MDHHS Michigan Department of Health & Human Services
Medical Services Administration BULLETIN MSA

**Bulletin Number:** MSA 21-18

**Distribution:** All Providers

**Issued:** June 1, 2021

**Subject:** Updates to the MDHHS 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 MDHHS Medicaid Provider Manual

The Michigan Department of Health and Human Services (MDHHS) has completed the July 2021 update of the online version of the MDHHS Medicaid Provider Manual. The manual will be available July 1, 2021 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

Listed below are HCPCS codes being adopted by MDHHS for dates of service on and after April 1, 2021 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
   J1427* J1554 J7402 J9037 J9349

2. Federally Qualified Health Centers

   J1554

3. Rural Health Clinics

    J1554

4. Tribal Health Centers

    J1554

5. 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 April 2021 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 Existing Codes

Effective for dates of service on and after April 1, 2021, existing Healthcare Common Procedure Coding System (HCPCS) codes will be activated for coverage as identified in the following provider categories:

Clinical Laboratories

0172U*

## C. RETROACTIVE COVERAGE OF EXISTING CODES

1. Effective for dates of service on and after February 27, 2021, MDHHS will cover the following HCPCS codes for Physicians, Practitioners, Medical 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:

   91303 0031A

2. Effective for dates of service on and after February 9, 2021, MDHHS will cover the following HCPCS codes for Physicians, Practitioners, Medical Clinics, Federally Qualified Health Centers, Rural Health Clinics and Tribal Health Centers:

   M0245 Q0245

**D. Discontinuation of Prior Authorization for Existing Codes**

MDHHS will discontinue requiring prior authorization of the following codes effective March 31, 2021:

81510 81511 81512

**E. Discontinued Coverage for All Applicable Provider Types**

The Food & Drug Administration (FDA) has revoked Emergency Use Authorization (EUA) status for emergency use for the following HCPCS codes effective April 16, 2021:

M0239 Q0239

**F. Discontinued HCPCS Procedure Codes for All Applicable Provider Types**

The following HCPCS codes are discontinued effective March 31, 2021:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 0098U | 0099U | 0100U | 0127U | C9068 | C9069 | C9070 | C9071 | C9072 |
| C9073 | C9122 | J7333 | J7401 | K1010 | K1011 | K1012 | | |

**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 MDHHS 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 questions, 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 July 2021 Updates

## TECHNICAL CHANGES*

| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| General Information for Providers | Section 9 – Inpatient Hospital Authorization Requirements | The section was removed from the General Information for Providers chapter and relocated to the Hospital chapter as subsections 2.1 through 2.2.<br><br>The following sections were re-numbered. | Section moved to Hospital Chapter to consolidate all prior authorization policy into one section. |
| Beneficiary Eligibility | Section 2 - mihealth Card | The 4th paragraph was revised to read:<br><br>The **mihealth** card is a plastic, magnetic strip identification card issued once to each beneficiary. The front of the card contains the beneficiary's name and beneficiary ID number. When a family is determined eligible for a health program, a **mihealth** card is issued to each eligible person in the household. All cards for a household are mailed to the head of the household. The **mihealth** card does not contain eligibility information and does not guarantee eligibility until verified using the CHAMPS Eligibility Inquiry that the person is covered. An example of the card follows:<br><br>*[image of mihealth card here]* | |
| Beneficiary Eligibility | 2.4 mihealth Card Sample | Subsection was deleted as information was incorporated into Section 2.<br><br>The following subsection was re-numbered. | |
| Beneficiary Eligibility | Section 7 – Newborn Eligibility | In the 1st paragraph, the last sentence was revised to read:<br><br>(Refer to the ~~General Information for Providers~~ Hospital Chapter of this manual for PACER requirements for newborns.) | |

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

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# Medicaid Provider Manual July 2021 Updates

## TECHNICAL CHANGES*

| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Coordination of Benefits | 2.6.D. Medicare Part D | Text was revised to read:<br><br>Beneficiaries enrolled in Medicare Part A and/or Part B are eligible for Medicare Part D. Medicaid does not pay for Medicare Part D covered drugs for Medicare ~~eligible~~ enrolled beneficiaries.<br><br>Medicaid will cover some of the drugs which are excluded from Part D. (Refer to the Pharmacy chapter for drug product coverage information.)<br><br>Medicaid does not cover ~~beneficiaries who are eligible for Part D but are not currently enrolled in~~ Part D drugs for beneficiaries who are enrolled in Medicare Part A and/or Part B and elect to opt out of a Medicare Prescription Drug Plan (PDP). Pharmacies should refer to the Pharmacy Benefits Manager (PBM) website for information on billing Medicare Part D when eligible beneficiaries have not yet enrolled in a Part D plan. (Refer to the Directory Appendix for website information.)<br><br>All questions regarding Part D coverage should be directed to Medicare. (Refer to the Directory Appendix for contact information.) | Language was updated to more accurately describe the coordination of benefits for Medicare Part D. |
| Billing & Reimbursement for Institutional Providers | 6.2.I. Newborn Eligibility | The last sentence was revised to read:<br><br>Refer to the ~~General Information for Providers~~ Hospital Chapter of this manual for PACER requirements for newborns. | |

