, reimbursement is included in the DRG payment. In the outpatient hospital (OPH) or Ambulatory Surgical Center (ASC), reimbursement generally follows CMS Outpatient Prospective Payment System (OPPS) guidelines. Injectables paid differently than CMS OPPS are listed on the MDHHS OPPS Wraparound Code List for OPH or ASC. ~~for the injection includes the cost of the drugs, supplies, administration and observation for any adverse reaction. Refer to the MDHHS OPPS Wraparound Code List available on the MDHHS website.~~ (Refer to the Directory Appendix for website information.) A list of outpatient physician-administered drugs and biological products carved out from MHPs is maintained on the MDHHS website. Information regarding prior authorization (PA) requirements is also available on the MDHHS website. (Refer to the Directory Appendix for website information. Refer to the Billing & Reimbursement for Institutional Providers chapter for billing instructions.) Refer to the Pharmacy Chapter of this manual for information regarding Medicare Part D.

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Medicaid Health Plans	1.2 Services Excluded from MHP Coverage but Covered by Medicaid	The 3rd bullet point was revised to read: • ~~Specific injectable drugs administered through a PIHP/CMHSP clinic to MHP enrollees are reimbursable by MDHHS on a fee-for-service basis. (Refer to the Injectable Drugs and Biologicals subsection of the Practitioner Chapter of this manual for additional information.)~~ • MDHHS also maintains a list of specific Medicaid program-covered physician-administered drugs and biological products that are not covered by MHPs. This list of physician-administered drugs and biological products, carved out from MHP coverage, will be reimbursed as a Fee-for-Service (FFS) benefit for all beneficiaries in FFS and for those enrolled in an MHP. (Refer to the Physician-Administered Drugs and Biological Products Not Covered by Medicaid Health Plans subsection of the Practitioner chapter of this manual for additional information. Refer to the Directory Appendix for website information for the physician-administered drugs and biological products list.)
		Practitioner	3.13 Injectable Drugs and Biologicals	The subsection title was revised to read: Injectable Drugs and Biological~~s~~ Products
		Practitioner	3.13.A. Coverage of the Injectable	Text was revised to read: Medicaid covers injectable drugs and biological~~s~~ products administered by a physician in the office, ~~or~~ clinic setting, and in the beneficiary's home. The drug or biological product must be Food and Drug Administration (FDA) approved and reasonable and necessary according to accepted standards of medical practice for the diagnosis or treatment of the illness or injury of the beneficiary. There must be sufficient clinical evidence demonstrating the effectiveness and safety of the drug or biological product.

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				An injectable drug is covered if the drug is: • Specific and effective treatment for the condition for which it is being given. • Given for the treatment of a particular documented diagnosis, illness, or condition (e.g., vitamin injections which are not specific replacement therapy for a documented deficiency or disease and are given simply for the general good and welfare of the patient). • Administered by the recommended or accepted administration method for the condition being treated. • Administered according to the recommended dosing schedule and amount for the condition being treated. ~~With the exception of the physician-administered injectable drugs listed in the Special Product Coverage section of the Pharmacy Chapter that are eligible to be billed as pharmacy claims, for any injections given by the physician~~ For any injectable drug that a practitioner purchases directly through a pharmacy, distributor or wholesaler which is administered in the office, clinic setting, or the beneficiary's home, the injectable drug is considered a physician service rather than a pharmacy benefit. The physician must not send the beneficiary to a pharmacy to obtain an injectable drug. ~~In addition, unless the physician-administered injectable drug is listed in the Special Product Coverage section of the Pharmacy Chapter as being eligible to be billed as pharmacy claims, the physician may not have the pharmacy bill directly to MDHHS for injectable drugs under the pharmacy benefit if the physician is administering the drug in the office, clinic, or beneficiary's home.~~ If a pharmacy sells injectable drug products to a physician, the pharmacy must obtain payment directly from the purchasing physician.

