MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Medicaid Health Plans 04-04

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Subject: Revised Policy Manual Chapter

Effective: July 1, 2004

Programs Affected: Medicaid

This bulletin transmits the new Medicaid Health Plans chapter. The chapter, along with the Medicaid Health Plan contract and the electronic Medicaid Provider Manual, contains all current policies, procedures, and information for Medicaid Health Plans. All previously issued Medicaid Health Plans/HMO chapters and bulletins are now obsolete.

The new chapter will be incorporated into the July 1, 2004 version of the online Medicaid Provider Manual. The manual is available at www.michigan.gov/mdch click on Providers, Information for Medicaid Providers.

Manual Maintenance

Discard Chapters III, IV, V, VII, and VIII and insert the new Medicaid Health Plan Chapter. (If utilizing the July 1, 2004 version of the online Medicaid Provider Manual available on the MDCH website, all paper chapters may be discarded.)

Discard all Medicaid policy bulletins unless listed on the Supplemental Bulletin List posted on the MDCH website.

This bulletin may be discarded after manual maintenance.

Questions

If you have questions about the manual, or are having problems locating information, you may contact Provider Inquiry at 1-800-292-2550 or providersupport@michigan.gov. If you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary.

Approved

Paul Reinhart, Director
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MEDICAID HEALTH PLANS (MHPS)

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SECTION 1 – GENERAL INFORMATION

The Michigan Department of Community Health (MDCH) contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. The selection process is described in a Request for Proposal (RFP) released by the Office of Purchasing, Michigan Department of Management and Budget. The MHP contract, referred to in this chapter as the Contract, specifies the beneficiaries to be served, scope of the benefits, and contract provisions with which the MHP must comply. Nothing in this chapter should be construed as requiring MHPs to cover services that are not included in the Contract. A copy of the MHP contract is available on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.)

MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies. (Refer to the General Information for Providers and the Beneficiary Eligibility chapters of the Medicaid Provider Manual for additional information.) Although MHPs must provide the full range of covered services listed below, MHPs may also choose to provide services over and above those specified. MHPs are allowed to develop prior authorization requirements and utilization management and review criteria that differ from Medicaid requirements. The following subsections describe covered services, excluded services, and prohibited services as set forth in the Contract.

1.1 SERVICES COVERED BY MEDICAID HEALTH PLANS (MHPS)

The following services must be covered by MHPs:

- Ambulance and other emergency medical transportation
- Blood lead services for individuals under age 21
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Childbirth and parenting classes
- Chiropractic services for individuals under age 21
- Diagnostic lab, x-ray and other imaging services
- Durable medical equipment and medical supplies
- Emergency services
- End Stage Renal Disease (ESRD) services
- Family planning services
- Health education
- Hearing and speech services
- Hearing aids for individuals under age 21
- Home health services
- Hospice services (if requested by enrollee)
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative nursing care (in or out of a facility)
- Maternal and Infant Support Services (MSS/ISS)
- Medically necessary transportation for enrollees without other transportation options
- Medically necessary weight reduction services
- Mental health care (up to 20 outpatient visits per contract year)
- Out-of-state services authorized by the MHP
- Outreach for included services, especially pregnancy-related and well-child care

- Pharmacy services
- Podiatry services for individuals under age 21
- Practitioner services (such as those provided by physicians, optometrists, or oral surgeons enrolled as a Medicaid Provider Type 10)
- Prosthetics and orthotics
- Therapies (speech, language, physical, occupational)
- Transplant services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSDT for individuals under age 21

1.2 Services Excluded from MHP Coverage but Covered by Medicaid

The following Medicaid services are not covered by MHPs:

- Custodial care in a licensed nursing facility; restorative or rehabilitative nursing care in a licensed nursing care facility beyond 45 days
- Certain dental services. (Refer to the Dental chapter of the Medicaid Provider Manual for additional information.)
- Specific injectable drugs administered through a PIHP/CMHSP clinic to MHP enrollees are reimbursable by the MDCH on a fee-for-service basis. (Refer to the Injectable Drugs and Biologicals subsection of the Practitioner chapter of the Medicaid Provider Manual for additional information.)
- Home and Community Based Waiver program services
- Inpatient hospital psychiatric services (MHPs are not responsible for the physician cost related to providing psychiatric admission physical and histories. However, if physician services are required for other than psychiatric care during a psychiatric inpatient admission, the MHP would be responsible for covering the cost, provided the service has been prior authorized and is a covered benefit.)
- Mental health services outside the MHP's contractual responsibility
- Outpatient partial hospitalization psychiatric care
- Personal care or home help services
- Services provided to persons with developmental disabilities and billed through Provider Type 21
- Services provided by a school district and billed through the Intermediate School District
- Substance abuse services through accredited providers, including:
  - Screening and assessment;
  - Detoxification;
  - Intensive outpatient counseling and other outpatient services; and
  - Methadone treatment
- Transportation for services not covered by the MHP.

