MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

Bulletin Number: MSA 19-27

Distribution: All Providers

Issued: August 30, 2019

Subject: Updates to the Medicaid Provider Manual; Clarification of Genetic Testing Prior Authorization and Documentation Requirements; Oral Maxillofacial Surgeon Fee Schedule Update; Maternal Infant Health Program Fee Schedule Update; Retroactive Coverage of Existing Codes

Effective: As Indicated

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

Updates to the Medicaid Provider Manual

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

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

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

Clarification of Genetic Testing Prior Authorization and Documentation Requirements

Prior authorization (PA) is required for most genetic laboratory tests. Refer to the Community Health Automated Medicaid Processing System (CHAMPS) Code Rate and Reference tool for guidance. Authorization must be obtained prior to the test being performed and should be requested using the Practitioner Special Services Prior Approval-Request/Authorization (MSA-6544-B) form.

PA requests require medical documentation submitted by the beneficiary's attending provider (i.e., MD, DO, PA, NP). Medical necessity letters or genetic testing request forms submitted by the performing laboratory and signed by the attending provider will not be accepted as clinical documentation. The following must be submitted along with the MSA-6544-B:

- Indication for the test. Indications should be beneficiary-specific and clinical in nature.
- Clinical notes that clearly detail the beneficiary's related signs and symptoms.
- Family history relevant to the beneficiary's condition and test being requested. A family pedigree analysis must be made available upon request.
- Other related testing or clinical findings of the beneficiary or family member.
- Clinical documentation supporting that the test results will be used to significantly alter the management or treatment of the disease. This definitive treatment or action plan should be specific to the beneficiary and completed by the provider who will manage the patient using the test results.
- The name and NPI number of the laboratory performing the test.

Oral Maxillofacial Surgeon Fee Schedule Update

Physicians and dentists enrolled in the Community Health Automated Medicaid Processing System (CHAMPS) with the specialty designation of Oral Surgeon/Maxillofacial will refer to the Oral Maxillofacial Surgeon Fee Schedule effective October 1, 2019. Physicians enrolled with the specialty designation of Maxillofacial Surgery may reference the Practitioner Fee Schedule for additional covered services. The Oral Maxillofacial Surgeon Fee Schedule has been updated to reflect a more complete scope of services to streamline claims processing. The fee schedules will be available October 1, 2019 at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Physicians/Practitioners/Medical Clinics.

Maternal Infant Health Program Fee Schedule Update

Contingent on State Plan Amendment (SPA) approval from the Centers for Medicare & Medicaid Services (CMS), the Maternal Infant Health Program (MIHP) fee schedule will be updated for services rendered on or after October 1, 2019. Reimbursement rates for MIHP services will reflect a 10% increase. The MIHP fee schedule can be accessed on the web at www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Maternal Infant Health Program.

Retroactive Coverage of Existing Codes Effective May 1, 2019

1. Physicians, Nurse Practitioners, Medical Clinics, Family Planning Clinics, Certified Nurse Midwives, Local Health Departments, Child and Adolescent Health Centers & Programs, Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers and Urgent Care Centers

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2. Physicians, Nurse Practitioners, Medical Clinics, Family Planning Clinics, Certified Nurse Midwives, Local Health Departments, Child and Adolescent Health Centers & Programs and Urgent Care Centers

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Retroactive Coverage of Existing Codes Effective June 1, 2019

Physicians, Nurse Practitioners, Medical Clinics, Outpatient Hospitals, Certified Nurse Midwives, Local Health Departments, Child and Adolescent Health Centers & Programs, Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers, Social Workers, Psychologists, Professional Counselors and Marriage and Family Therapists

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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, NPI number, and phone number so you may be contacted if necessary. Typical Providers may phone toll-free 1-800-292-2550. Atypical Providers may phone toll-free 1-800-979-4662.

Approved

Kate Massey, Director
Medical Services Administration

Michigan Department of Health and Human Services

Medicaid Provider Manual
October 2019 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	15.5.A. Standard Consent Form	In the 1st paragraph, the 1st sentence was revised to read: In cases when such consent is required, the Consent to Share Behavioral Health Information (form MDHHS-5515) must be used for all providers requesting release of information for behavioral health and/or substance use disorder related information.	Clarification.
Beneficiary Eligibility	12.2 Preadmission Screening	Text was revised to read: If a beneficiary is to be transferred from an acute care hospital to a NF, preadmission screening for mental illness/intellectual/developmental disability or a related condition must be completed prior to transfer.	To add the word "developmental" and coincide wording with the DCH-3877 and DCH-3878.
Billing & Reimbursement for Professionals	2.3.B. Rendering Provider	The 1st paragraph was revised to read: For claims requiring a rendering provider, the loop or field is mandatory. The rendering provider must be enrolled with the program for payment. If the ~~referring~~ rendering provider information is not reported on the claim, or if the provider is not enrolled in the Michigan Medicaid program, the claim cannot be paid. Claims for services rendered by nonphysician practitioners (e.g., physician assistants and nurse practitioners) must be billed under the non-physician practitioner's NPI and include the NPI of the supervising physician as applicable.	Correction.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	1.8.A. Standard Consent Form	In the 1st paragraph, the 1st sentence was revised to read: In cases when such consent is required, the Consent to Share Behavioral Health Information (form MDHHS-5515) must be used for all providers requesting release of information for behavioral health and/or substance use disorder related information.	Clarification.

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

Medicaid Provider Manual
October 2019 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services Non-Physician Behavioral Health Appendix	Section 3- Covered Services	The 1st paragraph was revised to read: Behavioral health professionals may receive direct reimbursement for Medicaid covered services when provided within their specific profession's scope of practice guidelines as defined by State law. Nonphysician behavioral health services are only covered in a non-facility setting or outpatient hospital clinic. Services covered by the PIHPs/CMHSPs are available and reimbursed through the PIHP/CMHSP.	Clarification.
Federally Qualified Health Centers	7.3.B. Beneficiary Consent	In the 2nd paragraph, the 1st sentence was revised to read: In cases when such consent is required, the Consent to Share Behavioral Health Information (form MDHHS-5515) must be used for all providers requesting release of information for behavioral health and/or substance use disorder related information.	Clarification.
Hospice	3.4.B. Nursing Facility	The 5th paragraph was revised to read: The Pre-Admission Screening/Annual Resident Review (PASARR) form (DCH-3877) must be completed for a hospice patient entering a NF unless the hospice beneficiary is entering for a five-day respite period. The DCH-3877 is not required for the respite period. The DCH-3877 is to identify individuals who may have a mental illness, ~~or~~ intellectual/developmental disability or a related condition. If the patient is on antipsychotic or antidepressant medications for purposes of pain control/symptom relief for end of life, it should be noted on the DCH-3877. This allows the Community Mental Health Services Program (CMHSP) worker to better evaluate the need for further (Level II) screening. If the patient is on any of the above mentioned psychotropic medications for a related mental illness, the CMHSP will determine the need for a Level II screening.	To add the word "developmental" and coincide wording with the DCH-3877 and DCH-3878.

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CHAPTER	SECTION	CHANGE	COMMENT
Hospital	5.8 Nursing Facility	In the 3rd paragraph, the 4th bullet point was revised to read: • A Pre-admission Screening/Annual Resident Review (PASARR) process must be performed prior to admission to a nursing facility. The purpose of the screening is to prevent placement of beneficiaries with mental illness, ~~or~~ intellectual/developmental disability or ~~having~~ a related condition into a nursing facility unless their medical needs clearly indicate that they require the level of care provided by a nursing facility. Level I screening is documented on the Preadmission Screening (PAS)/Annual Resident Review (ARR) (Mental Illness/Intellectual-Developmental Disability/Related Conditions Identification) form (DCH-3877). The Level I screening is part of the hospital discharge planning process and must be completed by a registered nurse, licensed Bachelor's or Master's Social Worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or physician. The PASARR process is not required when: ➢ An individual is admitted to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). ➢ An individual is admitted to, and residing in, a hospital swing bed. However, the PASARR process must be completed prior to admission if the individual transfers to a nursing facility. ➢ A resident is readmitted to a nursing facility after a hospital stay. If the Annual Resident Review date occurs during a period of hospitalization, the screening must be completed within 30 days of admission or readmission to the nursing facility. All individuals identified by Level I screening as possibly having a mental illness, ~~or~~ intellectual/developmental disability or ~~having~~ a related condition (a "yes" response to any question on the DCH-3877) must receive a Level II evaluation, unless it is documented that they meet one of the exemption criteria outlined on the Mental Illness/Intellectual-Developmental Disability/Related Condition Exemption Criteria Certification form (DCH-3878) or MDHHS/CMHSP finds that the individual does not meet the criteria for a serious mental illness under the PASARR provisions. …	To add the word "developmental" and coincide wording with the DCH-3877 and DCH-3878.

