MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 14-22

Distribution: All Providers

Issued: May 29, 2014

Subject: Updates to the Medicaid Provider Manual; Program Updates; ICD-10 Project Update; New Coverage of Existing Code; Discontinuing Coverage of Existing Codes; Habilitative Services for the Healthy Michigan Plan; Emergency Ambulance Transportation; Public Acts 64 through 78 of 2014; Modified Adjusted Gross Income (MAGI) Related Eligibility Policy Manual

Effective: As Indicated

Programs Affected: Medicaid, Healthy Michigan Plan, Children's Special Health Care Services, Children's Waiver, Maternity Outpatient Medical Services, MIChoice Waiver, *Plan First!*

Updates to the Medicaid Provider Manual

The Michigan Department of Community Health (MDCH) has completed the July 2014 update of the online version of the Medicaid Provider Manual. The manual is located at www.michigan.gov/medicaidproviders >> Policy and 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 and 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.

Program Updates

Adult Benefits Waiver

Effective April 1, 2014, the Adult Benefits Waiver (ABW) ended. Appropriate changes have been made throughout the Medicaid Provider Manual to reflect the ending of the ABW. The ABW chapter will remain in the manual to provide guidance to providers for services rendered but not yet billed. The Adult Benefits Waiver chapter and remaining references to ABW will be removed from the Medicaid Provider Manual in 2015. MDCH is also working to modify the websites, publications and forms that reference the ABW.

Healthy Michigan Plan

A Healthy Michigan Plan chapter has been added to the Medicaid Provider Manual. It contains language from bulletin MSA 14-11, issued on February 27, 2014. MDCH will issue future bulletins to provide additional information about the Healthy Michigan Plan. These bulletins will be incorporated into the Healthy Michigan Plan chapter on a quarterly basis.

Plan First! Family Planning Waiver

Effective April 1, 2014, new enrollments in *Plan First!* ended. The *Plan First!* Family Planning Waiver is set to end on June 30, 2014. Appropriate changes have been made throughout the Medicaid Provider Manual to reflect this change. The *Plan First!* Family Planning Waiver chapter and remaining references to *Plan First!* will be removed from the manual in 2015. MDCH is also working to make appropriate modifications to the websites, publications and forms that reference *Plan First!*.

Transitional Medical Assistance-Plus

Effective April 1, 2014, the Transitional Medical Assistance Plus (TMA-Plus) program ended. Appropriate changes have been made throughout the Medicaid Provider Manual to reflect the ending of TMA-Plus. The Transitional Medical Assistance Plus section of the Special Programs chapter will remain in the manual to provide guidance to providers for services rendered but not yet billed. The Transitional Medical Assistance Plus section and remaining references to TMA-Plus will be removed from the Medicaid Provider Manual in 2015. MDCH websites, publications and forms that reference TMA-Plus will also be modified.

ICD-10 Project Update

The Centers for Medicare & Medicaid Services (CMS) has announced that the U.S. Department of Health and Human Services will release an interim final rule that will include a new ICD-10 compliance date of October 1, 2015. The continued use of ICD-9-CM will be required for Health Insurance Portability and Accountability Act (HIPAA) covered entities through September 30, 2015. MDCH encourages providers to continue communications with software vendors, billing agents and/or service bureaus to ensure systems and procedures will support the use of ICD-10 code sets on all HIPAA transactions by the compliance date.

MDCH continues to present Medicaid providers and trading partners with the opportunity to test their ability to communicate with MDCH using ICD-10 coded transactions through Business-to-Business (B2B) testing. These activities are designed to help providers ensure that their remediation efforts to prepare for the ICD-10 transition have resulted in the creation of transactions that can be processed successfully.

Any questions regarding ICD-10 implementation should be directed to MDCH-ICD-10@michigan.gov. Providers should continue to frequently check the MDCH website at www.michigan.gov/5010icd10 for ICD-10 updates. Providers are encouraged to check for available ICD-10 trainings on the MDCH website at www.michigan.gov/medicaidproviders >>Hot Topics >> Medicaid Provider Training Sessions.

New Coverage of Existing Code

Durable Medical Equipment, Orthotics, Prosthetics and Medical Supplies -- Effective 7/1/2014

E1004 - Wheelchair accessory, power seating system, recline only, with mechanical shear reduction.
Prior authorization is required. Refer to the Medical Supplier database on the MDCH website for further coverage parameters.

Discontinuing Coverage of Existing Codes

MDCH will discontinue coverage of the following codes effective July 1, 2014:

Q4100, Q4103, Q4104, Q4105, Q4108, Q4111, Q4114, Q4117, Q4118, Q4119, Q4120, Q4122, Q4123, Q4124, Q4125, Q4126, Q4127, Q4128, Q4129, Q4130, Q4132, Q4133, Q4135, Q4136

The codes will be removed from the Physician Administered Drugs and Biologicals database.

Habilitative Services for the Healthy Michigan Plan

Effective July 1, 2014, the Centers for Medicare & Medicaid Services (CMS) has established modifier "SZ-Habilitative Services". As a follow-up to Bulletin MSA 14-11, modifier SZ must be reported in addition to the

procedure code for all habilitative services submitted on prior authorization requests and for claim adjudication to ensure proper payment effective with dates of service (DOS) on and after July 1, 2014.

Emergency Ambulance Transportation

As a result of guidance from CMS related to compliance with HIPAA billing requirements, MDCH will no longer require the National Provider Identifier (NPI) of the attending physician to be reported on emergency ambulance transportation claims billed on the institutional claim format effective immediately. Institutional ambulance providers are encouraged to continue reporting this information on all submitted claims; however, the exclusion of this information will no longer result in claim denial.

Public Acts 64 through 78 of 2014

Michigan Public Acts 64 through 78 of 2014, effective March 28, 2014, remove the phrases "mentally retarded" and "mental retardation" from a number of state statutes and replace them with "developmental disability" and "intellectual disability". Revisions have been made to the July 2014 version of the Medicaid Provider Manual to reflect the new language. MDCH is also working to make appropriate changes to its websites, publications and forms.

Modified Adjusted Gross Income (MAGI) Related Eligibility Policy Manual

The Modified Adjusted Gross Income (MAGI) Related Eligibility Policy Manual is now available on the MDCH website at www.michigan.gov/medicaidproviders >> Policy and Forms. The MAGI Manual contains MAGI-related eligibility policy used for determining financial eligibility for various programs administered by MDCH. Changes to the MAGI manual will be incorporated on a quarterly basis and will be communicated to providers via a quarterly update bulletin.

Manual Maintenance

If utilizing the online version of the manual at www.michigan.gov/medicaidproviders >> Policy and 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 MDCH 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 Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Stephen Fitton, Director
Medical Services Administration

Michigan Department of Community Health

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July 2014 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Throughout the Manual		Effective April 1, 2014, the Adult Benefits Waiver (ABW) ended. Appropriate changes have been made throughout the Medicaid Provider Manual to reflect the ending of the ABW. The Adult Benefits Waiver chapter will remain in the manual to provide guidance to providers for services rendered but not yet billed. The Adult Benefits Waiver chapter and remaining references to ABW will be removed from the Medicaid Provider Manual in 2015. Websites, publications and forms that reference the ABW will also be modified. (Changes also address the terms "County Health Plans" and "CHP".)	Updates.
Throughout the Manual		Effective April 1, 2014, the Transitional Medical Assistance Plus (TMA-Plus) program ended. Appropriate changes have been made throughout the Medicaid Provider Manual to reflect the ending of TMA-Plus. The Transitional Medical Assistance Plus section of the Special Programs chapter will remain in the manual to provide guidance to providers for services rendered but not yet billed. The Transitional Medical Assistance Plus section and remaining references to TMA-Plus will be removed from the manual in 2015. Websites, publications and forms that reference TMA-Plus will also be modified.	Updates.
Throughout the Manual		Michigan Public Acts 64 through 78 of 2014, effective March 28, 2014, remove the phrases "mentally retarded" and "mental retardation" from a number of state statutes with replacement language reading "developmental disability" and "intellectual disability". Revisions have been made throughout the manual to reflect the new language. Websites, publications and forms will also be modified to address the new language.	Updates.
General Information for Providers	Section 9 – Inpatient Hospital Authorization Requirements	In the 2nd paragraph, the following text was added after the 1st sentence: Services during inpatient stays or parts of stays where that stay has been denied as inappropriate or unnecessary may not be resubmitted to MDCH as outpatient charges. Charges resubmitted as outpatient charges are monitored, and any payment made may be recovered during a post-payment audit.	Information re-located from 9.1 Prior Authorization Certification Evaluation Review (PACER).

