



Medicaid Provider Manual

MEDICAID PROVIDER MANUAL OVERVIEW

SECTION 1 – INTRODUCTION

The following documents comprise the Michigan Medicaid Provider Manual and address all health insurance programs administered by the Michigan Department of Health and Human Services (MDHHS). MDHHS also issues periodic bulletins as changes are implemented to the policies and/or processes described in the manual. Bulletins are incorporated into the online version of the manual on a quarterly basis. (Refer to the Directory Appendix for website information.)

1.1 ORGANIZATION

The following table identifies each chapter and appendix in the manual, indicates what providers are affected, and provides a brief overview of each.

Chapter Title	Affected Providers	Chapter Content
General Provider Chapters		
Medicaid Provider Manual Overview	All Providers	Brief discussion of the organization of the manual and effectively using the document.
General Information for Providers	All Providers	Policies and general information regarding provider enrollment and participation, prior authorization, record retention, billing the beneficiary, fraud and abuse, etc.
Beneficiary Eligibility	All Providers	Policies and information regarding how to verify beneficiary eligibility, information on various eligibility categories, enrollment in contracted health plans, beneficiary utilization control, etc.
Coordination of Benefit	All Providers	Policies and information regarding coordination of benefits, Medicaid's payment liability, etc.
Billing & Reimbursement for Dental Provider	Providers billing the ADA 2012 or 837 Dental claim formats.	Policies and instructions for billing dental services.
Billing & Reimbursement for Institutional Providers	Providers billing the UB-04 or 837 Institutional claim formats.	Policies and instructions for billing institutional services.



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Chapter Title	Affected Providers	Chapter Content
Billing & Reimbursement for Professionals	Providers billing the CMS-1500 or 837 Professional claim formats.	Policies and instructions for billing professional services.
Provider/Service Specific Chapters		
Ambulance	Ambulance	Coverage policy related to emergency and non-emergency transports by ground, water or air ambulance.
Ambulatory Surgical Centers	Ambulatory Surgical Centers	Information regarding billing, coverage, and reimbursement policies related to Ambulatory Surgical Centers.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	Mental Health and Substance Abuse providers, Fee for Service – Psychologists, Social Workers, Counselors and Marriage and Family Therapists	Coverage policies and reporting requirements for services provided through Prepaid Inpatient Health Plans. Includes Children's Home and Community Based Services Waiver, Substance Abuse, and Habilitation Supports Waiver information. Includes Fee for Service Non-Physician Behavioral Health.
Children's Special Health Care Services	All Providers	Information regarding program eligibility, benefit package, etc.
Chiropractor	Chiropractor	Coverage policy related to chiropractic services.
Dental	Dentists/Dental Clinics	Coverage policy related to dental services and information on the <i>Healthy Kids Dental</i> Program.
Early and Periodic Screening, Diagnosis and Treatment	All Providers	Coverage policy for Medicaid beneficiaries younger than 21 years of age.
Emergency Services Only Medicaid	All Providers	Information regarding program eligibility, benefit package, etc.
Family Planning Clinics	Title X Clinics	Coverage policy related to family planning services provided through Title X clinics.



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Chapter Title	Affected Providers	Chapter Content
Federally Qualified Health Centers	Clinics designated by the U.S. Department of Health & Human Services (HHS) as FQHCs	Coverage and reimbursement policies applicable to FQHCs.
Healthy Michigan Plan	All Providers	Information regarding program eligibility, benefit package, healthy behaviors, cost sharing, etc.
Hearing Aid Dealers	Hearing Aid Dealers	Coverage policy related to the dispensing of hearing aids and alternative listening devices, and related supplies.
Hearing Services	Hearing Centers, Therapy Providers	Coverage policy related to hearing evaluations and speech/language services.
Home and Community Based Services	Integrated Care Organizations (ICOs), Prepaid Inpatient Health Plans (PIHPs), and Waiver Agencies	Coverage policy related to the requirements for Home and Community-Based Services (HCBS)
Home Health	Home Health	Coverage policy related to services provided by home health agencies.
Hospice	Hospice, Medical Suppliers	Coverage policy related to hospice services.
Hospital	Inpatient & outpatient hospitals	Coverage policy for inpatient and outpatient hospital services. Also includes cost reporting requirements, Graduate Medical Education and disproportionate share payment methodologies, appeals, etc.
Independent Diagnostic Testing Facilities and Portable X-ray Suppliers	Independent Diagnostic Testing Facilities and Portable X-ray Suppliers	Information regarding enrollment, billing, coverage and reimbursement for Independent Diagnostic Testing Facilities and Portable X-ray Suppliers.
Laboratory	Independent Clinical Labs	Coverage policy for laboratory services.
Local Health Departments	Local Health Departments	Coverage policy, cost reporting requirements, interim payments, and appeals for local health departments.
Maternal Infant Health Program	Certified MIHP providers	Provider certification requirements, beneficiary eligibility criteria, and covered services.



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Chapter Title	Affected Providers	Chapter Content
Maternity Outpatient Medical Services	Providers of Maternity Related Services	Program eligibility requirements, benefit package, and billing instructions.
Medicaid Health Plans	Contracted HMOs	Health plan participation and coverage policies.
Medical Supplier	Medical Suppliers/Durable Medical Equipment, Orthotists/Prosthetists	Coverage policies and parameters for medical supplies, durable medical equipment, orthotics, and prosthetics.
MI Choice Waiver	All Providers	Information regarding program eligibility, benefit package, etc.
MI Health Link	Integrated Care Organizations and related providers	Describes the MI Health Link program which integrates Medicare and Medicaid benefits into one coordinated delivery system.
Non-Emergency Medical Transportation	Non-Emergency Transportation Providers and Authorizing Parties	Coverage policy related to scheduled non-emergency, non-ambulance, medical transportation.
Nursing Facility	Nursing Facilities, Medical Suppliers	Coverage policy; certification, survey and enforcement policy; cost reporting and reimbursement methodology.
Nursing Facility Level of Care Determination	Nursing Facilities, MI Choice Waiver Program, Program of All-Inclusive Care for the Elderly (PACE), and the MI Health Link HCBS Waiver Program	Policies, processes, and criteria for Nursing Facility Level of Care Determination, Informed Choice, and Appeals
Pharmacy	Pharmacies	Coverage policy related to pharmacy services.
Practitioner	MD, DO, Oral-Maxillofacial Surgeons, DPM, PA, NP, CRNA, AA, CNM, Physical Therapists, Medical Suppliers	Coverage policy related to practitioner services.
Private Duty Nursing	Independent & PDN Agency	Coverage policy related to private duty nursing services provided through an agency or by an independent nurse.



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Chapter Title	Affected Providers	Chapter Content
Program of All Inclusive Care for the Elderly (PACE)	Contracted PACE providers	Information regarding program eligibility, benefit package, etc.
Rural Health Clinics	Rural Health Clinics	Coverage policy related to Rural Health Clinics.
School Based Services	Enrolled Intermediate School Districts, Medical Suppliers	Coverage policy for medical services provided to students eligible under the IDEA of 1990.
School Based Services Administrative Outreach Program Claims Development	Enrolled Intermediate School Districts	Coverage, claiming, and billing policies related to the SBS Administrative Outreach Program.
School Based Services – Random Moment Time Study	Enrolled Intermediate School Districts, Detroit Public Schools Community District, and Michigan School for the Deaf	Random moment time study process for the School Based Services Direct Medical Services program.
Special Programs	All Providers	General information about MDHHS health insurance programs that are not addressed elsewhere in this manual.
Therapy Services	Therapy Providers, Medical Suppliers	Therapy provider participation requirements and coverage policy.
Tribal Health Centers	Tribal Health Centers	Coverage policy for Tribal Health Centers, defined under the Indian Self-Determination and Education Assistance Act (Public Law 93-638 as those owned and operated by American Indian/Alaska Native tribes and tribal organizations under contract or compact with the Indian Health Service (IHS).
Urgent Care Centers	All Providers	Information regarding billing, coverage, and reimbursement policies related to Urgent Care Centers.
Vision	Ophthalmologists, Optometrists, Vision suppliers	Coverage policy for vision services and hardware.
Appendices		
Acronyms	All Providers	



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Chapter Title	Affected Providers	Chapter Content
Directory	All Providers	
Glossary	All Providers	
Forms	All Providers	Provides samples of forms identified in the manual and instructions for form completion, when appropriate. Providers may also download forms directly from the MDHHS website.

1.2 PRINTING

MDHHS does not provide a printed copy of the Provider Manual but does provide the information via compact disc (CD) to enrolled providers upon request. (Refer to the Manual Updates Section of this chapter for additional information.)

Should the user elect to print portions of the manual for his use, please note the following:

- The version date is noted at the bottom of each page on the left hand side. When researching policy, it is imperative that the most current version be used.
- The page number at the bottom right hand side of each page represents the page number within that chapter, not within the whole document.
- The name of the chapter is on the bottom of each page.
- It is recommended that any printing be done in black and white, not color, as printing in color can be very expensive. The features on each page are adequately effective in black and white.



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SECTION 2 - NAVIGATION THROUGH THE MANUAL

2.1 BROWSE CAPABILITIES

Each chapter within the manual is linked with all other manual chapters and appendices. Users can easily navigate from chapter to chapter by clicking on the bookmark navigation keys located on a palette on the left side of the screen. (See the following illustrations.) To jump to a topic using its bookmark, click the bookmark icon or text in the palette that represents that topic. The bookmarks in the manual correspond to chapter titles, section titles, subsections and appendices.

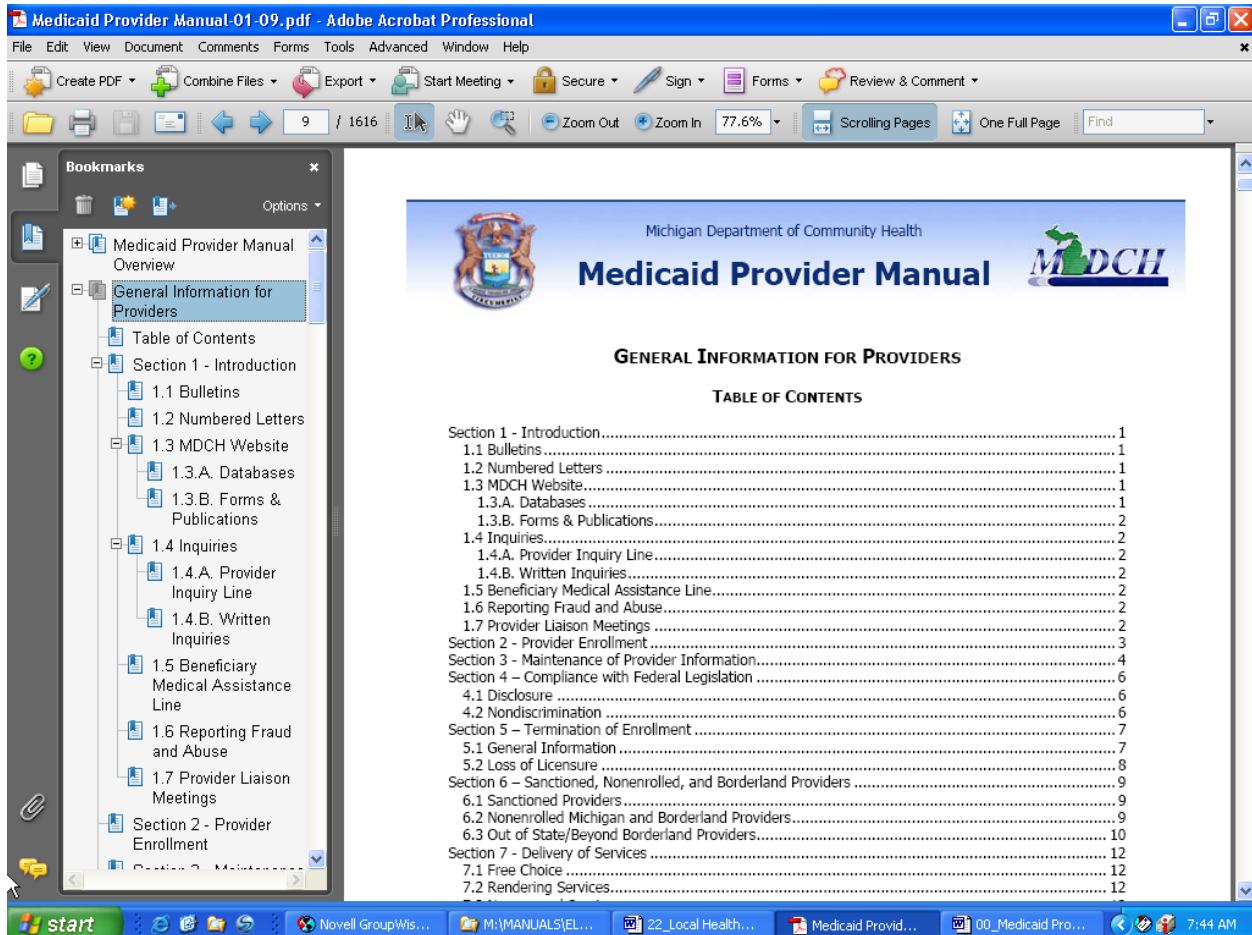
Bookmarks can be expanded or collapsed to easily link to the desired information. Primary headings, such as chapter titles, display as the first level of bookmarks. If a primary heading has secondary headings (i.e., section titles, subsections), they are displayed underneath the primary heading. Primary headings can be collapsed to hide the secondary headings. When a primary heading is collapsed, it has a plus (+) sign next to it. Click on the plus (+) sign to expand the bookmarks to display secondary headings. When all headings are displayed, a minus (-) sign appears next to the heading. (See the illustrations below.)

The screenshot shows the Adobe Acrobat Professional interface. The main window displays the 'Medicaid Provider Manual Overview' document. On the left, a 'Bookmarks' palette is open, listing various sections of the manual such as 'Medicaid Provider Manual Overview', 'General Information for Providers', 'Beneficiary Eligibility', and 'Coordination of Benefits'. The main document content includes the title 'Medicaid Provider Manual Overview' and 'SECTION 1 - INTRODUCTION'. Below the introduction, there is a subsection '1.1 ORGANIZATION' which includes a table identifying chapters and their affected providers.

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General Provider Chapters		
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Coordination of Benefits	All Providers	Policies and information regarding coordination of benefits, Medicaid's payment liability, etc.
Billing & Reimbursement for Dental Providers	Providers billing the ADA 2006 or 837 Dental claim	Policies and instructions for billing dental services.



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Users can also navigate from section to section within each chapter by clicking on the Section Titles within the Table of Contents.

2.2 SEARCH CAPABILITIES

Users can access the powerful online search capabilities of Adobe Acrobat to quickly locate information within the manual. There are two search methods:

- Click on Edit, Find on the tool bar and enter a keyword in the Find dialog box, or
- Click on the Binoculars on the toolbar and enter a keyword in the dialog box.

Always use the most specific term or acronym for the search, rather than a general term. (Refer to the Acronym Appendix for a list of all those used in the manual.) Start the search on the first page of the manual to assure that all relevant information is located.

In order to locate all of the information pertinent to a subject, search by the acronym if the word or term has one.



SECTION 3 – MANUAL UPDATES

3.1 QUARTERLY UPDATES

The Medicaid Provider Manual located on the MDHHS website is updated quarterly to reflect information that has been added, deleted or changed via policy bulletins and other communications during the previous quarter. The contact information contained in the Directory Appendix is also updated quarterly.

A policy bulletin, detailing the manual changes made each quarter, is sent to all Medicaid-enrolled providers and is communicated by e-mail to those subscribed to the Medicaid ListServ.

A compact disc (CD) version of the Medicaid Provider Manual is available upon request. (Refer to the Directory Appendix for contact information.)

3.2 HISTORIC MANUALS

The current version of the manual is maintained on the MDHHS website. Previous versions of the electronic manual are available back to January 2004. Refer to the Directory Appendix for information on ordering CD versions of the manual.



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SECTION 1 – INTRODUCTION

This chapter applies to all providers.

The Michigan Department of Health and Human Services (MDHHS) acts as the fiscal intermediary for several health insurance programs including, but not limited to, Medicaid, Healthy Michigan Plan, Children's Special Health Care Services (CSHCS), the Refugee Assistance Program (RAP), Maternity Outpatient Medical Services (MOMS), and the Repatriate Program. Although coverage, limitations, and administration may differ, billing procedures and reimbursement methods are essentially the same.

This chapter is used for all health insurance programs administered by MDHHS. Any reference to Medicaid in the manual and bulletins pertains to all programs administered by MDHHS unless specifically stated otherwise. Reference to the state mental health facilities includes only those facilities owned and operated by MDHHS. It does not include proprietary facilities for the mentally ill or developmentally disabled.

1.1 BULLETINS

This manual is the provider's primary source of policy information. Revisions to the manual regarding policy and procedural changes are communicated to the provider via Policy Bulletins. Providers affected by a bulletin should retain it until it is incorporated into the online version of the manual unless instructed otherwise. Bulletins are numbered for the provider's reference. The first two digits of the bulletin number refer to the year. The next two digits refer to the specific sequence number assigned to the bulletin (e.g., 03-04).

Bulletins are distributed to affected providers by U.S. mail or e-mail. Providers are expected to maintain current contact information in CHAMPS for timely notification. Bulletins are also posted on the MDHHS website. (Refer to the Directory Appendix for website and contact information.)

1.2 NUMBERED LETTERS

The purpose of a numbered letter is to educate, inform, and/or clarify issues related to MDHHS policies, procedures, and/or decisions that affect multiple providers.

1.3 FILE TRANSFER

The MDHHS–File Transfer application allows for the secure electronic transfer of files between MDHHS and Medicaid providers, Medicaid Health Plans, and other organizations. This application is a front-end interface for secure file transfer protocol (FTP) functionality, is Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant, and uses 128-bit encryption. File types for transfer include, but are not limited to, Medicaid cost report software, Medicaid filed cost reports, Medicaid filed reconciliation reports, and claim and encounter files containing protected health information.

All users requesting access to the MDHHS–File Transfer application must have their own unique MILogin user identification (ID) and password, and the user ID and password must not be shared. Each approved user must be authorized to view any sensitive data that may be transmitted.



MDHHS program areas that use the MDHHS–File Transfer application to securely communicate with providers are authorized to limit the number of users per organization. MDHHS may contact the requestor directly to collect additional information regarding the users that will be applying, the area type(s) they need access to (shared and/or provider specific), and when user access should be removed. MDHHS is not responsible for communications that are undeliverable or are otherwise not received due to a provider’s or authorized user’s failure to maintain or provide accurate information.

MDHHS-File Transfer is accessed through MILogin. Refer to the Directory Appendix for website information.

1.4 LISTSERV COMMUNICATIONS

The MDHHS Medical Services Administration (MSA) offers individuals the option of receiving automated announcements regarding the Michigan Medicaid Program (i.e., changes to policy, billing issues, training opportunities, etc.) through subscription to an e-mail listserv. Subscription instructions are posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

1.5 MDHHS WEBSITE

The MDHHS website provides electronic access to the Medicaid Provider Manual, policy bulletins, proposed policy issued for public comment, as well as a variety of other valuable provider information and resources. (Refer to the Directory Appendix for website information.)

1.5.A. ADDITIONAL CODE/COVERAGE RESOURCE MATERIALS

MDHHS maintains procedure/revenue code fee information in a series of website databases and professional fee schedules. These list procedure codes, descriptions, and fee screens. This information is updated as changes in coverage and/or fees are implemented. Databases and fee schedules are only available on the MDHHS website. (Refer to the Directory Appendix for website information.)

Additional pertinent coverage parameters, such as documentation and billing indicators, are accessible via the Medicaid Code and Rate Reference tool. Medicaid Code and Rate Reference is an online code inquiry system that provides real-time information for the following:

- Age restrictions;
- Documentation requirements;
- Prior authorizations, and medical conditions that may bypass these requirements;
- Service frequency limitations; and
- Rate information.

(Refer to the Directory Appendix for website information.)



1.5.B. FORMS & PUBLICATIONS

In an effort to reduce the administrative burden on providers, forms required by Medicaid are available for electronic download from the MDHHS website. Many publications regarding MDHHS programs and resources are also available.

1.5.C. DISCLAIMER

The Medicaid Provider Manual serves as the policy reference guide and will supersede any discrepancies regarding rates or coverage on the website, databases, fee schedules, or Medicaid Code and Rate Reference tool.

1.6 INQUIRIES

MDHHS has several methods of resolving inquiries. Questions regarding policies and procedures should be directed to Provider Inquiry. (Refer to the Directory Appendix for contact information.)

1.6.A. PROVIDER INQUIRY LINE

If billing assistance is required, the Provider Inquiry Line is available for immediate resolution of inquiries. (Refer to the Directory Appendix for contact information.)

1.6.B. WRITTEN INQUIRIES

Complex problems may require research and analysis. The problem should be clearly explained, in writing, with complete documentation (e.g., RA) attached and sent to Provider Inquiry.

1.7 BENEFICIARY MEDICAL ASSISTANCE LINE

If assistance to the beneficiary is required, the Beneficiary Helpline is available to assist them. (Refer to the Directory Appendix for contact information.) Beneficiaries enrolled in a Medicaid Health Plan (MHP) should be referred to their plan for assistance. Plan member services contact information is included on the beneficiary's plan membership card.

1.8 REPORTING FRAUD AND ABUSE

Any provider, beneficiary, or employee who suspects Medicaid fraud or abuse is encouraged to report that information to MDHHS. Information about fraud and abuse reporting requirements is located on the MDHHS website. (Refer to the Directory Appendix for website and contact information.)

1.9 PROVIDER LIAISON MEETINGS

MDHHS routinely schedules meetings to meet with provider specialty groups (e.g., physicians, hospitals, pharmacies, etc.) to discuss issues of interest/concern. The meetings are arranged through the various provider professional associations, though all affected providers and interested parties are welcome to attend. A calendar of most provider liaison meetings is posted on the MDHHS website, along with contact information. A calendar of Pharmacy Liaison meetings is posted on the MDHHS Pharmacy Benefits Manager website. (Refer to the Directory Appendix for website and contact information.)



1.10 CLAIMS PROCESSING SYSTEM

The Community Health Automated Medicaid Processing System (CHAMPS) is the web-based MDHHS Medicaid claims processing system. CHAMPS is comprised of the following subsystems: Provider Enrollment (PE), Eligibility and Enrollment (EE), Prior Authorization (PA), Claims and Encounters (CE), and Contracts Management (CM). This web-based system allows for the following functions to be completed online: provider enrollment, provider updates, claims status, direct claim entry, batch claim submission, claim adjustments/voids, payment status, prior authorization, eligibility verification, member search and ordering/referring provider verification. (Refer to the Directory Appendix for contact and website information.)



SECTION 2 - PROVIDER ENROLLMENT [CHANGE MADE 4/1/20]

Consistent with 42 CFR 431.51(c)(2), 42 CFR 455.452, and pursuant to Michigan's Social Welfare Act (Public Act 280 of 1939 [MCL 400.111e]), the Medicaid single state agency is required, and has the authority, to set reasonable standards and screening related to the qualifications of providers, and may define exclusions that the Medicaid Director determines necessary to protect the best interests of the program and its beneficiaries. An eligible provider who complies with all licensing laws and regulations applicable to the provider's practice or business in Michigan, who is not currently excluded from participating in Medicaid by state or federal sanction or exclusion, is a valid provider type in CHAMPS, and whose services are directly reimbursable per MDHHS policy may enroll as a Medicaid provider. Out-of-state providers must be licensed and/or certified by the appropriate standard-setting authority in the state they are practicing. (Refer to the Beyond-Borderland Area subsection of this chapter for more information.) In addition, some providers must also be certified as meeting Medicare or other standards as specified by MDHHS.

MDHHS is prohibited by federal law from issuing Medicaid payment to any financial institution or entity whose address is outside of the United States. Any individual or entity that provides services to, or orders, prescribes, refers or certifies eligibility for services for, individuals who are eligible for medical assistance under the Medicaid State Plan is required to be screened and enrolled in Medicaid.

The following disclosing individuals are also required to be screened as part of the provider's enrollment:

- An individual with a 5% or greater direct or indirect ownership interest in the provider. This requirement pertains to individuals as well as groups of individuals;
- An agent. An agent is any person who has been delegated the authority to obligate or act on behalf of a provider such as a fiduciary agent or contractor;
- An individual who is on the Board of Directors of a provider entity. A Board of Directors is a group of individuals who are selected or elected to establish corporate management-related policies and to make decisions on major company issues; or
- An individual who is a managing employee. A managing employee would be a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of the institution, organization, or agency, either under contract or through some other arrangement, whether or not the individual is a W-2 employee.

Providers must have their enrollment approved through the on-line MDHHS CHAMPS Provider Enrollment (PE) subsystem to be reimbursed for covered services rendered to eligible Medicaid beneficiaries. Enrollment in CHAMPS neither requires nor mandates those providers who are part of a managed care network to accept Medicaid Fee-for-Service beneficiaries. Refer to the Directory Appendix for contact information related to the online application process, including a CHAMPS Preparation Checklist of required information.

A provider's participation in Medicaid will be effective on the date the provider's on-line application is submitted, or a provider may request that enrollment be retroactive to a specific date when completing the on-line application. Retroactive enrollment is not considered prior to the effective date of licensure/certification. Enrollment may be retroactive one year from the date the request is received if the provider's licensure/certification is effective for that entire period. Retroactive enrollment eligibility is not a waiver for claims/services that do not meet established Medicaid billing criteria.



All providers are required to revalidate their Medicaid enrollment information a minimum of once every five years, or more often if requested by MDHHS. MDHHS will notify providers when revalidation is required. Providers must notify MDHHS within 35 days of any change to their enrollment information.

Providers must have their social security number (SSN), employer identification, or tax identification number (EIN/TIN) registered with the Michigan Department of Technology, Management & Budget Vendor Registration prior to enrolling with MDHHS.

Providers electing to appoint another person to enter their MDHHS enrollment information in the CHAMPS PE subsystem on their behalf must complete and retain a copy of the MDHHS Provider Electronic Signature Agreement Cover Sheet (MDHHS-5405) and the MDHHS Electronic Signature Agreement (DCH-1401). Both forms must be submitted to the Provider Enrollment Section per instructions provided on the cover sheet. (Refer to the Forms Appendix for a copy of the MDHHS-5405 and the DCH-1401.)

(paragraph deleted per bulletin MSA 19-37)

For information regarding substitute physician or a locum tenens arrangement, refer to the Practitioner Chapter of this manual.

A Medicaid Health Plan (MHP) is responsible for reimbursing a contracted provider or subcontractor for its services according to the conditions stated in the subcontract. The MHP must also reimburse noncontracted providers for properly authorized, medically necessary covered services.

2.1 PROVIDER OWNERSHIP AND CONTROL DISCLOSURES

Provider enrollment information, including home address, date of birth, and Social Security Number, is required from providers and other disclosed individuals (e.g., owners, managing employees, agents, etc.).

2.1.A. REQUIRED DISCLOSURE INFORMATION

Providers (including fiscal agents and managed care entities) are required to disclose the following information on ownership and control during enrollment, revalidation, and within 35 days after any change in ownership:

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include, as applicable, primary business address, every business location, and P.O. Box address.
- Date of birth and Social Security Number (in the case of an individual).
- Other Tax Identification Number, in the case of a corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a five percent or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.



- The name of any other fiscal agent or managed care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and Social Security Number of any managing employees.

2.1.B. CRIMINAL OFFENSE NOTIFICATION

Providers must notify the state licensing agency and MDHHS Provider Enrollment of any person(s) with an ownership or controlling interest in a facility that has been convicted of a criminal offense related to their involvement in any programs under Medicare, Medicaid, or Social Services Block Grants since the inception of these programs.

2.2 ENROLLMENT APPLICATION FEES

Enrollment application fees are required from all institutional providers, as defined by the Centers for Medicare & Medicaid Services (CMS). Individual physicians and non-physician practitioners are not considered institutional providers and, as such, are not subject to an application fee. Providers who are enrolled in or have paid the application fee to Medicare or another state's Medicaid or Children's Health Insurance Program (CHIP) are not required to pay an application fee to the Michigan Medicaid Program. The fee is required for each enrolled provider type at the time of initial enrollment and re-enrollment. The fee is not required for revalidation or interim updates to provider enrollment information. The application fee amount is established by CMS and updated annually.

2.3 ENROLLMENT SCREENING

MDHHS conducts Medicaid provider enrollment screening per federal and state rules and regulations.

2.3.A. PROVIDER CATEGORICAL RISK ENROLLMENT SCREENING

2.3.A.1. CATEGORIZATION OF PROVIDERS BASED ON LEVEL OF RISK

Provider types must be categorized based on the potential risk of fraud, waste, and abuse to the Medicaid Program. MDHHS has adopted the risk categorization established by the Centers for Medicare & Medicaid Services (CMS) for provider types. For all other provider types, MDHHS establishes the risk level. A provider's categorical risk level may be adjusted to "high" due to payment suspension, overpayment status, or Office of Inspector General (OIG)/Medicaid Program exclusion status and after listing of a temporary moratorium.

2.3.A.2. SCREENING ACTIVITIES BASED ON RISK CATEGORY AND PROVIDER TYPE

Additional provider screening activities are required and will be conducted based on the provider's categorical risk level. The following table summarizes the general screening activities by risk category and type of provider.



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Category	Type of Provider	Screening Activities
High	<ul style="list-style-type: none"> Prospective (newly enrolling) home health agencies Prospective (newly enrolling) DMEPOS suppliers 	<ul style="list-style-type: none"> Fingerprint based criminal background checks Unannounced pre- and post-enrollment site visits Verifications, including licensure, Social Security Number, Taxpayer Identification Number, National Provider Identifier (NPI), OIG exclusion status, and information regarding disclosed individuals
Moderate	<ul style="list-style-type: none"> Ambulance services Community Mental Health centers Comprehensive Outpatient Rehabilitation Facilities (CORFs) Hospice organizations Independent clinical laboratories Physical therapists enrolling as individuals or as group practices Revalidating home health agencies Revalidating DMEPOS suppliers 	<ul style="list-style-type: none"> Unannounced pre- and post-enrollment site visits Verifications, including licensure, Social Security Number, Taxpayer Identification Number, NPI, OIG exclusion status, and information regarding disclosed individuals Criminal background check
Limited	<ul style="list-style-type: none"> All other provider types 	<ul style="list-style-type: none"> Verifications, including licensure, Social Security Number, Taxpayer Identification Number, NPI, OIG exclusion status, and information regarding disclosed individuals Criminal background check

2.3.B. SITE INSPECTIONS

All enrolled providers must permit unannounced on-site inspections as a condition of participation. MDHHS will conduct pre-enrollment and post-enrollment site visits of providers designated as "moderate" and "high" categorical risk. (Refer to the Provider Categorical Risk Enrollment Screening subsection within this chapter for further information.)

2.3.C. CRIMINAL BACKGROUND CHECKS

All enrolled providers, or any person with a five percent or more direct or indirect ownership interest in the provider, must consent to criminal background checks, including fingerprinting, as a condition of participation. MDHHS will conduct criminal background checks and will require submission of fingerprints from providers designated as "high" categorical risk when directed by CMS.



2.3.D. VERIFICATION OF PROVIDER INFORMATION

MDHHS conducts verifications, including licensure, Social Security Number, Taxpayer Identification Number, NPI, information regarding disclosed individuals, OIG exclusion status, and other databases, as required.

2.3.E. HOME HELP – PERSONAL CHOICE AND ACKNOWLEDGEMENT OF PROVIDER SELECTION

A beneficiary receiving personal care services through the Medicaid Home Help program may select any family member or other individual who has been convicted of certain crimes by signing a personal acknowledgement form. The beneficiary must submit their request on the Personal Choice and Acknowledgement of Provider Selection form (MSA-119) that indicates receipt of notification of the criminal offense(s) which prompted the exclusion and must indicate their selection of that provider to deliver services. The selection shall not be considered effective and eligible for payment until the signed acknowledgement has been received, processed, and recorded by MDHHS.

Personal choice selections are subject to the following restrictions:

- The provider does not have a disqualifying conviction that is one of the four exclusions under 42 USC 1320a-7.
- The provider is 18 years or older.
- The provider is not legally responsible for the beneficiary.
- The provider must be capable of providing the required services and must be otherwise qualified to do so.
- The provider has complied with the criminal history screening conducted by MDHHS.
- The provider is not an agency or associated with an agency.

A personal choice selection may be applied for the limited purpose of providing Home Help services to the specific beneficiary identified in form MSA-119. A personal choice selection shall not be construed as approval, authorization or permission to provide services to other beneficiaries. Providers selected through the personal choice provisions of this section must be registered in CHAMPS and other systems (if applicable) for the purposes of monitoring, contacting, and generating payments; however, such individuals shall be prohibited from either being placed in the provider referral database or receiving referrals for additional beneficiaries through that process.

2.4 TEMPORARY MORATORIA

A temporary moratoria, numerical caps, or other limits may be placed on the enrollment of new providers or provider types identified as having a significant potential or increased risk for fraud, waste, or abuse as long as it would not adversely impact beneficiary access to medical assistance.



SECTION 3 - MAINTENANCE OF PROVIDER INFORMATION

Maintenance of provider information is done through the CHAMPS PE online system. (Refer to the Establishing Provider Access in CHAMPS section for additional information.) Providers must notify MDHHS via the on-line system within 35 days of any change to their enrollment information. (Refer to the Directory Appendix for CHAMPS PE access information.)

Examples of such changes include:

- A change in the provider's Federal Employer ID Number (or Tax ID Number).
- Moving to a new office
- Adding another office or location
- Leaving the current employer/partnership
- Changing the address(es) to which RAs and/or correspondence are sent
- Retiring from practice
- Closing a business
- Provider files Chapter 11, Reorganization
- Provider files Chapter 7, Bankruptcy
- Any action taken by a licensing authority or hospital that affects health care privileges
- Any criminal conviction
- Addition/change of a specialty
- Employer/partnership additions or changes
- Change/loss of licensure status
- New employees/providers
- New contractual obligations to a clinic, employer, contractor, or other entity
- Clinical Laboratory Improvement Amendments (CLIA) changes
- A change in ownership
- Name change
- E-mail address
- Addition/change of information related to the participating or collaborating physician and/or agreements

Providers must contact the Provider Enrollment Unit to change a Pay To address. (Refer to the Directory Appendix for contact information.)

The Provider Enrollment Unit disenrolls providers if postal mail is returned as nondeliverable.

Nursing Facility providers should refer to the Nursing Facility Chapter for additional instructions.



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Failure to notify MDHHS of any change in identification information may result in the loss of Medicaid enrollment, lapse of provider eligibility, or nonpayment of services.



SECTION 4 – ESTABLISHING PROVIDER ACCESS IN CHAMPS

4.1 PROVIDER DOMAINS

Providers must register for a MILogin account to access the CHAMPS system. (Refer to the Directory Appendix for website information.) All users within a provider's organization who need access to information within CHAMPS (Provider Enrollment, Claims, Prior Authorization, etc.) must obtain a MILogin user ID and password. The CHAMPS Provider Enrollment online system allows providers to easily update their information at any time or submit a new provider enrollment application with an approval process of approximately one to two weeks.

The MILogin user who submits the Provider Enrollment application becomes the Provider Domain Administrator for that application. The Provider Domain Administrator has the responsibility of assigning rights for all users within the organization to access the provider's file. Multiple Provider Domain Administrators may be established for a single organization, but a separate application must be completed and approved for each administrator.

4.2 PROVIDER PROFILES

In addition to establishing a provider domain and obtaining necessary user IDs and passwords, the provider must select the appropriate profiles to access applicable subsystems within CHAMPS. The following is a list of available profiles and their definitions.