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CHAPTER	SECTION	CHANGE	COMMENT
Laboratory	5.5.B. Prior Authorization Requirements and Documentation	Text was revised to read: ~~For genetic testing that requires prior authorization, the following documentation must be submitted prior to the testing being performed:~~ Prior authorization (PA) is required for most genetic laboratory tests. Refer to the Community Health Automated Medicaid Processing System (CHAMPS) Code Rate and Reference tool for guidance. Authorization must be obtained prior to the test being performed and should be requested using the Practitioner Special Services Prior Approval-Request/Authorization form (MSA-6544-B). PA requests require medical documentation submitted by the beneficiary's attending provider (i.e., MD, DO, PA, NP). Medical necessity letters or genetic testing request forms submitted by the performing laboratory and signed by the attending provider will not be accepted as clinical documentation. The following must be submitted along with the MSA-6544-B: • Indication for the test. Indications should be beneficiary specific and clinical in nature. • Clinical notes that clearly detail the beneficiary's related signs and symptoms, ~~including relevant family history~~. • Family history relevant to the beneficiary's condition and test being requested. A family pedigree analysis must be made available upon request. • Other related testing or clinical findings of the beneficiary or family member. • Clinical documentation supporting that the test results will be used to significantly alter the management or treatment of the disease. This definitive treatment or action plan should be specific to the beneficiary and completed by the provider who will manage the patient using the test results. • The name and NPI number of the laboratory performing the test.	Clarification.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Medical Supplier	2.3 Diabetic Equipment and Related Supplies	Subsection was re-formatted; this is a new title and subsection now reflects three categories. 2.3.A. Blood Glucose Monitoring Equipment and Supplies 2.3.B. Continuous Glucose Monitoring Equipment and Supplies 2.3.C. External Infusion (Insulin) Pump and Supplies	
Medical Supplier	2.3 Blood Glucose Monitoring Equipment and Supplies	Subsection was re-formatted; this subsection is now identified as 2.3.A.	
Medical Supplier	2.14 External Infusion (Insulin) Pump and Supplies	Chapter was re-formatted and information was relocated; this subsection is now identified as 2.3.C. The following subsections were re-numbered.	
MI Health Link	7.6.D. Triggers From the Level I Assessment	The 1st paragraph was revised to read: The Michigan Medicaid Nursing Facility Level of Care Determination tool must be conducted for all individuals according to the Michigan Medicaid Nursing Facility Level of Care Determination requirements in the Medicaid policy (refer to the Nursing Facility Level of Care Determination Chapter of the Medicaid Provider Manual) and additional guidance provided by MDHHS. For the MI Health Link program only, the Nursing Facility Level of Care Frailty Review criteria will be applied at the time the LOCD is conducted for the individual if the individual does not meet LOCD criteria under Doors one through seven. Additionally, for the MI Health Link program, the LOCD must be conducted by a Care Coordinator holding a credential as described in the ICO Care Coordinator subsection of this chapter.	Exception to the Nursing Facility Level of Care Determination Chapter that applies only to MI Health Link.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	5.1.B. Correct/Timely Preadmission Screening/Annual Resident Review (PASARR)	The 2nd and 3rd paragraphs were revised to read: A Level I Preadmission Screen must be performed for all individuals admitted to a Medicaid-certified nursing facility regardless of payer source. The Level I screening form (Preadmission Screening [PAS]/Annual Resident Review [ARR] (Mental Illness/Intellectual-Developmental Disability/Related Conditions Identification~~)~~; DCH-3877) is available on the MDHHS website. (Refer to the Directory Appendix for website information.) The nursing facility is required to ensure that the PASARR Level I screening has been completed and passed (does not trigger a PASARR Level II) by the individual prior to admission. Placement options for beneficiaries who were determined through Level II Preadmission screening to have ~~either (1)~~ a mental illness, ~~or (2) an~~ intellectual/developmental disability ~~(~~or a related condition~~)~~ are determined through the federal PASARR screening process requirements as to whether or not they need nursing facility services, specialized services, and/or mental health services.	To add the word "developmental" and coincide wording with the DCH-3877 and DCH-3878.
Nursing Facility Coverages	7.4 Preadmission Screening/Annual Resident Review (PASARR)	The 2nd paragraph was revised to read: The purpose of the PASARR process is to encourage community care by supporting the placement of individuals with Mental Illness (MI) or Intellectual/Developmental Disability (I/DD) or ~~having~~ a related condition in a nursing facility only when their medical needs clearly indicate that they require the level of care provided by a nursing facility. For individuals with mental illness or an intellectual/developmental disability or having a related condition, the PASARR process ensures the appropriate determination of the need for nursing facility services and the need for specialized services. The PASARR process also includes an appeals system for individuals who wish to dispute a PASARR determination.	To add the word "developmental" and coincide wording with the DCH-3877 and DCH-3878.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages.	Section 8 – PASARR Process	In the 3rd paragraph, the 5th bullet point was revised to read: • A beneficiary receiving Medicaid hospice services (Benefit Plan ID of Hospice) entering a nursing facility for the five-day hospice respite benefit. A Level I screening must be completed if the beneficiary enters the facility for a length of time beyond the five-day respite period. The purpose of the Level I screening is to identify individuals who may have a mental illness, ~~or~~ intellectual/developmental disability or ~~have~~ a related condition. If the patient is on psychotropic or antidepressant medications for purposes of pain control/symptom relief for end of life, note that information on the DCH-3877. This allows the Community Mental Health Services Program (CMHSP) to better evaluate the need for Level II screening. If the patient is on any of the above mentioned psychotropic medication groups for a related mental illness, the CMHSP will determine the need for Level II screening. In the table in the last paragraph, under "Borton vs. Califono Transfer Trauma", text was revised to read: Transfer trauma protections apply to individuals with mental illness, ~~or~~ intellectual/developmental disability or a related condition who were determined during a PASARR Level II evaluation to not need nursing facility services. Transfer Trauma is defined as any adverse psychological and/or physical effects occasioned by the transfer of a nursing facility patient that would be materially detrimental to the physical or mental health of the patient.	To add the word "developmental" and coincide wording with the DCH-3877 and DCH-3878.
Nursing Facility Coverages	8.1 Level I Screening	The 1st paragraph was revised to read: The purpose of the Level I Screening is to identify individuals who may have a mental illness, ~~or~~ intellectual/developmental disability or ~~have~~ a related condition. Level I Screening is documented on the "Preadmission Screening (PAS)/Annual Resident Review (ARR) (Mental Illness/Intellectual-Developmental Disability/Related Conditions Identification)" form (DCH-3877). (Refer to the Forms Appendix for a sample form.) The DCH-3877 must be completed and signed by a registered nurse, licensed Bachelor's or Master's Social Worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or physician.	To add the word "developmental" and coincide wording with the DCH-3877 and DCH-3878.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	8.2 Level II Evaluation	Text was revised to read: The purpose of the Level II evaluation is to assess individuals who are identified as having a mental illness, ~~or~~ intellectual/developmental disability or ~~as having~~ a related condition to determine the need for nursing facility services, specialized services, and/or mental health services. All individuals identified by Level I screening as possibly having a mental illness, ~~or~~ intellectual/developmental disability or ~~having~~ a related condition (a "yes" response to any question on the Level I screening form, DCH-3877) must receive a Level II evaluation~~,~~ unless it is documented that they meet one of the exemption criteria outlined in the next subsection, or the MDHHS/CMHSP finds that the individual does not meet the criteria for a serious mental illness under the PASARR provisions. The CMHSP is responsible for providing the nursing facility and the individual and/or legal representative with written documentation that the individual does not meet the PASARR criteria for a serious mental illness. If the individual is seeking admission to a nursing facility, the Level II evaluation, when indicated, must be completed prior to admission.	To add the word "developmental" and coincide wording with the DCH-3877 and DCH-3878

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	8.3 Level II Evaluation Exemption	The 1st paragraph was revised to read: If the individual qualifies for an exemption to the Level II evaluation based on the criteria outlined below, the DCH-3878, "Mental Illness/Intellectual-Developmental Disability/Related Condition Exemption Criteria Certification" form must be completed. (Refer to the Forms Appendix for a sample form.) ~~The DCH-3878 may be completed by a registered nurse, licensed Bachelor's or Master's Social Worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner, or physician.~~ The DCH-3878 must be completed, signed, ~~along with a printed name,~~ and dated by a physician's assistant, nurse practitioner, or a physician. In the 2nd paragraph, the 2nd bullet point was revised to read: • The individual has a primary diagnosis of dementia (such as Alzheimer's disease or another dementing illness). An exemption due to dementia cannot be claimed for any individual who is also identified as having an intellectual/developmental disability or ~~having~~ a related condition, or for any individual with another primary psychiatric diagnosis. For example, an individual diagnosed with dementia and a primary diagnosis of depression may not be exempted. A physician's assistant, nurse practitioner or physician must certify that the individual meets the clinical criteria for dementia and does not have another primary psychiatric diagnosis, intellectual/developmental disability, or a related condition.	To match the wording and requirements on the DCH-3878 form; To add the word "developmental" and coincide wording with the DCH-3877 and DCH-3878.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	8.4 Level II Evaluation Completion	The 1st paragraph was revised to read: Individuals who are identified at the Level I screening as having a mental illness, ~~or~~ intellectual/developmental disability or ~~having~~ a related condition, and who do not meet exemption criteria outlined previously, must be referred to the local CMHSP for a Level II evaluation. Level II evaluations are conducted by mental health professionals through the local CMHSP under contract with MDHHS. The evaluation involves an interview with the individual, review of medical records, and consultation with nursing facility and/or hospital staff. The mental health professional must conduct the Level II evaluation in accordance with the MDHHS OBRA Operations Manual. A copy of this manual may be requested from the MDHHS OBRA Office or the local CMHSP. The 4th paragraph was revised to read: Once completed, the CMHSP forwards all documentation of the Level II evaluation to MDHHS. Based on this documentation, MDHHS determines whether the individual requires nursing facility services or can be served in an alternate setting. MDHHS also determines whether specialized services or other mental health services are needed to treat the individual's mental illness, ~~or~~ intellectual/developmental disability or a related condition. The 7th paragraph was deleted. ~~Given that all other admission criteria outlined in this chapter are met, a nursing facility may admit an individual on the basis of a verbal Pre-admission Screening determination from MDHHS. This determination may be communicated to the nursing facility by the CMHSP.~~	To add the word "developmental" and coincide wording with the DCH-3877 and DCH-3878. Obsolete information - We no longer do phone authorizations.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	10.20 Mental Health Services	Text was revised to read: Nursing facilities are required to have a written agreement with the local CMHSP outlining their working relationship to provide screening, evaluation and specialized services to nursing facility residents. The agreement must include a description of the process to be used to ensure the annual review of residents previously identified as having a mental illness, ~~or~~ intellectual/developmental disability or a related condition. The agreement must also specify the means through which the facility and the CMHSP will deliver mental health services for nursing facility residents. Completion of required Pre-admission Screening and Annual Resident Review is included in the facility's per diem rate. Prior to admission to a nursing facility, all individuals, regardless of payment source, must receive the Level I Pre-admission Screening (PAS) to identify the need for mental health and specialized services. Additional screening for mental health and specialized services is done as an Annual Resident Review (ARR), or more frequently in response to a change in a beneficiary's condition. (Refer to the PASARR Process section of this chapter for more information.) Mental health services provided by the nursing facility staff, as specified in the resident's plan of care, are included in the facility's per diem rate. Nursing facilities must provide mental health, ~~and/or~~ intellectual/developmental disability or related condition services that are of lesser intensity than specialized services to all residents who need such services.	To add the word "developmental" and coincide wording with the DCH-3877 and DCH-3878.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Coverages	10.20.A. Specialized Services	The 3rd paragraph was revised to read: "Specialized Services" are defined as those mental health services for residents who have a mental illness, ~~or~~ intellectual/developmental disability or a related condition which are: • Of greater intensity than those normally required from a nursing facility; • Provided in conjunction with usual nursing facility services; • Determined through the PASARR process; • Provided or arranged for by the local CMHSP acting on behalf of the State; or • Result in the continuous and aggressive implementation of an individualized plan of care. The 5th paragraph was revised to read: Specialized services for residents with a **intellectual/developmental disability or related condition** include specialized professional involvement because the service need is related to the resident's intellectual/developmental disability or related condition. Evaluators must carefully distinguish between those service needs that require the involvement of an intellectual/developmental disability professional~~,~~ and those which are "generic" and do not require specifically-trained professionals. For example, administering medication is a "generic" service, while teaching a resident to self-administer may be a "specialized service" because it requires the involvement of an intellectual/developmental disability professional to design and monitor the program.	To add the word "developmental" and coincide wording with the DCH-3877 and DCH-3878.
Nursing Facility Certification, Survey & Enforcement Appendix	2.1 Dual Certification	The 1st paragraph was revised to read: MDHHS requires all new Medicaid-certified nursing facility beds to also be certified for Medicare. ~~Requests~~ Applications for certification of new Medicaid beds that are not Medicare-certified will be denied. ~~Requests~~ Applications for initial Medicare certification may be made to the ~~provider's SSA team manager~~ LARA-BCHS. Facilities must meet state and federal regulations for certification.	