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CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	9.1 Prior Authorization Certification Evaluation Review (PACER)	The following language was removed from the 8th paragraph (2nd and 3rd sentences): Services during inpatient stays or parts of stays where that stay has been denied as inappropriate or unnecessary may not be resubmitted to MDCH as outpatient charges. Charges resubmitted as outpatient charges are monitored, and any payment made may be recovered during a post-payment audit.	Information re-located to Section 9 – Inpatient Hospital Authorization Requirements.
General Information for Providers	12.1 Billing Provider	In the 2nd paragraph, "(Mt. Pleasant Regional Center)" was removed from the 1st sentence.	Obsolete information.
Beneficiary Eligibility	2.1 Benefit Plans	The following benefit plans were discontinued as of April 1, 2014. (The statement "**Discontinued as of April 1, 2014.**" was added to information for the benefit plans.) ABW – Adult Benefits Waiver Program ABW-ESO – Adult Benefits Waiver (Emergency Services) ABW-MC – Adult Benefits Waiver Program (Managed Care) INCAR – Incarceration - Other INCAR-ABW – Incarceration - ABW (No Benefits) TMA-PLUS – Full Fee-for-Service Transitional Medical Assistance - Plus TMA-PLUS-E – Transitional Medical Assistance – Plus Emergency Services	Updates.
Beneficiary Eligibility	2.1 Benefit Plans	The following benefit plan was discontinued as of July 1, 2014. (The statement "**Discontinued as of July 1, 2014.**" was added to information for the benefit plan.) Plan First! – Family Planning Waiver	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans	The following new benefit plans were implemented as of April 1, 2014: MA-HMP – Healthy Michigan Plan – Service Type Codes: 1, 33, 35, 47, 48, 50, 71, 86, 88, 91, 92, 98, AL, MH, UC MA-HMP-ESO – Healthy Michigan Plan Emergency Services – Service Type Codes: 86 and 1, 47, 48, 50, 88, 91, 92, MH, UC with the statement (Emergency Services Only) MA-HMP-INC – Healthy Michigan Plan Incarceration – Service Type Code: 48 MA-HMP-MC– Healthy Michigan Plan Managed Care – Service Type Codes: 1, 33, 35, 47, 48, 50, 71, 86, 88, 91, 92, 98, AL, MH, UC	Updates.
Beneficiary Eligibility	2.1 Benefit Plans	Benefit Plan Descriptions were revised as follows: **CWP – Children's Home and Community Based Services Waiver** (2nd paragraph) The CWP enables Medicaid to fund necessary home and community-based services for children with developmental disabilities who have challenging behaviors and/or complex medical needs, meet the criteria for admission to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) and who are at risk for placement without waiver services. **SPF – State Psychiatric Hospital** This benefit plan allows claims adjudication for offsite inpatient medical care provided to beneficiaries who are between the ages of 22 and 64 and otherwise reside in a State Psychiatric Facility.	Updates.
Beneficiary Eligibility	2.1 Benefit Plans	Benefit Plan information for ICF/MR-DD was revised to read: **Benefit Plan ID:** ICF-IID **Benefit Plan Name:** Intermediate Care Facility for Individuals with Intellectual Disabilities **Benefit Plan Description:** The facility primarily provides health-related care and services above the level of custodial care to individuals with intellectual disabilities, but does not provide the level of care or treatment available in a hospital or SNF. This is an all-inclusive program.	Updates.

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CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.3 Level of Care Codes	In the 3rd paragraph, in the Description for Level of Care Code 08, "Mt. Pleasant Regional Center" was removed.	Obsolete information.
Beneficiary Eligibility	Section 11 - Application for Medical Assistance	In the 1st paragraph, the last sentence was deleted. The following text was added after the 1st paragraph: The Application for Health Coverage & Help Paying Costs form (DCH-1426) is used for potential beneficiaries. The form may be obtained from the local DHS office or is available on the MDCH website. (Refer to the Directory Appendix for website information.) The Medicaid Patient of Nursing Home Application (DHS-4574) may be used as an alternative to the DCH-1426. The DHS-4574 is a Medicaid application/redetermination form used to determine Medicaid eligibility for the nursing facility patient only. The application forms are self-explanatory. Questions regarding the forms should be referred to the local DHS office.	Updates.
Beneficiary Eligibility	11.1 Medicaid Application/ Redetermination	Subsection was deleted.	Information was incorporated in Section 11 - Application for Medical Assistance.
Beneficiary Eligibility	11.2 Healthy Kids	Subsection was deleted.	Obsolete information.
Beneficiary Eligibility	11.3 Hospitals and Nursing Facilities	Re-numbered as 11.1.	
Beneficiary Eligibility	11.4 Initial Assessment of Assets	Re-numbered as 11.2.	

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	2.3.B. Attending Provider	The 1st paragraph was revised to read: The attending provider NPI is a requirement for all claims submitted within the institutional claim format with one exception. Hospital-owned ambulance Medicaid-enrolled providers submitting Emergency Ambulance Transport claims may report the attending provider NPI, however, completion of this field is not required. For all institutional claims, the attending physician …	Clarification regarding NPI reporting requirement.
Billing & Reimbursement for Institutional Providers	7.1.E. Date of Service	The following text was added at the end of the 2nd paragraph: Per Federal Regulations, the MDCH OPPS uses Medicaid NCCI and MUE values for OPH claims processing. The Medicaid NCCI and MUE values are reviewed with the quarterly file updates.	Clarification.
Billing & Reimbursement for Institutional Providers	7.3 Ambulance	The following text was added at the end of the 1st paragraph: Hospital-owned ambulance Medicaid-enrolled providers submitting Emergency Ambulance Transport claims may report the National Provider Identifier (NPI) of the attending physician, however, completion of this field is not required.	Clarification regarding NPI reporting requirement.
Billing & Reimbursement for Institutional Providers	8.5 Ventilator Dependent Care and Complex Care	The following text was added as a 2nd paragraph: For Medicare-Medicaid nursing facility crossover claims, refer to the Medicare-Medicaid Nursing Facility Crossover Claims with Group Health Incorporated (GHI) (Coordination of Benefits) and the Ventilator-Dependent Care Units subsections for additional information regarding ventilator-dependent care units.	Clarification.
Billing & Reimbursement for Professionals	6.1 General Information	The following bullet points were added to "Place of Service Codes": • 25 - Birthing Center • 53 - Community Mental Health Center	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Dental	2.4 Approved Prior Authorization Requests	The 4th paragraph was revised to read: While a beneficiary is eligible, all treatment authorized must be completed within one year from the date of authorization. If treatment is not completed within one year, the PA request must be updated before continuing treatment. The provider has 15 days prior to the end of the prior authorization period to request a one-time 180-day extension. New prior authorization requests ...	Rewording for clarification.
Dental	4.2 Nursing Facility	Subsection text was revised in its entirety to read: Dental services provided to a beneficiary who resides in a nursing facility are the same benefits as those identified in the Covered Services section of this chapter. All dental services provided to a nursing home beneficiary in a nursing facility, or any other place of service, require the written order of a licensed referring physician (MD, DO). The order must be signed and dated by the physician and a copy of this order must be retained in the beneficiary's medical record and the beneficiary's dental record. All dental services provided in a nursing facility must be noted in the beneficiary's medical record. Documentation must include an updated medical history, the patient's primary concerns, the current oral health status, and the treatment plan and services rendered.	Clarification of referral and documentation requirements of any dental services rendered to nursing home residents in the facility or another location.
Dental	6.3 Restorative Treatment	The following text was added at the end of the 1st paragraph: The prognosis of the tooth to be restored, as well as the overall treatment plan for the beneficiary, should be evaluated prior to restoration. A reasonable projection of a successful outcome is expected. In the 2nd paragraph, the following text was added as the 2nd sentence: A prior authorization for dentures and partial dentures which includes extraction of the restored tooth within the first two years following placement requires a documented reason for the extraction.	Clarification of prognosis regarding restorative treatment outcomes.