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# Medicaid Provider Manual July 2021 Updates

## TECHNICAL CHANGES*

| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Hospital | Section 2 – Prior Authorization | The following subsections were added:<br>2.1 Inpatient Hospital Authorization Requirements<br>2.1.A. Prior Authorization Certification Evaluation Review (PACER)<br>2.1.A.1. Admissions/Readmissions/Transfers That Require a PACER Number<br>2.1.A.2. Admissions/Readmissions/Transfers That Do Not Require a PACER Number<br>2.1.A.3. PACER Readmissions<br>2.1.A.4. PACER Transfers<br>2.1.B. Contractor Monitoring<br>2.1.C. Confidentiality<br>2.1.D. Admissions and Continued Stays for Distinct Part Rehabilitation Units and Freestanding Rehabilitation Hospitals<br>2.1.E. Admission/Transfer for Long-Term Acute Care Hospital (LTACH)<br>2.2 Termination of Benefits | Information was moved from the General Information for Providers Chapter to consolidate all prior authorization policy into one section. |

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## TECHNICAL CHANGES*

| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Hospital | 3.20.A. Pregnancy-Related Laboratory Services | The last paragraph was removed.<br><br>~~Nurse-midwives may order only the laboratory tests listed below. Hospitals are not reimbursed for any other tests ordered by a nurse-midwife.~~<br><br>• ~~Acetone and diabetic acid (ketone bodies); qualitative; semi-quantitative~~<br>• ~~Albumin; qualitative, semi-quantitative, quantitative (such as Esbach)~~<br>• ~~Antibody titer Rh system; albumin, saline and/or AHG technique~~<br>• ~~Blood count; RBC, WBC, Hemoglobin, Hematocrit, indices (MCV, MCH, MCHC)~~<br>• ~~Blood typing; ABO, Rh(D), RBC antibody screening~~<br>• ~~Culture, presumptive (screening), for Neisseria gonorrhea, Candida, Hemophilus, or beta hemolytic Streptococcus group A, etc.~~<br>• ~~Culture, urine, definitive; with or without colony count~~<br>• ~~Cytopathology, vaginal and/or cervical smears (e.g., Papanicolaou type) screening (cytopathological examination for malignancy, microbial flora, inflammatory features and hormonal evaluation)~~<br>• ~~Glucose; qualitative, quantitative, timed specimen, tolerance~~<br>• ~~Hemoglobin, electrophoretic separation; qualitative~~<br>• ~~Hepatitis B test~~<br>• ~~Human immunodeficiency virus detection~~<br>• ~~Pregnancy test~~<br>• ~~Prenatal laboratory services; routine (Obstetric panel)~~<br>• ~~Quantitative sediment analysis and quantitative protein (Addis count); 12- or 24-hour specimen Reticulocyte count, manual~~ | CNM scope of practice allows for the ordering and medical management of a large number of laboratory tests and is not restricted to those currently listed in this section. |

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| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| | | • ~~Rubella test; titer~~<br>• ~~Sickle cell slide test~~<br>• ~~Skin test, tuberculosis, tine test~~<br>• ~~Susceptibility (sensitivity) for aerobes by Kirby-Bauer procedure for specific pathogens, using 10-12 discs per pathogen; also for susceptibility (sensitivity) for anaerobes by generally accepted standard techniques using 5-12 discs per pathogen (specify number of pathogens)~~<br>• ~~Syphilis testing, flocculation or precipitin (VDRL, RPR, etc.); qualitative~~<br>• ~~Trepanema antibodies, fluorescent, absorbed (FTA-abs)~~<br>• ~~Urinalysis, complete (physical appearance, pH, specific gravity, microscopic examination, qualitative chemistry with or without semi-quantitative confirmation)~~<br>• ~~Wet mount, smear, tissue; direct microscopic examination~~ | |
| Maternity Outpatient Medical Services | 1.3 Verifying Eligibility | Text was revised to read:<br><br>~~MOMS enrollees are given a Guarantee of Payment for Pregnancy Related Services (DCH-1164) letter. The letter is intended to assure providers that MDHHS will reimburse for pregnancy-related services provided to the beneficiary. The letter includes information on eligibility, covered services, billing instructions, etc. (A sample of the letter is included in the Forms Appendix.)~~<br><br>~~Once a woman is determined eligible for the MOMS program, a MOMS Eligibility Letter is issued. The letter contains the beneficiary's identification (ID) number.~~<br><br>MOMS beneficiaries are identified in the eligibility response with the Benefit Plan ID of MOMS. (Refer to the Beneficiary Eligibility chapter for additional information.) When a woman is determined eligible for the MOMS program via the presumptive eligibility process, a presumptive eligibility decision notice is shared. This notice includes the MOMS coverage dates. | |