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				MDHHS allows a select list of physician-administered drugs to be covered through the pharmacy benefit as identified in the Special Product Coverage section of the Pharmacy Chapter. If the practitioner uses a pharmacy to acquire the drug for administration, the pharmacy must submit the claim as a pharmacy claim. (Refer to the Special Product Coverage section of the Pharmacy chapter for additional information.) If the beneficiary has other insurance that allows the injectable drug product to be obtained at the pharmacy by the beneficiary, then the other insurance rules (e.g., Medicare Part D) must be followed; however, the reimbursement of the beneficiary's liability (i.e., coinsurance/deductible/ copay) may be covered as a physician service. When administering a dose drawn from a multidose vial, only the amount administered to the beneficiary is covered. If a drug is only available in a single use vial and any drug not administered must be discarded, the amount of the drug contained in the vial is covered.
		Practitioner	3.13.B. Physician-Administered Drugs and Biological Products Not Covered by Medicaid Health Plans (new subsection; the following subsections were re-numbered)	New subsection text reads: MDHHS will maintain a list of specific Medicaid program covered physician-administered drugs and biological products that are not covered by MHPs. This list of physician-administered drugs and biological products, carved out from MHP coverage, will be reimbursed as a Fee-for-Service (FFS) benefit for all beneficiaries in FFS and for those enrolled in an MHP. A list of the specific drugs covered under this policy will be maintained on the MDHHS website. The list may be modified as new drugs are approved or added to the physician-administered carve-out. No notice of changes to the list will be issued directly to providers. (Refer to the Directory Appendix for website information.)

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Practitioner	3.13.B.1. Prior Authorization Requirements for Carve-out Injectable Drugs and Biological Products (new subsection)	New subsection text reads: Certain drugs on the carve-out list of physician-administered drugs and biological products not covered by MHPs may require prior authorization (PA). The purpose of PA is to review the medical need for certain services. It does not serve as an authorization of fees or beneficiary eligibility. When indicated on the MDHHS-maintained list, PA requests will require a completed Practitioner Special Services Prior Approval-Request/Authorization form (MSA-6544-B), a Program Review Division (PRD) documentation checklist, and all supporting documentation. Providers are to contact the PRD to obtain the PRD documentation checklist for drugs and biological products that require PA. Once all required documentation is collated, information must be submitted according to form MSA-6544-B completion and submission instructions. (Refer to the Forms Appendix for a copy of the form and completion instructions and to the Directory Appendix for PRD contact information.)
		Practitioner	3.13.B.2. Billing Considerations for Carve-out Injectable Drugs and Biological Products for Medicaid Health Plan Enrollees (new subsection)	New subsection text reads: When multiple medical services are provided in conjunction with a carve-out physician-administered drug, FFS claims will process for payment of the carve-out drug service line only; all other claim lines will be denied with Claim Adjustment Reason Code (CARC) 24 – Charges are covered under a capitation agreement/managed care plan. The associated services that are denied by FFS are to be billed to the beneficiary's health plan for payment.

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Directory Appendix	Health Plan Information	Contact/Topic: Medicaid Health Plan Carve-out Web Address Information was revised to read: Medicaid Health Plan Pharmacy Program Carve-out https://michigan.fhsc.com >> Providers >> Drug Information >> Medicaid Health Plan Carveout Medicaid Health Plan Injectable Drugs and Biologicals Carve-out www.michigan.gov/medicaid >> Providers >> Billing & Reimbursement >> Provider Specific Information >> Medicaid Health Plan Carve-out
		Directory Appendix	Provider Resources	Addition of: Contact/Topic: Medicaid Health Plan Carve-out Web Address: www.michigan.gov/medicaid >> Providers >> Billing & Reimbursement >> Provider Specific Information >> Medicaid Health Plan Carve-out Information Available/Purpose: A list of outpatient physician-administered drugs and biological products carved-out from the Michigan Medicaid Health Plans (MHPs)