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CHAPTER	SECTION	CHANGE	COMMENT
Dental	6.7.A. Extractions	Subsection text was revised in its entirety to read: An extraction of an erupted tooth includes elevation and/or forceps removal. It includes minor contouring of the bone and closure if needed. A surgical extraction requires the removal of bone and/or sectioning of a tooth and may require the elevation of the mucoperiosteal flap. Minor contouring of the bone and closure of the tissue is included. The extraction procedure code submitted for reimbursement must follow the CDT guidelines and is not based on the amount of time required, the difficulty of the extraction, or any special circumstances. An extraction is not a covered benefit if exfoliation is imminent. Multiple extractions in the same quadrant for preparation of complete dentures are not considered surgical extractions unless guidelines for surgical extractions are met. The extraction of an impacted tooth is not covered for prophylactic removal of asymptomatic teeth that exhibit no overt pathology.	Clarification of the difference between a simple extraction and a surgical extraction.
Dental	6.8 Adjunctive General Services	Subsection was separated into two subsections to provide more specific explanation of covered and non-covered adjunctive services benefits.	Clarification of this section.

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CHAPTER	SECTION	CHANGE	COMMENT
Dental	6.8.A. Anesthesia (new subsection)	New subsection text reads: Intravenous (IV) sedation and general anesthesia are covered benefits for all beneficiaries. Anesthesia services may be billed separately from the surgical procedure. A diagnosis code for anesthesia is required on all claim forms. IV sedation and general anesthesia are not a benefit for the convenience of the dentist or beneficiary and are limited to situations when these anesthesia services are medically necessary. Apprehension and/or anxiety of the beneficiary are not considered valid medical reasons for IV sedation or general anesthesia. IV sedation or general anesthesia is not covered when it is used preceding the administration of local anesthesia as the primary anesthetic agent. IV sedation and general anesthesia may not be billed in combination with the other. Non-intravenous conscious sedation is a benefit for beneficiaries ages 0-5. It includes the administration of sedative and/or analgesic agents and requires appropriate monitoring in the office setting. Nitrous oxide analgesia is not a separate reimbursable procedure. Nitrous oxide analgesia and locally administered anesthetics are included in the reimbursement of the procedure performed.	
Dental	6.8.B. Professional Visits (new subsection)	New subsection text reads: A hospital call is a covered benefit for all ages when dental care must be provided in a hospital for medical reasons. The hospital call can be submitted in addition to the applicable procedure codes for the services provided on the date of service.	
Dental	8.2.A. Orthodontic Services	In the 1st paragraph, the following text was added after the 1st sentence: Only CSHCS approved orthodontists may provide accepted standards of orthodontic treatment. Services that are non-traditional or experimental are not covered. In the 3rd paragraph, the 2nd sentence was revised to read: Refer to the Dental database on the MDCH website for procedure codes and age limits.	Clarification of accepted standards of orthodontic treatment and approved providers. Specific ages limits for each stage of interceptive treatment are no longer valid.

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CHAPTER	SECTION	CHANGE	COMMENT
Dental	9.1 Coverage and Service Area Information	In the 2nd paragraph, the "Number" for Washtenaw County was revised to read "81".	Correction.
Hospital	3.29.A. Operating Room	In the 2nd paragraph, text after the 2nd sentence was revised to read: Per Federal Regulations, the MDCH OPPS uses Medicaid NCCI and Medically Unlikely Edit (MUE) values for OPH claims processing. Medicaid NCCI and MUE values are reviewed with the quarterly file updates.	Clarification.
Hospital	4.1 Noncovered Admissions	The following text was added as the 2nd paragraph: Services during inpatient stays or parts of stays where that stay has been denied as inappropriate or unnecessary may not be resubmitted to MDCH as outpatient charges. Charges resubmitted as outpatient charges are monitored, and any payment made may be recovered during a post-payment audit.	Clarification.
Hospital Reimbursement Appendix	1.2 Outpatient Code Editor with Ambulatory Payment Classification	In the 1st paragraph, the following text was added as the 2nd sentence: Per Federal Regulations, the MDCH OPPS uses Medicaid NCCI and MUE values for OPH claims processing. Medicaid NCCI and MUE values are reviewed with the quarterly file updates.	Clarification.
Local Health Department	Throughout the chapter	"MDCH Contract Management Section" was revised to read "MDCH Grants and Purchasing Division/Grants Section".	Update.
Medical Supplier	1.7.C. Emergency Prior Authorization	In the 2nd paragraph, the 2nd sentence was revised to read: ... "verbal PA request" must be in box 25 of the MSA-1653-B or box 28 on the MSA-1653-D. In the 4th paragraph, 1st bullet point, the 2nd sentence was revised to read: (Include the date of the verbal authorization in box 25 of the MSA-1653-B or box 28 on the MSA-1653-D).	Correction.

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CHAPTER	SECTION	CHANGE	COMMENT
Medical Supplier	2.19 Incontinent Supplies	Under "Services Covered Through the Contract", addition of: **HCPCS Code:** T4544 **Nomenclature:** Adult disposable incontinence product, protective underwear/pull-on, above extra large **CSHCS Coverage:** (blank) **Mandatory for Medicaid/Medicare:** X	Code was announced in bulletin MSA 13-54.
Mental Health/ Substance Abuse	1.5 Programs Requiring Special Approval	In the 1st paragraph, the bullet point for "Crisis Observation Care" was removed.	Pursuant to the 2011 1915(b) waiver renewal that was approved by CMS for the period starting October 1, 2011, this service was deleted because it was not being utilized. Removing this service from manual satisfies the conditions of approval.
Mental Health/ Substance Abuse	Section 3 – Covered Services	The 2nd sentence was revised to read: ..., nor is the PIHP responsible for providing the Children's Waiver Services or Serious Emotional Disturbance Waiver Services described in this chapter. The following text was added at the end of the paragraph: NOTE: Certain services are State Plan EPSDT services when delivered to children birth-21 years as noted specifically under those services listed in the Additional Mental Health Services (B3s) section of this chapter. Each affected service is appropriately identified within the subsections.	Michigan's 1915(b) Specialty Services and Supports Waiver, effective October 1, 2011, was approved by the Centers for Medicare and Medicaid Services (CMS) with the agreement that certain 1915(b)(3) services for individuals under 21 years of age would be moved to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program/ Michigan Medicaid State Plan covered services.

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CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	3.19 Occupational Therapy	Text under "Evaluation" was revised to read: Physician/licensed physician assistant/family nurse practitioner -prescribed activities provided by an occupational therapist ... Under "Therapy", text in the 3rd paragraph was revised to read: Services must be prescribed by a physician/licensed physician's assistant/family nurse practitioner and may be ...	Current language indicates that only a physician can prescribe this service; however, a PA and a FNP can also prescribe.
Mental Health/ Substance Abuse	3.29 Wraparound Services for Children and Adolescents (new subsection)	Relocation of policy previously found under Section 17 - Additional Mental Health Services (B3s): • 17.3.N. Wraparound Services for Children and Adolescents • 17.3.N.1. Organized Structure • 17.3.N.2. Qualified Staff • 17.3.N.3. Plans of Service • 17.3.N.4. Amount and Scope of Service • 17.3.N.5. Evaluation and Outcomes Measurement	Michigan's 1915(b) Specialty Services and Supports Waiver, effective October 1, 2011, was approved by the Centers for Medicare and Medicaid Services (CMS) with the agreement that certain 1915(b)(3) services for individuals under 21 years of age would be moved to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program/ Michigan Medicaid State Plan covered services. This addition identifies this as one of the services that were required to be moved.
Mental Health/ Substance Abuse	12.3 Additional Substance Abuse Services (B3s) (new subsection)	Re-location of policy previously found under Section 18 - Additional Substance Abuse Services (B3s): • Section 18 - Additional Substance Abuse Services (B3s • 18.1 Sub-Acute Detoxification • 18.2 Residential Treatment	Per request of CMS, since these two services are identified in the state plan, they cannot be identified as B3 services; moving these services to Section 12 will resolve this issue.