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## TECHNICAL CHANGES*

| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Maternity Outpatient Medical Services | 3.1 Submitting Medical Claims | Text was revised to read:<br><br>~~Providers should not bill Medicaid without a valid MOMs ID number. MOMS claims should be held until the beneficiary's MOMS ID number can be obtained from the eligibility response, the MOMS Eligibility Letter, or the beneficiary's **mihealth** card. (Refer to the Beneficiary Eligibility Chapter for additional information.) The "M" or "I" number that may appear in the upper right-hand corner of the Guarantee of Payment for Pregnancy Related Services (DCH-1164) letter cannot be used to identify MOMS beneficiaries on claims submitted to MDHHS.~~<br><br>~~If a provider is unable to obtain the MOMS ID number in a reasonable period of time, a copy of the DCH-1164 may be faxed to the MDHHS Customer Services Division and a beneficiary ID number requested. (Refer to the Directory Appendix for contact information.) The name and phone number of a contact person should be included with the fax request. MDHHS then provides the beneficiary's ID number to the requester.~~<br><br>MOMS claims should be held until the beneficiary's eligibility can be verified using:<br>• CHAMPS Eligibility Inquiry<br>• HIPAA 270/271 (Eligibility Inquiry/Response) transactions<br>• Web-based options<br><br>(Refer to the Beneficiary Eligibility Chapter for additional information.)<br><br>Providers must use the appropriate Z30 International Classification of Diseases (ICD) diagnosis code as the primary diagnosis on claims for family planning services. | |

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| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Maternity Outpatient Medical Services | 3.2 Submitting Pharmacy Claims | Text was revised to read:<br><br>Pharmacy services provided to MOMS beneficiaries must be billed to the MDHHS Pharmacy Benefits Manager (PBM). (Refer to the Directory Appendix for contact information.) ~~Pharmacies have the option of billing the PBM in one of two ways:~~<br><br>• ~~Hold the claim until the beneficiary ID number is available in the eligibility response and then bill via the PBM's online system; or~~<br>• ~~Submit a claim, along with a copy of the DCH 1164, to the PBM per the instructions in the PBM manual.~~<br><br>Family planning supplies not furnished by the practitioner as part of the medical services must be prescribed by a Medicaid enrolled practitioner and dispensed by a pharmacy. Exceptions include condoms and similar supplies that do not require a prescription. | |
| Maternity Outpatient Medical Services | 3.3 Remittance Advice | The subsection was removed.<br><br>~~MOMS claim adjudication information is included in the weekly Remittance Advice (RA), merged alphabetically with Medicaid and other MDHHS-administered programs. (Refer to the Billing & Reimbursement Chapters for additional information.)~~ | Removal of obsolete information. |
| Nursing Facility Certification, Survey & Enforcement Appendix | 5.13 Choosing the Compliance Date | Text was revised to read:<br><br>LARA follows CMS policy related to revisits. On ~~a first~~ any revisit, the compliance date is the accepted Plan of Correction completion date if it is determined at the time of the revisit that the deficiencies were corrected and the facility is in substantial compliance. If a revisit survey identifies that the facility had a deficiency after the completion date that was corrected before the revisit date, the actual correction date is used.<br><br>~~On the second revisit, the compliance date is the revisit date, unless there is specific evidence of earlier compliance. In this case, observation of compliance is relevant, as is evidence indicating a specific date of correction.~~<br><br>~~On third or subsequent revisits, the compliance date is the revisit date, without exception.~~ | |