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CHAPTER	SECTION	CHANGE	COMMENT
		The 4th paragraph was revised to read: A provider that ~~requests~~ applies for new Medicaid certification for some beds in a nursing facility must dually certify all Medicaid beds in the facility before any new Medicaid bed certifications will be approved for the facility, even if the existing Medicaid-certified beds were granted an exception under this policy. For example, a nursing facility has a distinct part or unit that is certified as Medicaid-only and is granted an exception under this policy. The provider adds a new wing and ~~requests~~ applies for Medicaid certification for the new beds. The new beds will be approved for Medicaid certification only if all Medicaid beds in the nursing facility are also certified for Medicare, including the beds in the historically Medicaid-only unit. The last paragraph was revised to read: A provider must ~~request~~ apply for and receive dual Medicaid and Medicare certification for new Medicaid beds acquired through the CON process, e.g. new construction or the redistribution of certified beds.	
Nursing Facility Certification, Survey & Enforcement Appendix	2.2 Medicaid Bed Certification Liimits	Text was revised to read: Individual facilities seeking to enroll in the Medicaid program or seeking to increase the number of Medicaid-certified beds must apply as outlined in the Medicaid Nursing Facility Bed Certification Process subsection of this appendix. ~~Requests~~ Applications to the SMA will be reviewed in date order and must be received 45 days before the first of the month beginning the next quarter of the provider's cost reporting year. MDHHS will authorize Medicaid-certified beds, limited by the aggregate Upper Bed Limit (set in 1996 at 47,542), based on the criteria outlined in the Criteria for Evaluation of Medicaid Bed Certification ~~Requests~~ Applications subsection. Preference will be given to facilities that are ~~requesting~~ applying for Medicaid certification in order to dually certify beds, to facilities that are creating innovative living environments for beneficiaries who choose nursing facility care, and to facilities in geographic areas with limited Medicaid accessibility. Changes in bed certifications will take place after approval is granted effective on the first of the month beginning the next quarter of the provider's cost reporting year. Changes in bed certifications will not be approved on a retroactive basis.	

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Certification, Survey & Enforcement Appendix	2.3 Criteria for Evaluation of Medicaid Bed Certification Requests	The subsection title was revised to read: Criteria for Evaluation of Medicaid Bed Certification ~~Requests~~ Applications The 1st paragraph was revised to read: The SMA (MDHHS-MSA) will collaborate with the SSA (LARA-BCHS) when making a determination regarding the approval or denial of any application for Medicaid bed certification and provider enrollment. Approval or denial of an application to MDHHS for Medicaid bed certifications will be based on the following criteria: In the 1st paragraph, the following bullet points were revised: • [2nd bullet point] The nursing facility's historical and current survey performance demonstrates no regulatory deficiencies or only deficiencies with minimal impact on residents. The nursing facility has not been subject to one of the following actions or concerns within two calendar years or the preceding eight full quarters (or as noted) of the filing of an application for Medicaid bed certification: ➢ [2nd bullet point, 5th sub-bullet point] Repeat citations at the harm or substandard quality of care level. "Repeat citation" is defined as two citations of the same federal deficiency, or two or more citations within the same regulatory grouping, at the substandard quality of care, harm, or Immediate Jeopardy levels, issued within the ~~last two years~~ preceding eight full quarters or two standard survey cycles. (The time frame for this criterion may exceed eight quarters.) This criterion considers deficiencies resulting from both standard and abbreviated surveys. ➢ [2nd bullet point, 6th sub-bullet point] A number of citations at Level Two or above on the scope and severity grid on two consecutive standard surveys that exceeds twice the statewide average number of citations. (The time frame for this criterion may exceed ~~two years~~ eight quarters.) ➢ [2nd bullet point, 7th sub-bullet point] A number of citations resulting from abbreviated surveys at Level Two or above on the scope and severity grid during ~~any~~ the two preceding calendar years that exceeds twice the statewide average of abbreviated survey citations.	Made the policy clearer to identify what part of the state survey agency (SSA) at LARA the SMA collaborates with in making bed certification determinations. The change is being made to clarify or define what "two years" means. To enable the Department to define what period of time is being reviewed, the criteria look-back period will include the preceding eight full quarters. Changes made to provide consistency throughout with words such as 'application' and 'collaborate'. Changed 'request' and 'coordinate' respectively.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Certification, Survey & Enforcement Appendix	2.4 Medicaid Nursing Facility Bed Certification Process	Text was revised to read: Current providers who wish to change their Medicaid-certified beds (increase, decrease, relocate) and providers who wish to enroll in the Medicaid Program may do so as outlined in this subsection. A written ~~request~~ application to change Medicaid-certified beds must contain the following: • Number and location of facility beds. • Current certification designation of all facility beds by unit or wing. • Requested number and proposed location of increased, decreased, or relocated Medicaid beds, with an attached layout of the facility showing the current and proposed distribution of beds. A provider may ~~request~~ apply for a change in Medicaid bed certifications ~~at the time of annual survey and~~ any time throughout the year up to once per quarter. The change in bed certifications will take place after approval is granted effective on the first of the month beginning the next quarter of the provider's cost reporting year. Changes in bed certifications will not be approved on a retroactive basis. In addition to the process outlined below, nursing facilities must abide by the procedures outlined in the State Operations Manual, Chapter 3, Section 3202, Change in Size or Location of Participating SNF and/or NF. MDHHS will respond to Medicaid bed certification ~~requests~~ applications with a determination within 45 days of receipt of all requested information.	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Certification, Survey & Enforcement Appendix	2.4.A. Bed Certification Process for Medicaid Enrolled Providers	Text was revised to read: Nursing facilities that are currently enrolled with Medicaid and want to change their number of Medicaid-certified beds must file a written ~~request with their SSA team manager and with the SMA.~~ application to both LARA (BCHS) and MDHHS (SMA). (Refer to the Directory Appendix for application mailing instructions related to Medicaid bed certification changes.) The SMA and the SSA will ~~coordinate~~ collaborate regarding the consideration and disposition of ~~requests~~ applications for additional Medicaid beds. The SSA will conduct surveys as needed. Medicaid approval or denial of the application will be based on the considerations outlined in the Criteria for Evaluation of Medicaid Bed Certification ~~Requests~~ Applications and the Dual Certification subsections of this appendix. Once the SMA makes a determination regarding the ~~request~~ application for additional Medicaid bed certifications, the provider, the SSA, MDHHS Provider Enrollment, and the MDHHS LTC Reimbursement and Rate Setting Section (RARSS) will be notified, in writing, by the SMA. If the ~~request~~ application is denied, the provider will be notified of their appeal rights in writing. If the ~~request~~ application is approved, the SSA will be notified by the SMA of the change. The SSA will also notify the provider of the change.	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Certification, Survey & Enforcement Appendix	2.4.B. Bed Certification Process for Nursing Facilities Not Enrolled in Medicaid	The 2nd and 3rd paragraphs were revised to read: Non-Medicaid providers seeking to receive Medicaid certification for nursing facility beds and receive Medicaid payment must file a written ~~request~~ application with ~~their~~ both the SSA ~~team manager~~ and with the SMA. The SMA and the SSA will ~~coordinate~~ collaborate regarding the consideration and disposition of the ~~request~~ application for Medicaid bed certifications. The SSA will conduct surveys as needed. Medicaid approval or denial of the application will be based on the considerations outlined in the Criteria for Evaluation of Medicaid Bed Certification ~~Requests~~ Applications subsection of this appendix. Once the SMA makes a determination regarding the ~~request~~ application for ~~additional~~ Medicaid bed certifications, the provider, the SSA, MDHHS Provider Enrollment, and RARSS will be notified, in writing, by the SMA. If the ~~request~~ application is denied, the SMA will notify the provider of their appeal rights in writing. If the ~~request~~ application is approved, the SMA will notify the provider ~~or~~ and the SSA of the change. The SSA will also notify the provider of the change.	