Profile	Definition
Domain Administrator	The individual who assigns or removes domain and profile access for CHAMPS users
CHAMPS Full Access	Full FFS access to Provider Enrollment, Prior Authorization, Eligibility, and Claims Subsystems
CHAMPS Limited Access	View only access to Provider Enrollment and full FFS access to Prior Authorization, Eligibility, and Claims Subsystems
Prior Authorization Access	FFS access to Prior Authorization only
MCO Provider Access	View Only access to MCO Provider Enrollment
Eligibility Inquiry	Access to Eligibility only
Provider Enrollment Access	Full FFS access to Provider Enrollment only
Provider Enrollment View Access	View Only access to Provider Enrollment
Billing Agent Access	Access to Billing Agent Provider Enrollment only
Claims Access	Access to Claims and Encounters only

There are available profiles for Fee for Service (FFS), Managed Care Organization (MCO), and Pharmacy providers along with Billing Agents. Profiles must be established to grant access to each subsystem



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(Provider Enrollment, Claims, Prior Authorization) within CHAMPS. Users may have multiple profiles if necessary.

Profiles available for each type of provider accessing CHAMPS are as follows:

Provider/Profile	Domain Administrator	CHAMPS Full Access	CHAMPS Limited Access	Prior Authorization Access	MCO Provider Access	Eligibility Inquiry	Provider Enrollment Access	Provider Enrollment View Access	Billing Agent Access	Claims Access
FFS Provider	X	X	X	X		X	X	X		X
MCO Provider	X		X		X	X		X		X
Billing Agent	X						X	X	X	X
Pharmacy	X	X	X			X	X	X		X

Additional information regarding CHAMPS access is available on the MDHHS website. (Refer to the Directory Appendix for website information.)



SECTION 5 – NONDISCRIMINATION

In accordance with federal regulations, including Section 1557 of the Patient Protection and Affordable Care Act, an individual shall not be excluded from participation in, be denied the benefits of, or be subjected to discrimination on the grounds prohibited under Title VI of the Civil Rights Act of 1964, 42 USC 2000d et seq. (race, color, national origin), Title IX of the Education Amendments of 1972, 20 USC 1681 et seq. (sex, gender identification, sexual orientation), the Age Discrimination Act of 1975, 42 USC 6101 et seq. (age), or Section 504 of the Rehabilitation Act of 1973, 29 USC 794 (disability), under any health program or activity, any part of which is receiving federal financial assistance, or under any program or activity that is administered by an Executive Agency or any entity established under Title I of the Affordable Care Act or its amendments.

All Michigan Medicaid program participants and providers are to ensure compliance with all relevant Federal and State nondiscrimination provisions. Failure to comply may result in the provider's disenrollment from the Michigan Medicaid program.

To report noncompliance, contact the Michigan Department of Civil Rights or the U.S. Office for Civil Rights, Department of Health and Human Services. (Refer to the Directory Appendix for contact information.)



SECTION 6 – DENIAL OF ENROLLMENT, TERMINATION AND SUSPENSION

6.1 TERMINATION OR DENIAL OF ENROLLMENT

MDHHS may terminate or deny enrollment in the Michigan Medicaid program. Termination of enrollment means a provider's billing privileges have been revoked and all appeal rights have been exhausted or the timeline for appeal has expired. Denial of enrollment means the provider's application will not be approved for participation in the Medicaid program.

MDHHS must terminate or deny a provider's enrollment in Michigan's Medicaid program for the following reasons:

- Termination on or after January 1, 2011 under Medicare or the Medicaid program, or the Children's Health Insurance Program (CHIP) of any other state.
- Convicted of a relevant crime described under 42 USC 1320a-7(a):

- Conviction of program-related crimes

Any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under subchapter XVIII or under any State health care program.

- Conviction relating to patient abuse

Any individual or entity that has been convicted, under Federal or State law, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service.

- Felony conviction relating to health care fraud

Any individual or entity that has been convicted for an offense which occurred after August 21, 1996, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph [1]) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.

- Felony conviction relating to controlled substance

Any individual or entity that has been convicted for an offense which occurred after August 21, 1996, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Providers who have been excluded due to one of the federal mandatory exclusions listed above will remain on the MDHHS Sanctioned Provider List until the minimum period for their exclusion has been completed and the provider has requested a lifting of their sanction from the sanctioning body.



- Failure to comply with the enrollment requirements of the Social Welfare Act, Public Act 280 of 1939 (MCL 400.111b -111e) and the provider screening and enrollment requirements pursuant to 42 CFR 455.416. The basis for termination or denial of enrollment under this section includes, but is not limited to, the provider's:
 - failure to submit timely and accurate information;
 - failure to cooperate with MDHHS screening methods;
 - failure to submit sets of fingerprints as required within 30 days of a CMS or MDHHS request;
 - failure to permit access to provider locations for site visits;
 - falsification of information provided on the enrollment application or subsequent information requests;
 - inability to verify their identity; or
 - failure to comply with Medicaid policies regarding submission of claims and billing Medicaid beneficiaries.
- The provider is excluded from participating in a provider capacity in Medicare, Medicaid or any other Federal health care programs.
- The provider is convicted of violating the Medicaid False Claims Act, the Health Care False Claims Act, a substantially similar statute, or a similar statute by another state or the federal government.
- The provider has a federal or state felony conviction within the preceding 10 years of their provider enrollment application, including but not limited to, any criminal offense related to:
 - murder, rape, abuse or neglect, assault, or other similar crimes against persons;
 - extortion, embezzlement, income tax evasion, insurance fraud, and other similar financial crimes;
 - the use of firearms or dangerous weapons; or
 - any felony that placed the Medicaid program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
- The provider has a federal or state misdemeanor conviction within the preceding five years of their provider enrollment application, including but not limited to, any criminal offense related to:
 - any misdemeanor crime listed as a permissive exclusion in 42 USC 1320a-7(b);
 - rape, abuse or neglect, assault, or other similar crimes against persons;
 - extortion, embezzlement, income tax evasion, insurance fraud, or other similar financial crimes; or
 - any misdemeanor that placed the Medicaid program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.



For the purposes of the excluded offenses mentioned above, an individual or entity is considered to have been convicted of a criminal offense when:

- a judgment of conviction has been entered against the individual or entity by a federal, state, tribal or local court regardless of whether there is an appeal pending;
- there has been a finding of guilt against the individual or entity by a federal, state, tribal or local court; or
- a plea of guilty or nolo contendere by the individual or entity has been accepted by a federal, state, tribal, or local court.

The criminal history screening will be conducted by MDHHS through reputable and reliable data sources. Screenings for providers will be done as required by law and as deemed necessary by MDHHS for the protection of the Medicaid program and beneficiaries. For criminal offenses that fall under the mandatory exclusions of 42 USC 1320a-7(a), the definition of conviction will conform with 42 USC 1320a-7(i), which may include, but is not limited to, a record relating to criminal conduct that has been expunged.

Any entity that offers, in writing or verbally, discounts on co-pay amounts, fax machines, computers, gift cards, store discounts and other free items, or discounts/waives the cost of medication orders if an entity uses their services:

- may violate the Medicaid False Claim Act and Medicaid/MDHHS policy, which may result in disenrollment from Medicaid/MDHHS programs.
- may violate the Michigan Public Health Code's prohibition against unethical business practices by a licensed health professional, which may subject a licensee to investigation and possible disciplinary action.

Pursuant to MCL 400.111e, the Medicaid Director may terminate or deny enrollment if that action is necessary to protect the health of medically indigent individuals, the welfare of the public, and/or the funds appropriated for the Medicaid program. Additionally, the Medicaid Director may reduce or extend a provider's exclusion from the Medicaid program if, in the Medicaid Director's judgment, the continuation or reduction of the exclusion period is necessary to protect beneficiaries or the Medicaid program.

Providers who are already enrolled at the time of a finding by MDHHS will have their enrollment ended as of the date MDHHS was notified of the excluded offense. Claims with dates of service on and after the provider's enrollment termination date will be denied.

6.2 ENROLLMENT AND REINSTATEMENT AFTER TERMINATION OR DENIAL

Providers who are excluded from participation in the Medicaid program due to conviction of a crime listed in the previous subsection may request enrollment or reinstatement upon a showing that the provider's participation is in the best interest of the Medicaid program and of Medicaid beneficiaries. Factors that may be considered when determining whether enrollment or reinstatement in the Medicaid program is in the best interest of the Medicaid program and beneficiaries includes, but is not limited to:

- whether the exclusion poses an undue hardship to beneficiaries;
- whether the provider is the sole community physician or sole source of specialized services in the community;



- subsequent offenses of the provider;
- amount of time that has lapsed since the excluded offense;
- whether all conditions, terms of probation or parole, penalties, fines, etc. of the felony or misdemeanor offenses that resulted in exclusion have been fully completed;
- provider's participation in Medicare or other state Medicaid programs; or
- other factors that demonstrate the provider does not otherwise pose a risk to the Medicaid program or beneficiaries.

Requests for reinstatement must be sent in writing to the Medicaid Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.)

MDHHS will address requests for enrollment and reinstatement within 30 days after all requested information has been provided.

6.3 SUSPENSION

Summary suspension prevents further payment after a specified date, regardless of the date of service (DOS).

If an indication of fraud or Medicaid misuse/abuse is discovered during any of the following, MDHHS considers it as a basis for summary suspension:

- An evaluation of billing practices.
- The prior authorization (PA) process.
- An on-site review of financial and medical records and a written report of this review is filed.
- The construction of a profile to evaluate patterns of utilization of Medicaid beneficiaries served by the provider.
- A peer review of services or practices.
- A hearing or conference between MDHHS and the provider (and counsel, if so requested).
- Indictment or bindover on charges under the Medicaid or Health Care False Claims Act or similar state/federal statute.

6.4 LOSS OF LICENSURE/LIMITED LICENSES

For providers who must be licensed to practice their profession, continued enrollment in Medicaid is dependent upon maintaining licensure. Failure to renew a provider's license results in disenrollment from Medicaid effective the date of final lapse of the provider's license.

Limited or suspended licenses may result in disenrollment or denial of enrollment if MDHHS determines the basis of the action to be detrimental to the health or safety of medically indigent individuals, the welfare of the public, and/or the funds appropriated for the Medicaid program.

Suspension or revocation of a provider's license by the appropriate standard setting authority results in termination of Medicaid participation effective on the date the provider is no longer licensed. In the case



of a provider not located in Michigan, suspension or revocation would be administered by the appropriate state licensing board.

If a provider is no longer licensed to practice (e.g., the license was suspended, lapsed, or revoked), MDHHS does not reimburse for services ordered, prescribed, referred or rendered by that provider after the termination of the license. Medicaid payments obtained for services rendered during a period when the provider was unlicensed must be refunded to the State.

A provider may submit an on-line application to MDHHS to request re-enrollment as a Medicaid provider when his license is reinstated. Refer to the Provider Enrollment Section of this Chapter for information on the enrollment process.

6.5 PAYMENT SUSPENSION

MDHHS may temporarily suspend payments to a provider after determining there is a credible allegation of fraud for which an investigation is pending under the Medicaid program. An allegation of fraud may be from any source, including fraud hotline complaints, claims data mining and patterns identified through provider audits, civil false claims cases, and law enforcement investigations. Allegations are considered to be credible when they have indications of reliability and the State Medicaid Agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis. Providers will be notified within 90 days of initiation of payment suspension. The notification will include the general allegations as to the nature of the suspension action, the period of suspension, and the circumstances under which the suspension will be terminated. Providers may submit written evidence for consideration through the administrative appeal process. All payment suspensions will include referral to the MDHHS Office of Inspector General.

6.6 APPEALS

Providers may appeal the decision to terminate or deny enrollment. Denial of enrollment due to a temporary enrollment moratorium is appealable, but the scope of review is limited to whether the temporary moratorium applies to the provider appealing the denial. The basis for imposing a temporary moratorium is not subject to review. Refer to the Provider Appeal Process section of this chapter for additional information.



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SECTION 7 – SANCTIONED, BORDERLAND, AND OUT-OF-STATE/BEYOND BORDERLAND PROVIDERS

7.1 SANCTIONED PROVIDERS

Pursuant to Section 1128 and Section 1902(a)(39) of the Social Security Act, Medicaid does not reimburse providers for any services/items that were ordered, prescribed, referred or rendered by sanctioned (suspended, terminated, or excluded) providers. If a provider is presented with an order, prescription or referral from a sanctioned provider, that provider should inform the beneficiary that the service/item cannot be provided because the provider has been excluded from Medicaid participation. The beneficiary may elect to purchase the service/item after being notified of the provider's sanction and agrees, in writing, to pay for the service/item out of pocket.

Provider sanctions may be initiated by MDHHS, the U.S. Department of Health & Human Services (HHS) (i.e., Medicare), or other sanctioning body. Notice of a provider's sanction is provided in a cumulative list of sanctioned providers and is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

It is recommended providers check the MDHHS Sanctioned Provider List on the MDHHS website, as well as the websites of other sanctioning bodies, to avoid accepting orders, prescriptions or referrals for Medicaid beneficiaries from these sanctioned providers.

Although MDHHS makes every attempt to publish timely, accurate information about sanctioned providers, a sanctioned provider is excluded from Medicaid participation even if that provider has not been included on Medicaid's list of sanctioned providers. Any payments that may be unintentionally made to a sanctioned provider or a provider acting on an order, prescription or referral from a sanctioned provider must be refunded to Medicaid.

7.2 BORDERLAND PROVIDERS

Borderland is defined as a county that is contiguous to the Michigan border. It also includes the five major cities beyond the contiguous county lines. The borderland area includes:

Indiana	Fort Wayne (city); Elkhart, LaGrange, LaPorte, St. Joseph, and Steuben (counties)
Minnesota	Duluth (city)
Ohio	Fulton, Lucas, and Williams (counties)
Wisconsin	Ashland, Green Bay, and Rhinelander (cities); Florence, Iron, Marinette, Forest, and Vilas (counties)



Note for Hospice Providers: An out-of-state/borderland hospice provider cannot cross over the border into Michigan to provide services to a Medicaid beneficiary unless:

- The agency is licensed and Medicare-certified as a hospice in Michigan; or
- The state in which the provider is licensed and certified has a reciprocal licensing agreement with the State of Michigan.

If one of these conditions is met and the hospice provides services across state lines, its personnel must be qualified (e.g., licensed) to practice in Michigan.

Medicaid will not cover services for a beneficiary who enters a hospice-owned residence outside of Michigan. The Community Health Automated Medicaid Processing System (CHAMPS) will not recognize the core-based statistical area (CBSA) code of another state. Additionally, when a Michigan Medicaid beneficiary voluntarily enters a hospice-owned residence in another state to receive routine hospice care, they are no longer considered a Michigan resident and, therefore, are not eligible for hospice benefits under Michigan Medicaid.

Note for Home Health Providers: An out-of-state/borderland home health provider cannot cross over the border into Michigan to provide services to a Medicaid beneficiary unless they are Medicare certified as a home health agency in Michigan. If this condition is met, and the home health agency provides services across state lines, its personnel must be qualified (e.g., licensed) to practice in Michigan.

Note for Nursing Facilities: An out-of-state/borderland nursing facility is not allowed to enroll with Michigan Medicaid. Historically, the only borderland nursing facilities that were allowed to enroll with Michigan Medicaid were those facilities where Michigan beneficiaries were admitted to the facilities prior to October 1, 2007 or were admitted where placement was approved by Medicaid due to closure of a Michigan facility. The last of such placements and Medicaid facility enrollment ended August 1, 2016.

7.3 OUT OF STATE/BEYOND BORDERLAND PROVIDERS

Reimbursement for services rendered to beneficiaries is normally limited to Medicaid-enrolled providers. MDHHS reimburses out of state providers who are beyond the borderland area if the service meets one of the following criteria:

- Emergency services as defined by the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and the Balanced Budget Act of 1997 and its regulations; or
- Medicare and/or private insurance has paid a portion of the service and the provider is billing MDHHS for the coinsurance and/or deductible amounts; or
- The service is prior authorized by MDHHS. MDHHS will only prior authorize non-emergency services to out of state/beyond borderland providers if the service is not available within the state of Michigan and borderland areas.

Managed Care Plans follow their own Prior Authorization criteria for out of network/out of state services. Providers participating in Medicaid Health Plan and Dental Health Plan networks should refer to the Dental chapter (Healthy Kids Dental section) and the Medicaid Health Plans chapter of this manual for additional prior authorization information.

Providers must be licensed and/or certified by the appropriate standard-setting authority.



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All providers rendering services to Michigan Medicaid beneficiaries must complete the on-line application process described in the Provider Enrollment Section of this Chapter in order to receive reimbursement. Exceptions to this requirement may be made in special circumstances. These circumstances will be addressed through the Prior Authorization process.

Out of state/beyond borderland providers enrolled with the Michigan Medicaid program may submit their claims directly to CHAMPS. Providers should refer to the appropriate Billing and Reimbursement chapter of this manual for billing instructions.

MDHHS is prohibited by federal law from issuing Medicaid payment to any financial institution or entity whose address is outside of the United States.

Out of state/beyond borderland providers have a responsibility to follow Michigan Medicaid policies, including obtaining PA for those services that require PA.

All non-emergency services rendered by providers require the referring physician to obtain written PA from MDHHS as indicated in the Prior Authorization Section of this chapter.

When a Michigan provider has referred a Medicaid beneficiary to a provider beyond the borderland area, the referring provider should instruct the provider to refer to this manual or the MDHHS website for enrollment instructions. (Refer to the Directory Appendix for website information.)



SECTION 8 - DELIVERY OF SERVICES

8.1 FREE CHOICE

Beneficiaries are assured free choice in selecting an enrolled licensed/certified provider to render services unless they are patients in a state-owned and-operated psychiatric facility, enrolled in a Medicaid Health Plan (MHP), or otherwise specified.

8.2 RENDERING SERVICES

Enrollment in Medicaid does not legally require a provider to render services to every Medicaid beneficiary seeking care, except as noted below. Providers may accept Medicaid beneficiaries on a selective basis. However, a Medicare participating provider must accept assignment for Medicare and Medicaid dual eligibles.

Hospitals must provide emergency services as required by the Emergency Medical Treatment and Active Labor Act (EMTALA), 42USC 1395dd.

If a Medicaid-only beneficiary is told and understands that a provider is not accepting them as a Medicaid patient and asks to be private pay, the provider may charge the patient for services rendered. The beneficiary must be advised prior to services being rendered that their **mihealth** card is not accepted and that they are responsible for payment.

All such services rendered must be in compliance with the provider enrollment agreement; contracts (when appropriate); Medicaid policies; and applicable county, state, and federal laws and regulations governing the delivery of health care services. (Refer to the Billing Beneficiaries Section of this chapter for more information.)

8.3 NONCOVERED SERVICES

The items or services listed below are not covered by the Medicaid program:

- Acupuncture
- Autopsy
- Biofeedback
- All services or supplies that are not medically necessary
- Experimental/investigational drugs, biological agents, procedures, devices or equipment
- Routine screening or testing, except as specified for EPSDT Program or by Medicaid policy
- Elective cosmetic surgery or procedures
- Charges for missed appointments
- Infertility services or procedures for males or females, including reversal of sterilizations
- Charges for time involved in completing necessary forms, claims, or reports



When the beneficiary needs a medical service recognized under State Law, but not covered by Medicaid, the service provider and the beneficiary must make their own payment arrangements for that noncovered service. The beneficiary must be informed, prior to rendering of service, that Medicaid does not cover the service. A Medicaid beneficiary in a nursing facility can use his patient-pay funds to purchase noncovered services subject to MDHHS verification of medical necessity and the provider's usual and customary charge. (Refer to the Nursing Facility Chapter for additional information.)

8.4 NONDISCRIMINATION IN DELIVERY OF SERVICE

Providers must render covered services to a beneficiary in the same scope, quality, and manner as provided to the general public. Within the limits of Medicaid, providers must take the necessary steps to ensure compliance with all relevant nondiscrimination provisions. Failure to comply may result in the provider's disenrollment from the program. Refer to the Nondiscrimination section of this chapter for additional information.

8.5 SERVICE ACCEPTABILITY

MDHHS may determine that a provider did not order, prescribe, refer, or render services/items within the scope of currently accepted medical/dental practice or the service was not provided within Medicaid limitations. In such cases, MDHHS reviews the situation and may:

- Refuse to reimburse for the service.
- Require the provider to repeat or correct the service at no additional charge to Medicaid or the beneficiary (e.g., an inaccurate vision prescription was written).
- Recover any monies paid to the provider for the service.
- Require the service to be done immediately (e.g., provide services to complete an incomplete examination or treatment).

Failure to comply with any of the last three items may result in the provider's disenrollment from Medicaid.

8.6 ORDERING, PRESCRIBING AND REFERRING SERVICES/ITEMS

All providers ordering, prescribing and/or referring services/items to Michigan Medicaid beneficiaries must be enrolled in the Michigan Medicaid program. These regulations apply to Fee for Service Medicaid and Medicaid Health Plan providers. Claims for beneficiaries with Medicare or private insurance coverage will not be exempt from this requirement. (Refer to the specific Billing & Reimbursement chapters for additional information.)



SECTION 9 – INPATIENT HOSPITAL AUTHORIZATION REQUIREMENTS

The information in this section applies to in-state and borderland hospitals. Information regarding out-of-state hospital authorization requirements can be found in the Out-of-State/Beyond Borderland Providers subsection of this chapter.

All inpatient admissions must be medically necessary and appropriate, and all services must relate to a specific diagnosed condition. In the event that an inpatient stay is deemed medically inappropriate or unnecessary, either through a pre-payment predictive modeling review or a post-payment audit, providers are allowed to submit an outpatient claim for all outpatient services and any inpatient ancillary services performed during the inpatient stay. Elective admissions, readmissions, and transfers for surgical and medical inpatient hospital services must be authorized through the Admissions and Certification Review Contractor (ACRC). The physician/dentist should refer to the Prior Authorization Certification Evaluation Review (PACER) subsection of this chapter for specific requirements.

Medically inappropriate or unnecessary inpatient admissions may be resubmitted as outpatient claims for all outpatient services and any inpatient ancillary services performed during the inpatient stay. For claims with dates of discharge on or after October 1, 2014, when an inpatient claim is deemed medically inappropriate or unnecessary through a pre-payment predictive modeling review or a post-payment audit, hospitals are allowed to submit a hospital outpatient Type of Bill (TOB) 013X for all outpatient services and any inpatient ancillary services performed during the inpatient stay. Examples of services related to medically inappropriate or unnecessary inpatient admission include:

- all elective admissions, readmissions, and transfers that are not authorized through the PACER system;
- admissions or readmissions which have been inappropriately identified as emergent/urgent;
- selected ambulatory surgeries inappropriately performed on an inpatient basis; and
- any other inpatient admission determined to have not been medically necessary.

Medicaid does not cover inpatient hospital admissions for the sole purpose of:

- Cosmetic surgery (unless prior authorized)
- Custodial or protective care of abused children
- Diagnostic procedures that can be performed on an outpatient basis
- Laboratory work, electrocardiograms (ECGs), electroencephalograms (EEGs), and diagnostic x-rays
- Observation
- Occupational Therapy (OT)
- Patient education
- Physical Therapy (PT)
- Routine dental care
- Routine physical examinations not related to a specific illness, symptom, complaint, or injury
- Speech pathology



- Weight reduction or weight control (unless prior authorized)

If Medicaid does not cover the services of the physician/dentist or hospital, the physician/dentist or hospital must not bill the beneficiary, a member of the beneficiary's family, or other beneficiary representative.

9.1 PRIOR AUTHORIZATION CERTIFICATION EVALUATION REVIEW (PACER) [CHANGE MADE 4/1/20]

Elective admissions, all readmissions within 15 days of discharge, continued stays (when appropriate), and all transfers for surgical or medical inpatient hospital services to and from any in-state or borderland (text added 4/1/20) hospital enrolled in the Medicaid program require authorization through the ACRC. This includes transfers between an acute care hospital, an enrolled distinct part rehabilitation unit of the same hospital, or a Long Term Acute Care Hospital (LTACH). Authorization requirements for out-of-state/beyond borderland hospitals can be found in the Out-of-State/Beyond Borderland Providers subsection of this chapter. (text added 4/1/20) All cases are screened using the Medicaid approved Severity of Illness/Intensity of Services (SI/IS) criteria sets and the clinical judgment of the review coordinator. An ACRC physician/dentist makes all adverse decisions.

The ACRC performs medical/surgical and rehabilitation admission, readmission, and transfer reviews through the PACER system and assigns PACER numbers.

The attending/admitting physician/dentist or representative is responsible for obtaining the PACER number before admitting, readmitting, or transferring the beneficiary, with exceptions as noted below. (Refer to the Directory Appendix for PACER authorization contact information.)

The physician/dentist is responsible for providing the PACER number to the admitting hospital. The PACER number is issued on the day that the admission is approved by the ACRC. This number is valid for the entire medical or surgical admission unless otherwise noted in this section. PACER authorization must be requested prior to the admission of the beneficiary.

Physicians/dentists are asked to provide the procedure code(s) when a surgical admission/readmission is requested.

Authorization through the ACRC for the hospital admission does not remove the need for prior authorization (PA) required by Medicaid for specific services. The PA for the service must be obtained before the ACRC authorization is requested.

NOTE: Do not report the PACER number on the professional claim.

Approval of an admission only confirms the need for services to be provided on an inpatient hospital basis. Payment for the admission is subject to eligibility requirements, readmission, and third party liability (TPL) reimbursement policy, along with any pre- and post-payment determinations of medical necessity.

If an admission, readmission, transfer, or continued stay is not approved, MDHHS does not reimburse for services rendered.



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<p>Reconsiderations</p>	<p>The attending physician/dentist or the hospital may request reconsideration of the adverse determination of the ACRC regarding the need for admission, readmission, transfer, or continued stay. This reconsideration right applies regardless of the current hospitalization status of the beneficiary. Reconsiderations must be requested within three business days of the adverse determination. (Refer to the Directory Appendix for ACRC contact information.) If requested by the ACRC, the provider must provide written documentation. The provider is notified of the reconsideration decision within one business day of receipt of the request or the date of receipt of written documentation. If the initial adverse determination is overturned, the adverse determination is considered null and void. If the initial adverse determination is upheld or is modified in such a manner that some portion of the hospital care is not authorized, the hospital is liable for the cost of care provided from the date of the initial determination, unless this determination is overturned in the Medicaid appeals process.</p>
<p>Technical Denials</p>	<p>If the provider fails to request a PACER number on a timely basis, the provider should make this request as soon as the omission is noted. When the provider contacts the ACRC by telephone with an untimely request, the review coordinator sends the provider a form to complete, explaining the circumstances of the untimely request. If upon review of this written documentation the untimeliness is waived, the case is reviewed for medical necessity and the appropriateness of the admission, readmission, or transfer. If approved, the ACRC gives the provider a PACER number. If the untimeliness issue is not approved, the attending physician/dentist and the hospital are notified in writing within 24 hours of the decision. The physician/dentist or hospital may request further review of the ACRC decision by Medicaid relative to timeliness.</p>
<p>Continued Stay Denials</p>	<p>If the ACRC does not authorize the admission or the continued stay for an admission and the beneficiary remains in the hospital for one or more days after Medicaid payment is not authorized, the hospital is at risk of Medicaid nonpayment for those days. The provider may request post-discharge review by the ACRC, regardless of whether reconsideration was requested on the case, in writing within 30 calendar days of the discharge from the hospital. A copy of the medical record must accompany the post-discharge review request.</p> <p>Post-discharge review is conducted for only those days that were not authorized during the telephone review. The ACRC informs the provider, in writing, of the ACRC decision within 14 calendar days of the receipt of the request and documentation. If some or all of the previously nonauthorized days are approved, a new PACER number is issued and included in the notification of the decision. If the initial adverse determination is upheld, the notification includes the previously issued PACER number. If the provider is dissatisfied with the decision of the ACRC, the decision may be appealed.</p> <p>The hospital may bill Medicaid only for the days authorized by the ACRC. If the ACRC has made an adverse determination and issued a final PACER number, the hospital may submit a claim with this PACER number for only the authorized days while the case is in the reconsideration, post-discharge review, or formal appeals process. Submission of such a claim does not imply acceptance of the ACRC determination.</p>



9.1.A. ADMISSIONS/READMISSIONS/TRANSFERS THAT REQUIRE A PACER NUMBER

The following require a PACER number:

- All elective admissions.
- All readmissions within 15 days of discharge (including newborns). [NOTE: If a beneficiary is readmitted to the same hospital within 15 days for a related (required as a consequence of the original admission) condition, Medicaid considers the admission and the related readmission as one episode for payment purposes. The related admissions must be combined on a single claim. No PACER number is issued for continuation of care.]
- All transfers for medical/surgical services to and from any hospital enrolled in the Medicaid program (including newborns).
- Transfers between a medical/surgical unit and an enrolled distinct part rehabilitation unit of the same hospital.
- Transfer to an LTACH or admission from an LTACH to an acute care hospital.
- Authorization of continued stays in freestanding and distinct part rehabilitation units.

NOTE: If a newborn does not yet have a Medicaid ID number and a transfer or readmission occurs within 15 days, providers must request a retroactive PACER number when a newborn Medicaid ID number is issued.

9.1.B. ADMISSIONS/READMISSIONS/TRANSFERS THAT DO NOT REQUIRE A PACER NUMBER

The following do **not** require a PACER number:

- Emergent/urgent inpatient hospital admissions. (All transfers and 15-day readmissions to the same or a different hospital do require PACER through the ACRC.)
- All admissions and transfers to distinct-part psychiatric units or freestanding psychiatric hospitals and all continued stays in a psychiatric unit/hospital. (Authorization must be obtained through the local Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP).)
- Obstetrical patients admitted for any delivery.
- Newborns admitted following delivery.
- Admissions of beneficiaries who are eligible for CSHCS only.
- Medicaid beneficiaries enrolled in a Medicaid Health Plan (MHP). (Authorization must be obtained through the MHP.)
- When a beneficiary is admitted to a hospital that is not enrolled with the Michigan Medicaid Program.



- When a beneficiary becomes Medicaid eligible after the admission, readmission, transfer, or certification review period. (When Medicaid eligibility is determined retroactively, "Retroactive Eligibility" must be entered in the Remarks section of the inpatient hospital claim.)
- Medicare Part A beneficiaries.
- Commercial insurance coverage for admissions, readmissions, transfers, or continued stays.

9.2 PACER READMISSIONS

To be separately reimbursable, all readmissions (whether to the same or a different hospital) for hospital services must be prior authorized through the ACRC. The request for a PACER number for an elective readmission, whether to the same or a different hospital, must be made prior to readmission. The request for a PACER number for an emergent/urgent readmission to the same hospital must be made by the next business day following the readmission. The request for a PACER number for an emergent/urgent readmission to a different hospital must be made prior to the beneficiary's discharge from a transferring hospital. Medicaid defines readmission, for purposes of review, as any admission/hospitalization of a beneficiary within 15 days of a previous discharge, whether the readmission is to the same or a different hospital.

If the hospital intends to combine an admission and a readmission into a single episode for DRG payment purposes, the ACRC should not be contacted for a separate PACER number for the readmission.

Before contacting the ACRC, the provider should assemble as much information as possible regarding the medical condition of the beneficiary upon the first discharge and at the time of the readmission. When contacted for a PACER number, the ACRC either:

- Agrees that the original admission and the readmission are unrelated, as well as medically necessary, and issues a PACER number so that the stays may be billed and paid separately by the same hospital;
- Authorizes a readmission to a different hospital as medically necessary and issues a PACER number;
- Asks the caller to obtain additional information and call back no later than the next business day; or
- Questions the relatedness of two stays at the same hospital or the medical necessity for the readmission and refers the call to a physician/dentist advisor who may issue or deny a PACER number.

If a PACER number is not provided for a readmission due to relatedness (required as a consequence of the original admission), the hospital must combine the two stays into a single episode for DRG payment purposes (using the Leave of Absence revenue code 0180 for the time between discharge and readmission), or request reconsideration of the ACRC physician/dentist advisor's decision within three business days. If the initial admission has already been billed, the hospital must submit a claim replacement to combine the two stays.

If it is determined a readmission is medically unnecessary, the hospital may only bill for the first admission.



9.3 PACER TRANSFERS

If a beneficiary needs to be transferred, authorization for the transfer must be obtained through the ACRC. Authorization for a transfer is granted only if the transfer is medically necessary and the care or treatment is not available at the transferring hospital. Transfers for convenience are not considered. Transfers include the following situations:

- Transfer from one inpatient hospital to another.
- Transfer from one unit of an inpatient hospital to another unit of the same hospital (i.e., distinct-part rehabilitation unit).

Transfer to a distinct-part psychiatric unit of a general hospital or a freestanding psychiatric hospital is subject to review and approval by the beneficiary's PIHP/CMHSP. Do not contact the ACRC for a PACER number. (Authorization must be obtained through the local PIHP/CMHSP).

The following describes the appropriate requestor and timeframes for transfer authorization:

- Elective transfers – the transferring physician/dentist or designee must obtain authorization prior to transfer.
- Emergent/urgent transfers – the authorization must be obtained by the transferring physician/dentist no later than the next business day, or by the receiving physician/dentist or hospital before discharge.

If the transfer is approved, a PACER number is issued. The receiving hospital must use this PACER number when billing. The transferring hospital continues to use the original PACER number if a PACER number was required for the admission.

9.4 CONTRACTOR MONITORING

MDHHS monitors ACRC review and case determinations to verify that the ACRC is:

- appropriately applying review criteria in compliance with Medicaid policy.
- making proper determination of medical necessity and appropriateness of setting.
- performing all duties in a manner acceptable to MDHHS.

9.5 CONFIDENTIALITY

As an agent of the State, the ACRC may access all records related to care provided to Medicaid beneficiaries and is subject to the same state and federal confidentiality requirements as Medicaid staff. The failure of a hospital to make all records available to the contractor results in denial of that case and subjects that hospital to Medicaid participation sanctions. Additionally, the contractor makes allowable disclosures of statistical information after MDHHS review and approval.



9.6 ADMISSIONS AND CONTINUED STAYS FOR DISTINCT PART REHABILITATION UNITS AND FREESTANDING REHABILITATION HOSPITALS

Admissions and continued stays require authorization through the ACRC.

Continued stays beyond 30 days require additional inpatient authorization.

- The hospital must call the ACRC between the 27th and 30th day of the stay if the stay is expected to exceed 30 days. If the continued stay is certified, a PACER number is issued. The PACER number must appear on the hospital's claim if the stay is greater than 30 days but less than 60 days.
- The hospital must call the ACRC between the 57th and 60th day of the stay if the stay is expected to exceed 60 days. If the continued stay is approved, the hospital is given another PACER number. This PACER number must appear on the hospital's claim if the stay is greater than 60 days.

9.7 ADMISSION/TRANSFER FOR LONG-TERM ACUTE CARE HOSPITAL (LTACH)

A transfer or admission from an acute care hospital or inpatient rehabilitation unit to an LTACH requires a PACER number.

- The acute care hospital or inpatient rehabilitation unit is responsible for obtaining the PACER number before the discharge to an LTACH.
- If the LTACH admission meets InterQual LTACH criteria, a PACER number will be issued for no more than 30 days.
- Subsequent prior authorization and continued stay approvals must be obtained by the LTACH.
- A transfer from the LTACH to an acute care hospital will require an inpatient PACER number.

9.8 TERMINATION OF BENEFITS

The hospital's Utilization Review Committee may issue a notice of noncoverage to the beneficiary if it determines that the admission or continued stay in the hospital is not medically necessary. The notice should be substantially similar to the sample letters contained in the Forms Appendix of this manual.

If the beneficiary or beneficiary's representative disagrees with the notice, the beneficiary or representative may contact the ACRC to appeal the decision. If the ACRC previously issued an adverse determination for the period of hospitalization covered by the notice, the ACRC informs the beneficiary of concurrence with the hospital decision. If the ACRC did not previously issue an adverse determination for the period, a review of the medical record is conducted. The ACRC contacts the hospital to obtain a copy of the medical record. An ACRC physician advisor reviews the medical necessity of the admission or continued stay. The ACRC reviews and issues a decision on the case within three business days of receipt of the hospital's Utilization Review Committee notice of noncoverage and the beneficiary's supporting medical records.