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## TECHNICAL CHANGES*

| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Pharmacy | 1.9 Medicare Part D Benefit | The 1st paragraph was revised to read:<br><br>The Medicare Modernization Act of 2003 provides a prescription drug benefit to Medicare beneficiaries. The benefit is commonly referred to as Medicare Part D. Dually ~~eligible~~ enrolled Medicare/Medicaid beneficiaries must obtain all Part D covered drugs through their Medicare Part D Plan (PDP or MA-PD).<br><br>The following text was added after the text burst box:<br><br>Medicaid does not cover Part D drugs for beneficiaries who are enrolled in Medicare Part A and/or Part B and elect to opt out of a Medicare Prescription Drug Plan (PDP). Pharmacies should refer to the Pharmacy Benefits Manager (PBM) website for information on billing Medicare Part D when eligible beneficiaries have not yet enrolled in a Part D plan. (Refer to the Directory Appendix for website information.) | Language was updated to more accurately describe the coordination of benefits for Medicare Part D. |
| Practitioner | 14.3.H. Reimbursement | The 1st paragraph was revised to read:<br><br>CoCM is a bundled monthly payment that represents a model of care rendered by all team members. The primary care provider is the sole biller for CoCM and services are not to be billed by the psychiatric consultant. The primary care provider agency is expected to have its own contract with the psychiatric consultant and will pay for his or her services as part of the CoCM. Providers are expected to adhere to the American Medical Association's CPT coding guidelines for Psychiatric Collaborative Care Management Services ~~as reported by CPT codes 99492, 99493, and 99494~~. | Removing language that described specific codes that were initially listed within the policy bulletin.<br><br>These codes are subject to change and no longer need to be included in the MPM. |
| Practitioner | 14.3.I. Federally Qualified Health Center and Rural Health Clinic Reimbursement | Text was revised to read:<br><br>CoCM services provided by a FQHC or RHC provider (e.g., MD/DO, certified NP, certified CNS, PA) do not qualify as an encounter. It may, however, be reimbursed outside of the Prospective Payment System. ~~FQHCs and RHCs should use HCPCS code G0512 to report CoCM services.~~ | Removing language that described specific codes that were initially listed within the policy bulletin.<br><br>These codes are subject to change and no longer need to be included in the MPM. |

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## TECHNICAL CHANGES*

| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Directory Appendix | Provider Assistance | Under "Children's Special Health Care Services (CSHCS)", the mailing address was revised to read:<br><br>CSHCS Program<br>~~320 S. Walnut~~<br>400 S. Pine St., 4th floor<br>Lansing, MI 48913 | Update. |
| Directory Appendix | Eligibility Verification | Under "Michigan Public Health Institute (MPHI)", the web address was revised to read:<br><br>https://hpb.mihealth.org | Update. |
| Directory Appendix | Prior Authorization<br><br>(Authorization of Services) | Under "Prior Authorization – Dental", the following fax number was added:<br><br>Change Request fax number: 517-241-7813 | Update. |
| Directory Appendix | Billing Resources | The entry for "Electronic Healthcare Transactions" was removed. | Removal of obsolete information. |
| Directory Appendix | Provider Resources | Under "MDHHS Bureau of Epidemiology and Population Health; Division of Communicable Diseases" the zip code for the mailing address was revised to read:<br><br>Lansing, MI ~~48909~~ 48913 | |
| Directory Appendix | Provider Resources | Under "MDHHS Bureau of Family Health Services; Division of Immunization", the zip code for the mailing address was revised to read:<br><br>Lansing, MI ~~48909~~ 48913 | |

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## TECHNICAL CHANGES*

| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Directory Appendix | Provider Resources | Under "American Academy of Pediatric Dentistry (AAPD)", the web address was revised to read:<br><br>~~http://www.aapd.org >> Policies and Guidelines >> Infant Oral Health Care (under Clinical Guidelines)~~<br><br>https://www.aapd.org/research/oral-health-policies--recommendations/ | Update. |
| Directory Appendix | Provider Resources | Under "Women, Infants, and Children (WIC) Program", the web address was revised to read:<br><br>~~www.michigan.gov/wiccc~~ https://www.michigan.gov/wic | Update. |
| Directory Appendix | MI Choice Waiver Resources | For all entries that reflected a mailing address of '400 S. Pine St., Lansing, MI', the zip code was revised to read:<br><br>Lansing, MI ~~48909~~ 48913 | |
| Directory Appendix | Nursing Facility Resources | Under "Pre-Eligibility Medical Expenses (PEME)", the e-mail address was revised to read:<br><br>~~Martina2@michigan.gov~~ MDHHS-MSA-PEME@michigan.gov | Update. |