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Certification, Survey & Enforcement Appendix	2.4.C. Bed Certification Process During a Change in Ownership (CHOW)	The 1st through 5th paragraphs were revised to read: A provider seeking a change in ownership of a nursing facility must first receive approval through the CON process within MDHHS. The new provider can avoid a delay in payment and address any potential certification issues by submitting a written 90-day advance notice, plus a copy of the sale and/or lease agreement, to the SSA ~~team manager~~, the SMA/LTC Services Section and RARSS. (Refer to the Directory Appendix for contact information.) The following are changes in ownership that must be reported to the SMA and the SSA, regardless of whether a CON is required: • A change from sole proprietorship to partnership or corporation, • A change from partnership to sole proprietorship or corporation, • A change from corporation to sole proprietorship, partnership or corporation, • Sale or lease of a nursing facility, • Transfer or sale of stock resulting in a change of the controlling interest in a privately held company, • Consolidation or merger of two or more corporations that results in the creation of a new corporation. If the new owner does not want to make any changes in bed certifications, no additional action regarding certifications is required and the certifications continue as they were under the previous owner. However, if the facility has beds designated as Medicaid-only, the new owner must dually certify all Medicaid beds within one year as outlined in the Dual Certification subsection. As part of the CHOW approval process, the SMA may deny bed certifications and recommend against Medicaid enrollment based on the criteria in the Criteria for Evaluation of Medicaid Bed Certification ~~Requests~~ Applications subsection. In addition, dual certification requirements apply as outlined in the Dual Certification subsection.	

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CHAPTER	SECTION	CHANGE	COMMENT
		If the new owner wants to change the bed certifications, a written ~~request~~ application must be filed with the SSA ~~team manager~~ and with the SMA Long Term Care Services Section. The SMA and the SSA will ~~coordinate~~ collaborate regarding the consideration and disposition of the ~~request~~ application for ~~additional~~ changes in the Medicaid bed certifications. The SSA will conduct surveys as needed. Medicaid approval or denial of the application will be based on the considerations outlined in the Criteria for Evaluation of Medicaid Bed Certification ~~Requests~~ Applications subsection. Once the SMA makes a determination regarding the ~~request~~ application for ~~additional~~ changes in the Medicaid bed certifications, the provider, the SSA, MDHHS Provider Enrollment, and the RARSS will be notified, in writing, by the SMA. If the ~~request~~ application is denied, the SMA will notify the provider of appeal rights in writing. If the ~~request~~ application is approved, the SMA will notify the SSA of the change. The SSA will also notify the provider of the change.	
Nursing Facility Certification, Survey & Enforcement Appendix	2.4.D. Bed Certification Process for a New Nursing Facility or Newly Licensed Nursing Facility Beds	The 2nd and 3rd paragraphs were revised to read: Providers seeking to receive Medicaid certification for ~~the~~ new nursing facility beds and receive Medicaid payment must file a written ~~requests~~ application with t~~he SSA team manager and with the~~ both the SMA and the SSA. The SMA and the SSA will ~~coordinate~~ collaborate regarding the consideration and disposition of the ~~request~~ application for Medicaid bed certifications. Medicaid approval or denial of the application for additional bed certifications will be based on the Criteria for Evaluation of Medicaid Bed Certification ~~Requests~~ Applications. Once the SMA makes a determination regarding the ~~request~~ application for new or additional Medicaid bed certifications, the provider, the SSA, MDHHS Provider Enrollment, and RARSS will be notified in writing. If the ~~request~~ application is denied, the SMA will notify the provider of appeal rights in writing. If the ~~request~~ application is approved, the SMA will notify the SSA of the change. The SSA will also notify the provider of the change.	

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Certification, Survey & Enforcement Appendix	2.5 Medicaid Enrollment as a Ventilator Dependent Care Unit (VDCU) and Additional VDCU Beds	Text was revised to read: Medicaid approval or denial of Medicaid enrollment as a VDCU and ~~requests~~ applications to increase the number of VDCU beds is based on Medicaid policies in the Dual Certification and the Criteria for Evaluation of Medicaid Bed Certification ~~Requests~~ Applications sections of this appendix. In addition, VDCU ~~requests~~ applications will be coordinated with ~~the facility's team manager in the~~ LARA - ~~Bureau of Community and Health Systems (~~BCHS~~) Long-Term Care Division and the Health Facilities Division, Health Facilities Engineering Section~~ Health Facility Licensing, Permits and Support Division.	
Nursing Facility Certification, Survey & Enforcement Appendix	2.11 Re-entry After De-certification	In the table in the 3rd paragraph, under the description for 'Application', text was revised to read: The nursing facility must make application for program re-entry to the SSA. The SSA forwards the completed application and evidentiary confirmation to CMS and the SMA for review and processing. A nursing facility may apply for re-certification at any time; however, the Criteria for Evaluation of Medicaid Bed Certification ~~Requests~~ Applications apply as outlined in this section.	
Nursing Facility Cost Reporting & Reimbursement Appendix	Section 2 – Ownership Changes and Medicaid Termination	The Appendix was re-formatted and information was relocated; this section is now identified as Section 3.	Placing the definition section before the other sections will aid in understanding the terminology used in the subsequent sections.
Nursing Facility Cost Reporting & Reimbursement Appendix	Section 3 – Definitions	The Appendix was re-formatted and information was relocated; this section is now identified as Section 2.	Placing the definition section before the other sections will aid in understanding the terminology used in the subsequent sections.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	8.8 Interest	The 6th bullet point was revised to read: • Working capital borrowings are considered funds borrowed for ~~a relatively short period of~~ 12 months or less to meet current normal operating expenses. For lines of credit, the borrowing shall be compliant with the 12 month requirement if the provider repays the entire amount withdrawn within 12 months of the date of the first draw. If the entire amount of the working capital borrowing is not repaid within 12 months, then all the interest expense associated with the borrowing is unallowable.	Clarification to help providers understand 12 months is a firm limit and not just an example.
Nursing Facility Cost Reporting & Reimbursement Appendix	9.13.C. Life of an Approved Plan	The 11th paragraph was revised to read: All requests for an exception to policy will include a review of the facility's historical and current survey performance. Criteria regarding survey history (found in the Criteria for Evaluation of Medicaid Bed Certification ~~Requests~~ Applications subsection of the Nursing Facility Certification, Survey & Enforcement Appendix of this manual) are also applicable to this exception request.	
Nursing Facility Cost Reporting & Reimbursement Appendix	9.13.E. Amending a Plan	In the 2nd paragraph, the last sentence was revised to read: As noted, all requests will include a review of the facility's historical and current survey performance consistent with the Criteria for Evaluation of Medicaid Bed Certification ~~Requests~~ Applications subsection of the Nursing Facility Certification, Survey & Enforcement Appendix of this manual.	
Nursing Facility Cost Reporting & Reimbursement Appendix	Section 11 – Appeals Process	The last paragraph was revised to read: The provider retains their right to an administrative hearing regardless of the outcome of the internal conference. The provider may waive the internal conference and directly request an administrative hearing. The review and hearings process for providers has been promulgated in the administrative rules located on LARA's website. The process is explained in more detail in the MDHHS Administrative Hearing pamphlet on the MDHHS website. (Refer to the Directory Appendix for website information.)	Clarification to help providers understand the appeal process.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Level of Care Determination	Section 1 – General Information	The 1st paragraph was revised to read: The Michigan Department of Health and Human Services (MDHHS) is required to assess all individuals seeking Medicaid-funded long-term services and supports (LTSS) that require level of care eligibility to determine their functional need for those services. The determination is an essential component of eligibility for services provided in nursing facilities, the MI Choice Waiver Program, the Program of All-Inclusive Care for the Elderly (PACE), and the MI Health Link Home and Community Based Services (HCBS) Waiver Program. Policies contained herein apply equally and consistently to each of these programs except as noted. The last paragraph was revised to read: The LOCD is a "point in time" assessment; that is, it determines the individual's functional eligibility at the time of the assessment. MDHHS assumes that beneficiaries will maintain functional eligibility until they are determined otherwise through a reassessment or the LOCD's End Date. A face-to-face ~~assessment~~ LOCD is an in-person meeting between the qualified and licensed health professional and the individual ~~in order to conduct the LOCD~~ seeking functional eligibility.	Clarification.
Nursing Facility Level of Care Determination	3.1 LOCD Assessment Requirement for Reimbursement	The 1st sentence was revised to read: The LOCD must be conducted prior to or on the day of an individual's admission to a nursing facility or enrollment in MI Choice Waiver Program, PACE, or MI Health Link ~~Home and Community Based Services (~~HCBS~~)~~ Waiver Program to ensure reimbursement for a Medicaid eligible beneficiary.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Level of Care Determination	3.2 Persons Authorized to Conduct the LOCD	Text was revised to read: ~~Michigan.~~ A qualified and licensed health professional ~~may~~ must be a physician, registered nurse, licensed practical nurse, licensed social worker (Limited License Bachelor of Social Work, Limited License Master Social Worker, Licensed Bachelor Social Worker, or Licensed Master Social Worker), physician's assistant, nurse practitioner, licensed psychologist, physical therapist, respiratory therapist, occupational therapist or speech therapist. Once the LOCD is completed by a qualified and licensed health professional, a clinical or non-clinical staff person may enter the LOCD information in CHAMPS. When the LOCD data are entered, CHAMPS applies the MDHHS algorithm to determine eligibility. ~~For individuals receiving services through the MI Health Link HCBS Waiver program, the LOCD must be conducted according to MI Health Link program requirements.~~	This is a requirement and stating "must" for clarification. MI Health Link program LOCD processes have changed and align more closely with the rest of the programs that require an LOCD.
Nursing Facility Level of Care Determination	3.4 Adoption of an Existing LOCD by Another Provider	The 1st paragraph was revised to read: The LOCD is associated with the beneficiary, rather than the provider serving the beneficiary. Therefore, if a beneficiary is seeking admission to or enrollment in a program and has a current LOCD in CHAMPS, the provider may adopt that LOCD to confirm functional eligibility. When adopting a current LOCD, the provider must print out the computer-generated FOC from that LOCD record and complete the form with proper signatures and date. A qualified and licensed health professional from the admitting or enrolling provider must sign and date the CHAMPS-generated FOC ~~for~~ from the adopted LOCD record. The FOC must also be signed by the beneficiary or their legal representative.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Level of Care Determination	3.6 Verification Review of LOCD	The 1st paragraph was revised to read: The purpose of the verification review (LOCD-VR) is to determine if the LOCD was conducted properly according to policy and resulted in the correct determination of eligibility. A randomly selected sample of LOCDs will be reviewed by MDHHS or its designee. CHAMPS will randomly select a statistically significant sample of LOCDs entered in the system. Upon submission of the LOCD in the system, CHAMPS will immediately notify the provider if the LOCD was selected for review with a pop-up message. The provider is required to submit all relevant documentation used to support the LOCD including, but not limited to, observation notes, assessment reports, physician orders or notes, caregiver reports, cognitive test results, time studies, nursing or case management notes, intervention reports, or evidence of other medical or community services provided. The related CHAMPS LOCD Application ID must be indicated on all documents for tracking purposes. Documents must be uploaded electronically in CHAMPS within one business day of the LOCD being selected for verification review in CHAMPS. The last paragraph was revised to read: When the individual is found to not meet LOCD criteria, MDHHS or its designee will provide to the individual an Adequate Action Notice including appeal rights per Medicaid policy. Services provided to the individual during the verification review process will not be eligible for Medicaid reimbursement.	Clarification.
Nursing Facility Level of Care Determination	3.8.C. Passive Assessment Decisions	The subsection title was revised to read: Passive ~~Assessment~~ Redetermination Decisions	Clarification.
Nursing Facility Level of Care Determination	6.2 Adequate Action Notice	Text was revised to read: For individuals who are not currently receiving LTSS in a program or setting that requires an LOCD, an adequate action notice is provided when the initial LOCD determines the individual does not meet LOCD criteria. The adequate action notice must include all the language in the sample adequate action notices for LTSS available on the MDHHS LOCD website. (Refer to the Directory Appendix for website information.)	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
School Based Services Random Moment Time Study	1.3 Staff Pools and Confidence Levels	The 5th paragraph was revised to read: Valid moments are completed moments that have been received by the Contractor and determined to be complete and accurate. Invalid moments are moments that are assigned to staff who are no longer in the position as selected, moments that are outside of paid work hours, and moments not returned for any other reason ~~(including Activity Code 18)~~.	Update.
School Based Services Random Moment Time Study	3.2 Random Moment Time Study Form Completion	The 1st paragraph was revised to read: There are two steps to completing a time study form: • In the first step, for the designated moment, the time study participant provides the answers to ~~three~~ the questions ~~(What are you doing? Who are you with? Why are you doing it?)~~. These questions relate to their activities at the time of their randomly selected moment. • In the second step, the time study forms are collected from the participants, and the Contractor assigns the appropriate activity code for that moment based on the answers to the ~~three time~~ study questions.	
School Based Services Random Moment Time Study	Section 4 – Administrative Outreach and Direct Medical Activity Code Summary	Section 4 was revised in its entirety.	Code updates.
Therapy Services	Section 3 – Prior Authorization Requests	The 10th paragraph was revised to read: Prior authorization requests should be submitted with the appropriate therapy modifier to distinguish the discipline under which the service is being requested. ~~and~~ When the therapy is habilitative, a modifier that represents the nature of the therapy being requested ~~(habilitative vs rehabilitative therapy)~~ must also be reported. Requests for maintenance therapy services should also contain the appropriate maintenance modifier. Refer to the Billing & Reimbursement Chapters for additional modifier information.	Clarification.