If issued, the notice is the responsibility of the hospital's Utilization Review Committee and is not related to any decision that may have been rendered by the ACRC on the case. The decision must be based on the findings of the Utilization Review Committee and not on the determination of the ACRC.



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As with any benefit denial, the beneficiary or beneficiary's representative may request an administrative hearing. The Michigan Office of Administrative Hearings and Rules (MOAHR) provides an administrative hearing to appellants requesting a hearing who do not agree with a decision made by MDHHS or a MDHHS contracted agency (i.e., any agency, organization, or health plan contracted by MDHHS) that either determines eligibility for a MDHHS program, or delivers a service provided under a MDHHS program to a beneficiary, patient or resident. MOAHR issues timely, clear, concise and legally accurate hearing decisions and orders. The MOAHR Policy and Procedures Manual explains the process by which each different type of case is brought to completion. The MOAHR manual is available on the MDHHS website. (Refer to the Directory Appendix for website information.)



SECTION 10 - PRIOR AUTHORIZATION

10.1 GENERAL INFORMATION

There may be occasions when a beneficiary requires services beyond those ordinarily covered by Medicaid or needs a service that requires prior authorization (PA). In order for Medicaid to reimburse the provider in this situation, MDHHS requires that the provider obtain authorization for these services before the service is rendered. Providers should refer to their provider-specific chapter for PA requirements. (Refer to the Directory Appendix for contact information for PA.)

Requests for PA (except pharmacy) may be submitted in writing, via Direct Data Entry (DDE) through CHAMPS, or electronically (utilizing the ASC X12N 278 5010 Health Care Services Review/Request transaction) if the provider is an MDHHS-approved EDI submitter. Providers wishing to submit a 278 transaction should refer to the Electronic Submission Manual and the MDHHS Companion Guide for the HIPAA 278 Health Care Services Review/Request transaction for further information. Both documents are available on the MDHHS website. (Refer to the Directory Appendix for website information.) Refer to the Pharmacy Chapter for information related to pharmacy PA.

PA requirements for MHP enrollees may differ from those described in this manual. Providers should contact the individual plans regarding their authorization requirements.

PA may not be required if the beneficiary has Medicare or other insurance coverage. (Refer to the Coordination of Benefits Chapter for additional information.)

10.1.A. FFS DIRECT DATA ENTRY (DDE) IN CHAMPS

The CHAMPS PA system allows FFS providers to submit single PA requests through the online web portal. CHAMPS validates both beneficiary and provider information. An error message is returned to the user if the information is incorrect. Any provider may request PA, however, the provider NPI entered in the servicing provider field must represent the provider who will be rendering the service.

Once the PA request is successfully entered, the provider receives a tracking number. If the request is approved by MDHHS, this tracking number becomes the prior authorization number to use for billing purposes. The tracking number is not valid for claims unless a PA request is approved. Modifications to existing prior authorizations on file can be requested via fax to the Program Review Division. Private Duty Nursing providers with an authorization on file for a beneficiary in the Children's Waiver Program or Habilitation Supports Waiver should contact the Community Mental Health Services Program (CMHSP) for assistance. (Refer to the Directory Appendix for contact information.)

Supporting documentation may be linked to a DDE PA request either through facsimile or electronically. For electronically-submitted documentation, the DDE screen will open Internet Explorer on the user's computer and allow the retrieval of the appropriate record to link to the PA request. The system limits each PA request to 10 document attachments; each attachment is limited to a maximum size of 100MB. For documents submitted via facsimile, CHAMPS generates a cover sheet pre-populated with the beneficiary's ID number and the tracking number of the request. The fax cover sheet



contains the applicable fax number and must precede the documents being uploaded into CHAMPS. There is no system limit for the maximum number of pages for faxed documents.

PA Inquiry allows providers to check on the status of submitted PA requests or query on completed PAs on file. Up to seven (7) years of PA history is accessible to providers in CHAMPS.

10.2 PROCESSING REQUESTS

Based on documentation submitted, the PA request is either approved, disapproved, or returned for more information. Results of the request are returned to the provider via a letter. A separate letter is generated for each PA request regardless of the mode of submission and is viewable by providers in CHAMPS. Providers must immediately notify the beneficiary of the approval or denial of the PA request.

Approval of a PA request does not guarantee beneficiary eligibility or payment. It is the provider's responsibility to verify the beneficiary's eligibility for the date a service is actually rendered.

10.2.A. VERBAL PRIOR AUTHORIZATION

If a service requires PA but the situation requires immediate action to diagnose or correct a medical condition or avoid further damage, the provider may request PA by calling the MDHHS Program Review Division. (Refer to the Directory Appendix for contact information.)

If the service is required at a time when MDHHS cannot be contacted, the provider may perform the service and call MDHHS by the end of the next working day.

After verbal authorization is obtained, the provider must submit a written PA request (with supporting documentation) to MDHHS within 30 days. If the supporting documentation matches the information relayed for verbal authorization, MDHHS sends an approval to the provider.

10.2.B. APPROVAL

Payment is made only for services provided during the period of time the PA is valid and the beneficiary is eligible for Medicaid. Providers should carefully review the approval as it is for specific services and may be for only a specific period of time.

The prior authorized service must be the service that is rendered and billed. If there are changes in the plan of treatment or if the approved service does not accurately reflect the service to be provided, the Program Review Division should be contacted prior to rendering the service.

If a beneficiary elects to accept a service other than the service that was authorized, and that service also requires PA which was not obtained or is not covered by Medicaid, the beneficiary is responsible for payment of the entire service. In this situation, the provider must notify the beneficiary prior to rendering the service that Medicaid does not cover the service and the beneficiary is financially responsible for the entire service. It is suggested the beneficiary acknowledge this responsibility in writing.



10.2.C. DENIAL

If PA for the service is denied, it must not be billed to Medicaid. The beneficiary will be sent a letter notifying him of the denial with an explanation of his appeal rights. Once notified of the denial, the beneficiary may still wish to receive the service. The provider must reiterate to the beneficiary prior to rendering the service that Medicaid does not cover the service and the beneficiary is financially responsible for the entire service. It is suggested the beneficiary acknowledge this responsibility in writing.

10.2.D. REIMBURSEMENT

Procedure codes that do not have an MDHHS established fee screen require manual pricing. For certain services, manual pricing is completed through the claims processing process which requires documentation to be submitted with the claim. Other types of services require manual pricing to be completed through the PA process. For PA, it is the provider's responsibility to document the acquisition cost for the service or item submitted for consideration. Medicaid does not accept merchandise price quotes, estimates, retail prices, any document or price that does not indicate the actual cost of the item to the provider, or documentation that is greater than 90 days old. MDHHS reserves the right to set a dollar limit on how much MDHHS will reimburse for a Not Otherwise Classified (NOC) code or any manually priced procedure code for a specific range of products.

Documentation that may be accepted for PA requests includes:

- An invoice indicating what the medical supplier actually paid for the item to be provided to the specified beneficiary.
- An invoice indicating what the medical supplier actually paid for the same item requested on the PA but was purchased for a different beneficiary.
- An order form receipt from the manufacturer that indicates what the medical supplier actually paid for the item ordered for the specified beneficiary.
- For the manufacturer and/or custom-fabricated items, cost for materials and number of hours of labor.

Medicaid does not provide reimbursement if:

- The beneficiary was not eligible for Medicaid on the DOS. Reimbursement is denied on this basis even if the service has been prior authorized. **Exception:** For custom-fabricated equipment and devices, the beneficiary must be eligible for Medicaid on the date the item/service was ordered to be eligible for reimbursement.
- A service that is prior authorized is rendered in conjunction with a service that is not a separately reimbursable service and is not a Medicaid benefit.
- A service that is prior authorized and rendered in conjunction with another service that requires PA, and PA for the second service was not obtained.
- PA was required but was not obtained.



- The beneficiary has other insurance and the rules for coverage for other insurance were not followed.
- It was determined that PA was requested or obtained after the service was rendered. (The provider should refer to the Verbal Prior Authorization subsection above for an exception to this situation.)
- The service/item was ordered, prescribed or referred by a provider who has been sanctioned, and the sanction was in effect before PA was granted.
- The service/item was ordered, prescribed, or referred by a non-enrolled provider.

Providers cannot charge the beneficiary or beneficiary's representative for the provider's failure to obtain PA. If the provider failed to obtain PA for a service and the service was rendered, he cannot apply his fee for that service in calculating other reimbursement due to him from Medicaid.

10.3 PRIOR AUTHORIZATION (MEDICAID HEALTH PLANS ONLY)

Medicaid Health Plans (MHPs) are responsible for authorizing Medicaid-covered services in the Comprehensive Health Care Program (CHCP) benefit package for enrolled Medicaid beneficiaries, with certain exceptions such as emergency services. Providers must contact the MHPs before rendering services to MHP enrollees to obtain PA. Each MHP is responsible for establishing procedures for PA.

10.4 CUSTOM-FABRICATED MEDICAL EQUIPMENT, DEVICES AND MEDICAL SUPPLIES

Medicaid is responsible for payment of custom-fabricated equipment or devices, hearing aids, eyeglasses, dentures, prosthetics and orthotics authorized and ordered before the last date of Medicaid eligibility and delivered within 30 days after loss of eligibility. Medicaid or the MHP that authorizes and orders the equipment or item is responsible for paying for the item even though it is delivered after the beneficiary loses eligibility or has an enrollment change (fee-for-service [FFS] to MHP, MHP to FFS or MHP to MHP). The order must be placed before the change in enrollment status, and the service should be delivered within 30 days after the change in enrollment status.

If a provider determines that a beneficiary needs a durable medical equipment (DME) item that is authorized by either MDHHS or the current MHP and is ordered before a change in enrollment status, the party that authorized the service is responsible for payment.

If a custom-fabricated item, medical device, or equipment (e.g., prosthetic limb, custom-fabricated medical equipment such as a brace, custom motorized wheelchair, orthotics) is ordered for a beneficiary during a hospital stay but is not delivered until after discharge and enrollment status changes, payment must be made by the party responsible for the hospital stay.

This policy does not apply to mass-produced, readily available items that can be used by a person other than for whom it was ordered. It also excludes all rental items, all expendable/disposable medical supply items (e.g., diapers, dressings, ostomy supplies, IV infusion supplies) or any item that does not require a length of time (days or weeks) to special order for a specific person.



SECTION 11 - BILLING BENEFICIARIES

11.1 GENERAL INFORMATION

Providers cannot bill beneficiaries for services except in the following situations:

- A Medicaid copayment is required. (Refer to the Beneficiary Copayment Requirements subsection of this chapter for additional information about copayments.)
- A monthly patient-pay amount for inpatient hospital or nursing facility services. The local MDHHS office determines the patient-pay amount. Noncovered services can be purchased by offsetting the nursing facility beneficiary's patient-pay amount. (Refer to the Nursing Facility Chapter for additional information.)
- For nursing facility (NF), state-owned and -operated facilities or CMHSP-operated facilities determine a financial liability or ability-to-pay amount separate from the MDHHS patient-pay amount. The state-owned and -operated facilities or CMHSP-operated facilities liability may be an individual, spouse, or parental responsibility. This responsibility is determined at initiation of services and is reviewed periodically. The beneficiary or his authorized representative is responsible for the state-owned and -operated facilities or CMHSP ability-to-pay amount, even if the patient-pay amount is greater.
- The provider has been notified by MDHHS that the beneficiary has an obligation to pay for part of, or all of, a service because services were applied to the beneficiary's Medicaid deductible amount.
- If the beneficiary is enrolled in a MHP and the health plan did not authorize a service, and the beneficiary had prior knowledge that he was liable for the service. (It is the provider's responsibility to determine eligibility/enrollment status of each beneficiary at the time of treatment and to obtain the appropriate authorization for payment. Failure of the provider to obtain authorization does not create a payment liability for the beneficiary.)
- Medicaid does not cover the service. If the beneficiary requests a service not covered by Medicaid, the provider may charge the beneficiary for the service if the beneficiary is told prior to rendering the service that it is not covered by Medicaid. If the beneficiary is not informed of Medicaid noncoverage until after the services have been rendered, the provider cannot bill the beneficiary.
- Beneficiaries may be billed the amount other insurance paid to the policyholder if the beneficiary is the policyholder.
- The beneficiary is the policyholder of the other insurance and the beneficiary did not follow the rules of the other insurance (e.g., utilizing network providers).
- The provider chooses not to accept the beneficiary as a Medicaid beneficiary and the beneficiary had prior knowledge of the situation. The beneficiary is responsible for payment.

It is recommended that providers obtain the beneficiary's written acknowledgement of payment responsibility prior to rendering any nonauthorized or noncovered service the beneficiary elects to receive.

Some services are rendered over a period of time (e.g., maternity care). Since Medicaid does not normally cover services when a beneficiary is not eligible for Medicaid, the provider is encouraged to



advise the beneficiary prior to the onset of services that the beneficiary is responsible for any services rendered during any periods of ineligibility. Exceptions to this policy are services/equipment (e.g., root canal therapy, dentures, custom-fabricated seating systems) that began, but were not completed, during a period of eligibility. (Refer to the provider-specific chapters of this manual for additional information regarding exceptions.)

When a provider accepts a patient as a Medicaid beneficiary, the beneficiary cannot be billed for:

- Medicaid-covered services. Providers must inform the beneficiary before the service is provided if Medicaid does not cover the service.
- Medicaid-covered services for which the provider has been denied payment because of improper billing, failure to obtain PA, or the claim is over one year old and has never been billed to Medicaid, etc.
- The difference between the provider's charge and the Medicaid payment for a service.
- Missed appointments.
- Copying of medical records for the purpose of supplying them to another health care provider.

If a provider is not enrolled in Medicaid, they do not have to follow Medicaid guidelines about reimbursement, even if the beneficiary has Medicare as primary.

If a Medicaid-only beneficiary understands that a provider is not accepting him as a Medicaid patient and asks to be private pay, the provider may charge the beneficiary its usual and customary charges for services rendered. The beneficiary must be advised prior to services being rendered that his **mihealth** card is not accepted and that he is responsible for payment. It is recommended that the provider obtain the beneficiary's acknowledgement of payment responsibility in writing for the specific services to be provided.

11.2 BENEFICIARY COPAYMENT REQUIREMENTS

Beneficiary copayments may be required for the following Medicaid services:

- Physician office visits (including those provided by physician assistants, advanced practice registered nurses, and podiatrists)
- Chiropractic visits
- Outpatient hospital clinic visits
- Inpatient hospital stays
- Non-emergency use of the emergency room
- Dental services
- Hearing aids
- Pharmacy services
- Vision services



A list of current copayments is available on the MDHHS website. (Refer to the Directory Appendix for website information.) Different copayment requirements may apply for beneficiaries enrolled in a Medicaid Health Plan. Contact the appropriate plan for copayment information.

Preventive medicine evaluation and management services are not subject to beneficiary cost sharing.

11.2.A. BENEFICIARIES EXCLUDED FROM MEDICAID COPAYMENT REQUIREMENTS [TITLE REVISED AND CHANGE MADE 4/1/20]

Copayment requirements apply to Medicaid fee-for-service beneficiaries age 21 and older who do not meet one of the following exceptions:

- Medicare/Medicaid dual eligibles
- Children's Special Health Care Services (CSHCS) beneficiaries (including those also enrolled in Medicaid)
- Inpatient hospital stay initiated by an emergent admission
- Nursing facility residents
- Pregnancy-related services (claim must include a pregnancy-related diagnosis)
- Family planning services (as described in the Family Planning Clinics Chapter of this manual)
- Mental health specialty services and supports provided/paid through the Prepaid Inpatient Health Plans
- Mental health services provided through state psychiatric hospitals, the state Developmental Disabilities Center, and the Center for Forensic Psychiatry
- Services provided by a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Tribal Health Center (THC). Copays for prescriptions filled in an FQHC, RHC, or THC are only exempt based on the beneficiary's eligibility and/or specific drug exclusions listed in the Medicaid Copayments subsection of the Pharmacy Chapter. **(text added 4/1/20)**
- Native American Indians/Alaska Natives consistent with federal regulations at 42 CFR §447.56(a)(1)(x)
- Enrollees in the Breast and Cervical Cancer Control Program (BCCCP)

Beneficiaries excluded from Medicaid FFS copayments are also excluded from MHP copayment requirements. (Refer to the Medicaid Health Plans chapter for additional information.)

11.2.B. REFUSAL OF SERVICE DUE TO NON-PAYMENT OF COPAYMENT

A provider cannot refuse to render care or services to a Medicaid beneficiary if the beneficiary is unable to pay the copayment amount at the time the care or service is provided. However, the uncollected copayment is considered a debt. A provider must accept the beneficiary's assertion that he is unable to pay. No additional proof is required.



Care or services cannot be denied unless the provider has first given the beneficiary:

- Appropriate notice of the debt (including documentation such as a billing statement, invoice, cash register receipt, or other writing showing the copayment amount owed), and
- Reasonable opportunity to pay the debt.

A provider refusing to render care or services based on copayment debt must, at the request of the beneficiary, transfer the beneficiary's treatment record to a provider designated by the beneficiary or, if it is the provider's normal practice, provide the beneficiary a copy of his treatment record, with reasonable promptness under the circumstances. Providers may not charge the beneficiary or MDHHS for providing a copy of treatment records for this purpose.

A provider refusing to render care or services based on copayment debt must refer a fee-for-service beneficiary to the toll-free Medicaid Beneficiary Helpline number on the **mihealth** card if the beneficiary has questions or concerns about the denial or about accessing care or services from another provider. (Refer to the Directory Appendix for Beneficiary Helpline contact information.) Managed care enrollees must be referred to the Health Plan's customer service helpline number contained on the beneficiary's Health Plan card.

For all providers except physicians and dentists (MD, DO, DDS), care or services cannot be denied based on the beneficiary's copayment debt unless the provider:

- Has a written policy regarding denial of service based on copayment debt that includes appropriate notice and a reasonable opportunity for payment. The provider's policy must include the statement that a beneficiary will not be denied an item or service because he cannot pay the copayment for the item or service currently being requested. The policy must include the provider's method of furnishing adequate notice, as well as the minimum length of time and terms of payment allowed by the provider as a reasonable opportunity for payment.
- Has established procedures for maintaining business records that show the amount of the copayment debt, the date when the required notice was provided to the beneficiary, and the date(s) and amount(s) of any payment(s) received on the copayment debt.
- Gives written (or verbal, pursuant to #4 below) notice to the beneficiary at least the greater of 30 days (60 days for hospitals), or the period prescribed by the provider, prior to denial.

The notice must include:

- The time period within which the beneficiary must make payment, in whole or at the discretion of the provider in part, on his newly-created copayment debt in order to avoid denial of future service; and
- The dollar amount of the minimum payment that must be remitted as a prerequisite for continued service; and



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- The fact that the beneficiary cannot be denied future care, items, or services if he makes the required full or partial payment on his newly-created copayment debt in the above-designated period.
- Gives verbal notice in lieu of written notice when the provider:
 - Publicly and prominently posts their policy regarding denial of service based on copayment debt in a public area such as the provider's reception area; and
 - At the time that verbal notice is given, either provides a copy of the posted policy or verbally informs the beneficiary of the existence and location of the posted notice and the beneficiary's right to a copy of the notice upon request; and
 - Makes a copy of the written policy available to the beneficiary and to MDHHS immediately upon request.

If a provider gives verbal notice, rather than individual written notice, the provider cannot require the beneficiary to acknowledge in writing that he has been informed of his copayment rights and responsibilities. If the beneficiary refuses to sign an acknowledgement, the provider may note this in their records. Upon receipt of the required payment in the amount and during the time period designated in the individual notice, the provider cannot deny the beneficiary care, items, or services unless and until a new notice meeting the above requirements is given to the beneficiary.

The policies and procedures described above do not affect a provider's right to deny care, items, or services on the basis of debt unrelated to any copayment responsibility, or for other non-financial reasons, consistent with the provider's usual business practices for patients or customers who are not Medicaid beneficiaries.

11.2.C. COST-SHARING LIMITS

Medicaid cost-sharing, which includes premiums, contributions, copays and co-insurance incurred by individuals in a Medicaid household, may not exceed an aggregate limit of 5% of family income. MDHHS implements these limits on a calendar quarter basis through the tracking of applicable incurred cost-sharing, including paid claims for services as they are processed through the MDHHS Community Health Automated Medicaid Processing System (CHAMPS). Providers are expected to utilize the cost-sharing information in CHAMPS to determine whether cost-sharing may be assessed at the time of the visit and inform the beneficiary of their cost-sharing obligations.

The eligibility response within CHAMPS includes the following cost-sharing information for the current calendar quarter:

- Cost-Share Met (Y or N);
- Cap Amount Remaining; and
- Copayment (for various services).

If the "Cost-Share Met" is listed as "Y" in CHAMPS, a beneficiary may not be charged any cost-sharing for the remainder of that quarter. In addition, regardless of the approved copayment amount for a particular service, beneficiaries may not be charged any cost-sharing that exceeds the "Cap Amount Remaining" amount listed. Finally, beneficiaries and services that are exempt from cost-sharing as set forth in this Section will remain exempt from cost-sharing.



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For pharmacy providers, any remaining copay responsibility will be communicated in the National Council for Prescription Drug Programs (NCPDP) transaction response field 505-F5 (Patient Pay Amount). The Point of Sale (POS) system will determine whether the aggregate limit has been met.

Because CHAMPS tracks beneficiary costs incurred as claims are adjudicated, providers are directed to bill all claims in a timely fashion. Providers are also directed to review the remittance advice to ensure that any copay charged at the time of service was appropriate and to provide refunds if necessary. Medicaid Health Plans that charge copays to Medicaid beneficiaries may also have administrative responsibilities to work with their providers to provide refunds when necessary or as directed by MDHHS.



SECTION 12 - BILLING REQUIREMENTS

All claims must be submitted in accordance with the policies, rules, and procedures as stated in the manual and in compliance with applicable coding guidelines and conventions.

12.1 BILLING PROVIDER

Providers must not bill MDHHS for services that have not been completed at the time of the billing. For payment, MDHHS requires the provider name and NPI numbers to be reported in any applicable provider loop or field (e.g., attending, billing, ordering, prescribing, referring, rendering, servicing, supervising, etc.) on the claim. It is the responsibility of the attending, ordering, prescribing, referring or supervising provider to share their name, NPI and Michigan Medicaid Program enrollment status with the provider performing the service. Refer to the Billing & Reimbursement Chapters of this manual for additional information and claim completion instructions.

Providers rendering services to residents of the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) may not bill Medicaid directly. All covered services (e.g., laboratory, x-rays, medical surgical supplies including incontinent supplies, hospital emergency rooms, clinics, optometrists, dentists, physicians, and pharmacy) are included in the per diem rate.

12.2 CHARGES

Providers cannot charge Medicaid a higher rate for a service rendered to a beneficiary than the lowest charge that would be made to others for the same or similar service. This includes advertised discounts, special promotions, or other programs to initiate reduced prices made available to the general public or a similar portion of the population. In cases where a beneficiary has private insurance and the provider is participating with the other insurance, refer to the Coordination of Benefits Chapter of this manual for additional information.

12.3 TIMELY FILING BILLING LIMITATION

Each claim received by MDHHS receives a unique identifier called a Transaction Control Number (TCN). This is an 18-digit number found in the Remittance Advice (RA) that indicates the date the claim was entered into the Community Health Automated Medicaid Processing System (CHAMPS). The TCN is used when determining active review of a claim. (Refer to the Billing & Reimbursement Chapters for additional information.)

A claim must be initially received and acknowledged (i.e., assigned a TCN) by MDHHS within 12 months from the date of service (DOS).^{*} DOS has several meanings:

- For claims using the institutional format and MHPs, it is the "To" or "Through" date indicated on the claim.
- For all other providers, it is the date the service was actually rendered or delivered.

^{*}Initial pharmacy claim must be received within 180 days.



All claims must be resolved within one year from the date of service unless an exception exists as noted below. It will no longer be necessary to maintain continuous activity through multiple claim submissions. Claim replacements requesting additional payment must meet exception criteria to be considered beyond one year from DOS.

Only the following types of claims require documentation of previous activity in the Remarks section of the claim (e.g. previous TCNs):

- Claim replacements;
- Claims previously billed under a different provider NPI number;
- Claims previously billed under a different beneficiary ID number; and
- Claims previously billed using a different DOS "statement covers period" for nursing facilities and inpatient hospitals.

This does not apply to state-owned and -operated facilities, as they do not receive a warrant. Note: Nursing Facilities – In cases where a nursing facility may need to submit a claim adjustment due to a change in the beneficiary's patient-pay amount and the claim has not had continuous active review, the adjustment must be submitted within six months from the date MDHHS made the change in the patient-pay amount. The Remarks section must note a reason for the adjustment.

Exceptions may be made to the timely filing billing limitation policy in the following circumstances.

- Department administrative error occurred, including:
 - The provider received erroneous written instructions from MDHHS staff;
 - MDHHS staff failed to enter (or entered erroneous) authorization or restriction in the system;
 - The MDHHS contractor issued an erroneous PA; and
 - Other administrative errors by MDHHS or its contractors that can be documented.Retroactive provider enrollment is not considered an exception to the timely filing billing limitation.
- Medicaid beneficiary eligibility/authorization was established retroactively more than 12 months after the DOS.
- Medicaid beneficiary eligibility/authorization was established retroactively less than 12 months after the DOS. Claims will be accepted up to six months after the retroactive eligibility determination date. Providers with claims that meet this retroactive eligibility exception must indicate 'timely filing' in the comment section of the claim.
- Judicial Action/Mandate: A court or MOAHR administrative law judge ordered payment of the claim. A copy of the judicial action or court order may be required to support this exception.



- Medicare processing was delayed: The claim must reflect that Medicaid was billed within 120 days of the date of payment, rejection or retroactive recovery of funds by Medicare. (Refer to the Coordination of Benefits Chapter in this manual for further information.)
- Provider returning overpayment: A claim replacement should be submitted with a comment that the provider is returning money. The replacement should be completed to reflect the return of money (e.g., including primary payer's payment or, if returning all the money, zeroing out the money fields).
- Primary insurance taking back payment after timely filing limitation has passed: Must submit a copy of insurance letter or EOB from primary insurance showing date money was taken back from paid claim. The claim must be submitted within 120 days of the primary insurance letter or remit date.

Providers who have claims meeting either of the first two exception criteria must contact their local MDHHS office to initiate the following exception process:

- The MDHHS caseworker completes and submits the Request for Exception to the Twelve-Month Billing Limitation for Medical Services form (MSA-1038) to MDHHS.
- Providers can determine if an MSA-1038 has been approved/denied by accessing the MSA-1038 status tool or by contacting the MDHHS caseworker. (Refer to the Directory Appendix, Eligibility Verification, for contact and website information.)
- Once informed of the approval, the provider prepares claims related to the exception, indicating "MSA-1038 approval on file" in the comment section.
- The provider submits claims to MDHHS through the normal CHAMPS submission process.

Refer to the Billing & Reimbursement chapters of this manual for additional information on claim submission or go to the MDHHS website for additional CHAMPS-related information. Questions regarding claims submitted under this exception should be directed to MDHHS Provider Inquiry. (Refer to the Directory Appendix for contact and website information.)

12.4 PROVIDER RETURNING OVERPAYMENTS

Medicaid providers performing self audits may discover an overpayment situation and wish to return the Medicaid overpayment to MDHHS. This process should only be used when the provider is unable to claim adjust or it is not practical to claim adjust. Sending in a check will not correct the underlying claim(s) data. Providers must:

- Document why the money is being returned (i.e., provider self audit) and identify provider NPI information, address, dates of service, and specialty area (i.e., durable medical items, pharmacy, physician practice, hospital, etc.) and include a basic information letter.
- Attach an excel spreadsheet document with the Tax ID, billing NPIs, and associated amounts (if multiple IDs exist for the entity) for the MDHHS Accounting Office to apply credit to.
- Make check payable to "State of Michigan" and mail to the MDHHS/Cashier's Unit - Attn: Bureau of Finance-MCU. (Refer to the Directory Appendix for contact information.)



12.5 PROFESSIONAL CORPORATION

For services involving multiple visits billed with a single procedure code (e.g., surgery and pre- and post-operative care, prenatal care) or initial or new services, the code/service may be billed only once by a professional corporation. Other members of the corporation may not bill separately any procedures related to the service. This policy includes services rendered in a partnership, employer-employee, or contractor relationship.

12.6 INVOICE COMPLETION FEE

A fee for completing the Medicaid claim cannot be charged to Medicaid, the beneficiary, or the beneficiary's representative.

12.7 CLAIM DOCUMENTATION

In some cases, MDHHS may require specific information with the claim (e.g., indication of medical necessity). Providers should refer to the provider-specific and Billing & Reimbursement Chapters of this manual for the information that may be needed on the claim.

A claim without the requested information may be reviewed:

- Prior to payment. (The claim may be rejected for missing, incorrect or insufficient information.)
- Subsequent to payment. (A post-payment audit/review may indicate that the information was insufficient or missing and a gross adjustment would be initiated to recover the payment.)

12.8 CLAIM CERTIFICATION

Providers certify by signature that a claim is true, accurate, and contains no false or erroneous information. The provider's signature or that of the provider's authorized representative may be handwritten, typed, or rubber-stamped on a paper claim.

When a provider's warrant is endorsed or deposited, it is certification that the services billed were actually provided. It further certifies that the claims (paper or electronic) paid by the warrant accurately document that the health care services provided were within the limitation of Medicaid (or compliance with a contract). The warrant's certification applies to original claims as well as resubmitted claims and claim adjustments.

This does not apply to state-owned and -operated facilities, as they do not receive a warrant.

Providers are held responsible for any errors, omissions, or resulting liabilities that may arise from any claim for medical services submitted to MDHHS under the provider's name or NPI number. Contractual arrangements (verbal or written) with employers, employees, contractors, etc. do not release the provider of the responsibility for services billed or signed under the provider's NPI number.

Providers are responsible for the supervision of a subordinate, officer, employee, or contracted billing agent who prepares or submits the provider's claims.



12.9 BILLING AGENTS

A billing agent that submits Medicaid claims via electronic media must be authorized by MDHHS before submitting claims. Once the billing agent has completed the business-to-business (B2B) testing requirements and is authorized by MDHHS, the provider must authorize the billing agent to submit his claims. The authorization for submitting claims via electronic media must be submitted even if the provider is acting as his own billing agent.

12.9.A. AUTHORIZATION OF BILLING AGENT

The billing agent initiates the authorization process through completion of the MDHHS CHAMPS PE on-line application. Refer to the Provider Enrollment Section of this Chapter and the Trading Partners portion of the MDHHS website for information on the application and billing agent authorization process. (Refer to the Directory Appendix for website information.)

12.9.B. PROVIDER ASSOCIATION WITH A BILLING AGENT

The process for a provider to authorize a billing agent to submit claims is accomplished through the CHAMPS PE on-line process. The enrolled provider must enter the on-line system and request association with a specific billing agent. Once that transaction is completed, the provider must notify the billing agent that he may begin submitting claims on the provider's behalf.

12.9.C. COMMUNICATION WITH BILLING AGENTS

MDHHS communicates changes in coverages, billing requirements, and fees/rates to its enrolled providers. If a provider contracts with a billing agent, it is the provider's responsibility to assure the billing agent is made aware of any changes that may impact submission of the provider's claims. Providers are responsible for the claims submitted by the billing agent, including improper billings, duplicate payments, etc.



SECTION 13 - THIRD PARTY LIABILITY

Federal regulations require that all identifiable financial resources available for payment, including Medicare, be billed prior to billing Medicaid. (Refer to the Coordination of Benefits Chapter of this manual for additional information.)

Medicaid does not reimburse for services provided to individuals being held in a detention facility against their will except for those directly related to an inpatient hospital stay (medical/surgical/psychiatric) provided in a non-state-owned facility. Benefit Plan IDs of INCAR-ESO, INCAR-MA, INCAR-MA-E and MA-HMP-INC, if provided in the eligibility response, all indicate that the beneficiary resides in a detention facility.

13.1 ESTATE RECOVERY PROGRAM

Pursuant to 42 USC §1396p, the federal government requires state Medicaid programs to seek recovery from the estates of certain deceased beneficiaries who received benefits from a state Medicaid program. This is referred to as the Estate Recovery Program. Under some circumstances, the state may choose not to seek or may defer recovery from the estate.

Estate recovery applies only to Medicaid beneficiaries who:

- are 55 years of age or older; and
- received long-term care services any time on or after September 30, 2007.

The Estate Recovery Program can only recover from assets flowing through the probate process.

When a provider has a balance in a patient trust account after the death of a beneficiary, any balance in the account should be refunded to the family to open a probate estate with those funds. Once an estate is opened in probate court, MDHHS will file a claim.



SECTION 14 – REIMBURSEMENT

14.1 PAYMENT IN FULL

Providers must accept Medicaid's payment as payment in full for services rendered, except when authorized by Medicaid (e.g., copayments, patient-pay amounts, other cost sharing arrangements authorized by the State). Providers must not seek nor accept additional or supplemental payment from the beneficiary, the family, or representative in addition to the amount paid by Medicaid, even when a beneficiary has signed an agreement to do so. This policy also applies to payments made by MHPs and PIHPs/CMHSPs/CAs for their Medicaid enrollees.

Contractors or nursing facility (including ICF/IID) operators must not seek nor accept additional or supplemental payment beyond the patient-pay or MDHHS ability-to-pay amount.

14.2 PRE- AND POST-PAYMENT REVIEW/AUDIT

Providers are subject to pre- and post-payment review/audit or an adjustment to the reimbursement rate.

- In pre-payment review, MDHHS may deny reimbursement for a service until it is satisfied the service meets Medicaid guidelines.
- In post-payment review/audit, MDHHS may initiate an adjustment to obtain monies paid for services that do not comply with Medicaid coverage, billing and/or reimbursement policies or that suspends or disenrolls the provider from Medicaid.

14.3 EMERGENCY SERVICES (MHPs ONLY)

Emergency services to the point of stabilization (as required to be provided under the Emergency Medical Treatment and Active Labor Act [EMTALA]), provided to a MHP enrollee inside or outside the MHP's service area, must be reimbursed by the MHP to the provider of services.

14.4 NON-PAYMENT AND REPORTING REQUIREMENTS FOR PROVIDER PREVENTABLE CONDITIONS (PPCs)

In accordance with federal regulations, Michigan Medicaid is prohibited from reimbursing providers for services related to Provider Preventable Conditions (PPCs), as defined below. Providers are required to report the occurrence of PPCs. This policy applies to all services performed on Medicaid beneficiaries, including dual-eligible beneficiaries and those enrolled in Medicaid Health Plans. MDHHS aligns with Medicare's policy and billing guidelines.

14.4.A. CATEGORIES OF PROVIDER PREVENTABLE CONDITIONS

Health Care Acquired Conditions (HCAC)	Applies to inpatient hospital settings and includes, at a minimum, the full list of conditions/secondary diagnosis codes identified by CMS as HCACs when not present on hospital admission.
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Other Provider Preventable Conditions (OPPC)	<p>Applies to conditions occurring in any health care setting that could have reasonably been prevented through the application of evidence based guidelines. Conditions currently identified by CMS include:</p> <ul style="list-style-type: none"> ▪ wrong surgical or other invasive procedure performed on a patient; ▪ surgical or other invasive surgery performed on the wrong body part; and ▪ surgical or other invasive procedure performed on the wrong patient.
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14.4.B. PAYMENT ADJUSTMENT AND REPORTING REQUIREMENTS FOR PPCs

Any reduction in payment will be limited to the amounts directly identifiable as related to the PPC and the resulting treatment. The beneficiary and/or their family are held harmless and the provider and/or facility/hospital must not bill the Medicaid beneficiary or their family (including co-payment, deductibles or coinsurance) for PPCs.

MDHHS will not accept Medicare primary or Medicaid secondary professional or institutional crossover claims resulting in zero liability.

Providers must report the occurrence of a PPC through the appropriate claim(s) type submission process. Providers are referred to the Billing & Reimbursement Chapters of this manual for specific information on reporting requirements and claim submission.