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CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	12.3 Excluded Services	Re-numbered as 12.4	
Mental Health/ Substance Abuse	Section 17 – Additional Mental Health Services (B3s)	The following text was added at the end of the paragraph: NOTE: Certain services found in this section are State Plan EPSDT services when delivered to children birth-21 years, which include community living supports, family support and training (Parent-to-Parent/Parent Support Partner) peer-delivered services, prevention/direct models of parent education and services for children of adults with mental illness, skill building, supports coordination, and supported employment.	Michigan's 1915(b) Specialty Services and Supports Waiver, effective October 1, 2011, was approved by the Centers for Medicare and Medicaid Services (CMS) with the agreement that certain 1915(b)(3) services for individuals under 21 years of age would be moved to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program/ Michigan Medicaid State Plan covered services.
Mental Health/ Substance Abuse	17.3.B. Community Living Supports	The following text was added as the 1st paragraph: NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.	Michigan's 1915(b) Specialty Services and Supports Waiver, effective October 1, 2011, was approved by the Centers for Medicare and Medicaid Services (CMS) with the agreement that certain 1915(b)(3) services for individuals under 21 years of age would be moved to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program/ Michigan Medicaid State Plan covered services. This addition identifies this as one of the services that were required to be moved.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	17.3.E. Crisis Observation Care	Subsection was deleted. Following subsections were re-numbered.	Pursuant to the 2011 1915(b) waiver renewal that was approved by CMS for the period starting October 1, 2011, this service was deleted because it was not being utilized. Removing this service from the Manual satisfies the conditions of approval.
Mental Health/ Substance Abuse	17.3.F. Family Support and Training	The following text was added as the 1st paragraph: NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.	Michigan's 1915(b) Specialty Services and Supports Waiver, effective October 1, 2011, was approved by the Centers for Medicare and Medicaid Services (CMS) with the agreement that certain 1915(b)(3) services for individuals under 21 years of age would be moved to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program/ Michigan Medicaid State Plan covered services. This addition identifies this as one of the services that were required to be moved.

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CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	17.3.H. Peer-Delivered or -Operated Support Services	The following text was added as the 1st paragraph: NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.	Michigan's 1915(b) Specialty Services and Supports Waiver, effective October 1, 2011, was approved by the Centers for Medicare and Medicaid Services (CMS) with the agreement that certain 1915(b)(3) services for individuals under 21 years of age would be moved to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program/ Michigan Medicaid State Plan covered services. This addition identifies this as one of the services that were required to be moved.
Mental Health/ Substance Abuse	17.3.I. Prevention-Direct Service Models	In the 1st paragraph, the 3rd and 5th bullet points were revised to read: • Children of Adults with Mental Illness/Integrated Services (NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years), • Parent Education (NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years).	Michigan's 1915(b) Specialty Services and Supports Waiver, effective October 1, 2011, was approved by the Centers for Medicare and Medicaid Services (CMS) with the agreement that certain 1915(b)(3) services for individuals under 21 years of age would be moved to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program/ Michigan Medicaid State Plan covered services. This addition identifies this as one of the services that were required to be moved.

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CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	17.3.J. Respite Care Services	In the 3rd paragraph, the following bullet point was added: • Licensed family child care home	Currently, respite can be provided in a licensed child care facility and in a licensed foster care home. The addition of respite in a licensed family child care home setting allows for a broader array of options to meet the individualized needs of children. A family-like setting may be a more clinically appropriate alternative to a larger licensed respite care facility for children with specialized needs. Respite in the family child care home is short term, intermittent and is not intended to be provided on a continuous long-term basis.

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CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	17.3.K. Skill-Building Assistance	The following text was added as the 1st paragraph: NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.	Michigan's 1915(b) Specialty Services and Supports Waiver, effective October 1, 2011, was approved by the Centers for Medicare and Medicaid Services (CMS) with the agreement that certain 1915(b)(3) services for individuals under 21 years of age would be moved to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program/ Michigan Medicaid State Plan covered services. This addition identifies this as one of the services that were required to be moved.
Mental Health/ Substance Abuse	17.3.L. Support and Service Coordination	The following text was added as the 1st paragraph: NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.	Michigan's 1915(b) Specialty Services and Supports Waiver, effective October 1, 2011, was approved by the Centers for Medicare and Medicaid Services (CMS) with the agreement that certain 1915(b)(3) services for individuals under 21 years of age would be moved to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program/ Michigan Medicaid State Plan covered services. This addition identifies this as one of the services that were required to be moved.

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CHAPTER	SECTION	CHANGE	COMMENT
Mental Health/ Substance Abuse	17.3.M. Supported/ Integrated Employment Services	The following text was added as the 1st paragraph: NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.	Michigan's 1915(b) Specialty Services and Supports Waiver, effective October 1, 2011, was approved by the Centers for Medicare and Medicaid Services (CMS) with the agreement that certain 1915(b)(3) services for individuals under 21 years of age would be moved to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program/ Michigan Medicaid State Plan covered services. This addition identifies this as one of the services that were required to be moved.
Mental Health/ Substance Abuse	17.3.N. Wraparound Services for Children and Adolescents	The following subsections were relocated to Section 3 - Covered Services (with new numbering of 3.29): • 17.3.N. Wraparound Services for Children and Adolescents • 17.3.N.1. Organized Structure • 17.3.N.2. Qualified Staff • 17.3.N.3. Plans of Service • 17.3.N.4. Amount and Scope of Service • 17.3.N.5. Evaluation and Outcomes Measurement	Michigan's 1915(b) Specialty Services and Supports Waiver, effective October 1, 2011, was approved by the Centers for Medicare and Medicaid Services (CMS) with the agreement that certain 1915(b)(3) services for individuals under 21 years of age would be moved to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program/ Michigan Medicaid State Plan covered services. This addition identifies this as one of the services that were required to be moved.

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CHAPTER	SECTION	CHANGE	COMMENT
	17.3.N.6. 1915(c) Children's Serious Emotional Disturbance Home and Community-Based Services Waiver (SEDW)	Re-numbered as 17.3.N.	
Mental Health/ Substance Abuse	Section 18 - Additional Substance Abuse Services (B3s)	The following subsections were relocated to 12.3 Additional Substance Abuse Services (B3s) (new subsection): • Section 18 - Additional Substance Abuse Services (B3s) • 18.1 Sub-Acute Detoxification • 18.2 Residential Treatment	Per request of CMS, since these two services are identified in the state plan, they cannot be identified as B3 services – moving these services to Section 12 will resolve this issue.
Mental Health/ Substance Abuse	Section 19 - Applied Behavior Analysis	Section 19 and its subsections were re-numbered with an "18" series.	
Nursing Facility Coverages	5.1.D.1. Michigan Medicaid Nursing Facility Level of Care Determination	In the 6th paragraph, the 4th bullet point was revised to read: Within 14 calendar days from the date a Medicaid financial application was registered with DHS (i.e., date-stamped by DHS on the date the application is received) by a current private-pay……	Clarification of 'registered'. Registered means the date the Medicaid application is received by DHS, which is the date DHS date-stamps that application. 'Registered' does not mean the date DHS enters the applicant's status in CHAMPS, which could be weeks/month after the Medicaid application is date-stamped.
Nursing Facility Coverages	5.1.D.6. Adverse Action Notice	In the 4th paragraph, the 1st sentence was revised to read: The MDCH designee may conduct an Immediate Review only for a Medicaid pending or a Medicaid eligible beneficiary who was determined medically/functionally ineligible based on a valid web-based Michigan Medicaid….	The LOCD has to be valid, conducted in appropriate time frames for the appropriate population.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
School Based Services	Throughout the chapter	The following revisions were made: • "Michigan School for the Deaf and Blind" was revised to read "Michigan School for the Deaf" • references to "57" ISDs/districts were revised to read "56" ISDs/districts	Name change; 2 schools merged
School Based Services	6.1.D. Cost Reconciliation and Settlement	In the 5th paragraph, the 3rd sentence was revised to read: The final settlement process will begin within 12-18 months after the close of the school fiscal year.	Updated internal procedures.
School Based Services Administrative Outreach Program	2.1 Implementation Plan	In the 2nd paragraph, the last sentence was revised to read: ... maintaining all necessary records for a minimum of seven (7) years after ...	Consistency in language.
School Based Services Administrative Outreach Program	2.6 RMTS Documentation and Recordkeeping/Audit File Requirements	The 2nd paragraph was revised to read: ... maintain all necessary records for a minimum of seven (7) years after ...	Consistency in language.
School Based Services Random Moment Time Study	1.3 Staff Pools and Confidence Levels	In the 1st paragraph, the last sentence was revised to read: ... on behalf of the 56 ISDs, Detroit Public Schools and Michigan School for the Deaf (hereafter ...	2 schools merged; Name change
Acronym Appendix		addition of: DMP = Document Management Portal MUE = Medically Unlikely Edit removal of: AIS = Alternative Intermediate Services	

