MDHHS Michigan Department of Health & Human Services

Medical Services Administration

BULLETIN MSA

Bulletin Number: MSA 20-59

Distribution: All Providers

Issued: September 1, 2020

Subject: Updates to the Medicaid Provider Manual; Code Updates

Effective: As Indicated

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

Updates to the Medicaid Provider Manual

The Michigan Department of Health and Human Services (MDHHS) has completed the October 2020 update of the online version of the Medicaid Provider Manual. The manual will be available October 1, 2020 at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Medicaid Provider 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.

Code Updates

A. NEW COVERAGE OF CODES - Effective July 1, 2020

Listed below are HCPCS codes being adopted by MDHHS for dates of service on and after July 1, 2020, and the provider groups allowed to bill these codes.

The symbol * will appear with those codes requiring prior authorization (PA).

1. Physicians, Practitioners, and Medical Clinics

J0223	J0691	J0742	J0791	J0896	J1201	J1429*
J1558	J3399*	J7169	J7204	J7333	J9177	J9198
J9246	J9358	Q5120	Q5121			

2. Urgent Care Centers

J0691 J1201

3. Local Health Departments

J0691

4. Child and Adolescent Health Centers & Programs

J0691

5. Federally Qualified Health Centers

J0691 J0791 J1201 J7333 J9246 J9358 Q5120

6. Rural Health Clinics

J0691 J0791 J1201 J7333 J9246 J9358 Q5120

7. Tribal Health Centers

J0691 J0791 J1201 J7333 J9246 J9358 Q5120

8. Outpatient Prospective Payment System (OPPS)/Ambulatory Payment Classification (APC) and Ambulatory Surgical Centers (ASC)

Codes covered differently than Medicare or specific to Michigan Medicaid services will be identified on the July 2020 version of the OPPS and ASC Wrap-Around Code List on the MDHHS website:

www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Outpatient Hospitals

www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Ambulatory Surgical Centers

B. NEW COVERAGE OF CODES – Effective October 1, 2020

The following HCPCS code is being adopted by MDHHS for dates of service on and after October 1, 2020, and applies to **Medical Suppliers.**

A4605

C. NEW COVERAGE OF EXISTING CODES

Effective for dates of service on and after July 1, 2020, existing HCPCS codes will be activated for coverage as identified in the following provider categories:

1. **Physicians, Practitioners, and Medical Clinics**

   62380

2. **Physicians, Practitioners, Medical Clinics, Certified Nurse Midwives, Local Health Departments, Child and Adolescent Health Centers and Programs, Federally Qualified Health Centers, Rural Health Clinics, Tribal Health Centers, Urgent Care Centers**

   90694

3. Please refer to specific databases/fee schedules for additional information regarding temporary coverage of codes during the COVID-19 emergency.

D. RETROACTIVE COVERAGE OF EXISTING CODE FOR OPPS

a. Effective for dates of service on and after June 25, 2020, MDHHS will cover the following HCPCS code for Clinical Laboratories:

   87426

b. Effective for dates of service on and after February 3, 2020, MDHHS will cover the following HCPCS code for Physicians, Practitioners, and Medical Clinics:

   Q5119

E. DISCONTINUED HCPCS PROCEDURE CODES FOR ALL APPLICABLE PROVIDER TYPES

The following HCPCS codes are discontinued effective June 30, 2020:

0124U	0125U	0126U	0127U	0128U	C9041	C9053	C9054
C9056	C9057	C9058	C9754	C9755	J9199		

Manual Maintenance

If utilizing the online version of the MDHHS Medicaid Provider Manual, 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 MDHHS 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