14.5 FACTORING

Factoring of Medicaid accounts by any provider is prohibited. A factor is defined in federal regulations as "an organization, that is, a collection agency or service bureau which advances money to a provider for his accounts receivable which have been assigned or sold, or otherwise transferred to this organization for an added fee or a deduction of the accounts receivable." Power of attorney arrangements, under which a check is payable to the provider but can be cashed by a factor, are prohibited. However, payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order.

Factor does not include a business representative, such as a billing agent or an accounting firm, which renders statements and receives payments in the name of the individual provider as long as the business representative's compensation for this service is:

- Reasonably related to the cost of processing the claim;
- Not related, in any way, to the dollar amount to be billed or collected; and
- Not dependent upon the actual collection of payment.

This policy is not applicable to State-owned and -operated facilities.



SECTION 15 – RECORD KEEPING

15.1 RECORD RETENTION

Providers must maintain, in English and in a legible manner, written or electronic records necessary to fully disclose and document the extent of services provided to beneficiaries. Necessary records include fiscal and clinical records as discussed below. Appointment books and any logs are also considered a necessary record if the provider renders a service that is time-specific according to the procedure code billed. Examples of services that are time-specific are psychological testing (per hour), medical psychotherapy (20-30 minutes), and vision orthoptic treatment (30 minutes). The records are to be retained for a period of not less than seven years from the DOS, regardless of change in ownership or termination of participation in Medicaid for any reason. This requirement is also extended to any subcontracted provider with which the provider has a business relationship.

15.2 ORDERS, PRESCRIPTIONS AND REFERRALS

Providers arranging or rendering services upon the order, prescription or referral of another provider (e.g., physician) must maintain that order, prescription and/or referral for a period of seven years.

15.3 BENEFICIARY IDENTIFICATION INFORMATION

Providers must retain the following beneficiary identification information in their records:

- Name
- Medicaid ID number
- Medical record number
- Address, including zip code
- Birth date
- Telephone number, if available
- Any private health insurance information for the beneficiary, if available

15.4 AVAILABILITY OF RECORDS

Providers are required to permit MDHHS personnel, or authorized agents, access to all information concerning any services that may be covered by Medicaid. This access does not require an authorization from the beneficiary because the purpose for the disclosure is permitted under the HIPAA Privacy rule. Health plans contracting with the MDHHS must be permitted access to all information relating to services reimbursed by the health plan.

Providers must, upon request from authorized agents of the state or federal government, make available for examination and photocopying all medical records, quality assurance documents, financial records, administrative records, and other documents and records that must be maintained. (Failure to make requested records available for examination and duplication and/or extraction through the method determined by authorized agents of the state or federal government may result in the provider's suspension and/or termination from Medicaid.) Records may only be released to other individuals if they



have a release signed by the beneficiary authorizing access to his records or if the disclosure is for a permitted purpose under all applicable confidentiality laws.

15.5 CONFIDENTIALITY

MDHHS complies with HIPAA Privacy requirements and recognizes the concern for the confidential relationship between the provider and the beneficiary and protects this relationship using the minimum amount of information necessary for purposes directly related to the administration of Medicaid.

All records are of a confidential nature and should not be released, other than to a beneficiary or his representative, unless the provider has a signed release from the beneficiary or the disclosure is for a permitted purpose under all applicable confidentiality laws (refer to the Availability of Records subsection of this chapter for additional information). Providers are bound to all HIPAA privacy and security requirements as federally mandated.

If the provider receives a court order, a subpoena, beneficiary request, or other authorized request for medical bills, payment, or claims adjudication information, the information should be released. At the same time, copies of the court order, subpoena, beneficiary request, other authorized request, and any additional information should be faxed to the MDHHS TPL Section. (Refer to the Directory Appendix for contact information.)

If there is a reason to suspect a duplicate payment has been or will be made, but the payment is not assigned, the provider should contact the TPL Section. TPL will make the necessary arrangements to collect the duplicate payment from the third-party source.

If the provider questions the appropriateness of releasing beneficiary records, he is encouraged to seek legal counsel before doing so.

15.5.A. STANDARD CONSENT FORM

In cases when such consent is required, the Consent to Share Behavioral Health Information (form MDHHS-5515) must be used for all providers requesting release of information for behavioral health and/or substance use disorder related information. The consent is required to be accepted, honored and used for all Fee for Service (FFS), Managed Care and Prepaid Inpatient Health Plan (PIHP) beneficiaries both from and to any of those providers or entities. The MDHHS-5515 is maintained and updated on the MDHHS website. (Refer to the Directory Appendix for website information.)

An interpreter must be provided to assist the individual if the individual does not understand the language used on the consent form or the language used by the person obtaining the consent. Services of an interpreter cannot be billed as separate services or billed to the beneficiary.

Providers receiving federal funding under the Victims of Crime Act, Violence Against Women Act, and/or Family Violence Prevention and Services Act should not use the MDHHS-5515 because they are subject to stringent consent requirements under these federal laws that are not satisfied by the form. These requirements are in place to address the heightened safety and privacy concerns that victims of domestic violence, sexual assault, stalking, or other crimes may have. These individuals may need additional safeguards for their behavioral health information.



For guidance on addressing issues related to consent and the provision of services for domestic violence, sexual assault, stalking, or other crimes, refer to the MDHHS website.

15.6 FISCAL RECORDS

The following fiscal records must be maintained:

- Copies of Remittance Advices (RA);
- PA requests and approvals for services and supplies (including managed care authorizations);
- Verification of medical necessity and the provider's usual and customary charge for the noncovered service;
- Record of third-party payments; and
- Copies of purchase invoices for items offered or supplied to the beneficiary.

15.7 CLINICAL RECORDS

The following table contains general guidelines for clinical documentation that must be maintained by all providers except nursing facilities. Clinical records other than those listed may also be needed to clearly document all information pertinent to services that are rendered to beneficiaries. All providers must refer to their specific coverage policy in this manual for additional documentation requirements. The clinical record must be sufficiently detailed to allow reconstruction of what transpired for each service billed. All documentation for services provided must be signed and dated by the rendering health care professional.

For services that are time-specific according to the procedure code billed, providers must indicate in the medical record the actual begin time and end time of the particular service. For example, some Physical Medicine procedure codes specify per 15 minutes. If the procedure started at 3:00 p.m. and ended at 3:15 p.m., the begin time and end time must be recorded in the medical record.

The medical record must indicate the specific findings or results of diagnostic or therapeutic procedures. If an abbreviation, symbol, or other mark is used, it must be standard, widely accepted health care terminology. Symbols, marks, etc. unique to that provider must not be used.

Examples:

- When a test is performed, at a minimum, the test value for that beneficiary for that test must be noted. Additionally, the normal range of values for the testing methodology should be annotated in the record.
- When an x-ray is taken, the results or findings must be indicated. For example, a chest x-ray may indicate "no pulmonary edema present" or "no consolidation."
- When a physical examination is performed, pertinent results or readings must appear.
- If blood pressure is taken, the actual reading must appear.
- If heart, lungs, eyes, etc. are checked, the results or findings must be detailed.
- Medical/surgical procedures performed must be sufficiently documented to allow another professional to reconstruct what transpired (e.g., "I-D" is not sufficient documentation).
- When a complete physical exam is rendered, the level of service must be fully documented.



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- If private duty nursing is provided, the care provided during each hour must be fully detailed.

Hospitals must retain any clinical information required to comply with 42 CFR 482.24. A nursing facility must retain any clinical information required to comply with 42 CFR 483.75 and the plan of care must comply with 42 CFR 483.20(d). These regulations are available from MDHHS or Centers for Medicare & Medicaid Services (CMS). (Hospitals and nursing facilities should refer to the Reimbursement Appendix of their chapters in this manual for additional record keeping requirements.)



Clinical Documentation Requirements

	Ambulance	CMHSP	Dentist	Family Planning	Hearing Aid Dealer	Hearing Center	Home Health	Hospice	Hospital	Lab	Medical Supplier	MI Choice	MIHP	Nursing Facility/Therapies	Pharmacy	Practitioner *	Private Duty Nursing Agency/RN & LPN	School Based Services	Vision
Date of Each Visit	*	*	*	*	*	*	*	*	*	*	*	*	*		*	*	*	*	*
Begin Time & End Time if Service is Time-Specific According to Procedure/Revenue Code Billed	*	*	*			*	*	*	*	*		*	*	*		*	*	*	
Presenting Symptom, Condition	*	*	*	*	*	*	*	*	*				*			*	*	*	
Diagnosis	*	*	*	*	*	*	*	*	*	*	*	*	*		*	*	*	*	*
Patient Histories, Plans of Care, Progress Notes, Consultation Reports	*	*	*	*		*	*	*	*		*	*	*			*	*	*	
Result of Exams		*	*	*		*	*	*	*							*	*	*	
Records of Medications, Drugs, Assistive Devices or Appliances, Therapies, Tests, and Treatments that are Ordered, Prescribed, Referred, or Rendered	*	*	*	*	*	*	*	*	*	*	*	*			*	*	*	*	
Physical Assessments and/or nursing activities that pertain to care provided & support the services rendered and billed	*	*	*	*			*	*	*			*	*			*	*	*	
Orders for Tests & Test Results		*	*	*	*	*	*	*	*	*					*	*	*	*	
Pictorial Records or Graphs & Written Interpretations of Tests	*	*	*	*		*			*	*						*		*	
Identification of Specimen, Type & Source				*			*		*	*						*	*		
Test Methodology		*	*	*					*	*						*			



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	Ambulance	CMHSP	Dentist	Family Planning	Hearing Aid Dealer	Hearing Center	Home Health	Hospice	Hospital	Lab	Medical Supplier	MI Choice	MIHP	Nursing Facility/Therapies	Pharmacy	Practitioner *	Private Duty Nursing Agency/RN & LPN	School Based Services	Vision
Name, Strength, Dosage, Quantity & Route of Drug, and Time Administered	x	x	x	x			x	x	x						x	x	x	x	
Ambulance Requestor's Name, Origination/ Terminating Location, Level & Type of Service	x								x							x		x	
Ordering, Prescribing or Referring Physician		x	x	x		x	x	x	x	x	x	x	x		x	x	x	x	x
Transportation Information other than Ambulance		x							x				x					x	
Other documentation necessary to process request							x	x			x		x				x	x	x

* Includes MD, DO, DPM, DC, OD, Certified Registered Nurse Anesthetist, Anesthesiologist Assistant, Physician Assistant, Advanced Practice Registered Nurse, Physical Therapist, Oral-Maxillofacial Surgeon, Medical Clinics (e.g., FQHCs, Public Health Clinics).



SECTION 16 – POST-PAYMENT REVIEW AND FRAUD/ABUSE

All Medicaid-reimbursed services are subject to review for conformity with accepted medical practice and Medicaid coverage and limitations. Post-payment reviews of paid claims may be conducted to assure that all services/items, providers, and settings were appropriate, necessary, and comply with Medicaid policy. Post-payment review also verifies that services were billed appropriately (e.g., correct procedure codes, modifiers, quantities, etc.), and that third party resources were utilized to the fullest extent available.

16.1 MDHHS OFFICE OF INSPECTOR GENERAL

The MDHHS Office of Inspector General, as a federal mandate (42 CFR 455.14), is responsible for investigating all suspected Medicaid provider (FFS or managed care) fraud and/or abuse. To report suspected fraudulent activities to MDHHS, contact the Office of Inspector General. (Refer to the Directory Appendix for contact information.) Suspected fraud and/or abuse is referred by the Office of Inspector General to the Michigan Department of the Attorney General, Medicaid Fraud Control Unit.

16.2 STATE LAW

The Michigan Department of Attorney General uses the following State laws for investigating provider fraud and abuse:

- Medicaid False Claim Act (MCLA 400.601 et. seq.) An individual, whether a provider, an employee, or an accomplice, convicted of such an activity is subject to a fine of up to \$50,000 and a prison sentence of four to ten years for each count, as well as full restitution to Medicaid of all funds fraudulently obtained. The provider may be suspended from participating in Medicaid for a period of time and, in some instances, his license to practice his profession may be suspended or revoked.

Examples of Medicaid fraud are:

- Billing for Services Not Rendered: A provider bills Medicaid for a treatment or procedure that was not actually performed (e.g., laboratory tests or x-rays that were not taken, full dentures were prior authorized and billed for when a partial denture was actually supplied).
- Billing Without Reporting Other Resources: A provider bills Medicaid the full charge for a service without reporting the amount billed and received from another source (e.g., a private insurance company) or charging the patient for the service or a copay for a covered benefit.
- Billing for a Brand Name Drug Not Dispensed: A pharmacy bills Medicaid for a brand name drug when a generic substitute (at a lower cost) was actually dispensed to the beneficiary.
- Billing for Unnecessary Services: A provider misrepresents the diagnosis and symptoms on a beneficiary's record in order to provide and bill for unnecessary tests and procedures.



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- Billing a DOS Other Than the Actual Date the Service was Rendered: A provider indicates a DOS other than the actual DOS that was during a time of beneficiary ineligibility or service noncoverage.
- Receiving Kickbacks: An ancillary provider (e.g., physical therapist, laboratory, pharmacy) may agree to pay a physician, nursing facility, or hospital administrator or owner a portion of his Medicaid reimbursement for services rendered to the physician's patient or a beneficiary residing in the facility. Payments to a physician or facility administrator or owner may be a cash payment, a vacation trip, a leased vehicle, inflated rental for space, etc. Often a kickback arrangement results in unnecessary tests or services being provided to the beneficiary in order to generate additional reimbursement.
- Fraudulent Cost Reports: A nursing facility or hospital including nonallowable costs or false information (e.g., understate patient census days) or including nonpatient care expenses (e.g., landscaping, interior design, or remodeling at the administrator's or owner's personal residence) in its cost report to justify a higher per diem or reimbursement rate from Medicaid.
- Social Welfare Act (MCLA 400.111d): A conviction may result in a denial, suspension, or termination of the provider's license or similar action from Medicaid.
- Public Health Code (MCLA 333.16226): A conviction may result in a fine or probation from Medicaid or the denial, suspension, or revocation of a provider's license.

MDHHS encourages provider assistance in reducing and reporting provider fraud and abuse in Medicaid and violation of HIPAA Privacy regulations. Any provider or employee suspecting that a fraudulent activity is occurring should contact the Michigan Department of Attorney General. (Refer to the Directory Appendix for contact information.)

16.3 FEDERAL LAW

The Office of Inspector General of the U.S. Department of Health & Human Services (HHS) investigates provider fraud, abuse and violation of HIPAA Privacy and Security regulations under federal laws.

The following federal laws are primarily used:

- Social Security Act (Section 1909). A conviction resulting in a penalty of up to five years imprisonment and/or a \$10,000 fine.
- Civil Monetary Penalties Law of 1981 (Section 1128A of the Social Security Act). A conviction may result in a civil monetary penalty of not more than \$2,000 for each item or service, and an assessment of not more than twice the amount claimed for each such item or service in lieu of damages sustained by the federal or state agency because of the fraudulent claim.

To report fraudulent activities to the federal investigators, contact the Office of Inspector General of the U.S. Department of Health & Human Services (HHS). Complaints regarding Michigan health facilities may be reported to the Michigan Health Facility Complaint Line. (Refer to the Directory Appendix for contact information.)



16.4 PATIENT ABUSE

Under federal law, the Department of Attorney General, Health Care Fraud Division (Medicaid Fraud Control Unit) is mandated to investigate and prosecute instances of patient abuse occurring in any Michigan facility receiving Medicaid funds.

Examples of patient abuse are:

- Physical abuse, involving assaulting, striking, or sexually abusing a patient.
- Threat or perceived threat of physical or sexual abuse.
- Neglect resulting from inadequate medical or custodial care or other situations that create health risks to the patient.
- Financial abuse, including misappropriation of patient's personal funds, comingling of patient and facility funds.
- Use of patient funds to pay for facility operations.
- Theft of patient's property.

The above examples are not all inclusive.

Complaints involving suspected abuse of patients within any Michigan facility receiving Medicaid funds should be reported to the Michigan Department of Attorney General's 24-hour toll-free hotline. Complaints may also be mailed to the Attorney General's Medicaid Fraud Unit. (Refer to the Directory Appendix for contact information.)

Pursuant to Section 111b of the Social Welfare Act of 1939 (PA 280, as amended, MCLA 400.111b[7]), a provider is required to make available, to authorized agents of the Department of Attorney General, any record required that must be maintained as a condition of participation in Medicaid.

The Michigan Department of Attorney General is also empowered to investigate and prosecute any complaint involving patient abuse by a provider that receives Medicaid funds. It does not matter whether or not the abused patient is receiving Medicaid benefits. (Patient abuse is defined as harm or threat of harm to a patient's health or welfare by a person responsible for the patient's health or welfare that occurs through nonaccidental physical or mental injury, sexual abuse, or maltreatment.)

16.5 BENEFICIARY FRAUD/ABUSE

A provider can contact the local MDHHS office in the beneficiary's county of residence to report beneficiary fraud, or contact the Office of Inspector General's Recipient Fraud Unit Hotline. (Refer to the Directory Appendix for contact information.)

The provider can also report beneficiary over-utilization of services by contacting the local MDHHS worker or the Benefits Monitoring Program. (Refer to the Directory Appendix for contact information.)



SECTION 17 - PROVIDER APPEAL PROCESS

Any provider participating in, or applicant wishing to participate in, Medicaid has the right to appeal any adverse action taken by MDHHS unless the adverse action resulted from an action over which MDHHS had no control (e.g., Medicare termination, license revocation, court's findings in a criminal case). The method of appeal depends upon the provider type and is subject to the Social Welfare Act, Public Act 280 of 1939 (MCL 400.01 et seq.); Chapters 4 and 6 of the Administrative Procedures Act of 1969 (MCL 24.271 to 24.287, MCL 24.301 to 24.306); and the Public Health Code, Public Act 368 of 1978 (MCL 333.20173b). Most providers are informed of the steps to be taken to appeal the action via the notice of adverse action. (Hospital providers may appeal at the time of adverse action, prior to the notice.) Institutional providers should refer to their respective chapters of this manual for the appropriate steps and time frames for appeal.

Any questions regarding this appeal process should be directed to MOAHR. (Refer to the Directory Appendix for contact information.)



SECTION 18 - REVIEW OF PROPOSED CHANGES

The following guidelines for the development of policies, procedures, forms, and instructions apply to the Medicaid, Children's Special Health Care Services, and other health insurance programs administered by MDHHS.

MDHHS consults with affected providers and other interested parties on those proposed changes in Medicaid policies, procedures, forms, and instructions which are determined significant enough to be communicated to providers by means of a provider bulletin. This consultation process involves a notification of the proposed change and the reasons for the change. MDHHS includes the distribution of draft policy to those parties who have expressed interest in reviewing and commenting on the changes.

Affected provider means any enrolled provider or provider association/organization that is impacted by the proposed changes. Any affected provider or other interested party who would like an opportunity to comment on any proposed changes in his area of interest (e.g., podiatry, hospital, vision) may do so.

Visit the MDHHS website to review draft policies or to request draft policies be sent to you for comment. You may also contact MDHHS directly to request to participate in the policy promulgation process. (Refer to the Directory Appendix for contact information.)

Your request to receive draft policies must include:

- Provider's/Individual's name;
- Telephone number;
- E-mail address;
- Involvement with Medicaid (e.g., Medicaid provider, drug manufacturer, interested party);
- Association/organization represented (if applicable); and
- Specific area(s) of interest to review and comment on (e.g., physician, ambulance, hospital, Maternal Infant Health Program (MIHP), dental, nursing facilities).

Copies of draft bulletins are sent to interested parties via e-mail and are posted on the MDHHS website for a minimum of 30 days. Anyone wishing to comment on proposed changes may submit comments electronically, by fax or by US mail within the comment period.

Comments received are considered and suggestions may be incorporated in the final policy if determined appropriate. Upon completion of the consultation process, a provider bulletin serves as final notice of the change. A summary of the comments made, MDHHS response, and a copy of the final bulletin are sent to those who submitted comments. Proposed changes may have to be implemented before comments are considered if specific action is ordered by governmental entities having authority over MDHHS with time frames that do not allow full compliance with the consultation process. In these cases, comments are requested from affected providers and are considered for incorporation after the implementation of the change.



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MDHHS consults with the Medical Care Advisory Council (composed of consumers, providers, and government officials) in the review of proposed policies and procedures prior to implementation. Numerous provider associations and organizations are also involved in the review process. A provider who feels that his association or the Medical Care Advisory Council adequately represents him may not wish to be included on the provider consultation list.



SECTION 19 - ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAM

The American Recovery and Reinvestment Act of 2009 (Recovery Act) provides the opportunity for state Medicaid programs to improve the nation's healthcare through health information technology (HIT) by authorizing incentives for certain eligible professionals (EP), eligible hospitals (EH), and Critical Access Hospitals (CAH) as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology in their first year of participation and demonstrate meaningful use of EHR technology for up to five remaining participation years.

The HIT provisions of the Recovery Act are primarily found in Title XIII, Division A, Health Information Technology, and in Title IV, Division B, Medicare and Medicaid Health Information Technology. These titles, taken together, are referred to as the Health Information Technology for Economic and Clinical Health (HITECH) Act. The Michigan Medicaid EHR Incentive Program is consistent with the Centers for Medicare & Medicaid Services (CMS) Final Rule 0033 published in the Federal Register (July 28, 2010).

The Recovery Act established 100 percent Federal Financial Participation (FFP) to provide incentive payments to eligible Medicaid providers to purchase, implement, and operate, including support services, staff training, and certified EHR technology.

Eligible professionals and hospitals must meet patient volume thresholds to be eligible for the program.

Incentive payments after the initial adoption, implementation, and upgrading of EHR technology require the provider to demonstrate "meaningful use" of the EHR technology. This is done through a means determined by the State and approved by CMS. The State may also require providers to report clinical quality measures as a part of "meaningful use". As required by CMS, the EHR technology must be compatible with State and Federal administrative management systems and certified with the Certification of Health IT Program under the Office of the National Coordinator for Health Information Technology (ONC).

To participate in the Medicaid EHR incentive program, providers must:

- register with the National Level Repository (NLR) at the federal level. To register with the NLR, providers must have a National Provider Identifier (NPI).
- register as a provider in the Community Health Automated Medicaid Processing System (CHAMPS). Those who are providing services through managed care entities must be individually registered as a Medicaid provider in CHAMPS to verify the provider is in good-standing and is eligible to receive an EHR incentive. Revisions to provider information in the EHR section of CHAMPS will need to be updated by the provider through the NLR.
- have an active user account in the National Plan and Provider Enumeration System (NPPES).
- Hospitals must be enrolled in the CMS Provider Enrollment, Chain and Ownership System (PECOS).

CMS will use the NLR, NPPES and PECOS to register the provider for the program and verify their registration prior to notifying Michigan of eligibility status.

Information specific to the Hospital EHR Incentive Program can be found in the Hospital Reimbursement Appendix Chapter of the Provider Manual. Additional information can be found on websites specific to the Incentive Program. (Refer to the Directory Appendix for website information.)



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SECTION 1 – DETERMINATION OF ELIGIBILITY

This chapter applies to all providers.

1.1 LOCAL MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES OFFICE DETERMINATION

Eligibility for Medicaid and most other health programs is determined at the local Michigan Department of Health and Human Services (MDHHS) office. MDHHS reviews the beneficiary's financial and nonfinancial (e.g., disability, age) factors and determines the types of assistance for which the beneficiary is eligible. Once eligibility is established, data from MDHHS is available via the CHAMPS Eligibility Inquiry. CHAMPS will also issue a **mihealth** card for new beneficiaries.

The MDHHS Medical Services Administration (MSA) determines eligibility for Children's Special Health Care Services (CSHCS).

Some Medicaid beneficiaries are in a deductible situation. This means the beneficiary has met all Medicaid eligibility criteria except he has excess income. (Refer to the Medicaid Deductible Beneficiaries (Spenddowns) Section of this chapter for additional information.)

Migrant agricultural workers may also be eligible for health care benefits. However, due to the transient nature of the migrant population, they might not receive their **mihealth** card. The provider must verify eligibility using the CHAMPS Eligibility Inquiry and/or vendor that receives eligibility data from CHAMPS. (Refer to the Verifying Beneficiary Eligibility Section of this chapter for additional information.)

1.2 ELIGIBILITY BEGIN DATE

Coverage is usually effective the first day of the month that the beneficiary becomes eligible.

- Not all beneficiaries, however, are eligible beginning the first day of the month. Coverage may become effective the actual day the beneficiary becomes eligible.
- In some instances, the beneficiary's eligibility may be retroactive up to three months prior to the month of application. This may occur if, during the retroactive period:
 - All eligibility requirements for the specific health care program were met; and
 - Medical services were rendered.

The provider may submit claims to the Michigan Department of Health and Human Services (MDHHS) for payment of any covered services rendered during the beneficiary's eligibility period. If the beneficiary has previously paid for services and the provider has billed MDHHS for the same services, the provider must refund to the beneficiary the portion of payment the beneficiary is responsible for, regardless of the amount MDHHS pays. (Refer to the Medicaid Deductible Beneficiaries (Spenddowns) Section of this chapter for additional information.)



1.3 REDETERMINATIONS

Beneficiary eligibility is redetermined annually but may occur more often as case circumstances dictate. Beneficiaries are notified of the need to have their cases redetermined and the process to be followed to accomplish this.

1.4 BENEFICIARY APPEALS

Beneficiaries may appeal their eligibility determination/redetermination by contacting their local MDHHS office.

1.5 CORRECTIVE ACTION

Beneficiaries that have been denied Medicaid eligibility and have filed a hearing request may be entitled to a reimbursement if they paid for Medicaid covered services during a corrective action period. The corrective action period begins on the date the hearing request is received by MDHHS and ends on the date that eligibility is established. The services received must have been provided during the established eligibility period, including any months of established retroactive eligibility.

The provider has the option to reimburse the beneficiary in full and bill Medicaid for services rendered. MDHHS encourages the provider to return the amount the beneficiary paid and bill Medicaid for the service. If the provider chooses not to reimburse the beneficiary, the beneficiary can request a direct reimbursement from the State.

In order to be eligible for a direct reimbursement from the State, the beneficiary, or someone legally responsible for the beneficiary's bills, must have paid for a Medicaid covered service during the corrective action period. The beneficiary cannot receive reimbursement for any required copays, patient pay amounts, amounts used to meet a Medicaid deductible, or care or services paid for through private insurance, Medicare, or any other form of government-sponsored or private health care coverage.

To request a refund of medical expenses, the beneficiary must provide a copy of all bills for medical services received on or after February 2, 2004 for which the beneficiary, or someone legally responsible for the beneficiary's bills, paid during the corrective action period to MDHHS.

Bills must include or contain:

- Beneficiary name
- Date the care or service was received
- Amount charged for the care or service
- Amount paid by the beneficiary or legally responsible party
- Date the bill was paid
- Procedure code(s) for the care or service
- Description of each care or service, e.g., office visit, physical therapy, etc. The drug name, quantity dispensed, and the name of the prescribing physician must be included for prescriptions.
- Proof of any payment made by a third party, such as an insurance company



SECTION 2 – MIHEALTH CARD

The **mihealth** card is issued for the following programs:

- Medicaid
- Healthy Michigan Plan
- CSHCS
- Maternity Outpatient Medical Services (MOMS)

The provider must verify eligibility using the CHAMPS Eligibility Inquiry and/or vendor that receives eligibility data from CHAMPS.

(Refer to the Verifying Beneficiary Eligibility Section of this chapter for additional information.)

The **mihealth** card is a plastic, magnetic strip identification card issued once to each beneficiary. The front of the card contains the beneficiary's name and beneficiary ID number. When a family is determined eligible for a health program, a **mihealth** card is issued to each eligible person in the household. All cards for a household are mailed to the head of the household. The **mihealth** card does not contain eligibility information and does not guarantee eligibility until verified using the CHAMPS Eligibility Inquiry that the person is covered.

The provider can use the **mihealth** card to access a beneficiary's eligibility information using the CHAMPS Eligibility Inquiry by entering the beneficiary ID number or swiping the card using a magnetic strip reader.

The 10-digit beneficiary identification (ID) number obtained from the CHAMPS Eligibility Inquiry must be used when billing Medicaid.

The provider should request the beneficiary present a **mihealth** card to access a beneficiary's eligibility information using the CHAMPS Eligibility Inquiry to verify health program eligibility before rendering any service. If the beneficiary does not have a **mihealth** card, the provider can also access the beneficiary's eligibility information with the following additional search methods:

- Member ID/Client Identification Number (CIN)/Pending Eligibility Recipient Identification (RID)
- Last Name, First Name and Date of Birth
- Last Name, First Name and Social Security Number (SSN)
- SSN and Date of Birth



Additional search options (use if needed with one of the search options above to obtain a unique member match):

- Gender
- Zip Code
- Case Number

If the beneficiary has lost his **mihealth** card, a replacement card may be issued by contacting the Beneficiary Helpline. (Refer to the Directory Appendix for contact information.) The provider is encouraged to verify a beneficiary's identity by requesting additional identification (e.g., driver's license, State Police ID, Social Security Card).

If the provider suspects fraud, the case should be reported to the Office of Inspector General. (Refer to the Directory Appendix for contact information.)

Suspected cases of beneficiary program abuse should be sent to the MDHHS Office of Inspector General. (Refer to the Directory Appendix for contact information.)

Occasionally, the provider may see a Statement of Medical Services Paid (MSA-110-EOB). This statement is for the beneficiary's information only and indicates services received and paid on his behalf by MDHHS.

2.1 BENEFIT PLANS [CHANGES MADE 7/1/20]

Providers will need to utilize the Benefit Plan ID(s) indicated in the eligibility response to determine a beneficiary's program coverage and related covered services for a specific date of service. A **"No Records Found!"** message will be displayed under the Benefit Plans section of the CHAMPS eligibility response if there is no Benefit Plan on file for the DOS entered.

Service type codes designate a covered benefit category at the benefit plan level if applicable. The service type codes at the benefit category level are applied unless a more specific service type code more closely describes the coverage intent of a benefit plan. For a complete listing of all service type codes and descriptions, refer to the CHAMPS information posted on the MDHHS website. (Refer to the Directory Appendix for website information.)



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Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source ¹	Covered Services (Service Type Codes)
ALMB	Additional Low Income Medicare Beneficiary	This benefit plan is part of the Medicare Savings Program (MSP), also known as the "Buy-In" Program. It pays the Medicare Part B premium.	No Benefits	XIX	N/A
APS	Ambulatory Prenatal Services	This program provides presumptive eligibility for pregnant women limited to ambulatory prenatal care services only. Covered services include physician visits for prenatal care, prescription drugs related to pregnancy, and prenatal laboratory tests.	Fee-for-service	XIX	4, 5, 50, 69, 88, 98, BU
AUT	Autism Related Services	This plan is for beneficiaries who are at least 18 months and less than 21 years of age who are diagnosed with Autism Spectrum Disorder. The benefit includes Applied Behavioral Analysis services at two different levels: <ul style="list-style-type: none"> ▪ Level 2, or EIBI, is a higher level of benefit for beneficiaries who have Autistic Disorder ▪ Level 1, or ABI, is available to beneficiaries who do not qualify for Level 2 	Managed Care Organization	XIX	MH
BHHMP	Medicaid Behavioral Health NOT Enrolled in an MHP	This plan covers Medicaid mental health and substance abuse services managed by the PIHP for Healthy Michigan Plan (HMP) recipients who have a specialty level of need and are not enrolled in a Medicaid Health Plan (Fee For Service - FFS).	Managed Care Organization	XIX	AL, MH
BHHMP-MHP	Healthy Michigan Plan Behavioral Health Enrolled in an MHP	This plan covers Medicaid mental health and substance abuse services managed by the PIHP for Healthy Michigan Plan (HMP) recipients who have a specialty level of need and are enrolled in a Medicaid Health Plan for Managed Care (MC).	Managed Care Organization	XIX	AI, MH



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Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source ¹	Covered Services (Service Type Codes)
BHMA	Medicaid Behavioral Health NOT Enrolled in an MHP	This plan covers Medicaid mental health and substance abuse services managed by the PIHP for MA recipients who have a specialty level of need and are not enrolled in a Medicaid Health Plan (Fee For Service - FFS).	Managed Care Organization	XIX	AI, MH
BHMA-MHP	Medicaid Behavioral Health Enrolled in an MHP	This plan covers Medicaid mental health and substance abuse services managed by the PIHP for MA recipients who have a specialty level of need and are enrolled in a Medicaid Health Plan for Managed Care (MC).	Managed Care Organization	XIX	AI, MH
BMP	Benefits Monitoring Program	The objectives of the Benefits Monitoring Program (BMP) are to promote quality health care, identify beneficiaries that may be mis/over-utilizing Medicaid benefits, modify improper utilization of services through education and monitoring, and ensure that beneficiaries are receiving medically necessary services. Beneficiaries remain in BMP through changes in eligibility, including enrollment into managed care. For beneficiaries with managed care, the Medicaid Health Plan (MHP) coordinates the member's care.	Managed Care Organization	XIX	N/A
CSHCS	Children's Special Health Care Services	This benefit plan is designed to find, diagnose, and treat children under age 21 with chronic illness or disabling conditions. Persons over age 21 with chronic cystic fibrosis or certain blood coagulation blood disorders may also qualify. Covers services related to the client's CSHCS-qualifying diagnoses. Certain providers must be authorized on a client file.	Fee-for-Service	V, GF	1, 33, 35, 47, 48, 50, 71, 86, 88, 98, AL, UC (Most providers must be authorized)



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Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source ¹	Covered Services (Service Type Codes)
CSHCS-MC	Children’s Special Health Care Services – Managed Care	This plan is assigned to CSHCS beneficiaries who also have full Medicaid coverage and are enrolled in a Medicaid Health Plan (MHP). The MHP receives a capitation payment and provides the full range of covered services. Specific services carved out of the MHP contract will remain covered through MA Fee-For-Service.	Managed Care Organization	V	1, 33, 47, 48, 50, 71, 86, 88, 98, AL, UC
CSHCS-MH	CSHCS Medical Home	This is a capitated "case management" benefit plan for CSHCS members. CSHCS Medical Home clients are identified by the Medical Home Indicator in the member's CSHCS eligibility file.	Managed Care Organization	V	CQ
CWP	Children’s Home and Community Based Services Waiver	<p>This benefit plan provides services that are enhancements or additions to Medicaid state plan services for children under age 18 with developmental disabilities who are enrolled in the Children’s Home and Community-Based Services Waiver Program (CWP). The CWP is a statewide Fee-for-Service program administered by Community Mental Health Service Programs (CMHSPs).</p> <p>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.</p> <p>NOTE: This benefit plan is obsolete as of 10/01/2019. Beneficiaries are now assigned to the CWP-MC benefit plan.</p>	Fee-for-Service	XIX	MH



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Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source ¹	Covered Services (Service Type Codes)
CWP-MC	Children's Waiver Program Managed Care	<p>This benefit plan provides services that are enhancements or additions to Medicaid state plan services for children under age 18 with developmental disabilities who are enrolled in the Children's Waiver Program (CWP). The CWP is a statewide managed care program.</p> <p>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.</p>	Managed Care Organization	XIX	N/A
DHIP	Foster Care and CPS Incentive Payment	<p>This benefit plan is designed to provide an incentive payment to the PIHPs to serve Medicaid-eligible children in foster care and Medicaid-eligible children in Child Protective Services, Risk Category I and II.</p> <p>There are two incentive payment options:</p> <ul style="list-style-type: none"> ▪ Incentive Payment 1 – is at least two different non-assessment behavioral health services were provided in the eligible month. ▪ Incentive Payment 2 – is at least one of either home-based services or wraparound services were provided in the eligible month. <p>If a PIHP provides services to a beneficiary in a given month meeting the criteria for both Incentive Payment 1 and 2, the PIHP will only receive payment for Incentive Payment 2.</p>	Managed Care Organization	XIX	MH