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## TECHNICAL CHANGES*

| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Directory Appendix | Nursing Facility Resources | Under "Nurse Aide Customer Service", the following changes were made:<br><br>**Contact/Topic:** ~~Nurse Aide Customer Service~~ Nurse Aide Trainers and Training Programs<br>**Phone # Fax #:** ~~800-752-4724~~ 517-896-0511<br>**Web Address:**<br>~~www.michigan.gov/lara >> Community and Health Systems >> Nurse Aide Training Program~~<br><br>www.Michigan.gov/Lara >> Bureau List >> Community and Health Systems >> Nurse Aide Training Program & Trainers | Update. |
| Directory Appendix | Nursing Facility Resources | The row regarding "MDS" was removed. | |
| Directory Appendix | Nursing Facility Resources | Under "MDS RAI Manual", web address information was revised to read:<br><br>www.cms.gov >> Medicare >> Nursing Home Quality Initiative >> SNF Quality Reporting Program >> MDS 3.0 RAI Manual | Update. |
| Directory Appendix | Nursing Facility Resources | Under "Beneficiary Benefit Plan ID(s) for the DOS, including Patient Pay Amount and MA Redetermination Date (if on file)", website information was revised to read:<br><br>MI Healthplan Benefits website ~~access enrollment form~~:<br><br>~~https://healthplanbenefits.mihealth.org~~ https://hpb.mihealth.org >> ~~Enrollment Form~~ Create an Account | Update. |

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## TECHNICAL CHANGES*

| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Forms Appendix | MSA-1680-B; Dental Prior Approval Authorization Request | Revisions to the form include:<br>• Added the change request fax number to the instruction sheet.<br>• Added orthodontic instructions to the tooth chart, section 20.<br>• Added additional indications to section 21, including implants, bridges and impacted teeth.<br>• Removed the "For MDHHS consultant use only" box as all requests are processed electronically by the Program Review Division (PRD) and this box is not used. | |
| Forms Appendix | DCH-1164; Guarantee of Payment Letter for Pregnancy-Related Services | Form DCH-1164; Guarantee of Payment Letter for Pregnancy-Related Services was removed. | Removal of obsolete form. |
| Forms Appendix | MSA-6544-B; Practitioner Special Services Prior Approval – Request/Authorization | Form was revised to reflect updated language and removal of laboratory tests from its applicability. | |

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# Medicaid Provider Manual July 2021 Updates

## BULLETINS INCORPORATED*

| BULLETIN NUMBER | DATE ISSUED | CHAPTER | SECTION | CHANGE |
|---|---|---|---|---|
| MSA 20-64 | 1/29/2021 | Independent Diagnostic Testing Facilities and Portable X-ray Suppliers | Section 4 – Portable X-ray Suppliers (PXRS) | The 4th and 5th paragraphs were revised to read:<br><br>Appropriate HCPCS and Level II HCPCS modifiers are required. If only one patient is served, report the appropriate HCPCS code. When more than one patient is served during a single trip to the same location, report the appropriate HCPCS code with the appropriate Level II HCPCS modifier (UN, UP, UQ, UR, US) relative to the number of patients served, irrespective of their insurance. The modifier determines the number of beneficiaries served at a location, and total payment for services is adjusted by the number of patients.<br><br>Portable x-rays furnished in a place of residence used as the patient's home, including a nursing facility, require the corresponding POS code. ~~For patients residing in a nursing facility, the transportation, set-up and personnel costs are included in the nursing facility's per diem rate with a PXRS and are not separately reimbursable. For information on the nursing facility coverage of transportation costs, refer to the Nursing Facility Chapter of this manual.~~<br><br>For dual-eligible beneficiaries during a Medicare Part A-covered skilled nursing facility stay, transportation and set-up costs will follow Medicare-consolidated billing policy and are not separately billable to Medicare Part B or to Medicaid. No transportation charge is payable unless the portable x-ray equipment was actually transported to the location where the x-ray was taken. |

*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)

Michigan Department of Health and Human Services

# Medicaid Provider Manual July 2021 Updates

## BULLETINS INCORPORATED*

| BULLETIN NUMBER | DATE ISSUED | CHAPTER | SECTION | CHANGE |
|---|---|---|---|---|
| | | Nursing Facility Coverages | 10.37.A. Non-Emergency Non-Ambulance Transportation | The 1st paragraph was revised to read:<br><br>The nursing facility is responsible for non-emergency non-ambulance transportation for all Medicaid beneficiaries, including Medicare/Medicaid beneficiaries when Medicare is covering the cost of the care. This transportation includes transport to medical appointments/treatment not available in the facility (e.g., dialysis treatment), as well as when the facility arranges for services to be provided at the facility (e.g., hearing aid dealer; ~~transportation costs of portable x-ray equipment and personnel~~). The facility must either arrange or provide transportation. Reimbursement for non-emergency non-ambulance transportation, whether the beneficiary is transported to the appointment or the services are provided at the facility, is included in the facility per diem rate. The per diem rate also includes transportation for newly-admitted beneficiaries from a hospital or another residence.<br><br>Excluded from the per diem rate are charges for the transportation of equipment for portable x-ray services by an enrolled Portable X-ray Supplier. (Refer to the Independent Diagnostic Testing Facilities and Portable X-ray Suppliers chapter of this manual for additional information.) |