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Dental Providers	Section 9 – Julian Calendar	The paragraph after the table was revised to read: For leap year, one day must be added to the number of days after February 28. The next three leap years are ~~2020,~~ 2024, ~~and~~ 2028, and 2032.	Update.
Billing & Reimbursement for Institutional Providers	Section 13 – Julian Calendar	The paragraph after the table was revised to read: For leap year, one day must be added to the number of days after February 28. The next three leap years are ~~2020,~~ 2024, ~~and~~ 2028, and 2032.	Update.
Billing & Reimbursement for Professionals	Section 9 – Julian Calendar	The paragraph after the table was revised to read: For leap year, one day must be added to the number of days after February 28. The next three leap years are ~~2020,~~ 2024, ~~and~~ 2028, and 2032.	Update.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	6.3 Provider Criteria	Text was revised to read: The PIHP must seek and maintain MDHHS approval through an enrollment process for the crisis residential program in order to use Medicaid funds for program services.	Standardizing the enrollment language for all MDHHS-approved programs.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	9.2.A. Approval	Text was revised to read: The PIHP must seek and receive MDHHS approval through an enrollment process, initially and every three years thereafter, for the intensive crisis stabilization services in order to use Medicaid funds for program services.	Standardizing the enrollment language for all MDHHS-approved programs.

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

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	17.3.E. Family Support and Training	In the last paragraph, the last bullet point was revised to read: • Parent-to-Parent Support is designed to support parents/family of children with serious emotional disturbance or intellectual/developmental disabilities, including autism, as part of the treatment process to be empowered, confident and have knowledge and skills that will enable the parent/family to improve their child's and family's functioning. Utilizing their lived experience, the trained parent support partner, who has or had a child with special mental health needs, provides education, coaching, and support and enhances the assessment and mental health treatment process. The parent support partner provides these services to the parents/caregivers. These activities are provided in the home and in the community. The parent support partner is an active member of the treatment team and participates in team consultation with the treating professionals. The parent support partner is to be provided regular supervision. Parent support partners may not have more than one provider role with any one family (i.e., may not be both parent support partner and peer support specialist for the same family).	Changes made to be consistent with language in the Covered Waiver Services section of the Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix.
Children's Special Health Care Services	Section 1 – General Information	The 1st paragraph was revised to read: CSHCS is mandated by the Michigan Public Health Code, Public Act 368 of 1978, Part 58, children and youth with special health care needs (MCL 333.5801 – 333.5879), in cooperation with the federal government under Title V of the Social Security Act, Sec. 501. [42 U.S.C. 701] (a) 1 (D) and the annual Michigan Department of Health and Human Services (MDHHS) Appropriations Act. ~~This makes~~ CSHCS is a separate program from Medicaid.	Clarification.
Nursing Facility Cost Reporting & Reimbursement Appendix	5.1 Plant Cost Certification Eligibility Criteria	In the 1st bullet point, the 1st sentence was revised to read: • The nursing facility provider is constructing a new building or incurring physical plant improvements with Certificate of Need (CON) approval, or the asset costs are, on average, $5,000 or more per licensed bed for a Class I or Class V facility or $3,000 or more per licensed bed for a Class III facility in capital expenditures in a single cost reporting period.	Clarifying that the Plant Cost Certification threshold also applies to Class V facilities (vent units).

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CHAPTER	SECTION	CHANGE	COMMENT
Therapy Services	Section 3 – Prior Authorization Requests	The 2nd, 3rd and 4th paragraphs were revised to read: Prior authorization (PA) is not required for the initiation of home health therapy services for up to a maximum of 24 visits within the first 60 consecutive days if: • the beneficiary has not received home health therapy services within the calendar year, and • services do not exceed the ~~visit~~ maximum. If a beneficiary has previously received home health therapy ~~and~~ services ~~were provided more than 60 days ago within the calendar year, authorization is needed~~ at the maximum 24 visits within the first 60 consecutive days of service for each calendar year, PA is needed. ~~Prior authorization (PA)~~ PA is needed when therapy limits are exceeded regardless of diagnosis.	Clarification.
Directory Appendix	Throughout	Addresses referencing "Lewis Cass Building (Bldg.)" were revised to read "Elliott-Larsen Bldg.". • Beneficiary Assistance; Medicare Buy-In Unit • Mental Health/Substance Abuse Resources; Children's Waiver Program • Nursing Facility Resources; Nursing Facility Rate Setting • Nursing Facility Resources; MDHHS OBRA Office • Reporting Fraud, Abuse, or Misuse of Services; MDHHS OBRA Office	Update.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 20-11	6/1/2020			The Hearing Aid Dealers chapter was removed. The Hearing Services chapter was removed. The Hearing Services and Devices chapter was added.
MSA 20-15	5/5/2020	School Based Services	2.5.A. Telemedicine for Behavioral Health Services (new subsection)	New subsection added.
MSA 20-33	5/21/2020	Pharmacy	13.6.A. Medicaid Copayments	In the "Copayment Exemptions" table, under "Other Exclusions", under text reading "Claims for the following drugs related to the treatment of Mental Health Conditions and Substance Use Disorders are exempt from copayments:", the following bullet point was added: • Opioid antidotes