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Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source ¹	Covered Services (Service Type Codes)
HHBH	Health Home Behavioral Health	Medicaid Health Home services are intended for beneficiaries with Severe Mental Illness (SMI) who have experienced high rates of inpatient hospital admissions or high rates of hospital emergency department usage and who may or may not have other chronic physical health conditions that are amenable to care coordination and management by the health home (i.e., congestive heart failure, insulin treated diabetes, chronic obstructive pulmonary disorder, seizure disorder). Individuals to whom these conditions apply may be determined by the state to be eligible to receive Health Home services.	Managed Care Organization	XIX	AI, MH
HH MICARE	Health Home MI Care Team	MI Care Team services are intended for Medicaid beneficiaries with specific chronic behavioral and physical health conditions, which includes a diagnosis of depression and/or anxiety and at least one of the following: heart disease, COPD, hypertension, diabetes, or asthma. Individuals to whom these conditions apply may be determined by the State to be eligible to receive MI Care Team services. MI Care Team services include a personalized care management plan and intense care coordination that addresses the physical and social needs of the individual.	Managed Care Organization	XIX	CQ
HK - Dental	Healthy Kids Dental	MDHHS contracts with dental health plans (DHPs) for the administration of dental services for Healthy Kids Dental (HKD) beneficiaries. The DHPs are paid a monthly capitation rate to provide covered services to enrolled Medicaid beneficiaries. The DHP is responsible for providing, arranging, and reimbursing covered dental services. DHPs may cover additional dental services not included on the MDHHS Dental Fee Schedule. Providers must contact the DHP for specific information about covered HKD benefits.	Managed Care Organization	XIX-XXI	35



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Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source ¹	Covered Services (Service Type Codes)
HK-EXP	Full Fee-for-Service Healthy Kids - Expansion	Benefits mirror Fee-for-Service Medicaid. This benefit plan covers children who are under the age of 19 from 100% FPL up to 160% FPL. This benefit plan is funded by CHIP.	Fee-for-Service	XXI	1, 33, 35, 47, 48, 50, 71, 86, 88, 98, AL, MH, UC (35: FFS dental only if HK-Dental Benefit Plan (revised 7/1/20) is not assigned for DOS)
HK-EXP-ESO	Healthy Kids - Expansion - Emergency Services Only	Benefits mirror Medical Assistance Emergency Services Only (MA-ESO). Children who do not meet the Medicaid citizenship requirements to be eligible for full Medicaid may be eligible for Emergency Services Only (ESO). This benefit plan is funded by CHIP. ²	Fee-for-Service	XXI	86; 1, 47, 48, 50, 88, 91, 92, MH, UC Emergency Services Only
Hospice	Hospice	This healthcare program is designed to meet the needs of terminally ill individuals when the individual decides that curative treatment is no longer in their best interest. These individuals choose palliative care, which is not a cure, but ensures comfort, dignity, and quality of life. Hospice is intended to address the needs of the individual with a terminal illness, while also considering family needs. Michigan Medicaid covers hospice care for a terminally ill beneficiary whose life expectancy is six months or less (if the illness runs its normal course), as determined by a licensed physician and the Hospice Medical Director.	Fee-for-Service	XIX	45



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Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source ¹	Covered Services (Service Type Codes)
HSW	Habilitation Supports Waiver Program	Beneficiaries with developmental disabilities may be enrolled in this Program to receive the supports and services as defined. HSW beneficiaries may also receive other Medicaid state plan or additional/B3 services. NOTE: This benefit plan is obsolete as of 10/01/2019. Beneficiaries are now assigned to the HSW-MC benefit plan.	Managed Care Organization	XIX	MH
HSW-MC	HSW Habilitation Supports Waiver Program Managed Care	Beneficiaries with intellectual or developmental disabilities may be enrolled in Michigan's Habilitation Supports Waiver (HSW) and receive the supports and services as defined. HSW beneficiaries may also receive other Medicaid state plan services.	Managed Care Organization	XIX	N/A
ICF-IID	Intermediate Care Facility for Individuals with Intellectual Disabilities	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.	Fee-for-Service	XIX	CG
ICO-MC	Integrated Care - MI Health Link	This capitated managed care program is for beneficiaries who are age 21 or older and who are dually eligible for Medicare and Medicaid. The benefit plan is active only in parts of the state. The benefit includes all Medicare and Medicaid physical health services, long term supports and services, and 1915b/c waiver services for qualifying individuals.	Managed Care Organization (revised 7/1/20)	XIX	1, 33, 35, 42, 47, 48, 50, 54, 56, 71, 86, 88, 98, AL, UC
INCAR-ESO	Incarceration – Emergency Services Only	This benefit plan restricts services to inpatient hospital emergencies only while an otherwise ESO eligible member is incarcerated.	Fee-for-Service	XIX	48 Emergency Services Only



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Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source ¹	Covered Services (Service Type Codes)
INCAR-MA	Incarceration - MA	A Medicaid-funded benefit plan that restricts services to an off-site inpatient hospital while an otherwise eligible member is incarcerated.	Fee-for-Service	XIX	48
INCAR-MA-E	Incarceration – MA - Emergency Services Only	This benefit plan restricts services to inpatient hospital emergencies only while an otherwise MA-ESO eligible member is incarcerated.	Fee-for-Service	XIX	48 Emergency Services Only
LTC-EXEMPT	Long Term Care Exempt	Beneficiaries that are excluded from Long Term Care and Support Services because of Divestment, not meeting LOCD or PASARR requirements, or not returning asset verification.	No Benefits	XIX	N/A
MA	Full Fee-for-Service Medicaid	Members are generally assigned to this benefit plan upon approval of their eligibility information and remain active even if eventually assigned to MA Managed Care (MA-MC). Once assigned to a Managed Care Organization, the health plan is the primary payer.	Fee-for-Service	XIX	1, 33, 35, 47, 48, 50, 71, 86, 88, 91, 92, 98, AL, MH, UC (35: FFS dental only if HK-Dental Benefit Plan (revised 7/1/20) is not assigned for DOS)
MA-ESO	Medical Assistance Emergency Services Only	Individuals who do not meet the Medicaid citizenship requirements to be eligible for full Medicaid may be eligible for Emergency Services Only (ESO). ²	Fee-for-Service	XIX	86; 1, 47, 48, 50, 88, 91, 92, MH, UC Emergency Services Only



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Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source ¹	Covered Services (Service Type Codes)
MA-FTW	Freedom to Work	Freedom to Work is available to a client with disabilities, age 16 through 64, who has earned income. The client must be disabled according to the disability standards of the Social Security Administration, except employment, earnings, and substantial gainful activity (SGA) cannot be considered in the disability determination. The client must be employed. There may be temporary breaks in employment up to 24 months if they are the result of involuntary layoff or are determined to be medically necessary. FTW coverage is retained when a participant is relocated due to employment.	Fee-For-Service	XIX	1, 33, 35, 47, 48, 50, 71, 86, 88, 91, 92, 98, AL, MH, UC (35: FFS dental only if HK-Dental Benefit Plan (revised 7/1/20) is not assigned for DOS)
MA-HMP	Healthy Michigan Plan	This plan provides health care benefits to adults 19 through 64 years of age, not covered by or eligible for Medicaid, with family incomes at or below 133% of the federal poverty level (FPL) and who are not eligible for or enrolled in Medicare. Eligibility is determined through the Modified Adjusted Gross Income (MAGI) methodology.	Fee-for-Service	XIX	1, 33, 35, 47, 48, 50, 71, 86, 88, 91, 92, 98, AL, MH, UC
MA-HMP-ESO	Healthy Michigan Plan Emergency Services Only	Individuals who do not meet the Healthy Michigan Plan citizenship requirements to be eligible for full coverage may be eligible for Emergency Services Only (ESO).	Fee-for-Service	XIX	86; 1, 47, 48, 50, 88, 91, 92, MH, UC Emergency Services Only
MA-HMP-INC	Healthy Michigan Plan Incarceration	This program restricts services to an inpatient hospital setting while an otherwise Healthy Michigan Plan eligible member is incarcerated.	Fee-for-Service	XIX	48



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Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source ¹	Covered Services (Service Type Codes)
MA-HMP-MC	Healthy Michigan Plan - Managed Care	This capitated program provides benefits to the Healthy Michigan Plan members through enrollment in a Medicaid Health Plan (MHP). Certain services not covered under this plan could be covered through MA-HMP Fee-for-Service.	Managed Care Organization	XIX	1, 33, 35, 47, 48, 50, 71, 86, 88, 91, 92, 98, AL, MH, UC
MA-MC	Medicaid - Managed Care	Full Medicaid for Managed Care Organization enrollment. This capitated plan will be set to a higher priority than MA (Fee-for-Service). Some services not covered under this plan could be covered in MA.	Managed Care Organization	XIX	1, 33, 47, 48, 50, 71, 86, 88, 98, AL, MH, UC
MA-MIChild	MIChild Program (CHIP)	MA-MIChild is a Medicaid program administered by the Department of Health and Human Services (MDHHS). It is for the low income uninsured children of Michigan's working families. Like Healthy Kids, MIChild is for children who are under age 19. Members are generally assigned to this benefit plan upon receipt of their eligibility information and remain active even if eventually assigned to MA Managed Care (MA-MC). Once assigned to a Managed Care Organization, the health plan is the primary payer.	Fee-for-Service	XXI	1, 33, 35, 47, 48, 50, 71, 86, 88, 98, AL, MH, UC (35: FFS dental only if HK-Dental Benefit Plan (revised 7/1/20) is not assigned for DOS)
MIChild-ESO	MIChild Program – Emergency Services Only (CHIP)	Benefits mirror HK-EXP-ESO. Aliens who are not otherwise eligible for full coverage because of citizenship status may be eligible for Emergency Services Only (ESO). This benefit plan is funded by CHIP. ²	Fee-for-Service	XXI	86; 1, 47, 48, 50, 88, 91, 92 MH, UC Emergency Services Only
		(Information for MI Choice removed 7/1/20 as information was obsolete.)			



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Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source¹	Covered Services (Service Type Codes)
MI Choice-MC	Home and Community Based Waiver Services - Managed Care	The MI Choice Waiver is a managed care program that provides home and community-based services for aged and other disabled adults who meet the nursing facility level of care. The program's goal is to provide long-term services and supports that allow persons to remain at home or similar community-based settings. These persons qualify for nursing facility services but choose to receive services in their home. MI Choice beneficiaries are eligible to receive Medicaid state plan services but are excluded from enrollment in a Medicaid Health Plan.	Managed Care Organization	XIX	42
MME-MC	Medicaid-Medicare Dually Eligible – Managed Care	Managed Care Organization enrollment for beneficiaries with dual Medicare and full Medicaid eligibility.	Managed Care Organization	XIX	1, 33, 47, 48, 50, 71, 86, 88, 98 AL, MH, UC
MOMS	Maternity Outpatient Medical Services	The Maternity Outpatient Medical Services (MOMS) program provides immediate health coverage for the unborn child of an undocumented pregnant woman. The MOMS program is available to provide immediate prenatal care. Prenatal health care services will be covered by MOMS for the entire pregnancy and for two calendar months after the pregnancy ends. Family Planning Services and supplies are covered under this plan using State of Michigan General Funds.	Fee-for-Service	XXI, GF	47, 48, 50, 69, 82, 88, 98, BU
NEMT	Non-Emergency Medical Transportation	This benefit plan provides Non-Emergency Medical Transportation (NEMT) for MA covered services. The NEMT benefit plan is administered by MDHHS through a contractor and is available in selected counties. NEMT for services covered by the Medicaid Health Plan is provided under the Medicaid Health Plan Benefit Plans (MA-MC, MME-MC, and CSHCS-MC).	Managed Care Organization	XIX	56



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Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source ¹	Covered Services (Service Type Codes)
NH	Nursing Home	This benefit is for qualifying members residing in a nursing home. A facility or institution must be licensed, certified, or otherwise qualified as a nursing home or long term care facility by the state in which services are rendered. This term includes skilled, intermediate, and custodial care facilities which operate within the terms of licensure.	Fee-for-Service	XIX	54
PACE	Program All-Inclusive Care for Elderly	This program is an innovative model of community-based care that enables elderly individuals, who are certified by their state as needing nursing facility care, to live as independently as possible. PACE provides an alternative to traditional nursing facility care by offering pre-paid, capitated, comprehensive health care services.	Managed Care Organization	XIX	1, 33, 35, 47, 48, 50, 54, 71, 86, 88, 98, AL, MH, UC
PIHP	Prepaid Inpatient Health Plan	This benefit plan provides specialty behavioral health services for individuals enrolled in MA. NOTE: This benefit plan is obsolete as of 10/01/2019. Beneficiaries are now assigned either the BHMA or BHMA-MHP benefit plan. (text added 7/1/20)	Managed Care Organization	XIX	AI, MH
PIHP-HMP	PIHP Healthy Michigan Plan	This benefit plan provides managed care specialty behavioral health services for individuals enrolled in the Healthy Michigan Plan. NOTE: This benefit plan is obsolete as of 10/01/2019. Beneficiaries are now assigned either the BHHMP or BHHMP-MHP benefit plan. (text added 7/1/20)	Managed Care Organization	XIX	AI, MH



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Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source ¹	Covered Services (Service Type Codes)
QDWI	Qualified Disabled Working Individual	A client must have applied for or be enrolled in Medicare Part A as a working disabled person who has exhausted Premium-free Part A and whose SSA disability benefits ended because the client's earnings exceed SSA's gainful activity limits. Medicaid pays the client's Medicare Part A premium only.	No Benefits	XIX	N/A
QMB	Qualified Medicare Beneficiary – All Inclusive	This benefit plan is part of the Medicare Savings Program (MSP), also known as the "Buy-In" program. A client must be entitled to Medicare Part A. Under certain income limits, Medicaid pays for Medicare Part B premiums, deductibles and co-insurance. This is an all-inclusive benefit plan.	Fee-for-Service	XIX	N/A
SED	Children's Serious Emotional Disturbance Waiver Program	The Waiver for Children with Serious Emotional Disturbances (SEDW) provides services that are enhancements or additions to Medicaid state plan services for children under age 21. MDHHS operates the SEDW through contracts with Community Mental Health Service Programs (CMHSPs). The SEDW is a fee-for-service program administered by the CMHSP in partnership with other community agencies and is currently available in a limited number of counties and CMHSPs. The SEDW enables Medicaid to fund necessary home and community-based services for eligible children. The CMHSP is responsible for assessment of potential waiver candidates. Application for the SEDW is made through the CMHSP, and the CMHSP is responsible for the coordination of the SEDW services. NOTE: This benefit plan is obsolete as of 10/01/2019. Beneficiaries are now assigned to the SED-MC benefit plan.	Fee-for-Service	XIX	MH



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Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source ¹	Covered Services (Service Type Codes)
SED-DHS	Children's Serious Emotional Disturbance Waiver Program - DHS	<p>The Waiver for Children with Serious Emotional Disturbances (SEDW) provides services that are enhancements or additions to Medicaid state plan services for children under age 21. MDHHS operates the SEDW through contracts with Community Mental Health Service Programs (CMHSPs). The SEDW is a fee-for-service program administered by the CMHSP in partnership with other community agencies and is currently available in a limited number of counties and CMHSPs. The SEDW enables Medicaid to fund necessary home and community-based services for eligible children. The CMHSP is responsible for assessment of potential waiver candidates. Application for the SEDW is made through the CMHSP, and the CMHSP is responsible for the coordination of the SEDW services. The SED-DHS Benefit Plan implements a collaborative agreement to expand behavioral health services for children in the foster care system and children adopted from Michigan's Child Welfare System.</p> <p>NOTE: This benefit plan is obsolete as of 10/01/2019. Beneficiaries are now assigned to the SED-MC benefit plan. (text added 7/1/20)</p>	Fee-for-Service	XIX	MH
SED-MC	Serious Emotional Disturbances Managed Care	<p>The Waiver for Children with Serious Emotional Disturbances (SEDW) provides services that are enhancements or additions to Medicaid state plan services for children under age 21. The SEDW is a statewide managed care program. The SEDW enables Medicaid to fund necessary home and community-based services for eligible children with a serious emotional disturbance who meet admission criteria for psychiatric hospitalization.</p>	Managed Care Organization	XIX	N/A



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Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source ¹	Covered Services (Service Type Codes)
SLMB	Specified Low Income Medicare Beneficiary	A client must have applied for or be enrolled in Medicare Part A. Under certain income limits, Medicaid pays the client's Medicare Part B premium only; Expanded Specified Low-Income Medicare Beneficiary (ESLMB): A client must have applied for or be enrolled in Medicare Part B and not be eligible for any other Medicaid coverage. Under certain income limits, Medicaid pays the client's Medicare Part B premium only. No specific benefits are defined for this plan.	No Benefits	XIX	N/A
Spend-down	Medical Spend-down	If the individual's net income is over the Medicaid limit, the amount in excess is established as a "spend-down amount." In order for the person to qualify for Medicaid during the months, he/she must incur medical bills equal to the spend-down amount. Medicaid will pay expenses incurred above this amount. If a group member is liable for bills incurred before the spend-down period began, these bills can be used to meet the spend-down.	No Benefits	XIX	N/A
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.	Fee-for-Service	XIX	48



Benefit Plan ID	Benefit Plan Name	Benefit Plan Description	Type	Funding Source ¹	Covered Services (Service Type Codes)
TCMF	Targeted Case Management	The benefit describes Targeted Case Management (TCM) services provided to pregnant women and children up to age 21 with household income up to and including 400% of the federal poverty level (FPL) who were served by the Flint water system on or between April 1, 2014 and the date the water is deemed safe by the appropriate authorities. Pregnant women will remain eligible throughout their pregnancy and will receive two months of post-partum coverage. Once eligibility has been established for a child, including those children born to pregnant women, the child will remain eligible until age 21 as long as other eligibility requirements are met. TCM services assist individuals in gaining access to appropriate medical, educational, social, and/or other services. TCM services include assessments, planning, linkage, advocacy, coordination, referral, monitoring, and follow-up activities.	Fee-for-Service	XIX and XXI	CQ
<p>¹ Social Security Act Title V, Title XIX, Title XXI, and/or State of Michigan General Funds</p> <p>² For the purpose of ESO coverage, federal Medicaid regulations define an emergency medical condition as a sudden onset of a physical or mental condition which causes acute symptoms, including severe pain, where the absence of immediate medical attention could reasonably be expected to:</p> <ul style="list-style-type: none"> ▪ Place the person’s health in serious jeopardy, or ▪ Cause serious impairment to bodily functions, or ▪ Cause serious dysfunction of any bodily organ or part. 					

2.2 PATIENT PAY INFORMATION

Patient pay is the beneficiary's financial liability. It is shown in whole dollars only and is provided in the CHAMPS eligibility response if the amount is on file for the DOS (e.g., 00050 is \$50.00, not 50 cents; 1285 is \$1,285.00; or 0 (zero) indicates no patient pay amount). This amount applies to inpatient hospitals, nursing facilities (including ICF/IIDs), and hospice while in a nursing facility. (Refer to the Patient Pay Amount Section of this chapter for more information.)

(Subsection 2.3 LOC to PET Crosswalk Table was deleted 7/1/20.)



2.3 SCOPE/COVERAGE CODES [RE-NUMBERED 7/1/20]

The beneficiary's scope/coverage code indicates the extent of Medicaid coverage. The scope/coverage code is two characters. The first character (numeric) indicates the scope of eligibility. This code is used for administrative purposes only.

Scope Code	Program	Qualifying Information
1	Medicaid	When used in conjunction with Coverage Codes D, E, F, K, Q, T, or V
2	Medicaid	When used in conjunction with Coverage Codes B, C, E, F, J, H, T, V, or 0 (zero)
3	Healthy Michigan Plan	When used in conjunction with Coverage Codes E or G
4	Refugees and Repatriates	When used in conjunction with Coverage Code F
7	MA-MICHILD (CHIP)	When used with Coverage Codes W or E

The second character (alpha) indicates the coverage available for this beneficiary. It is this part of the scope/coverage code that the provider should be aware of prior to rendering the service.

Coverage Code	Qualifying Information
0 (zero)	No Medicaid eligibility/coverage (refer to the Medicaid Deductible Beneficiaries (Spendedowns) Section of this chapter for additional information)
B	Qualified Medicare Beneficiary (QMB) (pays Medicare Parts A & B premiums, coinsurances, and deductibles)
C	Specified Low Income Medicare Beneficiary (SLMB) (pays Medicare Part B premium)
D	Freedom to Work Beneficiary (full Medicaid coverage)
E	Emergency or urgent Medicaid, MICHild, or Healthy Michigan Plan coverage only
F	Full Medicaid coverage
G	Healthy Michigan Plan



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Coverage Code	Qualifying Information
H	Additional Low Income Medicare Beneficiary (ALMB) (pays Medicare Part B premium)
J	Additional Low Income Medicare Beneficiary (ALMB) (pays part of Medicare Part B premium)
K	Freedom to Work Beneficiary (full Medicaid coverage)
Q	Medicare Qualified Disabled Working Individual
R	Resident County Hospitalization only (administered by the local MDHHS office which approves hospitalization and is the payer)
T	Healthy Kids (full Medicaid coverage)
V	Healthy Kids (emergency services only)
W	Full MA-MIChild

2.4 MIHEALTH CARD SAMPLE [RE-NUMBERED 7/1/20]





2.5 SPECIAL PROGRAMS – BENEFICIARY IDENTIFICATION [RE-NUMBERED 7/1/20]

Benefit Plan ID	Program/Eligibility Type
ALMB (No Medicaid coverage exists and no card issued.) CHAMPS Eligibility Response will indicate " No Records Found. "	Additional Low-Income Medicare Beneficiary (ALMB) Q1 – Medicaid pays the Medicare Part B premium provided funding is available
BMP	Benefits Monitoring Program
MA (Benefit Plan will be on file once the spend-down is met.)	Medicaid Spend-down met
MA-ESO, MA-HMP-ESO, or HK-EXP-ESO	Limited Medicaid Coverage (Medicaid only covers emergent/urgent services)
MA-MC, MA-HMP-MC	Beneficiary enrolled in a Medicaid Health Plan
QDWI (No Medicaid coverage exists and no card issued.) CHAMPS Eligibility Response will indicate " No Records Found. "	Qualified Disabled Working Individual (QDWI) - Medicaid pays the Medicare Part A premium
QMB	Qualified Medicare Beneficiary (QMB) Only - Medicaid pays Medicare Part B premiums, coinsurance, and deductibles
SLMB (No Medicaid coverage exists and no card issued.) CHAMPS Eligibility Response will indicate " No Records Found. "	Specified Low Income Medicare Beneficiary (SLMB) – Medicaid pays the Medicare Part B premium
Spend-down (No coverage exists and no card issued.)	Medicaid Spend-down not met
Spend-down & MSP (Medicare Savings Program) (No Medicaid coverage exists. Once the spend-down amount is met, the 'MA' Benefit Plan will be on file.)	Medicaid Deductible not met with QMB



SECTION 3 – VERIFYING BENEFICIARY ELIGIBILITY

The **mihealth** card does not contain eligibility information and does not guarantee eligibility. The provider can use the **mihealth** card to access a beneficiary's eligibility information using the CHAMPS Eligibility Inquiry and/or vendor that receives eligibility data from CHAMPS prior to rendering services.

3.1 CHAMPS ELIGIBILITY INQUIRY

Providers may verify beneficiary eligibility using:

- CHAMPS Eligibility Inquiry
- HIPAA 270/271 (Eligibility Inquiry/Response) transactions
- Web-based options

(Refer to the Directory Appendix for contact and website information.)

Beneficiary information is confidential under federal guidelines and must be used only for verifying beneficiary eligibility. If the beneficiary is eligible, the following information is available from the eligibility response:

- Beneficiary name, beneficiary ID number or MICHild Client Identification Number (CIN), gender, DOB.
- Benefit Plan ID(s) for the date of service (DOS). (Refer to the Benefit Plans subsection for additional information.)
- PET information (including the PET code), Source Provider ID (supplied through MDHHS), National Provider Identifier (NPI), provider name, telephone number, address, and the patient pay amount, if applicable.
- Medicaid Health Plan (MHP) Primary Care Physician (PCP), including the PCP name, telephone number, and NPI. (NOTE: Data is provided only if the date of service is the current date and a PCP record is on file.)
- Third-Party Liability (TPL), including the payer name, payer ID, coverage type code, group number, policy number, and policyholder ID.
- CSHCS restriction data, including qualifying diagnosis code(s) and authorized provider list if the provider submitting the inquiry is authorized for the DOS.

NOTE: The 270/271 response will report up to eight (8) diagnosis codes for a single date of service. Refer to CHAMPS Eligibility Inquiry to obtain all approved diagnosis codes if more than eight (8) diagnosis codes exist for the date of service.

- Other information: Transaction date (when the data was applied to the Eligibility Subsystem), current county of residence, MDHHS case number, MDHHS worker load number, and local MDHHS office phone number.
- Pending Eligibility (Medicaid-related programs only): Providers will have the option to see if eligibility is pending.



NOTES:

- Dental coverage information is identified by using the Benefit Plan ID data provided in the eligibility response. For Healthy Michigan Plan beneficiaries enrolled in a health plan, dental benefits must be verified through the health plan. (Refer to the Benefit Plans subsection of this chapter and the Enrollment Information subsection of the Dental Chapter for additional information.)

Note: The CHAMPS Eligibility Inquiry and 270/271 response will report "FFS Dental" for Medicaid, MICHild and Healthy Kids Expansion beneficiaries who have Fee For Service Dental.

- For Managed Care Organizations (MCOs), beneficiary scope and coverage information is included on the 834 format enrollment files. Additional information is available on the MDHHS website. (Refer to the Directory Appendix for website information.)
- The CHAMPS Eligibility Inquiry and 270/271 response will report the HIPAA Service Type code for services covered under each Benefit Plan and any applicable copay amounts. A generic or explicit response will be returned, determined by the type of inquiry (generic or explicit) received through the electronic 270 eligibility request. Always refer to the applicable chapters in this Manual to obtain detailed information on all covered services, including PA requirements, copay amounts/exclusions, and other requirements for the Benefit Plan ID(s) reported in the eligibility response.

Beneficiary eligibility may be queried using the beneficiary ID number or the Client Identification Number (CIN) (for MICHild inquiries only); or, if the ID number is not available, by using one of the following additional search options:

- Beneficiary social security number (SSN) and date of birth (DOB).
- Beneficiary name and SSN (or DOB).

NOTE: Additional search options (use if needed with one of the search options above to obtain a unique member match) include:

- Gender
- Zip Code

Date of Service criteria includes the following:

- Providers can enter a single DOS or up to a 3-month DOS span. (NOTE: DOS is not required for a pending eligibility inquiry since a response is returned if a pending record exists in CHAMPS.)
- Future DOS allowed only up to the end of the current month.
- Providers are allowed to submit a DOS within 12 months of the date of inquiry.

Providers must be enrolled for the DOS in order to receive the eligibility response.

3.2 ACCESSING CHAMPS ELIGIBILITY INQUIRY

CHAMPS is a web-based system. Providers should refer to the Eligibility Verification section of the Directory Appendix of this manual for website information.



NOTE: Options require providers to submit their NPI number or CHAMPS Provider ID number (HIPAA Exempt providers only).

3.3 ELIGIBILITY VERIFICATION FOR DATES OF SERVICE OVER 12 MONTHS OLD

MDHHS follows CMS guidelines regarding release of eligibility information. An exception is allowed for Hospital providers (Enrollment Type: FAO) to submit DOS older than 12 months for inpatient related services only to complete Medicare DSH audits. Providers must complete the DSH question under the "Manage Provider Checklist" page in the CHAMPS-PE Subsystem and receive approval from MDHHS. To obtain this information, hospitals should refer to the Eligibility Verification section of the Directory Appendix for contact information. There may be a transaction fee charged to the requester for these DSH inquiries.



SECTION 4 – MEDICAID DEDUCTIBLE BENEFICIARIES (SPENDDOWNS)

4.1 ELIGIBILITY

There are cases when beneficiaries have the medical need for Medicaid coverage but they have excess income. These beneficiaries are known as Medicaid deductible beneficiaries. Medicaid deductible means that the beneficiary must incur medical expenses each month equal to, or in excess of, an amount determined by the local MDHHS worker to qualify for Medicaid. Once the deductible amount has been incurred, the beneficiary becomes eligible for Medicaid benefits (Benefit Plan ID of MA). Providers must verify Medicaid coverage using the Benefit Plan ID(s) provided in the CHAMPS Eligibility Inquiry.

The process for a Medicaid deductible beneficiary to become Medicaid eligible is as follows:

- The beneficiary presents proof of any medical expenses incurred (e.g., insurance premiums, bills for prescriptions and/or office visits) to the MDHHS worker. Providers may estimate any other insurance or Medicare payment that may be applied to the incurred bill. If the exact charge is not immediately known, providers should estimate the charge on the incurred bill. This expedites the eligibility process.
- The local MDHHS worker reviews the medical bills incurred and determines if the amount of beneficiary liability is met and the first date of Medicaid eligibility.
 - It is fraud to provide beneficiaries with a notice of a bill incurred if no service has been rendered.
 - Bills for services rendered prior to the effective date of Medicaid eligibility are the beneficiary's responsibility.
- For the first date of eligibility, the MDHHS worker sends letters to those providers whose services are:
 - Entirely the beneficiary's responsibility.
 - Partly the beneficiary's responsibility and partly Medicaid's responsibility.
- A letter is also sent to the beneficiary indicating which services are the beneficiary's responsibilities for that first date of Medicaid eligibility.
- The beneficiary's Benefit Plan ID is changed to MA, MA-ESO, or MA-HMP to indicate the Medicaid eligibility period. The provider must verify eligibility using the CHAMPS Eligibility Inquiry when the beneficiary becomes eligible. Once the deductible amount is incurred, eligibility is established through the end of the month.

Providers may bill Medicaid for any covered services rendered during that eligible period.

Before billing, providers should verify that the Benefit Plan ID of MA, MA-ESO, or MA-HMP is on file for the DOS. This will assure that the claims will not be rejected for lack of eligibility.



4.2 RETROACTIVE ELIGIBILITY

Providers should be aware that, since bills have to be incurred before the deductible amount is met, there is always a period of retroactive eligibility. This may be several days or up to a period of three months from the current month. In this situation, the local MDHHS office may apply these old bills to the past three months or may prospectively apply them to the next several months, depending on the DOS and the date the bill was presented to the MDHHS worker.

It is the provider's option to bill Medicaid if the beneficiary has paid the provider for services rendered. MDHHS encourages the provider to return the amount the beneficiary paid and bill Medicaid for the service. If the provider decides to bill Medicaid, he must return all money the beneficiary paid over and above the amount identified as the beneficiary's responsibility on the Medicaid deductible letter. If the beneficiary is accepted as a Medicaid beneficiary, he cannot be charged more than indicated on the letter from the local MDHHS office (plus applicable copayment amounts).

4.3 BILLING INSTRUCTIONS

There may be services that are partly the beneficiary's liability and partly Medicaid's liability. If the provider chooses to bill Medicaid for this service, he should refer to the Billing & Reimbursement Chapters of this manual for instructions for submitting claims.

Beneficiaries are responsible for payment of expenses that were incurred to meet the deductible amount. Payment does not have to be made before Medicaid eligibility is approved. Providers may bill a beneficiary for services rendered after a claim rejects for lack of Medicaid eligibility.

(Refer to the Qualified Medicare Beneficiary Section of this chapter for information on Medicaid deductible beneficiaries and Benefit Plan ID of QMB.)



SECTION 5 – CONTRACTUAL CARE ARRANGEMENTS FOR LONG TERM CARE

A **life care contract** is created when an individual enters into an agreement with a continuing care retirement community to provide for all the individual's needs, including health care, for the rest of his life. The individual pays a one-time entrance fee and monthly payments thereafter. The continuing care retirement community assumes full financial responsibility if the individual is unable to make his monthly payments at a later date. An individual with a life care contract is not eligible for Medicaid.

A **continuing care contract** is created when an individual enters into an agreement with a continuing care retirement community to provide or pay for all, or some of, the individual's medical care for the rest of his life. The individual pays a one-time entrance fee and monthly payments thereafter. An individual with a continuing care contract may be eligible for some Medicaid services.



SECTION 6 – MEDICARE SAVINGS PROGRAM (MSP)

6.1 GENERAL INFORMATION

Federal regulations require that Medicaid purchase Medicare coverage for some beneficiaries and reimburse providers for the Medicare coinsurance and deductible amounts. If these beneficiaries are not also eligible for Medicaid, they have a Benefit Plan ID of QMB. Medicaid only reimburses providers for the Medicare coinsurance and deductible amounts up to the Medicaid maximum amount. Medicaid does not reimburse services not covered by Medicare.

6.2 MEDICAID DEDUCTIBLE BENEFICIARIES (SPENDDOWNS) AND MSP

Beneficiaries may be a MSP and also a Medicaid deductible beneficiary. The beneficiary will have a Benefit Plan ID of QMB until the deductible amount has been met. The Benefit Plan ID will change to MA once the deductible amount is met. For this Medicaid eligibility period, Medicaid reimburses the provider for Medicaid-covered services, as well as the Medicare coinsurance and deductible amounts up to the Medicaid allowable.

If Medicare covers the service, the provider may bill Medicaid for the coinsurance and deductible amounts only. For any Medicare noncovered services, the beneficiary should obtain proof of the incurred medical expense to present to the MDHHS worker so the amount may be applied toward the beneficiary's Medicaid deductible amount.



SECTION 7 – NEWBORN CHILD ELIGIBILITY

A newborn is defined as a child aged 0 (birth) to 1 year old. Generally, Medicaid automatically covers a child born to a woman eligible for and receiving Medicaid at the time of the birth. The mother is required to notify the local MDHHS office of the birth of the newborn within ten days of the birth. (Refer to the General Information for Providers Chapter of this manual for PACER requirements for newborns.)

If the mother is enrolled in a Medicaid Health Plan (MHP) at the time of delivery, the newborn's services are also the responsibility of the MHP unless the child is placed in foster care.

7.1 HOSPITAL NEWBORN NOTICE

In the few cases where this process may be delayed, the hospital's submission of the newborn birth through the State's Electronic Birth Certificate (EBC) system will add the Medicaid coverage and assign a MHP to the newborn. This process is the most efficient way for hospitals to obtain a Medicaid ID for newborns. If the facility is unable to submit the newborn birth through the EBC, the hospital may submit a Hospital Newborn Notice (form MSA-2565-C) to the local MDHHS office for Medicaid eligibility to be established and to obtain a Medicaid ID number. If the MSA-2565-C form is used, the local MDHHS office will open the newborn's MA case and return the form to the provider with the necessary billing information.

Eligibility information must be obtained using the CHAMPS Eligibility Inquiry or the HIPAA 270/271 transaction using the newborn ID number provided by MDHHS. The MDHHS Enrollment Services Section should be contacted when the eligibility inquiry does not locate the newborn. (Refer to the Directory Appendix for contact information.) All inquiries must include the following information to assist MDHHS in locating newborn ID numbers:

- Newborn's name (last, first, middle initial)
- Newborn's gender
- Newborn's DOB
- Mother's name (last, first, middle initial)
- Mother's Medicaid ID number
- Requesting person's name and telephone number

7.2 BILLING

When billing MDHHS for medical services rendered to the newborn, providers must use the newborn's Medicaid ID number. The mother's number cannot be used except when the delivering physician performs the newborn's care and circumcision during the mother's inpatient stay. In that situation, the delivering physician may bill for the newborn care and circumcision on the same claim as the delivery under the mother's Medicaid ID number.



SECTION 8 – BENEFITS MONITORING PROGRAM

State and federal regulations require the Medicaid program to conduct surveillance and benefits utilization review to ensure the appropriate amount, scope, and duration of medically necessary services are being provided to program beneficiaries. The Benefits Monitoring Program (BMP) is in place to closely monitor program usage and to identify beneficiaries who may be over-utilizing and/or misusing their Medicaid services and benefits.