1.3 Services that MHPs are Prohibited from Covering

- Elective therapeutic abortions and related services. Abortions and related services are covered when medically necessary to save the life of the mother or if the pregnancy is a result of rape or incest;
- Experimental/Investigational drugs, procedures or equipment; and
- Elective cosmetic surgery.

SECTION 2 - SPECIAL COVERAGE PROVISIONS

This section provides general information regarding MHP coverage requirements for certain services. Additional information regarding the MHP requirements related to these services is contained in the MHP contract. A copy of the contract is available on the MDCH website. (Refer to the Directory Appendix for website information.)

2.1 COMMUNICABLE DISEASE SERVICES

MHPs must allow enrollees to receive treatment services for communicable diseases from local health departments without prior authorization. For purposes of this section, communicable diseases are HIV/AIDS, STDs, tuberculosis, and vaccine-preventable communicable diseases.

2.2 EMERGENCY SERVICES

MHPs are responsible for emergency services, including the medical screening exams, consistent with the Emergency Medical Treatment and Active Labor Act (EMTALA) (41 USCS 1395 dd (a)) and the Federal Balanced Budget Act of 1997. MHPs may not require prior authorization for emergency screening and stabilization services provided to enrollees.

MHPs are not responsible for paying for non-emergency treatment services beyond screening that are not authorized by the MHP. Coverage for emergency services includes emergency transportation, hospital emergency room services, and professional services.

2.3 FAMILY PLANNING SERVICES

MHP enrollees have full freedom of choice of family planning providers, both in-plan and out-of-plan. MHPs may not require prior authorization for family planning services, including the detection and treatment of STDs. MHPs may advise out-of-network family planning providers, including public providers, to communicate with primary care providers (PCPs) once any form of medical treatment is undertaken.

2.4 FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS)

MHP enrollees may access services provided through a Federally Qualified Health Center (FQHC).

FQHC providers must obtain prior authorization from the MHP. However, the MHP may not refuse to authorize medically necessary services if the MHP does not have a FQHC in the network in the county. The MHP may require FQHC providers to share information and data with the MHP and to provide appropriate referrals to providers in the MHP's network.

2.5 MATERNAL AND INFANT SUPPORT SERVICES (MSS/ISS)

MHPs cover Maternal and Infant Support Services (MSS/ISS) for enrollees who qualify for these services under Medicaid policy. MHPs must utilize the criteria specified in Medicaid policy to determine an enrollee's need for the services and provide the MSS/ISS services specified in Medicaid policy. Only certified providers may deliver MSS/ISS services to MHP enrollees. MHPs work cooperatively with the local Family Independence Agency (FIA) office to maintain a referral protocol for those enrollees who

need the assistance of the FIA Children's Protective Services. MSS/ISS providers must work with the MHP and FIA Children's Protective Services to ensure appropriate care for MHP enrollees.

2.6 Out-of-Network Services

2.6.A. Professional Services

With the exception of the following services, MHPs may require out-of-network providers to obtain plan authorization prior to providing services to plan enrollees:

- Emergency services (screening and stabilization);
- Family planning services;
- Immunizations;
- Communicable disease detection and treatment at local health departments;
- Child and Adolescent Health Centers and Programs (CAHCP) services; and
- Tuberculosis services.

MHPs reimburse out-of-network (non-contracted) providers at the Medicaid fee-for-service (FFS) rates in effect on the date of service.