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

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 20-38	7/1/2020	Practitioner	14.3 Psychiatric Collaborative Care Model (CoCM) Services (new subsection)	New subsection was added; includes the following: • 14.3.A. General Information • 14.3.B. Target Population • 14.3.C. Psychiatric Collaborative Care Model ➢ 14.3.C.1. Episode of Care ➢ 14.3.C.2. Measurement-Based Treatment to Target Strategy ➢ 14.3.C.3. Required Documentation • 14.3.D. Collaborative Care Team Criteria • 14.3.E. Coverage of CoCM Services • 14.3.F. Noncovered Services • 14.3.G. Prior Authorization • 14.3.H. Reimbursement • 14.3.I. Federally Qualified Health Center and Rural Health Clinic Reimbursement • 14.3.J. Substance Use Disorder CoCM Reimbursement
MSA 20-39	6/4/2020	Hospital Reimbursement Appendix	Section 1 – Outpatient	The 1st paragraph was revised to read: Reimbursement to outpatient hospitals, including off-campus satellite clinics, hospital-owned ambulance services, freestanding dialysis centers (ESRDs), comprehensive outpatient rehabilitation facilities (CORFs), and rehabilitation agencies for outpatient services is made in accordance with Medicaid's Outpatient Prospective Payment System (OPPS). No facilities (i.e., critical access or children's hospitals) are excluded from Medicaid's Ambulatory Payment Classification reimbursement methodology. Payment made under OPPS is calculated utilizing current Medicare rates, with a MDHHS reduction factor applied, unless otherwise noted in this section. Separate OPPS reduction factors are established for Critical Access Hospitals (CAHs) and non-CAHs.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Hospital Reimbursement Appendix	7.8 Rural Access Pool	The 1st paragraph was revised to read: The Rural Access Pool (RAP) is a pool for hospitals that provide Medicaid services to low-income rural residents and will be created and renewed annually. Effective state FY 2021, eligibility for RAP is limited to non-critical access hospitals. To be eligible for this pool, hospitals must be categorized by CMS as a sole community hospital, or meet both of the following criteria:
MSA 20-45	6/4/2020	Hospital Reimbursement Appendix	2.3.A.3. APR-DRG Relative Weights	The 2nd paragraph was revised to read: The state establishes alternate weights for neonatal services from episodes that are assigned to one of the DRGs in the following range: 580x-640x. Effective, July 1, 2020, the NICU alternate weight reimbursement will apply to episodes with a DRG within 580x-640x and a minimum of one day with revenue code 0173 or 0174. Revenue codes reported should reflect the level of care provided to the patient in accordance with NUBC billing guidance. These weights are utilized for services rendered in a NICU. The remaining claims assigned to these DRGs are used for the base weights (non-alternate weights). No other alternate weights are assigned.
MSA 20-46	7/1/2020	Pharmacy	13.6.A. Medicaid Copayments	In the "Copayment Exemptions" table, under "Other Exclusions", under text reading "Claims for the following drugs related to the treatment of Mental Health Conditions and Substance Use Disorders are exempt from copayments:", the following bullet points were added: • Drugs used to treat Substance Use Disorder • Drugs used to treat Tobacco Use Disorder
MSA 20-47	7/1/2020	Non-Emergency Medical Transportation	5.1 Mileage	The last paragraph was deleted. (Obsolete information.) ~~As applicable, NEMT mileage reimbursement will align with standard mileage rates maintained by the Internal Revenue Service (IRS). Individuals with a vested interest or Medicaid beneficiaries providing their own NEMT will be reimbursed at the IRS rate for "medical or moving purposes", while volunteer drivers and foster care parents will be reimbursed at the IRS rate for "business miles driven".~~

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