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CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Provider Assistance	Under "Provider Enrollment Unit", the telephone number was revised to read: ~~517-335-5492~~ 1-800-292-2550	Provider enrollment questions should originate with the Provider Support line. Provider Support will transfer to PE Unit if necessary.
Directory Appendix	Health Plan Information	Under "Medicaid Health Plan Carveout", the website for "Medicaid Health Plan Pharmacy Program Carve-out" was revised to read: https://michigan.magellanrx.com/ >> Provider >> Documents >> Carveout Coverage >> Medicaid Health Plan Carveout	MagellanRx created a new website and a new URL.
Directory Appendix	Provider Resources	Information for "MDHHS Division of Family & Community Health" was removed.	Information can be found under "Maternal Infant Health Program Resources".
Directory Appendix	Maternal Infant Health Program Resources	Under "Maternal Infant Health Program", addition of e-mail address: mihp@michigan.gov	Update.
Directory Appendix	Nursing Facility Resources	Under "MDHHS, LTC Services", the phone number was revised to read: ~~517-373-6313~~ 517-241-4079	Update.
Directory Appendix	Pharmacy Resources	Under the entries for "MDHHS Pharmacy Benefit Manager (PBM)", the website addresses were revised to read: https://michigan.magellanrx.com Under "MAC Pricing Information", the website address was revised to read: https://michigan.magellanrx.com Under "Provider Liaison Meeting Calendar", the website address was revised to read: https://michigan.magellanrx.com	MagellanRx created a new website and a new URL.

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CHAPTER	SECTION	CHANGE	COMMENT
Forms Appendix	DCH-3878; Mental Illness/Intellectual Disability/Related Condition Exemption Criteria Certification	The title of the form was revised to read: Mental Illness/Intellectual-Developmental Disability/Related Condition Exemption Criteria Certification The word "developmental" was added to the form as needed.	The form was revised to include the term "developmental".
Forms Appendix	DCH-3877; Preadmission Screening (PAS)/ Annual Resident Review (ARR) (Mental Illness/ Intellectual Disability/Related Conditions Identification)	The title of the form was revised to read: Preadmission Screening (PAS)/Annual Resident Review (ARR) (Mental Illness/ Intellectual-Developmental Disability/Related Conditions Identification) The word "developmental" was added to the form as needed.	The form was revised to include the term "developmental".

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Medicaid Provider Manual
October 2019 Updates

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 19-04	3/1/2019	Medical Supplier	2.3.B. Continuous Glucose Monitoring Equipment and Supplies (new subsection)	New subsection text reads: **Definition**: Continuous glucose monitoring systems (CGMS) are devices that measure glucose levels taken from interstitial fluid continually throughout the day and night, providing real-time data to the beneficiary or physician. The CGMS is comprised of three parts: 1) A disposable sensor (attaches to the skin and inserts a tiny wire into the subcutaneous tissue to measure glucose levels), 2) The transmitter (attaches to the sensor and sends the data to a wireless receiver/monitor), and 3) A receiver/monitor (records and stores the data and alerts the beneficiary when glucose levels are too high or too low).

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE	
				Standards of Coverage	A personal use CGMS and supplies are covered for persons with Type I diabetes when all the following are met: • The beneficiary is under the care of one of the following: ➢ An endocrinologist; or ➢ A physician or non-physician practitioner (nurse practitioner, physician assistant or clinical nurse specialist) who is managing the beneficiary's diabetes. (The provider must provide documentation that the beneficiary completed a Medicaid-covered diabetes self-management education [DSME] training within one year prior to the written order); • The beneficiary has Type I diabetes requiring the administering of insulin three or more times per day or is currently using an insulin pump, and at least one of the following: ➢ Is unable to consistently and reliably identify hypoglycemic events (e.g., hypoglycemic unawareness); ➢ A recent history of hospitalization or emergency room visits for seizures or other conditions attributed to a hypoglycemic event; ➢ Coexistent morbidity that poses an unusual challenge with concomitant hypoglycemia (e.g., uncontrolled epilepsy);

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				➢ The presence of microvascular complication (e.g., vasculopathy, retinopathy); or ➢ Ketoacidosis or uncontrolled glucose. At least one of the above conditions must be documented (e.g., hypoglycemic unawareness). • The beneficiary's treatment plan recommends testing blood glucose a minimum of four times per day; • The beneficiary has poor diabetic control despite attempts to maximally optimize care (e.g., compliance) with hypoglycemic unawareness, seizures, unexplained hypoglycemic episodes, recurrent ketoacidosis, and/or HbA1c not in an acceptable range; • The beneficiary's current treatment plan requires frequent adjustments to insulin dosage throughout the day; • The endocrinologist/physician/non-physician practitioner documents beneficiary compliance with their treatment plan; and • The beneficiary or his/her caregiver is educated on the use of the device and is willing and able to use the CGMS.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE	
				Documentation	Documentation must be less than 90 days old and include all the following: • A written order by the treating physician/non-physician practitioner; • Diagnosis related to the need for the CGMS; • Length of need; • Number of finger-stick tests beneficiary performs per day; • Frequency of insulin administered per day or if the beneficiary is using an insulin pump; • Records of hypoglycemic events, HbA1c levels, uncontrolled ketoacidosis, hypoglycemic events, coexistent morbidity having occurred with hypoglycemia or the presence of a microvascular complication(s), as applicable; • Current treatment plan and beneficiary's compliance with the plan; and • Documentation of beneficiary completion of a Medicaid-covered certified DSME training program (if provider other than an endocrinologist is treating the beneficiary's diabetes). The DSME training program must have been completed within one year prior to the written order for the CGMS and include education on the use of CGMS (refer to the Hospital Chapter in this manual for additional information).