The purpose of the Benefits Monitoring Program is to:

- Promote quality health care;
- Promote patient safety through reduction of drug interaction and/or possible drug abuse, and duplication of medical services;
- Identify beneficiaries whose utilization patterns appear to be overutilization and/or misutilization of their Medicaid benefits;
- Analyze individual beneficiary health service utilization data;
- Improve beneficiary utilization of Medicaid services through educational contacts and monitoring;
- Improve the continuity of care and service coordination to prevent fragmentation of services, and
- Assure that beneficiaries are receiving health care services which are medically necessary and supported by evidence-based practices, thereby curtailing unnecessary costs to the program.

To accomplish these program objectives, the BMP performs the following functions:

- Identifies beneficiaries who appear to be over-utilizing and/or misusing covered services.
- Evaluates utilization of covered services to determine whether the services are appropriate to a beneficiary's medical condition(s).
- Educates beneficiaries regarding appropriate utilization.
- Monitors utilization patterns and institutes interventions to optimize program effectiveness.

The beneficiary may be subject to utilization control mechanisms if it is determined that the beneficiary is overusing and/or abusing Medicaid services. When a beneficiary is enrolled in the BMP, they will remain in the program even as they may move between enrollment in fee-for-service (FFS) and Medicaid Health Plan (MHP) settings. Responsibility for administration of the BMP functions transfers between FFS and MHP settings when a beneficiary's enrollment status changes.

In this chapter, references to responsibilities or actions of the Department mean the Medicaid FFS program or MHP under which the beneficiary is enrolled.

A beneficiary who is enrolled in the BMP will be identified with the Benefit Plan ID of BMP. BMP will be indicated on the CHAMPS Eligibility Inquiry response as additional information.



8.1 DEFINITIONS

The following definitions pertain to terminology used specific to the Benefits Monitoring Program and should not be used for interpretation of material found elsewhere in the Medicaid Provider Manual.

Beneficiary	An individual eligible to receive medical assistance through MDHHS.
Benefits Monitoring Program (BMP)	A program to control utilization in which a beneficiary who has been found to engage in misutilization is placed to allow the Department to monitor and assure the medical necessity of services for that beneficiary.
BMP Authorized Provider	A provider who has been approved to render services to a beneficiary enrolled in the Benefits Monitoring Program by MDHHS or MHP BMP staff. Active BMP Authorized Providers are contained in the CHAMPS Eligibility Inquiry response as additional information.
Emergency Medical Condition	Federal Medicaid regulations define an emergency medical condition (including emergency labor and delivery) as a sudden onset of a physical or mental condition which causes acute symptoms, including severe pain, where the absence of immediate medical attention could reasonably be expected to: <ul style="list-style-type: none"> ▪ Place the person’s health in serious jeopardy; or ▪ Cause serious impairment to bodily functions; or ▪ Cause serious dysfunction of any bodily organ or part.
Medicaid Health Plan (MHP)	MDHHS contracts with Medicaid Health Plans (MHPs), selected through a competitive bid process, to provide services to Medicaid beneficiaries.
Medical Assistance Program	The Department’s program to provide for medical assistance established by Section 105 of Act No. 280 of the Public Acts of 1939, as amended, being S400.105 of the Michigan Compiled Laws, and Title XIX of the federal Social Security Act, 42 U.S.C. S1396 et seq.
Misutilization	The use of medical assistance in excess of, or inappropriate to, the particular medical needs of the beneficiary as determined by the Department through investigation and analysis. Initial indicators of possible misutilization in light of a beneficiary’s medical condition shall include, but are not limited to, unusually frequent physician, pharmacy or emergency department visits, frequent use of ambulance and/or non-emergency medical transportation services, and unusually frequent acquisition of drugs subject to abuse.
Negative Action	Action by the Department (or MHP) to discontinue, terminate, suspend, or reduce public assistance or services.
Provider	An individual, firm, corporation, association, agency, institution, or other legal entity which has been approved to provide medical assistance to a beneficiary pursuant to the Medical Assistance Program.
The Department	The Michigan Department of Health and Human Services (MDHHS)



8.2 BMP ENROLLMENT CRITERIA

The criteria in the following subsections are used to identify beneficiaries to be placed in the BMP. Enrollment in the BMP is determined after review of the beneficiary's usage of medical services. Beneficiaries may be enrolled in BMP when any of the following criteria (alone or in combination) are present.

8.2.A. FRAUD

The beneficiary is suspected, or has been convicted, of fraud for one or more of the following:

- Selling or purchasing products/pharmaceuticals obtained through Medicaid.
- Altering prescriptions to obtain medical services, products or pharmaceuticals.
- Stealing prescriptions/pads; provider impersonation.
- Using another individual's identity to obtain medical services, products or pharmaceuticals.

8.2.B. MISUTILIZATION OF EMERGENCY DEPARTMENT SERVICES

Criteria include, but are not limited to, the following:

- More than three emergency department visits in one quarter.
- Repeated emergency department visits with no follow-up with a primary care provider (PCP) or specialist when appropriate.
- More than one outpatient hospital emergency department facility in one quarter.
- Repeated emergency department visits for non-emergent conditions.

8.2.C. MISUTILIZATION OF PHARMACY SERVICES

Criteria include, but are not limited to, the following:

- Utilizing more than three different pharmacies in one quarter.
- Aberrant utilization patterns for drug categories listed in the Drug Categories subsection of this chapter over a one-year period.
- Obtaining more than five prescriptions for drug categories listed in the Drug Categories subsection of this chapter in one quarter (including emergency prescriptions).
- Utilizing multiple prescribing providers for drug categories listed in the Drug Categories subsection, including when prescribing providers provide services to the beneficiary as a private pay patient (e.g., beneficiary pays cash for office visits while using the Medicaid pharmacy benefit to obtain prescriptions).



8.2.D. MISUTILIZATION OF PHYSICIAN SERVICES

Criteria include, but are not limited to, the following:

- Utilizing more than one physician/physician extender in different practices to obtain duplicate or similar services for the same or similar health condition.
- Utilizing more than one physician/physician extender in different practices to obtain duplicate prescriptions for a drug(s) listed in the Drug Categories subsection of this chapter (e.g., two prescriptions for Vicodin/hydrocodone written by different providers within an overlapping timeframe).
- Utilizing covered services to obtain prescriptions for drugs subject to abuse and paying cash to obtain the drugs.

8.2.E. OTHER

MDHHS will review additional criteria as misutilization patterns emerge or are identified by the Department.

8.3 DRUG CATEGORIES

MDHHS considers the following drug categories as having high potential for abuse:

- Narcotic Analgesics
- Barbiturates
- Sedative-Hypnotic, Non-Barbiturates
- Central Nervous System Stimulants/Anti-Narcoleptics
- Anti-Anxieties
- Amphetamines
- Skeletal Muscle Relaxants

8.4 NOTIFICATION AND ENROLLMENT

Notification of enrollment in the BMP is sent to the beneficiary to the address on file with MDHHS. It is the beneficiary's responsibility to report a change of address to MDHHS. This notification includes the following:

- Information regarding the utilization patterns and concerns;
- The enrollment effective date; and
- Instructions on the selection of providers (which must be approved by the Department).

The beneficiary is given 10 calendar days to contact the Department and discuss the findings prior to the enrollment effective date. Enrollment of a beneficiary in a MHP may be determined by the Department or the MHP using approved criteria. Enrollment in the BMP does not constitute a negative action by the Department or the MHP. Enrollment of a beneficiary in the BMP does not suspend, reduce, discontinue,



or terminate any services or assistance that a beneficiary is eligible for at the time of the beneficiary's enrollment in the BMP.

8.5 BENEFITS MONITORING PROGRAM CONTROL MECHANISMS

8.5.A. OBTAINING DRUGS SUBJECT TO ABUSE

Michigan's Pharmacy Benefits Manager (PBM) processes all point of sale (POS) prescription drug claims for MDHHS. Requests for prescriptions (including emergency prescriptions for the therapeutic drug categories listed above) are evaluated against other prescriptions filled for the beneficiary and paid by Medicaid in the last 34 days.

Beneficiaries in the BMP are prevented from filling or refilling prescribed medications listed in the Drug Categories subsection of this chapter until 95 percent of the medication quantity limits would have been consumed in compliance with the prescribed dose, amount, frequency and time intervals as ordered, and consistent with Medicaid limits.

Additional controls on drugs subject to abuse may be imposed. MDHHS may restrict access to these drug classes through pharmacy and/or prescribing provider assignment. Providers authorized to fill/prescribe drugs subject to abuse are identified by a "Y" indicator in the "Send to PBM" field of the CHAMPS Eligibility Inquiry response, BMP Restrictions page. Refer to the Assigned Providers subsection for additional information.

Drugs subject to abuse ordered in conjunction with exempt services, to include emergency (72 hour) medication supplies, may require communication with the MDHHS PBM and/or BMP program staff. (Refer to the Directory Appendix for contact information.) Refer to the Exempt Services subsection for additional information.

8.5.B. ASSIGNED PROVIDERS

The BMP may assign beneficiaries to providers through which covered services can be obtained. BMP Authorized Providers that may be assigned include, but are not limited to, any one or more of the following:

- Specific PCP
- Specific pharmacy
- Specific outpatient hospital
- Specific specialist provider
- Specific group practice

8.5.C. RESTRICTING BENEFITS

In some cases, the Department may find that a restriction of optional benefits (i.e., pharmacy) is an appropriate intervention. In the event of continued misutilization, as defined in the Definitions subsection and as outlined in the BMP Enrollment Criteria subsection (and its subsections), optional benefits may be reduced in accordance with federal and state regulations. Beneficiaries subject to a benefit restriction will receive



written notice of the action, the effective and end dates applicable, and appeal information.

8.5.D. EXEMPT SERVICES

The following services are exempt from the BMP:

- Emergency services
- Dental services
- Services rendered by a nursing facility provider
- Services rendered in an inpatient hospital
- Hospice services
- Optometry services

Although these services are exempt, controls on drugs subject to abuse are maintained in MDHHS information systems and will impact the beneficiary's ability to obtain certain pharmaceutical services using Medicaid benefits. Refer to the Obtaining Drugs Subject to Abuse subsection for additional information.

8.6 MONITORING AND REVIEW

Beneficiaries are placed in the BMP for a minimum of 24 months. The utilization of medical services and drugs is routinely monitored and the effectiveness of the BMP interventions is evaluated. The Department shall review the placement at least once every 24 months.

8.7 PROVIDER RESPONSIBILITIES

8.7.A. ALL PROVIDERS

Eligibility must be verified before providing service. BMP enrollees are indicated on the CHAMPS Eligibility Inquiry Response as additional information. If the BMP Provider Restriction Indicator is "Y", the hyperlink will be activated. The hyperlink will open the BMP Restrictions page which contains the BMP FFS and Managed Care Authorized Provider information.

When the beneficiary has FFS eligibility, the information in the BMP FFS Authorized Providers table directs payment. If there are no providers listed in the BMP FFS Authorized Providers table, the beneficiary is restricted only by the pharmaceutical refill tolerance for that date of service. The BMP may be contacted for additional information regarding covered services.

FFS reimbursement for BMP enrollees is limited to exempt services, services provided by an active BMP Authorized Provider per the beneficiary's eligibility file, and services provided by a referred provider when the following are present:

- The beneficiary was referred by an active BMP FFS Authorized Provider; and



- The referred provider has obtained a current Benefits Monitoring Program Referral (form MSA-1302) from the BMP FFS Authorized Provider.

Rendering (and referring, when applicable) provider NPI numbers are required on claim submissions.

When the beneficiary is enrolled in a MHP, the information in both the BMP FFS and Managed Care Authorized Providers tables is applicable. For FFS payment of services carved out of the MHP benefit, providers must be listed in the BMP FFS Authorized Providers table. The "Send to PBM" field must have a "Y" indicator for the prescribing physician for FFS payment of drugs subject to abuse which are carved out of the MHP benefit. The MHP may be contacted for additional information regarding covered services.

8.7.B. BMP AUTHORIZED PROVIDERS

The BMP assigns Authorized Providers who are responsible for supervising the case management and coordination of all prescribed drugs, specialty care, and ancillary services. These responsibilities encompass patient-centered care and do not amount to separate reimbursement. Reimbursement for any ambulatory service will not be made unless the service was provided, referred, prescribed, or ordered by the PCP and the claim includes the appropriate information.

The beneficiary may participate in the PCP and other provider assignment processes, both initially and through request for changes to established BMP Authorized Providers. If the Department has reason to suspect that a beneficiary's provider selection will not contribute to a reduction in utilization and/or be appropriate to the beneficiary's health condition(s), the selection may be denied. If the beneficiary fails to respond to the Department with provider selections, the Department may assign providers without beneficiary participation.

Written notice of provider assignments will be mailed to the beneficiary and the provider. When applicable (e.g., Department assigned providers, denial of request to change providers), appeal information and instructions will accompany written notice.

MDHHS reserves the right to end/terminate provider authorization for a BMP enrollee at any time. A replacement provider may be assigned following such an action. Instances will be determined on a case-by-case basis following periodic review, and must meet at least one of the following criteria:

- A review of utilization reveals that a provider is not contributing to a reduction in service utilization (including use of drugs subject to abuse) as defined by the BMP;
- The BMP Authorized Provider becomes a sanctioned provider; or
- The BMP Authorized Provider makes referrals to the emergency department for non-emergent conditions.



8.7.C. REFERRALS FOR BMP ENROLLEES

The BMP Authorized Provider must complete a MSA-1302 when referring a BMP enrollee for other specialty services. This form applies to beneficiaries with Medicaid FFS program eligibility. (Refer to the Forms Appendix for a copy of the form and form completion instructions.)

8.7.D. DISCHARGE FROM PRACTICE

It is the responsibility of the BMP Authorized Provider to notify the Department when a BMP enrollee is discharged from their practice. General practice standards should be followed with regard to patient notification. Written communication informing the beneficiary of the intent to sever the relationship and/or the MSA-1302 indicating "discharge from practice" may be sent to the Department to satisfy this responsibility.

8.7.E. REFERRALS TO BMP

To report potential misutilization of services, contact the MDHHS Benefits Monitoring Program. (Refer to the Directory Appendix for contact information.)

8.7.F. BENEFICIARY FRAUD

Suspected beneficiary fraud should be referred to the MDHHS Office of Inspector General. (Refer to the Directory Appendix for contact information.)

8.8 CHANGES IN ENROLLMENT

A beneficiary enrolled in the BMP will remain in the BMP for the minimum time period regardless of any change in enrollment status (e.g., change from fee-for-service to managed care, break in eligibility, incarceration, etc.). When a beneficiary in the BMP has a change in enrollment, responsibility for monitoring the beneficiary moves from the Department to the MHP or vice versa.

When a beneficiary has a break or change in eligibility that disrupts historical data collection and review, upon regaining full Medicaid eligibility, the beneficiary will, by default, remain in the BMP and periodic review will depend on availability of sufficient utilization data.

8.9 TERMINATION OF BMP ENROLLMENT

When the beneficiary's utilization has been determined to be at an appropriate level or there is a change in medical status, the Department may terminate the beneficiary's enrollment in BMP.

8.10 APPEALS

Any written notice of a negative action or denial of a beneficiary's provider choice shall include reference to the beneficiary's right to appeal. The appeal process shall conform to Michigan Administrative Code (MAC) Rules R400.901 to R400.922.

The MHP is the respondent in BMP-related hearings pertaining to actions taken by the MHP.



SECTION 9 – MEDICAID HEALTH PLANS

MDHHS contracts with health plans in the state. The Medicaid Health Plans (MHPs) are paid a monthly capitation rate to provide specific covered services to enrolled Medicaid beneficiaries. The MHP is responsible for providing, arranging, and reimbursing most medical services.

9.1 ENROLLMENT

Within the Medicaid population, there are groups that:

- Must enroll in a MHP.
- May voluntarily enroll in a MHP.
- Are excluded from enrollment in a MHP.

Mandatory Enrollment	<ul style="list-style-type: none"> ▪ Most people who are receiving full Medicaid benefits. ▪ People receiving Medicaid who participate in the Children’s Waiver or the Habilitation Supports Waiver. ▪ Supplemental Security Income (SSI) beneficiaries who do not receive Medicare. ▪ Pregnant women whose pregnancy is the basis for Medicaid eligibility. <div style="border: 1px solid black; background-color: yellow; padding: 10px; margin: 10px auto; width: 80%;"> <p>The newborn child is automatically enrolled in that health plan. Health plan responsibilities begin at the time of the child's birth. (Refer to the Newborn Child Eligibility Section of this chapter for more information.)</p> </div>
Voluntary Enrollment	<ul style="list-style-type: none"> ▪ Migrants ▪ Native American Indians of Federally recognized tribes ▪ Most people who are dually Medicare/Medicaid eligible
Excluded Enrollment	<ul style="list-style-type: none"> ▪ People without full Medicaid coverage (they receive emergency services only). ▪ People for whom Medicaid is purchasing Medicare coverage (QMB, SLMB, ALMB). ▪ People with Medicaid who reside in an ICF/IID or state psychiatric hospital. ▪ People in the MDHHS Traumatic Brain Injured residential rehabilitation program.



	<ul style="list-style-type: none"> ▪ People receiving nursing facility services. (Refer to the Excluded Health Plan Services subsection of this chapter for additional information.) ▪ Beneficiaries diagnosed with inborn errors of metabolism that have been authorized for and use metabolic formulas (B4157 and B4162) will receive all of their Medicaid services through the Medicaid Fee-For-Service Program. ▪ People being served under the MI Choice Waiver. ▪ People enrolled in the CSHCS Program without full Medicaid coverage. ▪ Medicaid Deductible beneficiaries. (Refer to Medicaid Deductible Beneficiaries (Spenddowns) Section of this chapter for additional information.) ▪ People with commercial managed care coverage. This includes beneficiaries enrolled in a Medicare health plan which is not approved to provide Medicaid service in their county. ▪ People in PACE (Program of All-Inclusive Care for the Elderly). ▪ Children in child caring institutions. ▪ People in the Refugee Assistance Program. ▪ People in the Repatriate Assistance Program. ▪ People who have been disenrolled from a Medicaid Health Plan. ▪ People receiving Private Duty Nursing Services. All beneficiaries enrolled in a health plan will be disenrolled retroactively to the first day of the month in which the PDN services are received. <div style="border: 1px solid black; background-color: yellow; padding: 5px; margin-top: 10px;"> <p>If one member of a family resides in a nursing facility or loses Medicaid eligibility, this does not exempt the other family members from enrollment in a health plan.</p> </div>
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9.2 MICHIGAN ENROLLS

Beneficiaries who are eligible to enroll in a MHP are covered for Medicaid services on a FFS basis until enrolled in a health plan.

Beneficiaries who are required or are eligible to enroll in a health plan have the opportunity to choose their health plan. They are given a pamphlet, "Choosing Your Health Plan", which provides them information on this process. If no selection is made, the beneficiary is automatically enrolled with a health plan in the beneficiary's county of residence. The beneficiary has 90 days after assignment of or choosing a health plan to change the health plan. After 90 days, the beneficiary is required to remain in the chosen health plan until the next open enrollment period.

MDHHS has contracted with MI Enrolls to:

- Inform beneficiaries which physicians, pharmacies, and hospitals are part of each health plan.



- Provide information to help the beneficiary choose a primary provider (a physician, nurse practitioner (NP), or physician’s assistant who manages all of the beneficiary’s health care).
- Answer beneficiary questions regarding how to use the health plan.
- Enroll beneficiaries in the health plan they choose, or automatically enroll them in a health plan.
- Change the beneficiary’s health plan.
- Provide a Request for an Administrative Hearing and Instructions form (DCH-0092).
- Provide a Medical Exception Request form (MSA-1628) for medical exception from Managed Care.
- Provide a Beneficiary Complaint form (MSA-0300).
- Provide the Special Disenrollment–For Cause Request form (MSA-0176).

(Refer to the Directory Appendix for MI Enrolls contact information.)

9.3 MEDICAL EXCEPTIONS TO MANDATORY ENROLLMENT

The intent of the medical exception process is to preserve continuity of medical care for a beneficiary who is receiving active treatment for a serious medical condition from an attending physician (MD or DO) who would not be available to the beneficiary if the beneficiary is enrolled in a MHP. The medical exception may be granted on a time-limited basis necessary to complete treatment for the serious condition. The medical exception process is only available to a beneficiary who is not yet enrolled in a MHP, or who has been enrolled for less than two months. MHP enrollment would be delayed until one of the following occurs:

- The attending physician completes the current ongoing plan of medical treatment for the patient's serious medical condition, or
- The condition stabilizes and becomes chronic in nature, or
- The physician becomes available to the beneficiary through enrollment in a MHP.

If the treating physician can provide service through a MHP that the beneficiary can be enrolled in, then there is no basis for a medical exception to managed care enrollment.

If a beneficiary is enrolled in a MHP, and develops a serious medical condition after enrollment, the medical exception does not apply. The beneficiary should establish relationships with providers within the plan network who can appropriately treat the serious medical condition.

9.3.A. DEFINITIONS

<p>Serious Medical Condition</p>	<p>Grave, complex, or life threatening.</p> <p>Manifests symptoms needing timely intervention to prevent complications or permanent impairment.</p> <p>An acute exacerbation of a chronic condition may be considered serious for the purpose of medical exception.</p>
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Chronic Medical Condition	<p>Relatively stable.</p> <p>Requires long term management.</p> <p>Carries little immediate risk to health.</p> <p>Fluctuates over time but responds to well-known standard medical treatment protocols.</p>
Active Treatment	<p>Active treatment is reviewed in regards to intensity of services when:</p> <ul style="list-style-type: none"> ▪ The beneficiary is seen regularly, (e.g., monthly or more frequently), and ▪ The condition requires timely and ongoing assessment because of the severity of symptoms and/or the treatment.
Attending/Treating Physician	<p>The physician (MD or DO) may be either a primary care doctor or a specialist whose scope of practice enables the interventions necessary to treat the serious condition.</p>
MHP Participating Physician	<p>A physician is considering participating in a MHP if he is in the MHP provider network or is available on an out-of-network basis with one of the MHPs with which the beneficiary can be enrolled. The physician may not have a contract with a MHP but may have a referral arrangement to treat the plan's enrollees. If the physician can treat the beneficiary and receive payment from the plan, then the beneficiary would be enrolled in that plan and no medical exception would be allowed.</p>

9.3.B. PROCESS FOR REQUESTING A MEDICAL EXCEPTION

The Medicaid beneficiary must initiate the review process for medical exception by completing Section I of the Medical Exception Request (form MSA-1628). Beneficiaries can obtain forms, discuss managed care options, or ask questions regarding the medical exception process by contacting MI Enrolls. (Refer to the Directory Appendix for contact information.) If the beneficiary has been enrolled in a MHP for more than two months, the medical exception request does not apply.

9.3.C. PHYSICIAN RESPONSIBILITY

The physician who is actively treating the beneficiary for the serious medical condition must complete Section II of the MSA-1628. If multiple physicians are involved, each one must complete a separate form. The physician completing the form must be actively treating the beneficiary, and must not be participating with or have any arrangement with a MHP with which the beneficiary can be enrolled. The information provided by the physician must include:

- A detailed description of the serious medical condition that is being treated, including the diagnosis and current active signs and symptoms in adequate detail to justify the degree of seriousness. Diagnosis alone is not sufficient.
- The length of time that the beneficiary has been actively treated for this condition by the physician completing the form.



- The treatment plan in place, including any planned interventions and a list of all current and anticipated medications.
- The frequency of visits.
- The anticipated length of time (in months) that the beneficiary will need this treatment.

A Medical Exception Request cannot be processed without all of the above information. MDHHS will verify that the treating physician is not available in any MHP in which the beneficiary can be enrolled. If an exception to managed care enrollment is granted, the MDHHS will identify a period of time, up to one year, for which it is approved. At the end of that period, the beneficiary will be eligible for enrollment in a MHP.

9.4 CHAMPS ELIGIBILITY INQUIRY

The CHAMPS Eligibility Inquiry transaction indicates the following for a beneficiary in a MHP:

- Benefit Plan ID of MA-MC, MA-HMP-MC, CSHCS-MC, or MME-MC
- MHP name, telephone number and address
- MHP Primary Care Physician (PCP), including the PCP name, telephone number, and NPI. (NOTE: Data is provided only if the date of service is the current date and a PCP record is on file.)

9.5 HEALTH PLAN MEMBERSHIP

Once enrolled in a health plan, that health plan sends member information to the beneficiary. The CHAMPS Eligibility Inquiry will indicate the Benefit Plan ID of CSHCS-MC, MA-HMP-MC, MA-MC, or MME-MC, including the MHP name and toll-free telephone number as additional information. The beneficiary also receives a membership card from the health plan.

9.6 COVERED HEALTH PLAN SERVICES

Services may be provided directly by the health plan or arranged through the health plan. Coverages include current Medicaid-covered services and any additional services the health plan may decide to provide that may not be Medicaid-covered services, other than excluded services listed below.

9.7 EXCLUDED HEALTH PLAN SERVICES

Services are either included or excluded from the health plan's monthly capitation rate. The following services are not included in the monthly capitation rate and may be provided by an enrolled provider who would be directly reimbursed by Medicaid.

- Dental custodial services. (Oral-maxillofacial surgeons providing medical services are included in the health plan's capitation rate and should follow health plan authorization rules.)
- Nursing facility (NF) custodial services. The health plan is responsible for restorative or rehabilitative care in a nursing facility up to 45 days in a rolling 12-month period. In order for a provider to receive Medicaid reimbursement for nursing care, the nursing facility beds must be Medicaid certified by the SMA and the provider must be enrolled with Medicaid. The SSA is responsible for conducting any required certification surveys for the SMA. If nursing facility



services will exceed this coverage, the health plan may initiate the disenrollment process by submitting the Request for Disenrollment Long Term Care form (MSA-2007). The provider may bill Medicaid after the disenrollment is processed.

Beneficiaries who reside in a nursing facility are excluded from subsequent enrollment in a MHP. If a beneficiary is in a facility prior to enrollment in a MHP and the nursing facility does the admission record in CHAMPS correctly, CHAMPS will automatically remove the MHP and set the nursing facility PET.

Services provided to persons with developmental disabilities and billed through the Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP).

- Substance abuse treatment services.
- Inpatient hospital psychiatric services and outpatient partial hospitalization psychiatric services.
- Personal care authorized through MDHHS.
- School-based services.
- Pharmacy and related services prescribed by providers under the State's contract for specialty behavior services.
- Drugs in the categories listed on the MHP carve-out list are excluded from the MHP contract. (Refer to the Directory Appendix for website information.)
- Private Duty Nursing (PDN) services.

9.8 HEALTH PLAN AUTHORIZATIONS

The health plan must provide or arrange for services covered by the plan. Services that are not covered by the health plan do not require the health plan's authorization. If providers render both a health plan covered and a health plan noncovered service, the health plan is responsible for providing/arranging and reimbursing for those health plan covered services. It is imperative that health plan providers obtain authorization from the health plan for plan-covered services.

For Medicaid-covered services:

- Non-emergency care – health plan authorization is required before rendering the service.
- Urgent care – health plan authorization is required before rendering the service.
- Emergency care to the point of stabilization – no authorization is required. The health plan is responsible for reimbursement of the service. The provider must inform the health plan as soon as possible that emergency services were provided. Post-stabilization treatment requires health plan authorization before rendering the service.

If a service requires PA from a health plan and from MDHHS (e.g., cosmetic surgery), the provider must obtain the authorization from the health plan but does not have to obtain a second PA from MDHHS.

9.9 COPAYMENTS

Health plan beneficiaries may be charged a copayment for physician, dental and outpatient hospital evaluation and management visits, non-emergency visits to the emergency department, the first day of



an inpatient hospital stay (except for emergent admissions), and pharmacy, podiatric, chiropractic, vision, or hearing services as described in this manual. Preventive medicine evaluation and management services are not subject to beneficiary cost sharing.

(Refer to the Dental Chapter of this manual for additional information.)

9.10 BILLING

9.10.A. HEALTH PLAN MEMBERS

The health plan receives a monthly capitation fee for each Medicaid beneficiary enrolled in the plan as part of its contract with MDHHS. Health plans and providers may not bill the beneficiary for services not authorized by the health plan unless the beneficiary was informed of his financial responsibility prior to receiving the service. Providers may bill Medicaid for a service that is excluded from the health plan contract, but Medicaid covered under FFS (e.g., dental services).

9.10.B. REFERRAL PROVIDERS

If the health plan refers a beneficiary to a provider for health plan covered services, the health plan is responsible for reimbursement of those services.

9.10.C. HEALTH PLAN AS A PRIVATE INSURANCE (OTHER INSURANCE CODE 89)

A beneficiary who has an existing private health plan through employment, spouse or other source cannot be enrolled in a MHP at the same time. MDHHS disenrolls that beneficiary from the MHP.

There may be FFS beneficiaries who are enrolled with a health plan as a private insurance. For example, the provider receives a monthly capitation rate for a beneficiary covered by a private health plan policy (such as Blue Care Network).

The monthly capitation payment must not be reflected on the Medicaid claim. In most instances, the provider is billing Medicaid for the copayment amount only. Medicaid only reimburses the provider for the Medicaid fee screen or copayment amount, whichever is less. (Refer to the Billing & Reimbursement Chapters of this manual for additional information.)

If Medicaid's maximum allowable amount is less than the copayment amount billed, the beneficiary or his representative may not be billed for the difference. The amount paid by Medicaid is considered as payment in full.



SECTION 10 – CHILDREN’S SPECIAL HEALTH CARE SERVICES

The MDHHS Medical Services Administration (MSA) determines eligibility for the CSHCS Program. CSHCS provides medically necessary services to individuals who are eligible and apply under the following circumstances:

- Persons under the age of 21 with one or more qualifying medical diagnoses.
- Persons age 21 and older with cystic fibrosis or hereditary coagulation defects commonly known as hemophilia.

Medical eligibility must be established by MDHHS before the individual is eligible to apply for CSHCS coverage. Based on medical information submitted by providers, a medically eligible individual is provided an application for determination of other CSHCS criteria. An individual may be eligible for CSHCS and eligible for other medical programs such as Medicaid, Healthy Michigan Plan, Medicare or MICHild. To be determined dually eligible, the individual must meet the eligibility criteria for CSHCS and all eligibility criteria for the other applicable program.

10.1 COVERAGE

The CSHCS coverage is limited to specialty health care services for the treatment of the beneficiary’s qualifying medical condition. CSHCS does not cover primary care, well child visits or immunizations. Those with additional coverage (e.g., Medicaid, MICHild) continue to receive their well child visits, immunizations, etc. through that source or coverage.

Dental interventions may be covered for certain qualifying diagnoses. Beneficiaries must receive services from a Medicaid-enrolled dentist/orthodontist. Services must be related to the qualifying diagnosis and authorized by CSHCS.

CSHCS does not cover the treatment service needs related to developmental delay, intellectual disability, autism, psychiatric, emotional, behavioral or other mental health diagnoses. A beneficiary who has both CSHCS and Medicaid or CSHCS and MICHild benefits receives his Medicaid or MICHild covered mental health services from the local PIHP/CMHSP.

CSHCS does not cover substance abuse treatment services. A beneficiary who has both CSHCS and FFS Medicaid or CSHCS and MICHild benefits receives his Medicaid or MICHild covered substance abuse treatment services from the regional PIHP. A beneficiary who has CSHCS and is enrolled in a Medicaid Health Plan may receive outpatient mental health visits through the Medicaid Health Plan. Provision of outpatient mental health services through the Medicaid Health Plan is available pursuant to the Beneficiary Eligibility subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter.

10.2 IDENTIFYING CSHCS ON THE CHAMPS ELIGIBILITY INQUIRY

The eligibility response will indicate when a beneficiary is enrolled in CSHCS for the date of service (DOS) entered in the inquiry. It will also identify if the provider NPI number entered is authorized to render CSHCS services for the beneficiary on that DOS. Providers will receive the Benefit Plan ID of CSHCS with one of the following messages in the eligibility response:



- This NPI is listed. See CSHCS guidelines. This message means the NPI is authorized by CSHCS to render services to this beneficiary on the specified date(s) of service. Services must be related to the beneficiary's CSHCS qualifying diagnosis.

Note: The 270/271 response will report up to eight (8) diagnosis codes for a single date of service. Refer to CHAMPS Eligibility Inquiry to obtain all approved diagnosis codes if more than eight (8) codes exist for the date of service.

- This NPI is not listed. See CSHCS guidelines. This message means the NPI is not authorized to render services to a CSHCS beneficiary on the specified date(s) of service. Some providers can render services to a CSHCS beneficiary without being authorized.

Refer to the Approved/Authorized Providers Section of the Children's Special Health Care Services Chapter of this manual for authorized provider information.

10.3 BENEFICIARY REVIEWS

Beneficiaries may request a Department Review for denial of eligibility determinations/redeterminations and denial of services. They may contact their local health department (LHD) or the CSHCS Program through the Parent Participation Program Family Phone Line. (Refer to the Directory Appendix for contact information.)



SECTION 11 – APPLICATION FOR MEDICAL ASSISTANCE

If a person is potentially eligible for health care coverage, excluding CSHCS, but has not applied for assistance, an application form should be completed. If the person is unable to complete the application form and a relative, guardian, or other representative of choice is not available to complete the form on their behalf, then the hospital or NF may do so.

The Application for Health Coverage & Help Paying Costs form (DCH-1426) is used for potential beneficiaries. The form may be obtained from the local MDHHS office or is available on the MDHHS 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 MDHHS office.

11.1 HOSPITALS AND NURSING FACILITIES

The individual or his authorized representative should sign applications when possible. The local MDHHS office must determine Medicaid eligibility even if the individual is receiving Supplemental Security Income (SSI) benefits. An individual is not automatically eligible for Medicaid just because he has SSI benefits and resides in a nursing facility.

For state-owned and -operated facilities, if the individual is unable to sign and the authorized representative is not available, the Reimbursement Office's authorized representative may sign the application using his personal signature and position title.

If retroactive Medicaid eligibility is requested, in addition to the application form, the Retroactive Medicaid Application (DHS-3243) must be completed for each retroactive month that eligibility is requested.

11.2 INITIAL ASSESSMENT OF ASSETS

The local MDHHS office must make an Initial Asset Assessment for a married resident in a nursing facility (even if not currently applying to Medicaid) or for a married individual who is applying for the MI Choice Waiver or the PACE program. The assessment must be made from the first day of continuous care received by the applicant/individual.

An initial assessment is a determination of the total amount of countable assets owned by an institutionalized or MI Choice waiver patient and/or his spouse on a given day. The day is usually the day the patient was admitted to the NF or MI Choice waiver.

Nursing facilities are required to notify patients, their families, or authorized representatives of the need to request the initial assessment in case of future Medicaid application. The Asset Declaration - Nursing Home Resident and Spouse (FIA-4574B), is to be completed by the patient and submitted to the local MDHHS office to request that an initial assessment be completed. The facility may assist the patient with



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the completion of this form. Any questions regarding the form, or requests for copies of the form, should be directed to the local MDHHS office.

The patient may refuse to complete the assessment, but it should be stressed that it is easier to obtain the assessment at the time of admission than it is to try to recreate the situation at a future date.



SECTION 12 – ELIGIBILITY DETERMINATION OF INSTITUTIONAL CARE

Nursing facilities, hospitals, state-owned and –operated facilities, CMHSP facilities, hospice, MI Choice Waiver, and MI Health Link agencies must enter beneficiary admissions, transfers, and discharges directly in CHAMPS. A completed admission will assign a PET code and benefit plan. Alternatively, when a discharge is completed in CHAMPS, the beneficiary’s PET code and benefit plan will end date to reflect the discharge date. The admission or discharge should be submitted even if Medicare or other insurance covers the person’s stay.

When completing an admission via CHAMPS, the facility must print the admission/enrollment form generated by CHAMPS and continue to obtain the potential beneficiary (or his/her authorized representative) signature on the form. The signature of the facility personnel completing the admission form must also be obtained. This signed form must be retained in the beneficiary’s record. If the facility has a signature on file, that should be noted in the signature box.