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 18-03	1/30/2018	Medical Supplier	1.4 Age Limitations	The subsection title was revised to read: Age ~~Limitations~~ Factors Text was revised to read: ~~Coverage may be different based on the beneficiary's age.~~ Coverage of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) may differ based on the beneficiary's age. When age factors exist, the DMEPOS provider can submit a prior authorization request for consideration of coverage beyond the policy standards of coverage. For specifics of HCPCS codes and age parameters, refer to the Coverage Conditions and Requirements section and the Healthcare Common Procedure Coding System (HCPCS) Codes subsection of this chapter and to the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Medical Supplier	1.5 Medical Necessity	In the 3rd paragraph, the following bullet point was added: • The safety and effectiveness of the product for age-appropriate treatment has been substantiated by current evidence-based national, state and peer-review medical guidelines. In the 3rd paragraph, the 3rd bullet point was revised to read: • The function of the service/device: ➢ meets accepted medical standards, practices and guidelines related to: ○ type, ○ frequency, and ○ duration of treatment; and ➢ ~~practices guidelines related to type, frequency, and duration of treatment; and~~ ➢ is within scope of current medical practice. The following text was added after the 5th paragraph: Medicaid does not cover equipment and supplies that are considered investigational, experimental or have unproven medical indications for treatment.

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Medical Supplier	1.7 Prior Authorization	The following text was added after the 2nd paragraph: Prior authorization coverage determinations are based on the evaluation of the documentation received and all of the following: • The beneficiary's benefit plan scope and coverages (e.g., Emergency Services Only); • Food and Drug Administration (FDA) and manufacturer product intended usage(s); • Healthcare Common Procedure Coding System (HCPCS) Level II code definitions as deemed by the American Medical Association; and • The safety and effectiveness of the product for age-appropriate treatment as substantiated by current evidence-based national, state and peer-review medical guidelines. MDHHS reserves the right to a final determination of whether the practitioner's submitted medical documentation sufficiently demonstrates the medical necessity for the services requested. Beneficiaries may request a fair hearing in accordance with 42 CFR Part 431 Subpart E for any MDHHS coverage denials. (Refer to the General Information for Providers chapter for additional information.)
		Medical Supplier	1.7.G. Age Parameters	The subsection was deleted. ~~Some services are only covered if the beneficiary is under the age of 21. For specifics regarding PA requirements and coverage, refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter or the Coverage Conditions and Requirements Section of this chapter.~~ The following sub-sections were re-numbered.

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 18-05	3/1/2018	Healthy Michigan Plan	Section 2 – Healthy Michigan Plan and Healthy Behaviors	The following text was added: In addition to the Healthy Michigan Plan HRA, there are two additional ways to participate in a healthy behavior.
		Healthy Michigan Plan	2.1 Initial Appointment with Primary Care	The following text was added: The HRA Provider Profile in CHAMPS allows providers to view shared beneficiary HRA data, attest online to a beneficiary's HRA, and see historical HRA data.
		Healthy Michigan Plan	2.2.A. Health Risk Assessment – For Health Plan Beneficiaries	In the 1st paragraph, the following bullet points were added: • Chronic conditions • Recommended cancer or other preventive screenings
		Healthy Michigan Plan	2.3 Preventive Health Service (new subsection)	New subsection text reads: MDHHS will use claims and encounter data to document healthy behaviors for managed care beneficiaries who utilize preventive and wellness services that meet the following criteria. • Make and keep an appointment for any of the following: ➢ Annual preventive visit ➢ Preventive dental services ➢ Appropriate cancer screening ➢ Tobacco cessation ➢ ACIP recommended vaccination(s) ➢ Other preventive screening

*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)

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Healthy Michigan Plan	2.4 Healthy Michigan Plan Health and Wellness Program Participation (new subsection)	New subsection text reads: All managed care plans must ensure their beneficiaries have access to evidence based/best practices wellness programs to reduce the impact of common risk factors such as obesity or hypertension. These programs can take many forms such as evidence-based tobacco cessation support, health coaching services, and free or reduced cost gym memberships. Managed care plan health and wellness programs must be approved by MDHHS to be eligible for inclusion in the Healthy Behaviors Incentives Program.

*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)