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				The initial order must be written for six months. If the beneficiary continues to be compliant with use of the CGMS and treatment plan, the practitioner may write an order for an additional six months. After the first year, an order(s) for replacement sensors, transmitters and receivers (following frequency rules) may be written for a 12-month period. **Note:** Children's Special Heath Care Services (CSHCS) beneficiaries require a prescription from a pediatric endocrinologist.
				PA Requirements: Prior authorization is not required for infants and toddlers (age 5 and under*) if standards of coverage and documentation requirements are met. Prior authorization is required for all other ages and conditions. *It is assumed that hypoglycemic unawareness is common within this age group.
				External Insulin Pump Combined with CGMSs: An external insulin pump combined with a CGMS is covered when the external insulin pump and the CGMS policy standards of coverage are met. To be considered for coverage, the device must be approved by the Food and Drug Administration (FDA) as a combined insulin pump/CGMS.
				Non-Covered: Smart devices (e.g., smart phones, iPads, tablets, personal computers) used with a CGMS are not classified as durable medical equipment and are not covered by Medicaid.

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				Payment Rules: The sensor, transmitter and receiver are purchase-only items, except for K0554 (may be purchased, rented or used item). The following HCPCS codes are included in the allowance for K0553 and may not be billed separately: A4233, A4234, A4236, A4244, A4245, A4246, A4247, A4250, A4253, A4255, A4256, A4257, A4258, A4259, E0607, E2100 and E2101. The product warranty must be expired prior to replacement of the transmitter and/or receiver. Providers must use the most appropriate HCPCS code for each brand/make/model of CGMS by reviewing the Food and Drug Administration (FDA) product approvals and the Pricing, Data Analysis and Coding (PDAC) contractor website for coding assignment. Upcoding a product to receive higher reimbursement is incorrect billing and could result in post-payment recovery of funds or provider audit. Refer to the Medicaid Code and Rate Reference tool for HCPCS code coverage parameters.
MSA 19-10	5/1/2019	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 ~~nurse practitioners,~~ physician assistants, advanced practice registered nurses, and podiatrists)

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			15.7 Clinical Records	The footnote for the chart at the end of the subsection was revised to read: * Includes MD, DO, DPM, DC, OD, ~~Certified Nurse Midwife,~~ Certified Registered Nurse Anesthetist, Anesthesiologist Assistant, ~~Nurse Practitioner,~~ Physician Assistant, Advanced Practice Registered Nurse, Physical Therapist, Oral-Maxillofacial Surgeon, Medical Clinics (e.g., FQHCs, Public Health Clinics).
		Billing & Reimbursement for Professionals	Section 1 – General Information	In the 2nd paragraph, the following bullet point was added: • Advanced Practice Registered Nurses (APRNs), including Certified Nurse Practitioners (NPs), Certified Clinical Nurse Specialists (CNSs), Certified Nurse-Midwives (CNMs) The following bullet points were removed: • ~~Certified Nurse Midwives~~ • ~~Certified Nurse Practitioners~~ In the 3rd paragraph, the following bullet point was added: • Advanced Practice Registered Nurse The following bullet points were removed: • ~~Nurse Practitioner~~ • ~~Certified Nurse Midwife~~

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		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], certified nurse practitioner [NP], certified clinical nurse specialist [CNS], or physician assistant [PA]) can provide family planning services. Family planning clinics are limited to providing only family planning services.
		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 ~~certified nurse midwife (CNM), nurse practitioner (NP),~~ physician, ~~or~~ physician assistant or advanced practice registered nurse must refer the newborn to a Medicaid-enrolled hearing center where screening must be completed prior to one month of age.
		Hospital	1.5.E. Hospital-Based Provider	The 1st sentence was revised to read: A hospital-based provider (HBP) is defined as a hospital-employed MD, DO, Certified Registered Nurse Anesthetist (CRNA), physician's assistant (PA), ~~nurse practitioner (NP),~~ advanced practice registered nurse (APRN) [including certified nurse practitioner (NP), certified clinical nurse specialist (CNS) or certified nurse midwife (CNM)], dentist, podiatrist, or optometrist~~, or nurse midwife~~.
			1.5.I. Services that Must be Billed by Other Providers	The following bullet point was added: • Advanced Practice Registered Nurse (APRN) The following bullet points were removed: • ~~Nurse Practitioner*~~ • ~~Nurse Midwife*~~

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			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 ~~nurse midwife, nurse practitioner,~~ physician, ~~or~~ physician assistant or advanced practice registered nurse to refer the newborn for the hearing screening prior to age one month.
			3.20 Laboratory	In the 2nd paragraph, the 3rd bullet point was revised to read: • Ordered by physicians (MD or DO), physician assistants, podiatrists, dentists, ~~nurse practitioners, or nurse midwives~~ or advanced practice registered nurses.
			3.26 Radiology	In the 1st paragraph, the 3rd bullet point was revised to read: • Ordered by physicians (MD or DO), physician assistants, podiatrists, dentists, or advanced practice registered nurses.
		Laboratory	Section 1 - General Information	In the 2nd paragraph, the 1st sentence was revised to read: Medicaid reimburses laboratories only for those services it is certified by the Clinical Laboratory Improvement Amendments (CLIA) to perform and for those services ordered by physicians (MD or DO), physician assistants (PAs), advanced practice registered nurses (APRNs) [including certified nurse practitioners (~~C~~NPs), certified clinical nurse specialists (CNSs) and certified nurse midwives (CNMs)], podiatrists (DPMs), or dentists.
		Medicaid Health Plans	1.1 Services Covered by Medicaid Health Plans (MHPs)	In the 1st paragraph, the following bullet point was added: • Certified Clinical Nurse Specialist services

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		Medical Supplier	1.6 Medical Necessity	In the 2nd paragraph, the 3rd sentence was revised to read: Neither a physician, clinical nurse specialist (CNS), nurse practitioner (NP) or physician assistant (PA) order nor a certificate of medical necessity by itself provides sufficient documentation of medical necessity, even though it is signed by the treating/ordering physician, CNS, NP or PA.
		MI Health Link	5.3.M. Private Duty Nursing	The 4th paragraph was revised to read: This service must be ordered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner. The ICO is responsible for ensuring there is a physician order for the PDN services authorized. The physician may issue this order directly to the provider furnishing PDN services. However, the ICO is responsible for ensuring the PDN provider has a copy of these orders and delivers PDN services according to the orders. The ICO shall maintain a copy of the physician orders in the Care Bridge Record. The individual's physician, physician's assistant, clinical nurse specialist, or nurse practitioner must order PDN services and work in conjunction with the ICO and provider agency to ensure services are delivered according to that order.
		MI Health Link	7.4 ICO Care Coordinator	The following bullet point was added to the 3rd paragraph: • Licensed clinical nurse specialist;
		MI Health Link	7.5.A. LTSS Supports Coordinator	The following bullet point was added to the 1st paragraph: • Licensed clinical nurse specialist;
		Nursing Facility Coverages	10.27 Physician Services	The last paragraph was revised to read: A physician visit is considered timely if it occurs no later than ten days after the required visit. After the initial visit, the physician may alternate personal visits between the physician and a physician assistant, clinical nurse specialist or nurse practitioner.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Practitioner	Section 1 – General Information	The 1st paragraph was revised to read: This chapter applies to physicians (MD, DO), Oral-Maxillofacial Surgeons (MD, DO), Doctors of Podiatric Medicine (DPM), Physician Assistants (PAs), Medical Clinics, Physical Therapists (PTs), Advanced Practice Registered Nurses (APRNs) [including Certified Nurse Practitioners (NPs), Certified Clinical Nurse Specialists (CNSs), and Certified Nurse-Midwives (CNMs)], Certified Registered Nurse Anesthetists (CRNAs), and Anesthesiologist Assistants (AAs)~~, and Nurse Practitioners (NPs)~~.
			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 physician assistants (PAs), certified registered nurse anesthetists (CRNAs)~~, nurse practitioners (NPs), clinical nurse specialists, and certified nurse midwives (CNMs),~~ and advanced practice registered nurses (APRNs), can also be considered HBPs under certain circumstances. The last paragraph was revised to read: (The HBP should refer to their provider-specific ~~chapter~~ section of this ~~manual~~ chapter for policies, procedures, and coverage information.)
			7.9.A. Provider Criteria	The 2nd paragraph was revised to read: Rendering IBCLC providers must be Medicaid-enrolled physicians, ~~nurse practitioners,~~ physician assistants or ~~nurse midwives~~ advanced practice registered nurses. When a Medicaid-enrolled practitioner provides delegation and supervision~~,~~ within the confines of his/her scope of practice~~,~~ to an individual with possession of a valid and current IBCLC certification, that Medicaid-enrolled health professional may bill for comprehensive lactation support services.

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			11.9 Assistant at Surgery/ Assistant Surgeon	The last paragraph was revised to read: Medicaid covers assistant at surgery services performed by a second physician, a physician's assistant (PA), a certified nurse practitioner (NP), a certified clinical nurse specialist (CNS) and, in limited instances, a certified nurse-midwife (CNM). PA, NP, CNS, and CNM services as assistant at surgery must be under the delegation and supervision of the physician employing the PA, NP, CNS or CNM, or a physician employed by the same group practice that employs the PA, NP, CNS or CNM. If the PA, NP, CNS and/or CNM are employees of the hospital, their services are covered as a part of the hospital charges.
			17.1 Telemedicine Services	The 2nd paragraph was revised to read: Where face-to-face visits are required (such as ESRD and nursing facility related services), the telemedicine service may be used in addition to the required face-to-face visit~~,~~ but cannot be used as a substitute. There must be at least one face-to-face hands-on visit (i.e., not via telemedicine) by a physician, ~~nurse practitioner, or~~ physician's assistant, or advanced practice registered nurse per month to examine the vascular site for ESRD services. The initial visit for nursing facility services must be face-to-face.
			Section 20 – Certified Nurse Practitioner	The following text was added: Medicaid covers services provided by qualified Medicaid enrolled nurse practitioners (NPs). Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter or the Medicaid Code and Rate Reference tool for additional information regarding coverage parameters.
			20.1 General Information	The subsection was deleted in its entirety.