2.6.B. Hospital Services

MHPs reimburse hospitals according to the terms of the contract between the MHP and the hospital. If a hospital does not have a contract with an MHP but has signed a hospital access agreement with the MDCH, the following conditions apply:

- The hospital agrees to provide emergent services and elective admission services, arranged by a physician who has admitting privileges at the hospital, to Medicaid beneficiaries enrolled in MHPs with which the hospital does not have a contract.
- MHPs agree to continue to use network-contracted providers when available and appropriate.
- The hospital will be entitled to payment by MHPs for all covered and authorized (if required) services provided in accordance with their obligations under the agreement.
- A rapid dispute resolution process will be available for hospitals and MHPs who are unable to achieve reconciliation solutions for outstanding accounts through usual means.
- MHPs reimburse out-of-network (non-contracted) hospital providers at the Medicaid fee-for-service (FFS) rates in effect on the date of service. The payment for inpatient stays includes the relevant DRG and capital costs.

Copies of the Hospital Access Agreement, Health Plan Obligations, and Rapid Dispute Resolution are available on the MDCH website. (Refer to the Directory Appendix of the Medicaid Provider Manual for website information.) Hospitals that have signed the Hospital Access Agreement and the MHPs are required to abide by the terms and conditions of the agreement.

2.7 Mental Health

MHPs are required to provide up to 20 visits per calendar year under the Mental Health Outpatient benefit, consistent with the policies and procedures established by Medicaid. Services may be provided through contracts with Prepaid Inpatient Health Plans (PIHP) and/or Community Mental Health Services Programs (CMHSP) or through contracts with other appropriate providers within the service area. For mental health needs that do not meet Medicaid's established criteria or are beyond the 20-visit limitation, MHPs must coordinate with the appropriate PIHP/CMHSP to ensure that medically necessary mental health services are provided. The Mental Health/Substance Abuse chapter of the Medicaid Provider Manual provides coverage policies for the PIHPs/CMHSPs.

2.8 Child and Adolescent Health Centers and Programs (CAHCP)

MHPs must allow enrollees to obtain services from a CAHCP without prior authorization from the MHP. In order to receive payment for covered services, CAHCPs must follow the MHP's billing policies and procedures.

If the CAHCP is in the MHP's provider network, the following conditions apply:

- Covered services must be administered or arranged by a designated primary care physician (PCP)
- The CAHCP must meet the MHP's written credentialing and re-credentialing policies and procedures.
- The CAHCP must meet the MHP's criteria for ensuring quality of care and ensuring that all providers are licensed by the State of Michigan and practice within their scope of practice as defined in Michigan's Public Health Code.

2.9 Substance Abuse, Inpatient and Outpatient

MHPs are not responsible for either inpatient or outpatient substance abuse services. Acute medical detoxification services for Medicaid beneficiaries are reimbursed directly by MDCH. (Refer to the Mental Health/Substance Abuse chapter of the Medicaid Provider Manual for information on substance abuse services provided through the PIHPs/CMHSPs.)

2.10 Tuberculosis Services

MHP enrollees may obtain testing for tuberculosis from Local Health Departments (LHDs) without MHP prior authorization. Treatment may also be provided by the LHD without prior MHP authorization and regardless of whether a contractual or coordinating relationship exists between the MHP and the LHD. In the absence of a contract or other coordinating agreement, MHPs will reimburse the LHD at Medicaid fee-for-service (FFS) rates in effect on the date of service.

SECTION 3 – CLAIMS, COPAYMENTS AND REIMBURSEMENT

MHP claim completion requirements must be consistent with MDCH claim completion requirements as detailed in the Billing and Reimbursement chapters of the Medicaid Provider Manual.

3.1 BLOOD LEAD TESTING

MHPs are encouraged to establish contractual or other coordinating relationships with local health departments (LHDs) that provide blood lead testing services. LHDs must conduct blood lead testing consistent with Medicaid policy. Similarly, MHPs must reimburse LHDs for blood lead testing as directed by Medicaid policy.

3.2 COPAYMENTS

MHPs may require that members pay copayments for certain services consistent with the requirements of the MHP Contract and Medicaid policy.

3.3 PAYMENT RESPONSIBILITY WHEN ENROLLMENT STATUS CHANGES

MHPs should refer providers to the Billing and Reimbursement chapters of the Medicaid Provider Manual for clarification of payment responsibility if a Medicaid or CSHCS beneficiary changes enrollment status during a course of treatment.

3.4 REIMBURSEMENT FOR NONCONTRACTED PROVIDERS

Reimbursement for providers who are contracted with the MHP is governed by the terms of the contract. MHPs are required to pay noncontracted providers at Medicaid FFS rates for all properly authorized, medically necessary services for which a clean claim is submitted. Noncontracted providers must comply with all applicable authorization requirements of the MHP and uniform billing requirements.