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## BULLETINS INCORPORATED*

| BULLETIN NUMBER | DATE ISSUED | CHAPTER | SECTION | CHANGE |
|---|---|---|---|---|
| | | Practitioner | 9.4 Transportation and Set-Up of Portable X-ray Equipment | Text was revised to read:<br><br>The transportation of portable x-ray equipment, set-up, and personnel ~~is covered~~ may be covered when furnished in a place or residence used as the patient's home, including a nursing facility, as reported by the corresponding HCPCS code. ~~These services must be provided under the order and general supervision of a physician. No transportation charge is payable unless the portable x-ray equipment was actually transported to the location where the x-ray was taken. For patients residing in a nursing facility, the transportation, set-up and personnel costs are included in the nursing facility's per diem rate and not separately reimbursable.~~ (Refer to the ~~Nursing Facility and the~~ Independent Diagnostic Testing Facilities and Portable X-ray Suppliers chapters of this manual for additional information.)<br><br>~~If only one patient is served, report the appropriate HCPCS code. When more than one patient is served during a single trip to the same location, report the appropriate HCPCS code with the appropriate Level II HCPCS modifier (UN, UP, UQ, UR, US) relative to the number of patients served, irrespective of their insurance. Total payment for services will be adjusted by the number of patients.~~ |
| MSA 21-03 | 2/17/2021 | Billing & Reimbursement for Professionals | 6.1 General Information | Under "Place of Service Codes", code 60 was removed.<br><br>~~60 – Mass Immunization Center~~ |
| | | Practitioner Reimbursement Appendix | 3.2 Eligible Primary Care Services | The 1st bullet point was revised to read:<br><br>• ~~99201~~ 99202 through 99215 for new and established patient office or outpatient evaluation and management (E/M) visits |

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<table>
<tr><th>BULLETIN NUMBER</th><th>DATE ISSUED</th><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th></tr>
<tr><td rowspan="3">MSA 21-02</td><td rowspan="3">4/1/2021</td><td rowspan="3">Billing & Reimbursement for Dental Providers</td><td>5.2 Loss or Change in Eligibility</td><td>Subsection text was revised in its entirety to read:<br><br>Services are not covered after loss or change in eligibility. Root canal therapy, authorized laboratory processed crowns, and authorized complete and partial dentures may be reimbursed if services were started prior to the loss/change in eligibility and completed within the month following the last date of eligibility.<br><br><table><tr><td>Electronic Claims</td><td>Treatment Start Date and Treatment Completion Date are required within Loop 2400 DPT.</td></tr><tr><td>DDE Claims</td><td>Treatment Start Date and Treatment Completion Date are required within the appropriate DDE fields.</td></tr><tr><td>Paper Claims</td><td>For complete or partial dentures and laboratory-processed crowns, the date of service on the claim should be the date of the initial impression (the completion date must be entered in the Remarks section).<br><br>For root canal therapy, the date of service should be the first treatment appointment (the completion date must be entered in the Remarks section).</td></tr></table></td></tr>
<tr><td>5.3 Incomplete Root Canal</td><td>Subsection was deleted.</td></tr>
<tr><td>5.3 Incomplete Procedures<br><br>(new subsection)</td><td>New subsection text reads:<br><br>When root canal treatment, authorized laboratory processed crowns or authorized denture services have commenced but extenuating circumstances have prevented completion (e.g., beneficiary death), providers are paid a reduced rate to offset a portion of the costs incurred. A request to amend the original PA must be submitted as described below. Refer to the Dental chapter of this manual for PA requirements.</td></tr>
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| | | | 5.3.A. Incomplete Crown<br><br>(new subsection) | New subsection text reads:<br><br>• Providers must bill procedure code D2999.<br>• Date of service is the date of the impression.<br>• Include the PA number on the claim. |
| | | | 5.3.B. Incomplete Root Canal<br><br>(new subsection) | New subsection text reads:<br><br>• Providers must bill procedure code D3999.<br>• Date of service is the date of the first treatment appointment.<br>• Include the PA number on the claim. |
| | | | 5.3.C. Incomplete Denture or Partial Denture<br><br>(new subsection) | New subsection text reads:<br><br>• Providers must bill procedure code D5899.<br>• Date of service is the date of the initial impression.<br>• Include the PA number on the claim. |