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CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Beneficiary Assistance	Under "MIChild/Healthy Kids/MOMS/Plan First!", the web address was revised to read: www.michigan.gov/mibridges	Update.
Directory Appendix	Billing Resources	Addition of the following: **Contact/Topic:** Beneficiary Co-Payments **Web Address:** www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Co-Payment Information **Information Available/Purpose:** Beneficiary co-payment requirements; frequently asked questions	Update.
Directory Appendix	Billing Resources	Under "MDCH Procedure Code Databases/Fee Screens, Documentation Requirements, Readmission Example, Beneficiary Copay Table, etc.", the following revisions were made: **Contact Topic:** Removal of "Beneficiary Copay Table" **Information Available/Purpose:** removal of "beneficiary copays"	Refer to Contact/Topic of Beneficiary Co-Payments.
Directory Appendix	Provider Resources	Information for Contact/Topic "MDCH Contract Management Section" was revised to read: **Contact/Topic:** MDCH Grants and Purchasing Division/Grants Section **Phone:** 517-241-3770 **Mailing Address:** 320 S. Walnut St. Lansing, MI 48913 **Information Available/Purpose:** LHD Comprehensive Agreements	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Reporting Fraud, Abuse, or Misuse of Services	Under "MDCH Office of Health Services Inspector General", the Mailing Address was revised to read: Michigan Department of Community Health Office of Health Services Inspector General PO Box 30062 Lansing, MI 48909-7979 And the phone number 517-335-5239 was removed.	Update.
Forms Appendix		MDCH organizational changes of: • re-naming "Bureau of Medicaid Financial Management and Administrative Services" to "Bureau of Medicaid Operations"; and • re-naming "Bureau of Medicaid Program Operations and Quality Assurance" to "Bureau of Medicaid Care Management and Quality Assurance" resulted in revisions to the following forms : • MSA-0001-EZ; Professional/Dental Claim Documentation Review Area Fax Cover • MSA-0002-EZ; Institutional Claim Documentation Review Area Fax Cover • MSA-0003-EZ; Consent Forms Approval Area • MSA-0004-EZ; Predictive Modeling Claim Documentation • DCH-0078; Request to Add, Terminate or Change Other Insurance • DCH-3890; Electronic Signature Verification Statement	Updates
Forms	MSA-1680-B; Dental Prior Approval Authorization Request	The title on the Instructions page was corrected to read "Dental Prior Approval Authorization Request". Field 14 was revised to read "Does patient live in a nursing home?"	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Forms	MSA-2565-C ; Facility Admission Notice	Revisions to Field 15 - Type of Facility include: • Revisions in terminology relative to use of "mental retardation" • removal of "(in AIS Facility)"	Per Public Acts 64 through 78 of 2014. Removal of obsolete information.

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Michigan Department of Community Health

Medicaid Provider Manual
July 2014 Updates

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 14-14	4/15/2014	Hospital Reimbursement Appendix	7.2.A. $45 Million Pool	In the 4th paragraph, Item 5 was revised to read: The regular DSH payment amount for each hospital is determined by comparing the results of the pool's payment allocation formula at each component of the regular DSH Pool — Diagnosis Related Group (DRG) Reimbursed Hospitals, Per Diem Reimbursed Hospitals and Units and Distinct-Part Rehabilitation Units — to the individual hospital DSH ceiling. Any amount not paid to a hospital because of its DSH ceiling is returned to the pool and redistributed using the same formula as the initial distribution, with hospitals over the ceiling removed from the calculation. This process continues until the entire pool is distributed. For the DRG Reimbursed Hospitals component, any funds not exhausted from the 50 percent IV sub pool will be placed into the 20 percent IV sub pool.
MSA 14-13	3/4/2014	School Based Services	6.2.A. Reimbursement	In the 1st paragraph, the 1st sentence was revised to read: Specialized transportation costs reported on the Michigan Department of Education Transportation Expenditure Report (form SE-4094) are only the costs associated with the special education buses, taxis, or private vehicles used for the specific purpose of transporting only special education children.
MSA 14-12	2/28/2014	Throughout the Manual		Effective April 1, 2014, enrollment in Plan First! ended. The Plan First! Family Planning Waiver is set to end on June 30, 2014. Appropriate changes have been made throughout the Medicaid Provider Manual to reflect this change. The Plan First! Family Planning Waiver chapter and remaining references to Plan First! will be removed from the manual in 2015. Websites, publications and forms that reference Plan First! will also be modified.
MSA 14-11	2/27/2014	Throughout the Manual		A Healthy Michigan Plan chapter has been added to the Medicaid Provider Manual. It contains language from bulletin MSA 14-11. MDCH will issue future bulletins to provide additional information about the Healthy Michigan Plan; these bulletins will be incorporated into the Healthy Michigan Plan chapter on a quarterly basis. Healthy Michigan Plan information has been added to various chapters throughout the manual as applicable. Websites, publications and forms will be created/modified as needed.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MSA 14-07	2/27/2014	Medicaid Provider Manual Overview	1.1 Organization	Under "Chapter Title" of "Billing & Reimbursement for Dental Providers", "Affected Providers" text was revised to read: Providers billing the ADA 2012 or 837 Dental claim formats.
		Billing & Reimbursement for Dental Providers	Section 1 - General Information	In the 1st paragraph, the 1st sentence was revised to read: This chapter applies to all providers billing the ADA 2012 or 837 Dental claim formats. The 2nd paragraph was revised to read: Dental providers must use the ASC X12N 837D 5010 dental format when submitting electronic claims and the ADA 2012 claim form for paper claims.
			3.2 Paper Claims	In the 1st paragraph, the 1st sentence was revised to read: The ADA 2012 claim form must be used when submitting paper claim forms.
			3.2.A. Guidelines to Complete Paper Claim Forms	In the 1st bullet point, the 1st sentence was revised to read: • Be sure the dates are within the appropriate boxes on the form. The following bullet point was added: • American Dental Association (ADA) standard completion instructions should be followed in completing the ADA 2012 claim form.
			3.3 Reporting Provider NPI	In the 1st paragraph, the last sentence was removed. ~~For the ADA 2006 paper claim form, the TIN must be reported in Item 51.~~
			Section 4 - ADA Completion Instructions	The sample view of the 2006 claim form was removed.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			4.1 Dental Claim Form Completion Instructions	Subsection text was revised to read: American Dental Association (ADA) standard completion instructions should be followed in completing the ADA 2012 claim form.
		Billing & Reimbursement for Institutional Providers	2.2 Paper Claims	In the 1st paragraph, the 1st sentence was revised to read: The National Uniform Billing Committee (NUBC) UB-04 claim form must be used when submitting paper claims.
		Billing & Reimbursement for Professionals	2.2 Paper Claims	The 1st paragraph was revised to read: The CMS-1500 claim form (02/12) must be used when submitting paper claims. It must be a form printed with red ink with the numbers OMB-0938-1197 FORM 1500 (02-12) in the lower right corner. Instructions for completing the CMS 1500 claim form are available on the NUCC website or through your CMS-1500 vendor. (Refer to the Directory Appendix for website information.)
			2.3 Reporting Provider NPI	In the 1st paragraph, the last sentence was removed. ~~For the CMS 1500 (08/05) paper claim form, the TIN must be reported in Item 25.~~
			Section 3 - Claim Completion	The sample view of the Health Insurance Claim Form was removed. Section text was revised to read: Instructions for completing the CMS 1500 claim form are available on the NUCC website or through your CMS-1500 vendor. (Refer to the Directory Appendix for website information.)
		Directory Appendix	Billing Resources	Under "National Uniform Claim Committee", "Information Available/Purpose" was revised to read: To obtain CMS-1500 (02-12) claim forms ...