In the event a beneficiary is admitted to a subsequent facility and the previous facility did not discharge the beneficiary, the new admission created in CHAMPS by the second facility will automatically discharge the beneficiary from the previous facility one day before the new facility admission date. The previous facility will receive an alert in CHAMPS that the beneficiary was discharged so they can modify the discharge date if needed (for example, if the beneficiary was discharged a week earlier before going to the second facility).

When a beneficiary is discharged, the facility must discharge the beneficiary via CHAMPS to avoid any access to care problems for the beneficiary in the community (e.g., durable medical equipment, medical supplies).

Hospice note: For Medicaid beneficiaries residing in a nursing facility and receiving hospice services when the beneficiary is discharged from hospice (involuntary or voluntary), the NF must complete an admission in CHAMPS to assign the nursing facility PET code and benefit plan. The nursing facility will receive a manual gross adjustment for the date of the admission. Alternatively, if the facility completes the admission in CHAMPS prior to the hospice discharging the beneficiary, the new admission created in CHAMPS will automatically discharge the beneficiary from hospice and the associated PET code one day before the nursing facility admission date.

12.1 PATIENT PAY AMOUNT

12.1.A. NURSING FACILITY DETERMINATIONS

After the Medicaid application has been submitted, the local MDHHS office determines eligibility for medical assistance. All allowable expenses and income are calculated, and any remaining income is then considered in determining the amount the beneficiary must pay toward his medical expenses each month. This monthly contribution by the beneficiary toward his care is called the Patient Pay Amount (PPA).



Nursing facilities have the following options to obtain the PPA and eligibility information:

- DHS-3227 – If the local MDHHS office is unable to determine final eligibility status within five working days of receipt of the application for medical assistance, the Tentative Patient Pay Amount Notice (DHS-3227) is sent to the facility as notification of the person's tentative PPA.
- Nursing facility's determination of potential PPA – A timely collection of the PPA is vital for nursing facilities as it helps eliminate the need to claim adjust Medicaid and the need to retroactively collect the PPA from the beneficiary. To help alleviate unneeded claim adjusting and to collect a PPA more timely, nursing facilities are encouraged to determine what a potential beneficiary's PPA will be and collect that PPA prior to receiving the DHS-3227. Subsequently, the facility would bill Medicaid showing that potential PPA as determined by the facility.
- CHAMPS Eligibility Inquiry and/or other available eligibility options to obtain the Benefit Plan ID, PET code authorization, facility information and PPA. (Refer to the Directory Appendix for contact and website information.)

CHAMPS Eligibility Inquiry and/or other available eligibility options should be used in the preparation of bills for services provided in that month. This avoids many billing problems stemming from eligibility information. The facility may contact the beneficiary's local MDHHS office as identified on the eligibility response if the information provided is incorrect.

The provider should contact MDHHS Provider Inquiry for answers to billing questions. (Refer to the Directory Appendix for contact information.)

Facilities are responsible for collecting the PPA. If the facility receives the DHS-3227, it indicates a tentative PPA to be collected by the facility. In determining the tentative PPA, MDHHS does not prorate for partial months. This amount is subject to change as the beneficiary's financial eligibility changes. The PPA must be exhausted before any Medicaid payment is made.

A beneficiary who has a PPA cannot legally be charged more than the Medicaid rate for a short stay in a facility. For example, if a beneficiary is in a long term care facility for two days in a month, the provider must collect no more than the Medicaid rate for two days from the PPA (even if the PPA is great enough to cover the higher private pay rate). The balance, or unused portion, of the PPA must be returned to the beneficiary or his family.

For necessary medical or remedial care recognized under the State law but not covered by the Medicaid Program, the Medicare Catastrophic Coverage Act of 1988, Public Law 100-360, allows NF beneficiaries to use their PPA to obtain these services. For additional information, the facility may contact MDHHS Long Term Care Services. (Refer to the Directory Appendix for contact information.)



12.1.B. HOSPITALS

Hospitals are not notified of a tentative patient pay amount via the DHS-3227. The hospital may obtain the patient pay amount by:

- The eligibility response. (Refer to the Verifying Beneficiary Eligibility section for additional information.)
- Submitting a claim to MDHHS. (Medicaid deducts the patient pay amount and the claim is processed accordingly.)
- Contacting the local MDHHS office.

12.1.C. STATE-OWNED AND -OPERATED FACILITIES/PIHPs/CMHSPs

MSA or the PIHP/CMHSP determines a financial liability, or ability to pay, separate from the MDHHS patient pay amount. The ability to pay may be an individual, spouse, or parental responsibility. It is determined and reviewed as required by the Mental Health Code. The beneficiary or his authorized representative is responsible for the ability to pay amount, even if the patient pay amount is greater.

12.1.D. EXCESS PATIENT PAY AMOUNTS

If the provider has an excess patient pay amount and has been billing Medicaid, the provider must return any overpayments made by MDHHS. This must be done using a replacement claim or void/cancel claim. The provider may then use the remaining funds for beneficiary private pay.

12.2 PREADMISSION SCREENING

If a beneficiary is to be transferred from an acute care hospital to a NF, preadmission screening for mental illness/intellectual/developmental disability or a related condition must be completed prior to transfer.



COORDINATION OF BENEFITS

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SECTION 1 – INTRODUCTION

This chapter applies to all providers.

Federal regulations require that all identifiable financial resources be utilized prior to expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries. Medicaid is considered the payer of last resort. If a beneficiary with Medicare or Other Insurance coverage is enrolled in a Medicaid Health Plan (MHP), or is receiving services under a Prepaid Inpatient Health Plan (PIHP) or Community Mental Health Services Program (CMHSP), that entity is responsible for the Medicaid payment liability.

Coordination of Benefits (COB) is the mechanism used to designate the order in which multiple carriers are responsible for benefit payments and, thus, prevention of duplicate payments. Third party liability (TPL) refers to an insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan), commercial carrier (e.g., automobile insurance and workers' compensation), or program (e.g., Medicare) that has liability for all or part of a beneficiary's medical coverage. The terms "third party liability" and "other insurance" are used interchangeably to mean any source, other than Medicaid, that has a financial obligation for health care coverage. Providers must investigate and report the existence of other insurance or liability to Medicaid and must utilize other payment sources to their fullest extent prior to filing a claim with the Michigan Department of Health and Human Services (MDHHS).

Billing Medicaid prior to exhausting other insurance resources may be considered fraud under the Medicaid False Claim Act if the provider is aware that the beneficiary had other insurance coverage for the services rendered.

1.1 SUBROGATION

As a condition of Medicaid eligibility, beneficiaries must assign MDHHS the right to seek recovery of other resource payments made on their behalf. If MDHHS identifies another resource for a paid claim, a bill will be generated to the other resource within the appropriate timely filing guideline. The other resource will reimburse Medicaid directly or reject the paid claim. MDHHS will review other resource rejections to determine if the rejection is appropriate or if the provider can resubmit the claim to the other resource for reimbursement.

1.2 CLAIM VOID PROCESS

MDHHS will send a Pending Claim Void notice via mail and the Archived Documents repository within CHAMPS when it is determined that a provider did not hold another resource liable for payment after Medicaid adjudicated the claim. If the claim was lacking information about the existence of another resource, the provider must resubmit the claim in CHAMPS as an adjustment and include the proper Claim Adjustment Reason Code within 30 days of the date provided on the Pending Claim Void notice. Pharmacy providers must resubmit the claim to the Pharmacy Benefits Manager (PBM) and include the proper Other Coverage Code. Pharmacies must also notify MDHHS within 30 days of the date provided on the Pending Pharmacy Claim Void notice to report the updated claim adjudication. MDHHS will automatically void the claim after the 30 days if no adjustment is made in CHAMPS from medical providers or if no notification is received from pharmacy providers. The provider will then have to bill the identified resource for the claim. It is the provider's responsibility to remediate with the primary payer prior to rebilling Medicaid for the claim.



1.3 VERIFICATION OF OTHER INSURANCE

Information about a beneficiary's other insurance is available through the CHAMPS Eligibility Inquiry and/or vendor that receives eligibility data from the CHAMPS 270/271 transaction. It is not displayed on the **mihealth** card. (Refer to the Beneficiary Eligibility Chapter for additional information.)

Providers should always ask the beneficiary if other insurance coverage exists at the time of service. If the beneficiary identifies other insurance coverage that is not listed in the eligibility response, the provider must use that other insurance and report it to MDHHS by contacting Medicaid Provider Inquiry or the Third Party Liability Section. If the beneficiary belongs to a network, the provider must refer him to that preferred provider for services needed. (Refer to the Directory Appendix for contact information.)

If the beneficiary does not agree with the other insurance information contained in the eligibility response, (e.g., other insurance coverage is no longer available), the beneficiary should be instructed to notify his local MDHHS office of the change. If the provider elects to initiate a change to the beneficiary eligibility response, the Request to Add, Terminate, or Change Other Insurance (form DCH-0078) should be completed. (Refer to the Forms Appendix for a copy of the form and additional instructions.)

The form should be submitted prior to billing Medicaid. If known, providers should include the policy's per diem payment amount in the comments section of the form. The TPL Section will verify the information provided and update the beneficiary's CHAMPS eligibility information accordingly. The provider should bill the other resource first. Once payment has been received, the provider may bill Medicaid. The Medicaid claim must include the payment amount received from the other resource.



SECTION 2 - CATEGORIES OF OTHER INSURANCE

The major categories of other insurance are:

- Commercial health insurance carriers (i.e., managed care carriers [MCC], preferred provider organizations [PPO], point of service organizations [POS], health maintenance organizations [HMO], long-term care [LTC] insurance policies), traditional indemnity policies, and military/veteran insurance (i.e., TRICARE and the Civilian Health and Medical Program of the Department of Veterans Affairs [CHAMPVA]).
- Auto Insurance (accident, no-fault)
- Workers' Disability Compensation
- Court-Ordered Medical Support
- General Liability Insurance
- Medicare

2.1 COMMERCIAL HEALTH INSURANCE, TRADITIONAL INDEMNITY POLICIES, AND MILITARY/VETERAN INSURANCE

If a Medicaid beneficiary is enrolled in a commercial health insurance plan or is covered by a traditional indemnity policy or military/veteran insurance, the rules for coverage by the commercial health insurance, traditional indemnity policy, or military/veteran insurance must be followed. This includes, but is not limited to:

- Prior authorization (PA) requirements.
- Provider qualifications.
- Obtaining services through the insurer’s provider network.

Beneficiaries must use the highest level of benefits available to them under their policy. Medicaid is not liable for payment of services denied because coverage rules of the primary health insurance were not followed. For example, Medicaid does not pay the point of service sanction amount for the beneficiary electing to go out of the preferred provider network. Medicaid is, however, liable for Medicaid-covered services that are not part of the primary health insurance coverage.

PA is not necessary for situations of other insurance coverage if all of the following apply:	PA is required for the following:
<ul style="list-style-type: none"> ▪ The beneficiary is eligible for the other insurance and the primary insurer rules are followed; ▪ The provider is billing a standard Healthcare Common Procedure Coding System (HCPCS) code that Medicaid covers, and the primary insurer makes payment or applies the service to the deductible; and ▪ The service/item complies with Michigan Medicaid standards of coverage as described in this manual. 	<ul style="list-style-type: none"> ▪ PA is required for cases where the other insurance benefit has been exhausted or the service/item is not a covered benefit. ▪ PA is necessary for all other situations, including not otherwise classified (NOC) codes.



Inappropriately recoded claims are rejected by MDHHS even if MDHHS issued PA.

MDHHS payment liability for beneficiaries with other insurance is the lesser of the beneficiary's liability (including coinsurance, copayments, or deductibles), the provider's charge minus contractual adjustments, or the maximum Medicaid fee screen minus the insurance payments. For inpatient hospital claims, refer to the Hospital Claim Completion - Inpatient section (Medicare subsection) of the Billing & Reimbursement for Institutional Providers chapter for additional information.

Providers may enter into agreements with other insurers to accept payment that is less than their usual and customary fees. Known as "Preferred Provider" or "Participating Provider" Agreements, these arrangements are considered payment-in-full for services rendered. Neither the beneficiary nor MDHHS has any financial liability in these situations.

Providers must secure other insurance adjudication response(s) which must include Claim Adjustment Reason Codes (CARCs) prior to billing Medicaid. Denials do not need to be obtained in cases where the parameters of the carrier would never cover a specific service (e.g., a dental carrier would never cover a vision service, etc.). In cases where the provider renders a service and the carrier indicates it does not cover that specific service, the provider needs only to bill the carrier once for the service and keep a copy of the denial in the beneficiary's file. When billing on paper, this documentation must be submitted as an attachment to the paper claim. When billing electronically, no attachment is necessary, as all required data must be included in the electronic submission. (Refer to the Billing & Reimbursement Chapters of this manual for additional information.)

If payments are made by another insurance carrier, the amount paid, whether it is paid to the provider or the beneficiary, must be reflected on the claim. It is the provider's responsibility to obtain the payment from the beneficiary if the other insurance pays the beneficiary directly. It is acceptable to bill the beneficiary in this situation. Providers may not bill a Medicaid beneficiary unless the beneficiary is the policyholder of the other insurance. Failure to repay, return, or reimburse Medicaid may be construed as fraud under the Medicaid False Claim Act if the provider has received payment from a third party resource after Medicaid has made a payment. Medicaid's payment must be repaid, returned, or reimbursed to MDHHS Third Party Liability Section. (Refer to the Directory Appendix for contact information.)

Insurance companies should not submit checks directly to Medicaid. Rather, providers must work directly with the insurance company or the beneficiary to obtain the insurance payment. If the insurance company pays the beneficiary directly, it is the provider's responsibility to obtain the payment from the beneficiary; if the policyholder is someone other than the beneficiary, it is the provider's responsibility to obtain the payment from the policyholder.

2.2 AUTOMOBILE INSURANCE (ACCIDENT, NO-FAULT)

Under Michigan's no-fault law, automobile insurance carriers are required to pay the medical expenses for injuries incurred in an automobile accident. However, in some instances, the insured's automobile policy contains a rider stating that his health insurance coverage takes priority over the automobile insurance carrier's policy. (This also applies to Coordination of Benefits riders.) In situations where more than one individual is involved in an accident, there is a possibility that multiple automobile insurance carriers are involved. As a result, the liable insurance carrier cannot always be readily identified at the time of initial medical treatment. The no-fault law is designed to designate an order of priority of liability. Providers must bill the automobile insurance carrier prior to billing Medicaid or the Medicaid managed care plan. Billing Medicaid or a Medicaid managed care plan prior to exhausting other insurance resources may be



considered fraud under the Medicaid False Claim Act if the provider is aware that the beneficiary had other insurance coverage for the services rendered.

The order of responsibility to pay for medical expenses for automobile accidents is as follows:

- The insurance company of the injured party, regardless of whether he was in his, or any, automobile.
- The insurance company of any resident relative of the house in which the injured party also resides.
- The insurer of the owner of the vehicle occupied. For nonoccupants (pedestrians) of the vehicle, the insurer of the vehicle involved.
- The insurer of the driver of the vehicle occupied. For nonoccupants (pedestrians) of the vehicle, the insurer of the driver involved.

Medicaid or the Medicaid managed care plan must be billed within six months from the date of filing the no-fault claim to keep the claim active. Providers must bill the appropriate procedure code, date of the accident, and any other pertinent information (e.g., the identification of the other insurance of the injured party) on the claim.

Providers may directly pursue no-fault or other casualty cases and submit claims directly to the other insurance carriers. If liability is in question, Medicaid may be billed. Medicaid or the Medicaid managed care plan pursues reimbursement from the other insurance through subrogation. For the purposes of this section, a Medicaid managed care plan must follow Medicaid policy regarding TPL.

2.3 WORKERS' DISABILITY COMPENSATION

Workers' Disability Compensation is a system established under state law that provides payments, without regard to fault, to employees injured in the course of their employment. Workers' Disability Compensation does not cover medical care incidental to or separate from the injury. Providers must establish if the beneficiary is covered by Workers' Disability Compensation. Billing Medicaid or a Medicaid managed care plan prior to exhausting other insurance resources may be considered fraud under the Medicaid False Claim Act if the provider is aware that the beneficiary had other insurance coverage for the services rendered.

If a claim has been filed and is contested, providers may bill Medicaid while the claim is pending resolution by Workers' Disability Compensation. The provider must bill the appropriate procedure code, the date the claim was submitted (if known), and any other pertinent information (e.g., employer, Workers' Disability Compensation carrier, and attorney's name). Medicaid or the Medicaid managed care plan may bill the compensation carrier, or may follow up in hearings as to redemption or settlement. For the purposes of this section, a Medicaid managed care plan must follow Medicaid policy regarding TPL.

2.4 COURT-ORDERED MEDICAL SUPPORT

Court-ordered medical support is medical coverage for beneficiaries that the court has ordered to be paid by an individual (who is also the policyholder) other than the beneficiary. This individual could be an absent parent, a grandparent, adoptive parent, etc. The provider must pursue recovery of the other insurance payment directly from the policyholder. In instances where the policyholder does not reside with the beneficiary (e.g., an absent parent), providers are encouraged to have the custodial parent obtain a Qualifying Medical Support Order through the local Friend of the Court. This allows the provider



to bill the other insurance directly (e.g., Blue Cross/Blue Shield). If there is not a Qualifying Medical Support Order on file for the beneficiary, providers must still obtain the other insurance payment from the policyholder. (Refer to the Directory Appendix for contact information.)

2.5 GENERAL LIABILITY

General liability insurance is coverage that generally pertains to claims arising out of the insured's liability for injuries or damage caused by the ownership of property, manufacturing operation, contracting operations, sale or distribution of products, or the operation of machinery, as well as professional services. If the beneficiary's injury is not work - or automobile-related, the beneficiary's medical services may be covered by another insurance carrier (e.g., homeowner's insurance policy). This insurance carrier is considered primary and must be billed according to the rules of the insurance carrier.

2.6 MEDICARE

2.6.A. MEDICARE ELIGIBILITY

Many beneficiaries are eligible for both Medicare and Medicaid benefits. If a provider accepts the individual as a Medicare beneficiary, that provider must also accept the individual as a Medicaid beneficiary.

Medicaid beneficiaries who are eligible for Medicare due to age, but not enrolled in Medicare Part A or Part B, will have claims paid by Medicaid for Medicaid covered services. Medicaid will only pay claims for services that fall under the Medicare Part for which the beneficiary is eligible, but not enrolled. The provider must bill Medicare for covered services when the beneficiary only has Part A or Part B. After the beneficiary obtains Medicare, affected claims will be voided and the provider must bill Medicare. After Medicare's payment is received, Medicaid should be billed for any coinsurance and/or deductible amounts. For Medicare Part A and Part B/Medicaid claims, Medicaid's liability never exceeds that of the beneficiary.

Medicaid beneficiaries may apply for Medicare at any time and are not limited to open enrollment periods. Beneficiaries may be eligible for Medicare if they are:

- 65 years of age or older.
- A disabled adult (entitled to SSI or RSDI due to a disability).
- A disabled minor child.



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2.6.B. MEDICARE PART A

Since Medicare Part A pays for care in an inpatient hospital, nursing facility (NF), services provided by a home health agency (HHA) or in other institutional settings, Medicaid's reimbursement for services under Medicare Part A may vary.

For QMBs, if MDHHS is paying a beneficiary's Medicare Part B premium and the beneficiary does not have free Medicare Part A, MDHHS also pays the beneficiary's Medicare Part A premium.

MDHHS monitors beneficiary files to identify all beneficiaries who currently have Medicare Part B coverage only, and have Part B buy-in. Once these beneficiaries are identified, MDHHS automatically processes Part A buy-in.

To expedite the buy-in process, providers may notify MDHHS, in writing, when a beneficiary covered by Medicare Part B only is admitted to an inpatient hospital. (Refer to the Directory Appendix for MDHHS Provider Inquiry contact information.)

The following information is required:

- Beneficiary's name, date of birth, and Medicaid identification (ID) number;
- Medicare Beneficiary Identifier (MBI) or Health insurance claim number (HICN);
- Inpatient hospital admission date; and
- Hospital name, address, and provider NPI number.

Special points to remember:

- Medicaid does not pay for any portion of the services Medicare would have otherwise covered if a provider's error prevents Medicaid from buying-in Medicare Part A.
- To bill a claim when Medicare Part A coverage for Medicare/Medicaid beneficiaries is exhausted prior to an admission or during an inpatient hospital stay, refer to the Billing & Reimbursement for Institutional Providers Chapter of this manual.
- To bill a claim when no Medicare payment has been made because the amount of Medicare coinsurance, plus the amount for lifetime reserve days, is greater than the Medicare diagnosis related group (DRG) amount, refer to the Billing & Reimbursement for Institutional Providers Chapter of this manual.

2.6.C. MEDICARE PART B

Medicare Part B covers practitioner's services, outpatient hospital services, medical equipment and supplies, and other health care services. When a beneficiary is eligible for and enrolled in Medicare Part B, Medicare usually pays for a percentage of the approved Medicare Part B allowable charges and Medicaid pays the applicable deductible and/or coinsurance up to Medicaid's maximum allowable amount. Coverage for outpatient therapeutic psychiatric coverage varies.



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Beneficiaries are encouraged to enroll in Medicare Part B as soon as they are eligible to do so. A beneficiary's representative can apply for Medicare Part B benefits on behalf of the beneficiary. After the beneficiary's death, MDHHS is responsible for making the application to the Social Security Administration (SSA) to cover medical services provided prior to the death.

2.6.D. MEDICARE PART D

Beneficiaries enrolled in Medicare Part A and/or Part B are eligible for Medicare Part D. Medicaid does not pay for Medicare Part D covered drugs for Medicare eligible beneficiaries.

Medicaid will cover some of the drugs which are excluded from Part D. (Refer to the Pharmacy chapter for drug product coverage information.)

Medicaid does not cover beneficiaries who are eligible for Part D but are not currently enrolled in a Medicare Prescription Drug Plan (PDP). Pharmacies should refer to the Pharmacy Benefits Manager (PBM) website for information on billing Medicare Part D when eligible beneficiaries have not yet enrolled in a Part D plan. (Refer to the Directory Appendix for website information.)

All questions regarding Part D coverage should be directed to Medicare. (Refer to the Directory Appendix for contact information.)

2.6.E. MEDICARE BUY-IN/MEDICARE SAVINGS PROGRAM

If a beneficiary is eligible for Medicare but has not enrolled, he can do so at any time throughout the year by applying with SSA. If the beneficiary is unable to pay the Medicare premiums, Medicaid may pay the premiums through a contractual agreement (called the Medicare Buy-In Agreement) with the federal government. However, Medicaid cannot buy-in for the beneficiary until he applies for Medicare and the SSA is aware that he is Medicaid-eligible, and the beneficiary has applied for the Medicare Savings Program through his local MDHHS office. Beneficiaries eligible for Buy-In but who have not enrolled in Medicare can enroll at any time throughout the year by applying with SSA. Medicaid beneficiaries who did not receive automatic enrollment into Medicare Part A and/or Part B or declined coverage should also seek enrollment. Beneficiaries who need to enroll in Medicare can visit their nearest Social Security office for assistance or contact the Michigan Medicare/Medicaid Assistance Program (MMAP) for health benefit information and counseling. (Refer to the Directory Appendix for contact information.)



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Some dual-eligible beneficiaries are classified as:

Qualified Medicare Beneficiaries (QMB)	Medicaid pays Medicare Part A and Part B premiums for these individuals, and reimburses providers for Medicare coinsurance and/or deductible amounts only to the extent that the total payment does not exceed the Medicaid maximum allowable amount. These beneficiaries are identified by the Benefit Plan ID of QMB in the eligibility response. Physicians and suppliers should be aware that services provided to QMBs are reimbursed on a Medicare assignment basis only. If a provider knowingly bills for Medicare services on other than an assignment basis, the U.S. Department of Health & Human Services (HHS) can seek sanctions.
Specified Low Income Medicare Beneficiaries (SLM/SLMB)	Medicaid pays only the Medicare Part B premiums for these individuals. Medicaid does not reimburse providers for any services rendered to the beneficiary. No mihealth card is issued to these individuals.
Additional Low Income Medicare Beneficiaries (ALMB)	Medicaid pays only the Medicare Part B premiums for these individuals. Medicaid does not reimburse the provider for any services rendered to the beneficiary. No mihealth card is issued to these individuals.

2.6.F. MEDICAID LIABILITY

If Medicare has paid 100 percent of the allowable charges and there is no coinsurance involved, then Medicaid has no payment liability.

Neither the beneficiary nor Medicaid is liable for any difference in the amount billed by the provider and Medicare's allowable fee.

If the beneficiary is in a Medicare Risk HMO, MDHHS pays fixed copays (except Medicare Part D) on the services up to the lesser of Medicaid's allowable amount minus the Medicare payment for the service or the beneficiary's payment liability, as long as the rules of the HMO are followed.

MDHHS reimburses providers for the coinsurance and deductible amounts subject to Medicaid reimbursement limitations on all Medicare approved claims even if Medicaid does not normally cover the service. MDHHS payment liability for beneficiaries with Medicare coverage (except Medicare Part D) is the lesser of:

- The beneficiary's liability for coinsurance, copayments, and/or deductibles minus any applicable Medicaid copayment, patient-pay, or deductible amounts.
- The Medicaid fee screen/allowable amount, minus any Medicare or other insurance payments and any applicable Medicaid copayment, patient-pay, or deductible amounts.
- The provider's charge, minus any Medicare or other insurance payments, contractual adjustments, and any applicable Medicaid copayment, patient-pay, or deductible amounts.



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For inpatient hospital claims, refer to the Hospital Claim Completion - Inpatient section (Medicare subsection) of the Billing & Reimbursement for Institutional Providers chapter for additional information.

Medicare coverage is not available for a Medicaid beneficiary who is 65 years or older and is an alien who has been in the country less than five consecutive years.

MDHHS does not pay for services denied by Medicare or other insurance plans due to noncompliance with Medicare or other insurance plan requirements. If the provider's service would have been covered and payable by Medicare or the other insurance plan but some requirement of the plan was not met, MDHHS will deny the claim. The provider and the beneficiary both have equal responsibility for complying with Medicare or the other insurance plan requirements.

Common noncompliance denials include, but are not limited to,:

- Failure to obtain a referral from a participating primary care provider (PCP).
- Failure to be seen by a participating provider.
- Failure to be seen in a participating place of service.
- Failure to obtain a second opinion.
- Failure to obtain prior authorization

In instances where MDHHS has denied payment or made a post-payment recovery due to noncompliance, it is the provider's responsibility to remediate with the primary payer prior to re-billing with Medicaid.

NOTE: This also applies to Fee-for-Service pharmacy claims, particularly claims submitted with Other Coverage Code (OCC) "3: Other Coverage Billed – Claim Not Covered." When the National Council for Prescription Drug Programs (NCPDP) standard does not provide MDHHS with a point-of-sale (POS) mechanism to verify full compliance with Medicare or commercial health insurance plan requirements, MDHHS will review and recover monies for noncompliance on a post-payment basis (e.g., when the primary payer denies the claim with NCPDP rejection code "75: Prior Authorization Required" and MDHHS is unable to verify at the POS whether prior authorization was requested and denied versus prior authorization not requested).



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When a Medicaid beneficiary is eligible for, but not enrolled in, Medicare Part B and/or Part D, MDHHS will pay claims for Medicare Part B or Part D services. Medicaid beneficiaries who did not receive automatic enrollment into Medicare Part A and/or Part B or declined coverage should also seek enrollment.

If Medicare reimburses for the service, Medicaid does not require PA for the service.

MDHHS identifies fee-for-service (FFS) beneficiaries who are retroactively eligible for Medicare. Medicaid payment for services provided to these beneficiaries is adjusted to recoup all monies except the Medicaid liability, and recovered via an automated claim adjustment. FFS providers are notified by MDHHS when these adjustments occur. The notification includes beneficiary detail. If a discrepancy in payment exists, the provider should contact Provider Inquiry. (Refer to the Directory Appendix for contact information.)

Beneficiaries cannot be charged for Medicaid-covered services, except for approved copays or deductibles, whether they are enrolled as a FFS beneficiary, MDHHS is paying the HMO premiums to a contracted health plan, or services are provided under PIHP/CMHSP capitation. Refer to the Commercial Health Insurance, Traditional Indemnity Policies, and Military/Veteran Insurance subsection of this chapter for exceptions when a beneficiary has third party resources.

2.6.G. EXCEPTIONS TO THE TIMELY FILING BILLING LIMITATION

When a delay in payment from Medicare causes a delay in billing Medicaid, an exception may be made if the provider can document that Medicare was billed within 120 days of the date of service and Medicaid was billed within one year of the date of payment, rejection or retroactive recovery of funds by Medicare. Medicaid payment is made provided all other requirements (e.g., beneficiary eligibility, medical necessity) are met. A copy of the Medicare claim submitted and Medicare's response must be attached to the Medicaid paper claim to document Medicare's delay. If billing electronically, a note should be added in the Remarks segment that the late billing is due to Medicare's delay in processing the claim. (Refer to the Billing & Reimbursement Chapters of this manual for additional information.)

2.6.H. LIFETIME RESERVE DAYS

Medicare allows a one-time additional 60 days of coverage known as Lifetime Reserve Days (LRD). A Medicaid beneficiary who has Medicare Part A must use these 60 days before Medicaid makes a payment, except for deductibles and coinsurance.

2.6.I. OUTPATIENT HOSPITAL LABORATORY SERVICES

Medicare pays most diagnostic and clinical laboratory tests at 100 percent. Therefore, Medicaid has no payment liability.



2.6.J. PSYCHIATRIC SERVICES

Diagnostic outpatient hospital psychiatric physician services, including the initial psychiatric diagnostic and evaluation interview, family counseling and psychological testing, are reimbursed as a Medicare Part B service.

2.6.K. OTHER INSURANCE PAYER ID

Other Insurance Payer IDs can be accessed in CHAMPS by individual beneficiary. All third-party carriers must be used to the fullest extent possible, prior to billing Medicaid and Children's Special Health Care Services (CSHCS) Programs, including Medicaid Health Plans (MHPs) and PIHPs/CMHSPs/CAs.



SECTION 3 - SPECIAL CONSIDERATIONS

3.1 MASTER MEDICAL

All insurance coverage, including Master Medical policy riders, must be used before filing a claim with Medicaid. If the beneficiary has a Master Medical policy rider (e.g., Blue Cross/Blue Shield), providers must identify whether the provider or policyholder must bill. If the policyholder must bill, the provider must provide a statement of charges to the beneficiary or policyholder to use when billing Master Medical. If there is a court order for medical support that includes Master Medical, the custodial parent may obtain a qualified medical support order for providers to be paid directly from the insurance carrier. Whether the payment is made to the policyholder or the provider, the provider must report it as other insurance payment on the bill submitted to Medicaid. Providers must pursue recovery of the insurance payment if it is made directly to the policyholder. The beneficiary, or his representative, must not be billed for this payment unless the beneficiary is the policyholder.

3.2 HOSPITAL CREDIT BALANCE REFUND PROCESS

A TPL hospital credit balance refers to funds that must be returned to MDHHS because a claim has been paid by another resource or paid incorrectly.

Providers must refund credit balance overpayments by submitting claim adjustments or claim voids through CHAMPS or submitting them via an electronic claim vendor. Providers are required to include a comment on the claim adjustment or claim void that reads "Credit Balance MM/DD/YYYY" where MM/DD/YYYY is the date the overpayment was identified.

Providers are required to resolve credit balances before submitting their fiscal year end cost report. Any credit balances adjusted through CHAMPS prior to the MDHHS designated contractor's audit need not be reported to the contractor. For credit balance adjustments performed via CHAMPS, the provider's documentation must match the identification date noted in the claim adjustment or claim void comments within CHAMPS.

3.3 COINSURANCE/DEDUCTIBLE AND/OR COPAYMENT

Medicaid responsibility for payment of coinsurance/deductible and/or copayment amounts is:

Coinsurance, Copayments, and Deductibles	Medicaid pays the appropriate coinsurance amounts, copayment amounts, and deductibles up to the beneficiary's financial obligation to pay or the Medicaid allowable amount (less other insurance payments), whichever is less. If the other insurance has negotiated a rate for a service that is lower than the Medicaid allowable amount, that amount must be accepted as payment in full and Medicaid cannot be billed.
Medicaid services not covered by another insurance	If the other insurance does not cover a service that is a Medicaid-covered service, Medicaid reimburses the provider up to the Medicaid allowable amount if all the Medicaid coverage rules are followed.



MDHHS cannot be billed for copays, coinsurance, deductibles, or any fees for services provided to beneficiaries enrolled in a MHP, or who are receiving services under PIHP/CMHSP capitation.

Beneficiaries are responsible for payment of all copays and deductibles allowed under the MHP/PIHP/CMHSP contract with MDHHS. If the beneficiary with other insurance coverage is enrolled in a MHP or receiving services under a PIHP/CMHSP capitation, the MHP/PIHP/CMHSP assumes the Medicaid payment liabilities.

Beneficiaries cannot be charged for Medicaid-covered services, except for approved copays or deductibles, whether they are enrolled as a FFS beneficiary, MDHHS is paying the HMO premiums to a contracted health plan, or services are provided under PIHP/CMHSP capitation.

(Refer to the Medicaid Liability subsection of this chapter for additional information on Medicare claims.)

3.4 CLAIM REPLACEMENT

A claim replacement should be submitted if another insurance makes a payment subsequent to Medicaid's payment. (For specific claim replacement instructions, refer to the Billing & Reimbursement Chapters of this manual.)

3.5 CLAIMS SUBJECT TO ADDITIONAL EDITS

If a beneficiary has Medicare or private insurance, submitted claims must contain the name and individual National Provider Identifier (NPI) of the practitioner who ordered, prescribed or referred the service(s)/item(s). If the applicable attending, ordering, prescribing or referring provider information is not reported on the claim, or if the provider is not enrolled in the Michigan Medicaid program, the claim cannot be paid.

3.6 EXCEPTIONS TO MEDICAID PAYER OF LAST RESORT

There are a few exceptions to the general rule that Medicaid is the payer of last resort. In limited circumstances where there is a federal statute making Medicaid primary to a specific program, the Medicaid program must pay before the federally-administered health program.

The following federally-administered programs are some examples of exceptions to Medicaid's payer of last resort rule:

- Crime Victims Compensation Fund
- Ryan White Program
- Indian Health Services
- Women, Infants and Children Program
- Grantees under Title V of the Social Security Act (Maternal and Child Health Services Block Grant)
- Veteran Benefits – emergency treatment provided in a non-VA facility
- Veteran Benefits – non-VA nursing home per diem payments



SECTION 4 – CROSSOVER CLAIMS

The crossover process allows providers to submit a single claim for individuals dually eligible for Medicare and Medicaid, or qualified Medicare beneficiaries eligible for Medicaid payment of coinsurance and deductible to a Medicare fiscal intermediary, and also have it processed for Medicaid reimbursement. Refer to the specific claim type chapters within this manual for further billing instructions.

Additional information about the crossover claim process is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

4.1 ACCEPTABLE CROSSOVER CLAIMS

MDHHS accepts Medicare Part A institutional claims (inpatient and outpatient) and Medicare Part B professional claims processed through the CMS Coordinator of Benefits Contractor, Group Health, Inc. (GHI). Claim adjudication will be based on the provider NPI number reported on the claim submitted to Medicare.

When a claim is crossed over to MDHHS, a remittance advice (RA) will be generated from the fiscal intermediary with the details of the Medicare payment and Remark Code MA07 (the claim information has also been forwarded to Medicaid for review). If this remark does not appear on the fiscal intermediary's RA, a separate claim will have to be submitted to MDHHS.

4.2 CLAIMS EXCLUDED FROM CROSSOVER PROCESS

The following types of claims will be **excluded** from the crossover process between MDHHS and Medicare:

- Totally denied claims
- Claims denied as duplicates or missing information
- Replacement claims or void/cancel claims submitted to Medicare
- Claims reimbursed 100 percent by Medicare
- Claims for dates of service outside the beneficiary's Medicaid eligibility begin and end dates

Providers must resolve denied claims with the fiscal intermediary unless the service is an excluded benefit for Medicare, but covered by Medicaid (e.g., insertion of an IUD or hearing aid supply). In those cases, the excluded Medicare service can be billed directly to MDHHS.