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| | | | 5.4 Diagnosis Reporting | Text was revised to read:<br><br>~~Diagnosis reporting is required for all oral and maxillofacial surgeries and/or anesthesiology services.~~<br><br>• ~~Electronic claims:~~<br>~~The diagnosis code(s) is required to be reported in Loop 2300 HI.~~<br>• ~~DDE claims:~~<br>~~The diagnosis code(s) is required in the applicable DDE diagnosis field.~~<br>• ~~Paper claims:~~<br>~~The diagnosis code(s) is required in the Remarks section.~~<br><br>Diagnosis reporting is required for all oral and maxillofacial surgical procedures, anesthesia and IV sedation services. ICD-10 diagnosis codes must be valid, contain the required number of characters, and be reported at the highest level of specificity based on the information available.<br><br>**Electronic Claims**: The diagnosis code(s) is required to be reported in Loop 2300 HI.<br>**DDE Claims**: The diagnosis code(s) is required in the applicable DDE diagnosis field.<br>**Paper Claims**: The diagnosis code(s) is required in the Remarks section. |
| | | | 5.6 Orthodontic Billing Instructions | The subsection was reformatted, with text being relocated to new subsections (noted below). |

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| | | | 5.6.A. Interceptive Orthodontic Treatment<br><br>(new subsection) | New subsection text reads:<br><br>For interceptive orthodontic treatment, submit a single claim for the entire interceptive treatment phase.<br>• The date of service is the banding/start date.<br>• Include the PA number on the claim.<br>• Reimbursement is made for the entire treatment time period and is considered payment in full. |
| | | | 5.6.B. Comprehensive Orthodontic Treatment<br><br>(new subsection) | New subsection text reads:<br><br>Comprehensive orthodontic treatment procedure codes are used in the first stage of each comprehensive treatment phase.<br><br>Billing instructions for comprehensive orthodontic treatment are as follows:<br>• The date of service is the banding insertion date.<br>• Include the PA number on the claim.<br><br>An initial payment is made with a claim submission using the comprehensive orthodontic procedure code and subsequent payments are made bi-annually using the periodic orthodontic treatment procedure code. |

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| | | | 5.6.C. Periodic Orthodontic Treatment<br><br>(new subsection) | New subsection text reads:<br><br>Billing instructions for periodic orthodontic treatment are as follows:<br>• The date of service is the first day of the six-month treatment period.<br>• The date of service cannot be the same as the banding insertion date.<br>• Include the PA number on the claim.<br>• The beginning and end dates for the entire time period should be entered in the Remarks section of the claim.<br>• If treatment ends prior to the completion of the six-month time period, the fee for the treatment time frame must be pro-rated.<br>➢ The date of service is the first day of the periodic treatment time period.<br>➢ Include the PA number on the claim.<br>➢ The fee charged should reflect the treatment time period (e.g., if only three months are needed to complete treatment, the charges should reflect half of the current periodic orthodontic treatment fee).<br>➢ The entire pro-rated time period is entered into the Remarks section of the claim.<br><br>When paid reimbursement to the provider has met the maximum allowable for the specific phase of treatment, no additional reimbursement will be made and the case is considered paid in full. |
| | | Children's Special Health Care Services | Section 9 – Benefits | In the 2nd paragraph, the 4th bullet point was revised to read:<br><br>• Dental (~~Specialty and~~ General and Enhanced) |
| | | | 9.1 Specialty Dental Benefits | The subsection was deleted. |

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| | | | 9.1 CSHCS Dental Benefits<br><br>(new subsection) | New subsection text reads:<br><br>CSHCS beneficiaries who have a qualifying diagnosis affecting the oral cavity may be eligible to receive select dental services based on the specific diagnoses and treatment plan. All CSHCS beneficiaries do not automatically qualify for dental benefits. Covered services may include general dental services, CSHCS enhanced dental services, or both.<br>• CSHCS general dental services are services covered under the Medicaid dental benefit.<br>• CSHCS enhanced dental services are additional services covered by the CSHCS program that are not covered by Medicaid. |

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| | | | 9.1.A. CSHCS General Dental Services<br><br>(new subsection) | New subsection text reads:<br><br>CSHCS general dental services may be covered for CSHCS enrollees when related to the CSHCS qualifying diagnosis. Examples of CSHCS qualifying diagnoses eligible for general dental services are identified below. The list is not all inclusive:<br><br>• Chemotherapy or radiation which results in significant dental side effects<br>• Cleft lip/palate/facial anomaly<br>• Convulsive disorders with gum hypertrophy<br>• Cystic Fibrosis<br>• Hemophilia and/or other coagulation disorders<br>• Pre- and post-transplant<br><br>CSHCS general dental services are those services covered under the Medicaid dental benefit. Services may include diagnostic, preventive, restorative, endodontics, prosthodontics, and oral surgery. The general dental benefit may include services performed by dental specialists (e.g., endodontists, oral surgeons, etc.). General dental services follow Medicaid coverage parameters, including frequency limits, prior authorization requirements, and age restrictions.<br><br>To request approval as a CSHCS General Dentistry provider, dentists must contact MDHHS. (Refer to the Directory Appendix for contact information.)<br><br>Hospital charges (e.g., general anesthesia, facility charges, etc.) may be covered for dental services provided through the inpatient or outpatient hospital facility for beneficiaries with certain CSHCS diagnoses, including cases where CSHCS does not cover the dental care itself. |