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			Claim Submission/Payment	Under "Paper Claim Submission", "Information Available/Purpose" was revised to read: CMS-1500 (02-12), CMS-1450 (UB-04), and ADA 2012 claims are to be mailed ...
MSA 14-06	2/27/2014	Billing & Reimbursement for Dental Providers	1.2 Predictive Modeling	The 2nd paragraph was revised to read: Requested records must be submitted either through Documentation EZ Link using the Predictive Modeling Claim Documentation form (MSA-0004-EZ) or through the Document Management Portal available in CHAMPS. Refer to: • the Forms Appendix for a copy of MSA-0004-EZ. • the MDCH website for information and tutorials on the Document Management Portal. • the Directory Appendix for Documentation EZ Link and Document Management Portal website information.
			3.1.B. Electronic Claims With Attachments	In the 1st paragraph, the last sentence was removed. ~~Providers will be notified of remaining documentation requirements and given up to 10 days to comply with the request.~~ The following text was inserted as the 2nd paragraph: As an alternative to Documentation EZ Link, the Document Management Portal in CHAMPS is available to upload documents. This tool allows providers and billers to submit supporting documentation electronically for Medicaid electronic claims. (Refer to the MDCH website for information and tutorials on the Document Management Portal. Refer to the Directory Appendix for website information.)
		Billing & Reimbursement for Institutional Providers	1.2 Predictive Modeling	The 2nd paragraph was revised to read: Requested records must be submitted either through Documentation EZ Link using the Predictive Modeling Claim Documentation form (MSA-0004-EZ) or through the Document Management Portal available in CHAMPS. Refer to: • the Forms Appendix for a copy of MSA-0004-EZ.

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				• the MDCH website for information and tutorials on the Document Management Portal. • the Directory Appendix for Documentation EZ Link and Document Management Portal website information.
			2.1.B. Electronic Claims With Attachments	In the 1st paragraph, the last sentence was removed. ~~Providers will be notified of remaining documentation requirements and given up to 10 days to comply with the request.~~ The following text was inserted as the 2nd paragraph: As an alternative to Documentation EZ Link, the Document Management Portal in CHAMPS is available to upload documents. This tool allows providers and billers to submit supporting documentation electronically for Medicaid electronic claims. (Refer to the MDCH website for information and tutorials on the Document Management Portal. Refer to the Directory Appendix for website information.)
			2.2.B. Providing Attachments with Paper Claim Forms	In the 3rd paragraph, the 1st sentence was revised to read: ... are the only types of documentation that may be associated to paper claims through the Documentation EZ Link web portal or the Document Management Portal in CHAMPS. The 4th paragraph was revised to read: Once confirmation is received that the consent forms are approved, it is not necessary to submit additional copies when billing for sterilization or hysterectomy services. The notation "Consent form sent via EZ Link/ Document Management Portal" must be included in the Remarks section of the paper claim. In the 5th paragraph, the 1st sentence was revised to read: Refer to the MDCH website for Documentation EZ Link and Document Management Portal instructions.
		Billing & Reimbursement for Professionals	1.2 Predictive Modeling	The 2nd paragraph was revised to read: Requested records must be submitted either through Documentation EZ Link using the Predictive Modeling Claim Documentation form (MSA-0004-EZ) or through the Document

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				Management Portal available in CHAMPS. Refer to: • the Forms Appendix for a copy of MSA-0004-EZ. • the MDCH website for information and tutorials on the Document Management Portal. • the Directory Appendix for Documentation EZ Link and Document Management Portal website information.
			2.1.B. Electronic Claims With Attachments	In the 1st paragraph, the last sentence was removed. ~~Providers will be notified of remaining documentation requirements and given up to 10 days to comply with the request.~~ The following text was inserted as the 2nd paragraph: As an alternative to Documentation EZ Link, the Document Management Portal in CHAMPS is available to upload documents. This tool allows providers and billers to submit supporting documentation electronically for Medicaid electronic claims. (Refer to the MDCH website for information and tutorials on the Document Management Portal. Refer to the Directory Appendix for website information.)
			2.2.B. Providing Attachments with Paper Claims	In the 3rd paragraph, the 1st sentence was revised to read: ... are the only types of documentation that may be associated to paper claims through the Documentation EZ Link web portal or the Document Management Portal in CHAMPS. The 4th paragraph was revised to read: Once confirmation is received that the consent forms are approved, it is not necessary to submit additional copies when billing for sterilization or hysterectomy services. The notation "Consent form sent via EZ Link/ Document Management Portal" must be included in the Remarks section of the paper claim. In the 5th paragraph, the 1st sentence was revised to read: Refer to the MDCH website for Documentation EZ Link and Document Management Portal instructions.

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		Directory Appendix	Claim Submission/Payment	Addition of: **CONTACT/TOPIC** Document Management Portal **MAILING/EMAIL/WEB ADDRESS** www.michigan.gov/medicaidproviders under "Hot Topics", select "Document Management Portal" **INFORMATION AVAILABLE/PURPOSE** Document Management Portal information and tutorials
MSA 14-05	2/27/2014	Practitioner	4.13.C. Injectables Administered Through PIHP/CMHSP for MHP Enrollees	Subsection text was revised to read: Specific injectable drugs administered by a physician or non-physician practitioner (e.g., physician assistant and nurse practitioner) through a PIHP/CMHSP clinic to Medicaid Health Plan (MHP) enrollees are reimbursable by MDCH on a fee-for-service basis when the following criteria are met: • The beneficiary has an open case with the PIHP/CMHSP; • The beneficiary receives the injections on a scheduled or routine basis as part of the PIHP/CMHSP treatment/supports regimen; and • The PIHP/CMHSP clinic notifies the beneficiary's MHP or primary care physician that this service is being rendered. A list of the specific drugs covered under this policy is maintained on the MDCH website. (Refer to the Directory Appendix for website information.) The list may be modified as new drugs are approved for Medicaid coverage. No notice of changes to the list will be issued directly to providers. Drugs on this list may be billed using the provider's NPI number(s) associated with the PIHP/CMHSP.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			4.13.D. Psychotropic Injectables Administered by Physicians Not Associated With a PIHP/CMHSP (new subsection)	New subsection text reads: Physicians not associated with a PIHP/CMHSP who are administering psychotropic injectable carve-out drugs in an outpatient setting to MHP enrollees must comply with the following criteria: • Physicians administering psychotropic injectable carve-out drugs must notify the beneficiary's MHP or primary care physician that this service is being rendered. • Injectable carve-out drugs covered by MDCH through FFS must be billed through CHAMPS using the physician's NPI. • FFS reimbursement by MDCH to physicians not associated with a PIHP/CMHSP is limited to psychotropic injectable carve-out drugs only. Physicians may not bill MDCH for additional services rendered during the visit, including any injectable administration cost. Physicians should bill the MHP for any additional services, if necessary, after obtaining MHP prior authorization as per the "Out-of-Network Services" policy located in the Medicaid Health Plan chapter.
MSA 14-04	2/27/2014	General Information for Providers	11.2.A. Beneficiaries Excluded From Copayment Requirements	In the 1st paragraph, the following bullet point was added: • Inpatient hospital stay initiated by an emergent admission
		Beneficiary Eligibility	9.9 Copayments	In the 1st paragraph, the 1st sentence was revised to read: Health plan beneficiaries may be charged a copayment for physician and outpatient hospital evaluation and management visits, non-emergency visits to the emergency department, the first day of an inpatient hospital stay (with the exception of emergent admissions), and pharmacy, podiatric, chiropractic, vision or hearing services as described in this manual.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Hospital	1.4 Copayments	In the 2nd paragraph, the 1st bullet point was revised to read: • $50 for the first day of an inpatient stay (applies to DRG or first day per diem payment; copay will not be applied to emergent admissions, transfers between acute care hospitals, from acute care to rehab, or to readmits within 15 days for the same DRG/diagnosis)
MSA 13-54	12/20/2013	School Based Services	2.1 Individuals with Disabilities Education Act Assessment and IEP/IFSP Development, Review and Revision	Under "Procedure Codes": • Addition of **52 Modifier (Reduced Services)** The 52 modifier is used to describe circumstances in which services provided were reduced in comparison to the full description of the service. • Removal of **92506** • Addition of **92521** - Evaluation of speech fluency (e.g., stuttering, cluttering) (Used by the speech pathologist for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), a REED (TL), or the IDEA evaluation (HT).) • Addition of **92522** - Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria) (Used by the speech pathologist for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), a REED (TL), or the IDEA evaluation (HT).) • Addition of **92523** - Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language) (Used by the speech pathologist for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), a REED (TL), the IDEA evaluation (HT), and/or reduced services (52).) • Addition of **92524** - Behavioral and qualitative analysis of voice and resonance