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			20.1 Covered Services (new subsection)	New subsection text reads: Medicaid covers medically necessary services provided by a NP, as defined in Public Act 368 of 1978 as amended, when all of the following requirements are met: • the services are the type that are considered physician's services if furnished by a Doctor of Medicine or Osteopathy (MD/DO); • the services are performed by a person who is licensed as an advanced practice registered nurse (APRN) under state law with the NP specialty certification granted by the Michigan Board of Nursing; • the NP is legally authorized to perform the service in compliance with state law; • the services are performed in collaboration with or under the terms of a valid practice agreement with a Medicaid-enrolled MD/DO; and • the services are not restricted to physicians or otherwise excluded by Medicaid program policy or federal and state statutes. NP services are subject to the limitations that apply to physician services. Certain services may be restricted to physicians by program policy or federal and state statutes and may not be covered for NPs. Professional services are only covered when the NP has personally performed the service and no other provider or entity has been paid for the service. Services provided jointly by the NP and physician are covered for a single practitioner only.

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			20.2 Enrollment of Certified Nurse Practitioners	The subsection title was revised to read: Enrollment of ~~Certified~~ Nurse Practitioners Subsection text was revised in its entirety to read: A NP who provides professional services to Medicaid beneficiaries is required to be a Medicaid-enrolled provider and uniquely identified on claims. To enroll as a Medicaid provider, the NP must complete an on-line application in the Community Health Automated Medicaid Processing System (CHAMPS) and enroll with an Individual (Type 1) National Provider Identifier (NPI) as either a Rendering/Servicing-Only or Individual/Sole Provider.
			20.2.A. Rendering/Servicing-Only Certified Nurse Practitioners	The subsection title was revised to read: Rendering/Servicing-Only ~~Certified Nurse Practitioners~~ Provider Text was revised to read: A physician-employed NP who renders services only under the physician's delegation and supervision under an employment relationship or agreement is required to be an enrolled provider and uniquely identified on claims for services. He/she may enroll as a Rendering/Servicing-Only Provider, and payment for ~~these~~ services will be made to the employing, supervising physician or physician group.

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			20.2.B. Individual/Sole Provider Certified Nurse Practitioners	The subsection title was revised to read: Individual/Sole Provider ~~Certified Nurse Practitioners~~ Subsection text was revised in its entirety to read: NPs enrolled as Individual/Sole Providers may receive direct reimbursement for services. Claims for services provided to FFS beneficiaries may be directly submitted to MDHHS. For beneficiaries enrolled in a MHP, the NP must negotiate provider terms and payment arrangements with each MHP. During enrollment and enrollment revalidation processes, the NP must report the NPI of their Medicaid enrolled collaborating physician by including the collaborating physician's NPI on the checklist and associating to the collaborating physician in the "Associate to Billing Provider/Other Association" step in CHAMPS. Disenrollment of the collaborating physician from the program may prompt disenrollment of the NP. To avoid interruption in enrollment, the NP must ensure his/her CHAMPS enrollment information reflects current collaborating physician information. Additional provider enrollment information can be found on the MDHHS website (refer to the Directory Appendix for website information) and in the General Information for Providers Chapter of this manual.

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			20.3 Collaborative Practice Agreement	The subsection title was revised to read: Nurse Practitioner Collaborative Practice Agreement Subsection text was revised in its entirety to read: As part of the enrollment and enrollment revalidation processes, the NP must attest to having a valid collaborative practice agreement with a Medicaid enrolled physician. Determination of medical necessity and appropriateness of services is the responsibility of the practitioner and physician based on the terms of the collaborative practice agreement. The collaborating physician does not have to be physically on the premises where the services are provided. The collaborative practice agreement is a written document that the practitioner and physician utilize to outline the performance of medical care services or the prescribing of schedule 2 to 5 controlled substances, or both. The agreement shall not include an act, task, or function that the practitioner or collaborating physician is not qualified to perform by education, training, or experience and that is not within the scope of the license held by the practitioner or physician. The agreement must include the effective date of delegation and subsequent review dates. The NP must maintain the collaborative practice agreement at his/her primary place of practice and provide the agreement to MDHHS upon request. The terms of the agreement, at a minimum, must include the following: • A process between the practitioner and collaborating physician for communication, availability, and decision making, including an emergency plan; • A protocol for designating an alternative physician for consultation in situations in which the collaborating physician is not available; • A description of the duties and responsibilities of the practitioner and collaborating physician based upon their education, training and experience;

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				• A provision that allows the practitioner or collaborating physician to terminate their agreement; and • The signatures of the practitioner and physician. The NP must notify MDHHS if the collaborative practice agreement is terminated. Termination or suspension of the agreement by either professional, or termination of the collaborating physician's enrollment, may lead to disenrollment of the NP from the program.
			20.4 Nurse Practitioner Billing and Reimbursement (new subsection)	New subsection text reads: Professional claims must include the NPI of the NP in the Rendering Provider field and the supervising or collaborating physician in the Supervising Provider field as applicable. Refer to the Billing & Reimbursement for Professionals and the Billing & Reimbursement for Institutional Providers Chapters for additional Information. Fee-for-Service reimbursement for NP services is based upon the limits and rates associated to physician professional services and are published on the NP/CNS fee schedule located on the MDHHS website. Provider specific information may be located utilizing the Medicaid Code and Rate Reference tool within CHAMPS. Refer to the Billing & Reimbursement Chapters for additional information. MHPs are responsible for reimbursing contracted providers or subcontractors for their services according to the conditions stated in the subcontract established between the practitioner and the MHP. Noncontracted providers must comply with all applicable authorization requirements of the MHP and uniform billing requirements. Refer to the Medicaid Health Plans Chapter for additional information. (Refer to the Surgery-General section of this chapter for information on an NP functioning as an assistant at surgery.)

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			Section 21 – Certified Clinical Nurse Specialist (new section and subsections; following sections and subsections were re-numbered)	New section text reads: Medicaid covers services provided by qualified Medicaid enrolled clinical nurse specialists (CNSs). Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter or the Medicaid Code and Rate Reference tool for additional information regarding coverage parameters.
			21.1 Covered Services (new subsection)	New subsection text reads: Medicaid covers medically necessary professional services provided by a CNS, as defined in Public Act 368 of 1978 as amended, when all of the following requirements are met: • the services are the type that are considered physician's services if furnished by a Doctor of Medicine or Osteopathy (MD/DO); • the services are performed by a person who is licensed as an advanced practice registered nurse (APRN) under state law, with the CNS specialty certification granted by the Michigan Board of Nursing; • the CNS is legally authorized to perform the service in compliance with state law; • the services are performed in collaboration with or under the terms of a valid practice agreement with a Medicaid enrolled MD/DO; and • the services are not restricted to physicians or otherwise excluded by Medicaid program policy or federal and state statutes. CNS services are subject to the limitations that apply to physician services. Certain services may be restricted to physicians by program policy or federal and state statutes and may not be covered for CNSs. Professional services are only covered when the CNS has personally performed the service and no other provider or entity has been paid for the service. Services provided jointly by the CNS and physician are covered for a single practitioner only.

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			21.2 Enrollment of Clinical Nurse Specialists (new subsection)	New subsection text reads: The CNS who provides professional services to Medicaid beneficiaries is required to be an enrolled provider and uniquely identified on claims for services to be considered eligible for reimbursement. To enroll, the CNS must complete an on-line application in the Community Health Automated Medicaid Processing System (CHAMPS) and enroll with an Individual (Type 1) National Provider Identifier (NPI) as either a Rendering/Servicing-Only or Individual/Sole Provider.
			21.2.A. Rendering/Servicing-Only Provider (new subsection)	New subsection text reads: A physician-employed CNS who renders services only under the physician's delegation and supervision under an employment relationship or agreement is required to be an enrolled provider and uniquely identified on claims for services. He/she may enroll as a Rendering/Servicing Only Provider, and payment for services will be made to the employing, supervising physician or physician group.
			21.2.B. Individual/Sole Provider (new subsection)	New subsection text reads: CNSs enrolled as Individual/Sole Providers may receive direct reimbursement for services. Claims for services provided to FFS beneficiaries may be directly submitted to MDHHS. For beneficiaries enrolled in an MHP, the CNS must negotiate provider terms and payment arrangements with each MHP. During enrollment and enrollment revalidation processes, the CNS must report the NPI of their Medicaid-enrolled collaborating physician by including the collaborating physician's NPI on the checklist and associating to the collaborating physician in the "Associate to Billing Provider/Other Association" step in CHAMPS. Disenrollment of the collaborating physician from the program may prompt disenrollment of the CNS. To avoid interruption in enrollment, the CNS must ensure his/her CHAMPS enrollment information reflects current collaborating physician information. Additional provider enrollment information can be found on the MDHHS website (refer to the Directory Appendix for website information) and in the General Information for Providers Chapter of this manual.