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| | | | 9.1.B. CSHCS Enhanced Dental Services<br><br>(new subsection) | New subsection text reads:<br><br>CSHCS enhanced dental services are additional services covered by the CSHCS program that are not covered by Medicaid. Examples of enhanced dental services may include orthodontics, dental implants, and augmented crown and bridge services beyond Medicaid's limited crown coverage. Examples of CSHCS diagnoses that may qualify for enhanced dental services are listed below. The list is not all inclusive:<br><br>• Amelogenesis imperfecta, Dentinogenesis imperfecta<br>• Anodontia which has significant effect on function<br>• Cleft palate<br>• Ectodermal dysplasia, epidermolysis bullosa with significant tooth involvement<br>• Juvenile periodontitis<br>• Juvenile rheumatoid arthritis and related connective tissue disorders with jaw dysfunction secondary to temporomandibular joint arthritic involvement<br>• Post-operative care related to neoplastic jaw disease<br>• Severe maxillofacial or craniofacial anomalies that require surgical intervention, including orthognathic surgery<br>• Traumatic injuries to the dental arches<br><br>Most CSHCS enhanced dental benefits require prior authorization. Treatment for enhanced dental services is not authorized beyond age 21. Refer to the CSHCS Dental Services section in the Dental chapter for additional information.<br><br>To request approval as a CSHCS provider of enhanced dental services, dentists must contact MDHHS. (Refer to the Directory Appendix for contact information.) |
| | | | 9.2 General Dental Benefits | The subsection was deleted.<br><br>The following subsections were re-numbered accordingly. |

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| | | Dental | | The Dental chapter was replaced in its entirety. |
| | | Acronym Appendix | | Addition of:<br>AAPD - American Academy of Pediatric Dentistry<br>HKD – Healthy Kids Dental<br>HMP – Healthy Michigan Plan<br>TMJ - temporomandibular joint<br>PRD - Program Review Division<br>Revisions to:<br>PA – Prior Authorization; Physician's Assistant; Public Act<br>PCP – Primary Care Physician; Person-Centered Planning; Primary Care Provider |

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| MSA 21-10 | 4/8/2021 | Pharmacy | 14.15 Vaccines | The 1st and 2nd paragraphs were revised to read:<br><br>The cost of the vaccine and administration of all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), including seasonal influenza vaccines, administered by pharmacists are covered for adults aged 19 years and older for Fee-For-Service Medicaid, Healthy Michigan Plan, and MOMS program beneficiaries. Additionally, pharmacies approved to participate in the Vaccines for Children (VFC) program may administer ACIP recommended vaccines to Medicaid, Healthy Michigan Plan, and MOMS beneficiaries ages 3 through 18 years. The cost of the VFC vaccine is at no cost to participating pharmacies. VFC enrolled pharmacies can bill administration fees for VFC vaccines as a Medicaid Fee-For-Service pharmacy benefit, including for beneficiaries ages 3 through 18 years of age who are enrolled in a Medicaid Health Plan. (Refer to the Directory Appendix for information on the Vaccines For Children program.)<br><br>~~Pharmacies may submit a claim for the vaccine and its administration for Fee-for-Service Medicaid and MOMS beneficiaries. In addition,~~ Pharmacies may submit a claim for seasonal influenza vaccine and its administration for CSHCS beneficiaries. For beneficiaries 19 years and older who are enrolled in a Medicaid Health Plan, the pharmacy provider must confirm coverage of pharmacist-administered vaccines with the plan.<br><br>The 6th paragraph was revised to read:<br><br>The pharmacy must submit the National Drug Code (NDC) for the product administered and the appropriate values in the Drug Utilization Review (DUR)/Professional Pharmacy Services (PPS) segment and the Professional Service Code respectively. MDHHS allows pharmacies to bill the cost of the vaccine when not purchased through the VFC program.~~; therefore,~~ The pharmacy should submit the allowed administrative fee in the incentive fee submitted field. |

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| | | Directory Appendix | Pharmacy Resources | Addition of:<br><br>**Contact/Topic:** Vaccines for Children Program<br><br>**Web Address:** https://www.michigan.gov/documents/mdhhs/Detailed_Flyer_-_Become_a_VFC_Provider_668245_7.pdf<br><br>**Information Available/Purpose:** Instruction regarding how to become a Vaccines for Children provider. |

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