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				(Used by the speech pathologist for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), a REED (TL), or the IDEA evaluation (HT).) • Addition of **92550** - Tympanometry and reflex threshold measurements • Addition of **92551** - Screening test, pure tone, air only • Addition of **92552** - Pure tone audiometry (threshold); air only (Used by the audiologist for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), a REED (TL), or the IDEA evaluation (HT).) • Addition of **92553** - Pure tone audiometry (threshold); air and bone (Used by the audiologist for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), a REED (TL), or the IDEA evaluation (HT).) • Addition of **92555** - Speech audiometry threshold • Addition of **92556** - Speech audiometry threshold; with speech recognition • Addition of **92557** - Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined) (Used by the audiologist for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), a REED (TL), or the IDEA evaluation (HT).) • Addition of **92558** - Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis • Addition of **92567** - Tympanometry (impedance testing)

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				(Used by the audiologist for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), a REED (TL), or the IDEA evaluation (HT).) • Addition of **92568** - Acoustic reflex testing, threshold • Addition of **92582** - Conditioning play audiometry (Used by the audiologist for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), a REED (TL), or the IDEA evaluation (HT).) • Addition of **92594** - Electroacoustic evaluation for hearing aid; monaural • Addition of **92630** - Auditory rehabilitation; pre-lingual hearing loss • Addition of **92633** - Auditory rehabilitation; post-lingual hearing loss • Addition of **95595** - Electroacoustic evaluation for hearing aid; binaural
			2.4.A. Speech, Language and Hearing Therapy	Under "Procedure Codes": • Removal of **92506** • Addition of **92521** - Evaluation of speech fluency (e.g., stuttering, cluttering). This code can be used with no modifier or with the HT, TL, or TM modifiers. • Addition of **92522** - Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria. This code can be used with no modifier or with the HT, TL, or TM modifiers. • Addition of **92523** - Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language). This code can be used with no modifier or with the HT, TL, TM, and/or 52 modifiers. • Addition of **92524** - Behavioral and qualitative analysis of voice and resonance. This code can be used with no modifier or with the HT, TL, or TM modifiers. • Addition of **92550** - Tympanometry and reflex threshold measurements

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				• Addition of **92551** - Screening test, pure tone, air only • Addition of **92552** - Pure tone audiometry (threshold); air only. This code can be used with no modifier or with the HT, TL, or TM modifiers. • Addition of **92553** - Pure tone audiometry (threshold); air and bone. This code can be used with no modifier or with the HT, TL, or TM modifiers. • Addition of **92555** - Speech audiometry threshold • Addition of **92556** – Speech audiometry threshold; with speech recognition • Addition of **92557** - Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined). This code can be used with no modifier or with the HT, TL, or TM modifiers • Addition of **92558** - Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis • Addition of **92567** - Tympanometry (impedance testing). This code can be used with no modifier or with the HT, TL, or TM modifiers. • Addition of **92568** - Acoustic reflex testing, threshold • Addition of **92582** - Conditioning play audiometry. This code can be used with no modifier or with the HT, TL, or TM modifiers. • Addition of **92630** - Auditory rehabilitation; pre-lingual hearing loss • Addition of **92633** - Auditory rehabilitation; post-lingual hearing loss
			2.4.B. Assistive Technology Device Services	Under "Procedure Codes": • Addition of **92594** - Electroacoustic evaluation for hearing aid; monaural • Addition of **95595** - Electroacoustic evaluation for hearing aid; binaural

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MSA 13-36	8/29/2013	School Based Services	Section 1 - General Information	In the 9th paragraph, the following term was added: **TL Modifier (Re-evaluation of Existing Data (REED))** The TL modifier is used with the appropriate procedure codes to identify when a re-evaluation of existing data (REED) was used in the determination of the child's eligibility for special education services.
			2.1 Individuals with Disabilities Education Act Assessment and IEP/IFSP Development, Review and Revision	Under "Procedure Codes": • Addition of: The **TL modifier** is used with the appropriate procedure codes to identify when a re-evaluation of existing data (REED) was used in the determination of the child's eligibility for special education services. • Revision to **96101**: (Used by the psychologist when billing for the evaluation [HT] or REED [TL] when the psychological testing is performed as part of the assessment/evaluation process.) • Revision to **96116**: (Used by the psychologist when billing for the evaluation [HT] or REED [TL] when the neurobehavioral status exam is performed as part of the assessment/evaluation process.) • Revision to **96118**: (Used by the psychologist when billing for the evaluation [HT] or REED [TL] when the neuropsychological testing is performed as part of the assessment/evaluation process.) • Revision to **97001**: (Used by the physical therapist billing for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), a REED (TL), or the IDEA evaluation (HT).) • Revision to **97003**: (Used by the occupational therapist billing for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), a REED (TL), or the IDEA evaluation (HT).) • Revision to **99367**: (Used by the physician billing for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), a REED (TL), or the IDEA evaluation (HT).)

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				• Revision to **H0031**: (Used by the psychologist, counselor or licensed social worker billing for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), a REED (TL), or the IDEA evaluation (HT).) • Revision to **T1001**: (Used by the RN billing for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), a REED (TL), or the IDEA evaluation (HT).) • Revision to **T1024**: (This code can only be used with the TM modifier. Used by the Designated Case Manager billing for the IEP/IFSP multi-disciplinary assessment (TM) or an assessment not related to the revision of the IEP/IFSP (no modifier). The Designated Case Manager cannot bill using the HT or TL modifiers.) • Revision to **V2799**: (Used by the orientation and mobility specialist billing for either the IEP/IFSP multi-disciplinary assessment (TM), an assessment not related to the IEP/IFSP (no modifier), a REED (TL), or the IDEA evaluation (HT).)
			2.2.A. Occupational Therapy Services	Under "Procedure Codes": Revision to **97003** – Occupational therapy evaluation. This code can be used by itself, or with the HT, TL, or TM modifiers.
			2.3.A. Physical Therapy Services	Under "Procedure Codes": Revision to **97001** – Physical therapy evaluation. This code can be used by itself or with the HT, TL, or TM modifiers.
			2.5 Psychological, Counseling and Social Work Services	Under "Procedure Codes": Revision to **H0031** - Mental health assessment, by non-physician (e.g., psychologist, counselor, licensed social worker). This code can be used by itself or with the HT, TL, or TM modifiers.
			2.7 Nursing Services	Under "Procedure Codes": Revision to **T1001** - Nursing assessment/evaluation. To be billed by the RN only. This code can be used by itself or with the HT, TL, or TM modifiers.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			2.8 Physician and Psychiatrist Services	Under "Procedure Codes": Revision to **99367** - Medical team conference with interdisciplinary team of health professionals, patient and/or family not present, 30 minutes or more; participation by physician. This code can be used by itself, or with the HT, TL, or TM modifiers.
MSA 13-29	8/23/2013	School Based Services	1.6 Service Expectations	In the 1st paragraph, the 2nd sentence was revised to read: All therapy services must be skilled (i.e., require the skills, knowledge, and education of a licensed occupational therapist, licensed physical therapist, or fully licensed speech-language pathologist or licensed audiologist).
			2.1 Individuals with Disabilities Education Act Assessment and IEP/IFSP Development, Review and Revision	Under "Provider Qualifications", the 4th bullet point was revised to read: • A fully licensed speech-language pathologist (SLP)
			2.4.A Speech, Language and Hearing Therapy	Under "Definition", the 3rd sentence was revised to read: Speech, language and hearing therapy must require the skills, knowledge and education of a fully licensed speech-language pathologist or audiologist to provide the therapy. Under "Provider Qualifications": The 1st bullet point was revised to read: • A fully licensed speech-language pathologist (SLP) In the 4th bullet point, the 1st sentence was revised to read: • A limited licensed speech language pathologist, under the direction of a fully licensed SLP or audiologist.
			2.4.B. Assistive Technology Device Services	Under "Provider Qualifications", the 2nd bullet point was revised to read: • A fully licensed speech-language pathologist (SLP)