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			21.3. Collaborative Practice Agreement (new subsection)	New subsection text reads: As part of the enrollment process, the CNS must attest to having a valid collaborative practice agreement with a Medicaid enrolled physician. Determination of medical necessity and appropriateness of services is the responsibility of the practitioner and physician based on the terms of the collaborative practice agreement. The collaborating physician does not have to be physically on the premises where the services are provided. The collaborative practice agreement is a written document that the practitioner and physician utilize to outline the performance of medical care services or the prescribing of schedule 2 to 5 controlled substances, or both. The agreement shall not include an act, task, or function that the practitioner or collaborating physician is not qualified to perform by education, training, or experience and that is not within the scope of the license held by the practitioner or physician. The agreement must include the effective date of delegation and subsequent review dates. The CNS must maintain the collaborative practice agreement at his/her primary place of practice and provide the agreement to MDHHS upon request. The terms of the agreement, at a minimum, must include the following: • A process between the practitioner and collaborating physician for communication, availability, and decision making, including an emergency plan; • A protocol for designating an alternative physician for consultation in situations in which the collaborating physician is not available; • A description of the duties and responsibilities of the practitioner and collaborating physician based upon their education, training and experience;

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				• A provision that allows the practitioner or collaborating physician to terminate their agreement; and • The signatures of the practitioner and physician. The CNS must notify MDHHS if the collaborative practice agreement is terminated. Termination or suspension of the agreement by either professional, or termination of the collaborating physician's enrollment, may lead to disenrollment of the CNS from the program.
			21.4. Billing & Reimbursement (new subsection)	New subsection text reads: Professional claims must include the NPI of the CNS in the Rendering Provider field and the supervising or collaborating physician in the Supervising Provider field as applicable. Refer to the Billing & Reimbursement for Professionals and the Billing & Reimbursement for Institutional Providers Chapters for additional information. Fee-for-Service reimbursement for CNS services is based upon the limits and rates associated to physician professional services and is published on the NP/CNS fee schedule located on the MDHHS website. Provider specific information may be located utilizing the Medicaid Code and Rate Reference tool within CHAMPS. Refer to the Billing & Reimbursement Chapters for additional information. MHPs are responsible for reimbursing contracted providers or subcontractors for their services according to the conditions stated in the subcontract established between the practitioner and the MHP. Noncontracted providers must comply with all applicable authorization requirements of the MHP and uniform billing requirements. Refer to the Medicaid Health Plans Chapter for additional information. (Refer to the Surgery-General section of this chapter for information on a CNS functioning as an assistant at surgery.)

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		Practitioner Reimbursement Appendix	2.1 Qualifying Practitioners	In the 3rd paragraph, the following bullet point was added: • Clinical Nurse Specialists
		Rural Health Clinics	Section 3 – Benefits	In the 1st paragraph, the 2nd bullet point was revised to read: • Licensed physician's assistant~~, certified family nurse practitioner (CFNP), certified pediatric nurse practitioner (CPNP) and certified nurse midwife (CNM)~~ and advanced practice registered nurse (NP, CNS, CNM) services, and the services and supplies incidental to these services as would otherwise be furnished by, or incidental to, physician services.
			3.1 Services and Supplies Incidental to an RHC Visit	In the 1st paragraph, the 3rd and 4th bullet points were revised to read: • Furnished as an incidental, although integral part of professional services furnished by a physician (MD, DO), dentist, optometrist, podiatrist, chiropractor, ~~C~~NP or CNS (~~who has~~ under the terms of a collaborative agreement with a physician), CNM, or licensed physician's assistant (under the terms of a practice agreement). • Furnished under the direct personal supervision of a physician (MD, DO), dentist, optometrist, podiatrist, chiropractor, ~~C~~NP or CNS (~~who has~~ under the terms of a collaborative agreement with a physician), CNM, or licensed physician's assistant (under the terms of a practice agreement). The last paragraph was revised to read: The direct personal supervision requirement is met in the case of a ~~C~~NP, CNS, CNM, or licensed physician's assistant only if such a person is permitted to supervise such services under the written policies governing the RHC.

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		Tribal Health Centers	3.1 Covered Services	In the 1st paragraph, the following bullet point was added: • Advanced practice registered nurse (APRN) services In the 1st paragraph, the following bullet points were deleted: ~~• Certified nurse practitioner (CNP) services~~ ~~• Certified nurse midwife (CNM) services~~ In the table in the last paragraph, text for "Certified Nurse Midwife (CNM)" was removed. ~~**Certified Nurse Midwife (CNM)**~~ | ~~CNM services must comply with coverages and limitations published in the Practitioner Chapter of this manual and in MDHHS Bulletins.~~ In the table in the last paragraph, the following text was added: **Advanced Practice Registered Nurse (APRN)** | APRN services must comply with the coverages and limitations published in the Practitioner Chapter of this manual and in MDHHS Bulletins.
		Acronym Appendix		Addition of: APRN – Advanced Practice Registered Nurse CNS – Clinical Nurse Specialist

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		Glossary Appendix		The definition for "Practitioner" was revised to read: An MD, DO, Podiatrist, Dentist, Oral-Maxillofacial Surgeon, Physician's Assistant, Advanced Practice Registered Nurse (Certified Nurse Practitioner, Certified Clinical Nurse Specialist, Certified Nurse-Midwife), Certified Registered Nurse Anesthetist, Anesthesiologist Assistant, Physical Therapist, Psychologist, Occupational Therapist, Optometrist, Speech Therapist, and Audiologist.
MSA 19-14	5/31/2019	Ambulance	1.4 Medical Necessity	The following text was added as the 1st paragraph: Medical necessity is established when the beneficiary's condition is such that use of any other method of transportation is contraindicated. In cases where a mode of transportation other than an ambulance could be used without endangering the beneficiary's health, no payment may be made for ambulance services regardless of whether such other transportation is available.
			1.5 Documentation Requirements (new subsection; following subsections were re-numbered)	New subsection text reads: Ambulance providers must maintain documentation of the medical necessity and appropriateness of service in the beneficiary's file. This documentation may be used to assess whether the transport meets medical necessity, eligibility, coverage, benefit category, and any other criteria necessary for payment. Documentation must be sufficiently detailed to allow reconstruction of what transpired for each service billed. (Refer to the General Information for Providers chapter of this manual for information on documentation.) The level of service and assessment findings must be fully documented. An ambulance provider must document the medical necessity and clinical significance of an ALS assessment in the beneficiary's file. The ambulance service must meet all program coverage criteria for payment to be made.

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			2.7 Mileage	The following text was added after the 1st paragraph: Ambulance mileage reimbursement is a covered Medicaid benefit when a transport occurs and has been reimbursed. Transports that are denied for any reason, including lack of emergency criteria, will also be denied for the mileage reimbursement.
			2.9 Non-Emergency	The following text was added after the 5th paragraph: The ordering provider may be held responsible if a medically unnecessary ambulance transport is ordered. The ordering provider may be subject to corrective action related to these services, including recoupment of funds. Additionally, any instances in which the ordering provider fails to document all required information necessary for a written order (e.g., physician certification statement) may be subject to recoupment of funds. The ambulance provider may be subject to corrective action, including the recoupment of funds, if it submits a claim for a medically necessary non-emergency ambulance transport without record of a written order.
			2.12 Interfacility Transfers (new subsection)	New subsection text reads: Hospital transfers to the nearest hospital that has the necessary service may be covered when the beneficiary has been stabilized at the first hospital but needs a higher level of care available only at the second hospital. Examples of medically necessary transfers include, but are not limited to, services not available at the first facility such as rehabilitation, a burn unit, ventilator assistance, or other specialized care. The ambulance provider must maintain documentation that clearly describes what service(s) is not available at the first facility. Transport from a hospital capable of treating the beneficiary to another hospital for the convenience or preference of the ordering provider, beneficiary or beneficiary's family is not a covered benefit.

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			Section 4 – Ambulance Coverage Exclusions	Text was revised to read: Circumstances under which Medicaid does not pay for ambulance transportation include, but are not limited to: ▪ Transport to services that are not Medicaid-covered. ▪ Transports that are not medically necessary, whether medical/surgical or psychiatric. ▪ Transport mileage when transports are denied for any reason, including lack of emergency criteria. • Medi-car, Medi-van, or wheelchair transports. • Transport to a funeral home. • Trips made for services, such as drawing blood and catheterization that could have been provided at the beneficiary's location. • Transportation of a beneficiary pronounced dead before the ambulance was called. • Round trips when a beneficiary is taken from a hospital to another facility and returned to the same hospital. As long as the beneficiary is an inpatient, all ancillary services are the responsibility of the hospital. • Transport of inmates to or from a correctional facility. • ~~Transports that are not medically necessary.~~

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MSA 19-16	5/31/2019	Hospital Reimbursement Appendix	8.7.C. GME Innovations Michigan Doctors (MIDocs) Program (new subsection)	New subsection text reads: The GME MIDocs program supports the expansion of residencies and subsequent retention efforts for approved high need specialties in underserved areas of the state where current and future physician shortages undermine the health and well-being of Medicaid beneficiaries. The MIDocs program offers physician training in integrated and patient-centered care for underserved populations that will further the state's Medicaid quality goals. To be eligible for MIDocs GME funding, the MIDocs participating medical school must enter into an agreement with the state agency specifying the number of MIDocs residents to be supported, the total annual cost of such residencies, any post-residency expenditures to retain physicians in underserved areas of Michigan, and the amount of other sources of funding available for the program, if any. Sponsoring institutions may receive funding from other sources but Medicaid will act as a payer of last resort to only cover costs not reimbursed through other sources. The state agency will pay the MIDocs participating medical school an amount equal to the amount of otherwise unreimbursed costs. The single state agency will approve four (4) agreements with MIDocs participating medical schools statewide each state fiscal year (SFY), covering residencies for the academic year (July-June (AY)) beginning within the SFY. The agreements will total $1.52 million in fiscal year 2019, $10.73 million in fiscal year 2020, $19.98 million in fiscal year 2021, $27.75 million in fiscal year 2022, and $28.5 million in fiscal year 2023. In addition, the following requirements must be met: • The MIDocs participating medical school must have submitted to the state agency its MIDocs program proposal for new or expanded residency program(s) to promote access in underserved areas of the state. • The new or expanded program(s) must possess appropriate accreditation credentials.

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				• The new or expanded program(s) must meet the MIDocs curriculum standards, including those related to didactic education on patient centered medical homes, interprofessional education, behavioral and physical health integration, and continuous quality improvement. • The MIDocs participating medical school must be the sponsoring institution of the residency program(s) or have an approved agreement with the sponsoring institution. • The MIDocs participating medical school or the sponsoring institution (if not the medical school) must have agreements with all training sites for the MIDocs residents. • If GME distributions exceed the expenses incurred by the MIDocs participating medical school, their affiliated sponsoring institution and/or the clinical training sites related to the MIDocs residencies, the size of the payment will be reduced to bring these elements into alignment.

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