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			2.9 Personal Care Services	Under "Prescription", the 2nd sentence was revised to read: The State definition of "other licensed practitioner" consists of Registered Nurse (RN), licensed Occupational Therapist, licensed Physical Therapist (PT), Master of Social Work (MSW), or fully licensed Speech Language Pathologist (SLP).
		School Based Services Random Moment Time Study	3.3.A. AOP Only Staff Pool	The 7th bullet point was revised to read: • Limited Licensed Speech Language Pathologists (without their American Speech-Language-Hearing Association Certificate of Clinical Competence)
			3.3.B. AOP & FFS/ Direct Medical Services Staff Pool	The 1st bullet point was revised to read: • Fully Licensed Speech-Language Pathologists

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Michigan Department of Community Health

MAGI Related Eligibility Policy Manual
July 2014 Updates

CHAPTER	SECTION	CHANGE	COMMENT
Throughout the Manual		Changed MA to Medicaid.	Correction.
1 - General Information	1.1 Rights and Responsibilities	The fourth paragraph was revised to read: An application, whether faxed, mailed or received from the Internet, must be registered with the receipt date if it contains at least the following information: The following language in the tenth and eleventh paragraphs was removed: Individuals must also cooperate with local and central office staff during quality control (QC) reviews. Refusal to provide necessary eligibility information or to cooperate with a QC review results in ineligibility for: • The individual about whom information is refused, and • That individual's spouse if living in the home, and • That individual's unmarried children under 18 living in the home.	The DCH-1426 application does not have a filing form.

CHAPTER	SECTION	CHANGE	COMMENT
	1.2 MAGI Related Groups	The section was revised as follows: The MAGI related groups are: • Children (U19). The income limit for children birth to age 1 is 195% FPL. The income limit for a child age 1-19 is 160% FPL. • Pregnant Women (PW). The income limit for pregnant women of any age is 195% FPL. • Parents and caretaker relatives (PCR). The income limit for parents and caretakers is 54% FPL. • Healthy Michigan Plan (HMP). The income limit for adults age 19-64 is 133% FPL. • MIChild. The income limit for children birth to 19 is 212% FPL. • Former Foster Care Children (FCTM). There is no income test for individuals 18-26 who were in foster care at 18. • MOMS. The income limit for pregnant women of any age is 195% FPL. More information regarding income limits is available at www.medicaid.gov.	Added FPL % to existing groups for policy clarification and removed reference to Plan First!.
	1.3 Application	The third paragraph was revised as follows HealthCare.gov is the federal online portal to complete an application or request assistance with the federal application. The following text was added as new fourth and fifth paragraphs: The DCH-1426, Application for Health Coverage and Help Paying Costs, is the State of Michigan (SOM) version of the federal health care application. This application may be used to apply for private health insurance plans, a tax credit that can help pay premiums for health coverage, all categories of Medicaid, and MIChild. Individuals may apply online at www.michigan.gov/mibridges. If an individual indicates a disability during the application process, additional information may be needed. A DHS-1004, Supplemental Health Care Questionnaire, will be provided to collect this information. The supplemental form must be returned to the local DHS office so that a determination of Medicaid eligibility based on age or disability may be completed.	Clarification. The DCH-1426 application is now available and in use.

MAGI Related Eligibility Policy Manual
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CHAPTER	SECTION	CHANGE	COMMENT
2 - Residency	2.1 Michigan Resident	The section was revised as follows: An individual is considered to be a Michigan resident if the individual attests to living in Michigan. When an individual attests to being temporarily absent from the state and the address provided indicates where the individual intends to return, the individual is considered a Michigan resident.	Changed to match BEM 220.
	2.3 Out-of-State Student	This section was deleted.	Changed to match BEM 220.
5 - Household Composition	5.4 Household Composition Examples	The second and third bullets for the first example were revised as follows: • Kayla's group is 3, Kayla, Samantha and Joy. • Samantha's group is 3, Kayla, Samantha and Joy.	Clarification.
6 - Assets	6.1 No Asset Test Required	The following sentence was added to the end of the section: The asset limits for SSI-Related Medicaid categories did not change. See Department of Human Services (DHS) Bridges Eligibility Manual (BEM) 400.	Clarification.
7 - Income	7.1 FPL Monthly Poverty Guidelines	The table was deleted and replaced with the following: Every individual is evaluated for eligibility based on MAGI rules. The MAGI rules are aligned with the income rules that will be applied for determination of eligibility for premium tax credits and cost-sharing reductions through exchanges.	Clarification. Table information was added to section 1.2.
	7.2 Countable Income Sources	Added the following bullet: • Pensions	Clarification.

CHAPTER	SECTION	CHANGE	COMMENT
	7.3 Non-countable Income Sources	Added the following language to the fourth bullet: • Veteran's Benefits, such as: ➢ Aid and attendance ➢ Augmented compensation ➢ Educational benefits ➢ Housebound allowance ➢ Unusual medical expenses	Clarification.

CHAPTER	SECTION	CHANGE	COMMENT
	7.3 Non-countable Income Sources (continued)	Added the following to the end of the section: • 5% Disregard ➢ The 5% disregard is the amount equal to 5% of the Federal Poverty Level for the applicable family size. ➢ It is not a flat 5% disregard from the income. ➢ The 5% disregard shall be applied to the highest income threshold. ➢ The 5% disregard shall be applied only if required to make someone eligible for Medicaid. • Reasonable Compatibility ➢ Attested income will be found not reasonably compatible with income from trusted sources if the difference exceeds 10%. ➢ If the group's attested income is below the income threshold for the program being tested and trusted data source also validates income below the income threshold, the no reasonable compatibility test is performed. Applicant is eligible. ➢ If the group's attested income is above the income threshold for the program being tested but trusted data source finds income below the income threshold, then no reasonable compatibility test is performed. Applicant is not eligible based on attested income. ➢ If the group's attested income is above the income threshold for the program being tested and the trusted data source validates income above the income threshold, then no reasonable compatibility test is performed. Applicant is not eligible based on attested income. ➢ If the group's attested income is below the income threshold for the program being tested but the trusted data source indicates income above the income threshold, then reasonable compatibility test is performed:	Clarification

CHAPTER	SECTION	CHANGE	COMMENT
		❖ If income is reasonable compatible, then the applicant is eligible. ❖ If the income is not reasonable compatible, then the program pends and the individual is required to provide proof of attested income.	
9 - Spousal Support	9.2 Referral to County Prosecutor	The second paragraph was revised as follows: Make the referral within 14 days of opening a case or whenever a referral is required.	Correction.
11 - Renewals	11.5 Reinstatement	The section was revised as follows: If a renewal results in a closure, the individual must be provided a notice that indicates what information was used to reach the decision of ineligibility. An individual has 90 days to submit documentation that the information used was not accurate. Coverage must be reinstated in this instance.	Clarification.
13 - Hearings	13.3 Responsibility for Processing a Hearing Request	The first sentence of the first paragraph was deleted. The second paragraph was deleted.	Correction.
14 - Medicaid Benefits		Added the following to the sixth paragraph list of bullets: • Healthy Michigan Plan	Program now available.

CHAPTER	SECTION	CHANGE	COMMENT
	Beneficiary Monitoring Program	Replaced Beneficiary Monitoring Program with Benefits Monitoring Program.	Name change.
	Twelve Month Billing Exceptions	The third paragraph, second bullet was modified as follows: • MAHS decision The sixth paragraph was modified as follows: A DHS supervisor, district manager, or other office designee must be copied on the email. A copy of the hearing decision is no longer required; however, the hearing registration number must be indicated on the MSA-1038.	Correction.
15 - Institutional Status	15.3 Other Public Nonmedical Institutions	The fifth and sixth paragraphs were modified as follows: An individual between the ages of 21 and 65 who is a resident of an Institution for Mental Diseases (IMD) may be eligible for Medicaid. If the individual is an inpatient of an IMD when he turns age 21, he is eligible to continue as an inpatient until age 22. The last sentence of the ninth paragraph was deleted.	Changed to match the Medicaid Provider Manual language and BEM 265.