Additional information regarding crossover billing and exclusions can be found on the MDHHS website. (Refer to the Directory Appendix for website information.)



BILLING & REIMBURSEMENT FOR DENTAL PROVIDERS

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SECTION 1 – GENERAL INFORMATION

This chapter applies to all providers billing the ADA 2012 or 837 Dental claim formats. It contains information needed to submit dental claims to the Michigan Department of Health and Human Services (MDHHS) for Medicaid and Children’s Special Health Care Services (CSHCS). It also contains information about how claims are processed and how providers are notified of MDHHS actions.

Dental providers must use the ASC X12N 837D 5010 dental format when submitting electronic claims and the ADA 2012 claim form for paper claims.

1.1 CLAIMS PROCESSING SYSTEM

All claims submitted and accepted are processed through CHAMPS. Paper claims are scanned and converted to the same file format as claims submitted electronically.

Claims processed through CHAMPS are edited for many parameters, including provider and beneficiary eligibility, procedure validity, claim duplication, frequency limitations for services, and combination of service edits. Electronic claims received by Wednesday may be processed as early as the next weekly cycle.

MDHHS encourages providers to send claims electronically. (Refer to the Electronic Submission Manual on the MDHHS website for additional information. Refer to the Directory Appendix for website information.) Electronic filing is more cost effective, more accurate, payment is received more quickly, and administrative functions can be automated.

1.2 PREDICTIVE MODELING

Predictive modeling, a pre-payment claims process in CHAMPS, uses advanced screening technology to identify Medicaid claims with billing irregularities. Claims flagged by the predictive modeling process will undergo a detailed analysis to determine the next step(s) to be taken. This may include a review of medical records and/or past claims. Providers must submit the requested records within 45 days of the date on the request for documents letter to avoid denials for lack of documentation. Records should not be submitted prior to receiving a request for documentation letter.

Requested records must be submitted through the Document Management Portal (DMP) available in CHAMPS. Refer to:

- the MDHHS website for information and tutorials on the Document Management Portal.
- the Directory Appendix for Document Management Portal website information.

1.3 CLAIM PAYMENT/CLAIM STATUS

Once claims have been submitted and processed through CHAMPS, an electronic health care claim payment/advice (ASC X12N 835 5010) is sent to the designated service bureau for providers choosing an electronic RA. The CHAMPS RA is also available to providers online or is sent to providers via paper if requested through the Provider Enrollment Subsystem. (Refer to the Remittance Advice Section of this chapter for additional information about both the electronic and paper RA.)



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To receive information on suspended claims, a provider-initiated 276 claim status request must be submitted and a 277 claim status response will be returned. Providers have the option to receive information on suspended claims via the CHAMPS claims inquiry screens as well.

1.4 ELECTRONIC FUNDS TRANSFER

Electronic Funds Transfer (EFT) is the method of direct deposit of State of Michigan payments into a provider's bank account. This replaces a paper warrant. To initiate an EFT, the facility should go to the Department of Technology, Management & Budget (DTMB) website. (Refer to the Directory Appendix for website information.)



SECTION 2 – GENERAL INFORMATION/PRIOR AUTHORIZATION

The Dental Prior Approval Authorization Request (MSA-1680-B) is a form designed to obtain authorization for those services that require prior authorization (PA), as indicated in the Dental Chapter. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

The dentist must remember the following:

- Radiographs must be sent along with the PA form and are returned only upon provider request.
- The PA form only needs to include the procedure that requires PA.
- Assess the general oral health and provide a five-year prognosis on the prosthesis requested.
- The dentist should make liberal use of the Pertinent Dental History and Medical areas on the request to better define symptomatology, treatment situations, etc. when the services requested or the accompanying documentation may leave unresolved questions. When health problems exist, they should be identified on the request along with any effect they might have upon the proposed plan of treatment.
- Any additional documentation submitted with the request must contain the beneficiary's name and identification (ID) number, date, and the dentist's name and NPI number.

Additional information is generally required to be submitted with or indicated on the PA form. This is to enable staff to make an accurate determination regarding the proposed plan of treatment.



SECTION 3 – HOW TO FILE CLAIMS

Dental claims may be submitted electronically or on paper. Electronic claim submission is the preferred method for submitting claims to MDHHS.

3.1 ELECTRONIC CLAIMS

Claims submitted electronically and accepted are received directly into CHAMPS, which results in faster payments and fewer claims that suspend or reject. (Refer to the Electronic Submission Manual on the MDHHS website for additional information. Refer to the Directory Appendix for website information.) Providers submitting claims electronically must use the ASC X12N 837D 5010 dental format. The payroll cut-off for electronic claims submission to MDHHS is Wednesday of each week.

Complete information on submission of electronic claims is available on the MDHHS website. (Refer to the Directory Appendix for website information.) The MDHHS Electronic Submission Manual and other resources, such as Companion Guides, are on the website. Information on the website is updated as version changes occur at the national level and are adopted by MDHHS.

3.1.A. AUTHORIZED BILLING AGENT

Any entity (service bureau or individual provider) wishing to submit claims electronically to MDHHS must enroll as an authorized billing agent. The Provider Enrollment Section of the General Information for Providers Chapter and the Trading Partners portion of the MDHHS website contain information related to the application and billing agent authorization process. (Refer to the Directory Appendix for website information.)

More than one billing agent per provider can be authorized to submit the provider's claims electronically. However, only one electronic billing agent may be the designated receiver of the electronic health care claim payment/advice ASC X12N 835 5010. Authorizations remain in effect until changed by the provider through the CHAMPS Provider Enrollment subsystem.

Any individual provider can submit claims electronically as long as the authorization process is completed and approved; however, many providers find it easier to use an existing authorized billing agent to submit claims to MDHHS. Billing agents prepare claims received from their clients, format to HIPAA compliant MDHHS standards, and submit the files to MDHHS for processing. Whether claims are submitted directly or through another authorized billing agent, providers receive a paper remittance advice (RA) that reflects their individual claims. Billing agents receive an RA that contains information on all the claims the agent submitted.

For more information on becoming an electronic biller or for a list of authorized billing agents, contact the Automated Billing Unit. (Refer to the Directory Appendix for contact information.)

3.1.B. ELECTRONIC CLAIMS WITH ATTACHMENTS

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 MDHHS website for information and tutorials on the Document Management Portal. Refer to the Directory Appendix for website information.)

If comments or additional information are required with an electronic claim, electronic submitters must enter the information in the appropriate segments of the electronic record. If an operative report or other paper attachment is required, providers must use the Document Management Portal. Within the Document Management Portal, the appropriate documentation category must be chosen along with completing specified information to successfully enter the document. MDHHS does not accept paper documentation via mail for any electronic claim. The Document Management Portal process allows MDHHS to communicate directly with providers to resolve claim attachment issues prior to finalizing claim adjudication.

Electronic submitters must:

- Include the notation "Documents uploaded in DMP" in the Claim Note area (NTE02 Segment, Loop 2300) and Reference Code "ADD" (NTE01 Segment, Loop 2300) within the electronic claim.
- Comply with all standard HIPAA reporting requirements, including using Claim Adjustment Segment (CAS) codes when submitting secondary or tertiary claims.

Refer to the MDHHS website for the Document Management Portal instructions. (Refer to the Directory Appendix for website information.)

Submission of electronic attachments via fax requires the use of a fax cover sheet which will be generated in the DMP system. (Refer to the MDHHS website for information on the Document Management Portal. Refer to the Directory Appendix for website information.)

3.2 PAPER CLAIMS

The ADA 2012 claim form must be used when submitting paper claim forms. The MDHHS Optical Character Reader (OCR) scans paper claims.

Claims may be prepared on a typewriter or on a computer. Handwritten claims are not accepted. Because claims are optically scanned, print or alignment problems may cause misreads, thus delaying processing of the claim. Keep equipment properly maintained to avoid the following:

- Dirty print elements with filled character loops.
- Light print or print of different density.
- Breaks or gaps in characters.
- Ink blotches or smears in print.
- Worn-out ribbons.

Dot matrix printers should not be used as they result in frequent misreads by the OCR.



Questions and/or problems with the compatibility of equipment with MDHHS scanners should be directed to MDHHS Provider Inquiry. (Refer to the Directory Appendix for contact information.)

Paper claims should appear on a remittance advice (RA) within 60 days of submission. Do not resubmit a claim prior to the 60-day period.

3.2.A. GUIDELINES TO COMPLETE PAPER CLAIM FORMS

To assure that the scanner correctly reads claim information, adhere to the following guidelines in preparing paper claims. Failure to do so can result in processing/payment delays or claims being returned unprocessed.

- American Dental Association (ADA) standard completion instructions should be followed in completing the ADA 2012 claim form.
- Be sure the dates are within the appropriate boxes on the form.
- Use only black ink.
- Do not write or print on the claim, except for the Provider Signature Certification.
- Handwritten claims are not acceptable.
- UPPER CASE alphabetic characters are recommended.
- Do not use italic, script, orator, or proportional fonts.
- 12-point type is preferred.
- Make sure the type is even (on the same horizontal plane) and within the boxes.
- Do not use punctuation marks (e.g., commas or periods).
- Do not use special characters (e.g., dollar signs, decimals, or dashes).
- Only service line data can be on a claim line. Do not squeeze comments below the service line.
- Do not send damaged claims that are torn, glued, taped, stapled, or folded. Prepare another claim.
- Do not use correction fluid or correction tape, including self-correcting typewriters.
- If a mistake is made, start over and prepare a clean claim form.
- Do not submit photocopies.
- Claim forms must be mailed flat, without folding, in 9" x 12" or larger envelopes. Do not fold the form.
- Put your return address on the envelope.
- Separate the claim form from the carbon.
- Separate each claim form if using the continuous forms and remove all pin drive paper completely. Do not cut the edges of forms.
- Keep the file copy.
- Mail Dental claim forms separately from any other claim form type.



3.2.B. PAPER CLAIMS WITH ATTACHMENTS

When a claim attachment(s) is required, it must be directly behind the claim it supports and be identified with the beneficiary's name and Medicaid ID Number. Attachments must be on 8 ½" x 11" white paper and one-sided. Do not submit two-sided materials. Multiple claims cannot be submitted with one attachment. Each claim form that requires an attachment must have a separate attachment. Do not staple or paperclip the documentation to the claim form.

Mail claim forms with attachments flat, with no folding, in a 9" x 12" or larger envelope and print "Ext. material" (for extraneous material) on the outside. Do not put claims without attachments in this envelope. Mail claims without attachments separately. Do not send attachments unless the attachment is required as unnecessary attachments delay processing of claims.

3.2.C. MAILING PAPER CLAIMS

All paper claim forms and claim forms with attachments must be mailed to MDHHS. (Refer to the Directory Appendix for contact information.)

3.3 REPORTING PROVIDER NPI

MDHHS requires that NPI numbers be reported in any applicable provider loop or field (e.g., billing, rendering, referring) on the claim. A provider's Taxpayer Identification Number (TIN) will also be used for claim adjudication. The TIN reported is either the provider's Employer Identification Number (EIN) or Social Security Number (SSN). For a Type 2 (Group) NPI, both the NPI and EIN must be reported at the billing provider loop for all electronic claims. For a Type 1 (Individual) NPI, both the NPI and EIN/SSN are required at the billing provider loop for electronic claims when a Type 2 NPI does not apply.

A Type 1 (Individual) NPI is the number associated with an individual healthcare professional (e.g., MD, DDS, CRNA, etc.). The individual may be a sole proprietor or be employed by a clinic, group practice, or other organization. If a sole proprietor, the Type 1 NPI must be reported in the billing provider loop or field of the claim for payment.

A Type 2 (Group) NPI is the number required for organizations such as clinics, group practices, and incorporated individuals who provide health care services and receive payment. For MDHHS, the Group NPI must be reported in the billing provider loop or field. Also, for dental and professional claims, the appropriate Type 1 (Individual) NPI of the specific provider performing the service must be reported in the rendering provider loop or field for proper claim adjudication. Do not enter the Type 2 (Group) NPI as the rendering provider.

MDHHS NPI claim editing will be applied to the billing, referring, and/or rendering provider as applicable. A claim cannot be paid if the NPI is missing or the reported NPI is invalid as it does not check digit and/or correctly crosswalk to the Provider Enrollment files for these provider loops or fields.

The ADA claim form does not contain fields for the referring provider. Paper claims which require this information must be submitted via CHAMPS Direct Data Entry (DDE). (Refer to the Directory Appendix for additional information.)



3.3.A. BILLING PROVIDER

The billing provider loop or field is mandatory to complete on all claims. The billing provider must be enrolled with the program for payment. If the billing provider NPI reported is an invalid number and/or represents a non-enrolled provider, the entire claim will be denied for payment.

3.3.B. RENDERING PROVIDER

The rendering provider loop or field must be completed within the professional/dental claim formats only when the provider is enrolled with MDHHS. For an organization (such as clinics and group practices), the rendering provider will be required. If MDHHS does not recognize the rendering provider's NPI, services rendered by these providers (e.g., dental hygienists) must be billed under the supervising dentist's NPI. The supervising dentist is responsible for ensuring the medical necessity and appropriateness of the services.

3.3.C. REFERRING PROVIDER

Referring provider information is a claim editing requirement for services rendered as a result of a referral. The claim must contain the name and individual NPI of the provider who referred the service(s)/item(s).

If referring provider information is not reported on the claim, or if the provider is not enrolled in the Michigan Medicaid program, the claim cannot be paid.

Rendering providers should ensure their referral sources are aware of this requirement. Referring providers may initiate the enrollment process at any time. (Refer to the General Information for Providers chapter for information regarding enrollment.)



SECTION 4 – ADA COMPLETION INSTRUCTIONS

4.1 DENTAL CLAIM FORM COMPLETION INSTRUCTIONS

American Dental Association (ADA) standard completion instructions should be followed in completing the ADA 2012 claim form.



SECTION 5 – SPECIAL BILLING INSTRUCTIONS

5.1 SUPERNUMERARY TEETH

Providers bill the appropriate procedure code and the supernumerary tooth number as identified using the ADA Universal/National Tooth Designation System. Supernumerary Permanent teeth are identified by the numbers 51 through 82, beginning with the upper right third molar, following the upper arch and continuing on the lower arch, concluding with the lower right third molar area in the same manner as permanent tooth numbers 1 through 32. For example, tooth number 51 would correlate with the position of tooth number 1 and tooth number 82 would correlate with the position of tooth number 32.

Refer to the 2012 ADA Claim form instructions for additional information.

5.2 LOSS OR CHANGE IN ELIGIBILITY

Providers can only bill for root canal therapy, complete and partial dentures, and laboratory-processed crowns if loss or change in eligibility occurs. Services must have been started prior to the loss or change in eligibility.

For incomplete services due to irreversible circumstances - Dentures:

- When denture services have commenced, but irreversible circumstances have prevented delivery, the dentist should bill using the Not Otherwise Classified (NOC) procedure code D5899. A copy of the lab bill and an explanation in the Remarks section of the claim must be included.

For services due to loss or change in eligibility:

- Complete or partial dentures, laboratory-processed crowns, and/or root canal therapy must have been started prior to the change in/loss of eligibility and completed within 30 days of the date of the change in/loss of eligibility.
 - Electronic Claims:
 - Treatment Start Date and Treatment Completion Date are required within Loop 2400 DPT.
 - DDE Claims:
 - Treatment Start Date and Treatment Completion Date are required within the appropriate DDE fields.
 - Paper Claims:
 - For complete or partial dentures and laboratory-processed crowns, the date of service on the claim should be the date of the initial impression (the completion date must be entered in the Remarks section).
 - For root canal therapy, the date of service should be the first treatment appointment (the completion date must be entered in the Remarks section).



5.3 INCOMPLETE ROOT CANAL

For an incomplete root canal:

- Providers must bill the Not Otherwise Classified (NOC) procedure code D3999.
- Provide an explanation in the Remarks section of the claim.
- Date of service should be the first treatment appointment.

5.4 DIAGNOSIS REPORTING

Diagnosis reporting is required for all oral and maxillofacial surgeries and/or anesthesiology services.

- Electronic claims:

The diagnosis code(s) is required to be reported in Loop 2300 HI.

- DDE claims:

The diagnosis code(s) is required in the applicable DDE diagnosis field.

- Paper claims:

The diagnosis code(s) is required in the Remarks section.

5.5 QUANTITY

The Quantity field is available for use for both electronic (Loop 2430 SVD/DVD05) and DDE claims to report the number of dental services rendered. The quantity for dental code D0230 (Intraoral periapical, each additional film) is required for proper claim adjudication.

5.6 ORTHODONTIC BILLING INSTRUCTIONS

For interceptive orthodontic treatment procedure codes, the fee is all inclusive. The date of service on the claim is the banding/start date. Include the PA number on the claim.

Comprehensive orthodontic procedure codes are to be used in the first stage of each comprehensive treatment phase. The date of service on the claim is the banding/start date. Include the PA number on the claim.

The periodic orthodontic treatment visit is for a six-month timeframe. The date of service on the claim is the first day of the six-month timeframe. The entire timeframe is entered in the Remarks Section of the claim form. Include the PA number on the claim.

If the periodic orthodontic treatment ends before an entire six-month timeframe is completed, the fee for the treatment timeframe must be prorated. The periodic orthodontic treatment fee is based on a six-month timeframe. The fee charged should reflect the periodic treatment timeframe. The date of service on the claim is the first day of the periodic timeframe. The entire prorated timeframe is entered into the Remarks Section of the claim form. Include the PA number on the claim.



5.7 INTERIM CARIES ARRESTING MEDICAMENT

CDT D1354 - Interim Caries Arresting Medicament Application is billable once per date of service regardless of the number of teeth treated up to a maximum of five (5) teeth per visit. Providers are required to enter the tooth number(s)/letter(s) of all teeth treated in the comments section of the claim. There is a maximum of six applications per lifetime. Silver Diamine Fluoride can be billed on the same date of service as other fluoride applications.



SECTION 6 – REPLACEMENT CLAIMS

6.1 GENERAL INFORMATION

Replacement claims must be submitted when all or a portion of the claim was paid incorrectly or a third party payment was received after MDHHS has made payment. Both the provider NPI and beneficiary ID numbers on the replacement claim must be the same as on the original claim. To replace a previously paid claim adjudicated with a Claim Reference Number (CRN) prior to October 1, 2007, both the Medicaid legacy provider ID number and the NPI must be reported on the replacement claim for successful adjudication. Reasons claims may need to be replaced:

- To return an overpayment (report "returning money" in Remarks section);
- To correct information submitted on the original claim such as changing the date of service, tooth number or incorrect charges;
- To correct an incorrect provider NPI number or beneficiary ID number (refer to the void/cancel process below);
- To report payment from another source after MDHHS paid the claim (report "returning money" in Remarks section); and/or
- To correct information that the scanner may have misread (state reason in Remarks section).

If all service lines on a claim were rejected, the services must be resubmitted as a new claim, not a replacement claim.

6.2 CLAIM REPLACEMENT AND VOID/CANCEL CLAIMS

Instructions for submitting an electronic replacement claim are contained in the MDHHS 837D Companion Guide available on the MDHHS website. (Refer to the Directory Appendix for website information.)

A void/cancel claim must be submitted if the original claim was paid under the incorrect provider ID or beneficiary ID number. To void/cancel an original claim adjudicated with a Claim Reference Number (CRN) prior to October 1, 2007, both the correct Medicaid legacy provider ID number and NPI must be reported along with the correct beneficiary ID number.

Providers using the paper dental claim form to submit a void/cancel claim must submit a new claim. Only one service line needs to be completed with zero dollars entered in the charges or money field. All money paid on the first claim line will be deleted. Upon notification through the Remittance Advice that the money has been deleted from the Medicaid system, a new claim with the correct provider NPI number and/or beneficiary ID may be submitted.

Replacement and void/cancel claims must be sent to the address noted in the Directory Appendix for that purpose. They are not to be sent to the address utilized for initial claims.



6.3 PAYMENT REFUNDS

Return of overpayments made by MDHHS, due to either payment from a third party resource or due to an error, must be done through the use of a replacement claim or void/cancel claim. This process will result in a debit against future payment.

This requirement does not apply to inactive providers or monies being returned to MDHHS due to settlements or lawsuits. In these situations, checks must:

- be made payable to the State of Michigan in the amount of the refund
- include the provider EIN (tax) number
- be sent to MDHHS Cashier's Unit. (Refer to the Directory Appendix for contact information.)

Do not submit a replacement claim and manually send a refund to the Cashier's Unit as this results in an incorrect refund amount.



SECTION 7 – CHANGES IN ELIGIBILITY AND ENROLLMENT (FFS/CSHCS)

7.1 GENERAL INFORMATION

It is the provider's responsibility to determine eligibility/enrollment status of beneficiaries at the time services are provided and obtain the appropriate authorizations for payment.

Medicaid or Children's Special Health Care Services (CSHCS) beneficiaries may lose their eligibility or change enrollment status on a monthly basis. Enrollment status changes include beneficiaries changing from FFS (Fee-For-Service Medicaid or CSHCS) to a Medicaid Health Plan (MHP), from one health plan to another health plan, or from a health plan to FFS. Normally the change occurs at the beginning of a month; however, some changes may occur during the month. It is important that providers check beneficiary eligibility before each service is provided to determine who is responsible for payment and whether authorization is necessary. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.)

7.2 BILLING REQUIREMENTS

Providers must use the date of delivery when billing for dentures and laboratory-processed crowns. However, when a beneficiary has a change in eligibility status and services have been started for root canal therapy, dentures and laboratory-processed crowns, the provider has 30 days from the change in/loss of eligibility to complete the services. The date of service on the claim form should be the date of the initial impression for dentures and laboratory-processed crowns, or the first treatment appointment for root canal therapy.



SECTION 8 – REMITTANCE ADVICE

A Remittance Advice (RA) is produced to inform providers about the status of their claims. RAs are available in paper and electronic formats, and utilize the HIPAA-compliant national standard claim adjustment group codes, claim adjustment reason codes, and remarks codes, as well as adjustment reason codes, to report claim status. Code definitions are available from the Washington Publishing Company. (Refer to the Directory Appendix for contact information.)

8.1 PAYMENT PROCESS

MDHHS processes claims and issues payments (by check or EFT) every week unless special provisions for payments are included in the provider enrollment agreement. An RA is issued with each payment to explain the payment made for each claim. If no payment is due or claims have rejected, an RA is also issued. If claims are not submitted for the current pay cycle or no gross adjustments are processed in the pay cycle, an RA is not generated.

If a claim does not appear on an RA within 60 days of submission, a new claim should be submitted. Providers should verify that the provider NPI number and beneficiary ID number are correct. Submitting claims prior to the end of the 60-day period may result in additional delays in claims processing for payment.

Payments to providers are issued by Tax Identification Number (TIN). All payments due to all providers enrolled with MDHHS under a specific TIN are consolidated and issued as one check or EFT.

Providers who would like to receive payments from MDHHS through EFT must register through the DTMB website. (Refer to the Directory Appendix for DMB website information.)

8.2 ELECTRONIC REMITTANCE ADVICE

The electronic RA is produced in the HIPAA-compliant ASC X12N 835 5010. Providers opting to receive an electronic RA receive all information regarding adjudicated (paid or rejected) claims in this format.

The electronic RA has many advantages:

- It can serve to input provider claim information into the provider's billing and accounting systems.
- It includes a MDHHS trace number to identify the associated warrant or electronic funds transfer (EFT) payment.
- It returns the provider's internal medical record number, line item control number, and patient control number when submitted on the original claim.
- It contains additional informational fields not available on the paper RA.

The 835 transaction corresponds to one payment device (check or EFT). All claims associated with a single TIN processed in a weekly pay cycle report on a single 835, regardless of how the claims were submitted (e.g., some paper, some electronic, multiple billing agents, etc.). Providers choosing to receive the 835 transaction must authorize a billing agent to receive the 835 per TIN. An addition of and/or change to the identification of the billing agent for the provider's 835 must be changed through their CHAMPS enrollment application.



For more information regarding the 835 these transactions. The guides are available through the Washington Publishing transactions issued by MDHHS, refer to the MDHHS 835 Companion Documents (Data Clarification Documents) on the MDHHS website. For general information about the 835, refer to the Implementation Guides for Company. (Refer to the Directory Appendix for contact information.)

8.3 PAPER REMITTANCE ADVICE

A paper RA is generated for all providers and/or billing agents who submit and process claims through CHAMPS. The RA is available online or is sent to providers only if requested through the CHAMPS PE subsystem. The RA contains three main sections: cover sheet, summary page, and detail page(s). Refer to the Forms Appendix for a sample copy of a Remittance Advice.

8.4 GROSS ADJUSTMENTS

Gross adjustments are initiated by MDHHS. A gross adjustment may pertain to one or more claims. Providers are notified in writing when adjustments are made to claims. Notification should be received before the gross adjustment appears on the RA.

The paper RA indicates gross adjustments have been made by:

- **Adjustment Reason Code:** Indicates the reason for the debit or credit memo or adjustment to payment. Standard Adjustment Reason Codes are used. Code definitions can be found in the 835 Implementation Guide.
- **Gross Adjustment Code:** This is the MDHHS gross adjustment code that corresponds to the gross adjustment description.

8.5 CLAIM ADJUSTMENT REASON/REMARK CODES

When claims are initially processed, the Claim Adjustment Reason/Remark column on the RA identifies which service lines have been paid or rejected and lists edits that apply.

If a service line is rejected, a Claim Adjustment Reason/Remark code prints in the Claim Adjustment Reason/Remark column of the RA. The provider should review the definitions of the codes to determine the reason for the rejection.



SECTION 9 – JULIAN CALENDAR [CHANGE MADE 10/1/20]

Day Month	January	February	March	April	May	June	July	August	September	October	November	December
1	1	32	60	91	121	152	182	213	244	274	305	335
2	2	33	61	92	122	153	183	214	245	275	306	336
3	3	34	62	93	123	154	184	215	246	276	307	337
4	4	35	63	94	124	155	185	216	247	277	308	338
5	5	36	64	95	125	156	186	217	248	278	309	339
6	6	37	65	96	126	157	187	218	249	279	310	340
7	7	38	66	97	127	158	188	219	250	280	311	341
8	8	39	67	98	128	159	189	220	251	281	312	342
9	9	40	68	99	129	160	190	221	252	282	313	343
10	10	41	69	100	130	161	191	222	253	283	314	344
11	11	42	70	101	131	162	192	223	254	284	315	345
12	12	43	71	102	132	163	193	224	255	285	316	346
13	13	44	72	103	133	164	194	225	256	286	317	347
14	14	45	73	104	134	165	195	226	257	287	318	348
15	15	46	74	105	135	166	196	227	258	288	319	349
16	16	47	75	106	136	167	197	228	259	289	320	350
17	17	48	76	107	137	168	198	229	260	290	321	351
18	18	49	77	108	138	169	199	230	261	291	322	352
19	19	50	78	109	139	170	200	231	262	292	323	353
20	20	51	79	110	140	171	201	232	263	293	324	354
21	21	52	80	111	141	172	202	233	264	294	325	355
22	22	53	81	112	142	173	203	234	265	295	326	356
23	23	54	82	113	143	174	204	235	266	296	327	357
24	24	55	83	114	144	175	205	236	267	297	328	358
25	25	56	84	115	145	176	206	237	268	298	329	359
26	26	57	85	116	146	177	207	238	269	299	330	360
27	27	58	86	117	147	178	208	239	270	300	331	361
28	28	59	87	118	148	179	209	240	271	301	332	362
29	29	--	88	119	149	180	210	241	272	302	333	363
30	30	--	89	120	150	181	211	242	273	303	334	364
31	31	--	90	---	151	---	212	243	---	304	---	365



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For leap year, one day must be added to the number of days after February 28. The next three leap years are 2024, 2028 and 2032. (revised 10/1/20)

Example: Transaction Control Number (TCN) 211215010000189001 – Header TCN always ends in 000
Position 1: "2" – DDE Web Submission
Position 2: "1" – FFS Claim
Positions 3-7: "12150" – YY = 12 (for 2012) + 3-digit Julian date = "150" (May 29)
Position 8: "1" – Original Claim
Positions 9-15: "0000189" – Sequence Number
Positions 16-18: "001" – Line Number. Will begin with 001 for every new claim and increment by 1 for each claim line. Any replacement or voids claim, use the header TCN. Header TCN always ends in 000 (211215010000189000).



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SECTION 1 – GENERAL INFORMATION

This chapter applies to providers billing the NUBC or 837 institutional claim formats. It contains information needed to submit institutional claims to the Michigan Department of Health and Human Services (MDHHS) for Medicaid programs and Children’s Special Health Care Services (CSHCS). It also explains how claims are processed and how providers are notified of MDHHS actions.

The following providers must use the ASC X12N 837 5010 institutional format when submitting electronic claims and the NUBC claim form for paper claims.

- Home Health Agencies
- Hospice
- Hospital
- Nursing Facilities
- Outpatient Therapy Providers*
- Private Duty Nursing Agencies

* Comprehensive Outpatient Rehabilitation Facilities, Outpatient Rehabilitation Agencies, CARF-Accredited Medical Rehabilitation Programs, CAA-Accredited University Graduate Education Programs

1.1 CLAIMS PROCESSING SYSTEM

All claims submitted and accepted are processed through CHAMPS. Paper claims are scanned and converted to the same file format as claims submitted electronically.

Claims processed through CHAMPS are edited for many parameters, including provider and beneficiary eligibility, procedure validity, claim duplication, frequency limitations for services, and combination of service edits. MDHHS uses the Medicaid National Correct Coding Initiative (NCCI) policies and edits. (Refer to the Directory Appendix for resource information.)

MDHHS encourages providers to send claims electronically. (Refer to the Electronic Submission Manual on the MDHHS website for additional information. Refer to the Directory Appendix for website information.) Electronic filing is more cost effective, more accurate, payment is received more quickly and administrative functions can be automated. Electronic claims submitted by Wednesday may be processed as early as the next weekly cycle.

1.2 PREDICTIVE MODELING

Predictive modeling, a pre-payment claims process in CHAMPS, uses advanced screening technology to identify Medicaid claims with billing irregularities. Claims flagged by the predictive modeling process will undergo a detailed analysis to determine the next step(s) to be taken. This may include a review of medical records and/or past claims. Providers must submit the requested records within 45 days of the date on the request for documents letter to avoid denials for lack of documentation. Records should not be submitted prior to receiving a request for documentation letter.

Requested records must be submitted through the Document Management Portal available in CHAMPS. Refer to:

- the MDHHS website for information and tutorials on the Document Management Portal.
- the Directory Appendix for Document Management Portal website information.



1.3 CLAIM PAYMENT/CLAIM STATUS

Once claims have been submitted and processed through CHAMPS, an electronic health care claim payment/advice (ASC X12N 835 5010) is sent to the designated service bureau for providers choosing an electronic RA. The CHAMPS RA is also available to providers online or is sent to providers via paper if requested through the Provider Enrollment Subsystem. (Refer to the Remittance Advice Section of this chapter for additional information about both the electronic and paper RA.)

To receive information on suspended claims, a provider-initiated 276 claim status request must be submitted and a 277 claim status response will be returned. Providers have the option to receive information on suspended claims via the CHAMPS claims inquiry screens as well.

1.4 ELECTRONIC FUNDS TRANSFER

Electronic Funds Transfer (EFT) is the method of direct deposit of State of Michigan payments into a provider's bank account. This replaces a paper warrant. To initiate an EFT, the facility should go to the Department of Technology, Management & Budget (DTMB) website. (Refer to the Directory Appendix for website information.)



SECTION 2 – HOW TO FILE CLAIMS

Institutional claims may be submitted electronically or on paper. Electronic claim submission is the preferred method for submitting claims to MDHHS.

2.1 ELECTRONIC CLAIMS

Claims submitted electronically and accepted are received directly into CHAMPS, resulting in faster payments and fewer claims that suspend or reject. (Refer to the Electronic Submission Manual on the MDHHS website for additional information. Refer to the Directory Appendix for website information.) Providers submitting claims electronically must use the ASC X12N 837 5010 institutional format. The payroll cut-off for electronic claims submission to MDHHS is Wednesday of each week.

Complete information on submission of electronic claims is available on the MDHHS website. (Refer to the Directory Appendix for website information.) The MDHHS Electronic Submission Manual and other resources, such as Companion Guides, are on the MDHHS website. Information on the website is updated as version changes occur at the national level and are adopted by MDHHS.

2.1.A. AUTHORIZED BILLING AGENTS

Any entity (service bureau or individual provider) wishing to submit claims electronically to MDHHS must enroll as an authorized billing agent. The Provider Enrollment Section of the General Information for Providers Chapter and the Trading Partners portion of the MDHHS website contain information related to the application and billing agent authorization process. (Refer to the Directory Appendix for website information.)

More than one billing agent per provider can be authorized to submit the provider's claims electronically. However, only one electronic billing agent may be the designated receiver of the electronic health care claim payment/advice ASC X12N 835 5010. Authorizations remain in effect until changed by the provider through the CHAMPS Provider Enrollment subsystem.

Any individual provider can submit claims electronically as long as the authorization process is completed and approved; however, many providers find it easier to use an existing authorized billing agent to submit claims to MDHHS. Billing agents prepare claims received from their clients, format to HIPAA-compliant MDHHS standards and submit the file to MDHHS for processing. Whether claims are submitted directly or through another authorized billing agent, providers receive a paper remittance advice (RA), which reflects their individual claims. Billing agents receive an RA that contains information on all the claims the agent submitted.

For more information on becoming an electronic biller or for a list of authorized billing agents, contact the Automated Billing Unit. (Refer to the Directory Appendix for contact information.)



2.1.B. ELECTRONIC CLAIMS WITH ATTACHMENTS

The Document Management Portal (DMP) 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 MDHHS website for information and tutorials on the Document Management Portal. Refer to the Directory Appendix for website information.)

If comments or additional information are required with an electronic claim, electronic submitters must enter the information in the appropriate segments of the electronic record. If an operative report, history and physical, prior authorization (PA), or other paper attachment is required, providers must use the Document Management Portal through CHAMPS to submit electronic attachments to MDHHS. Within the Document Management Portal, the appropriate documentation category must be chosen along with completing specified information to successfully enter the document. MDHHS does not accept paper documentation via mail for any electronic claim. The Document Management Portal process allows MDHHS to communicate directly with providers to resolve claim attachment issues prior to finalizing claim adjudication.

Consent forms (Consent for Sterilization [MSA-1959/HHS-687] and Acknowledgement of Receipt of Hysterectomy Information [MSA-2218]) must be submitted through the Document Management Portal. If submitted via facsimile, consent forms must be sent accompanied by the appropriate fax cover sheet. (Refer to the Forms Appendix for copies of the forms and to the Directory Appendix for website information.) MDHHS will notify the submitter of the status of their consent review within seven business days. Once the consent forms are approved and entered, it is not necessary to submit additional copies when billing for sterilization or hysterectomy services. All consent forms must be submitted through the Document Management Portal.

Electronic submitters must:

- Include the notation "Documents uploaded in DMP" in the Claim Note area (NTE02 Segment, Loop 2300) and Reference Code "ADD" (NTE01 Segment, Loop 2300) within the electronic claim.
- Comply with all standard HIPAA reporting requirements, including using Claim Adjustment Segment (CAS) codes when submitting secondary or tertiary claims.

Refer to the MDHHS website for Document Management Portal instructions. (Refer to the Directory Appendix for website information.)

2.2 PAPER CLAIMS

The National Uniform Billing Committee (NUBC) UB-04 claim form must be used when submitting paper claims. It must be a red-ink form with UB-04 CMS-1450 in the lower left corner. Use of forms other than the red ink version will result in errors when they are scanned by the Optical Character Reader (OCR). Providers are encouraged to bill electronically whenever possible.

Claims may be prepared on a typewriter or on a computer. Handwritten claims are not accepted. Because claims are optically scanned prior to processing, print or alignment problems may cause



misreads, thus delaying processing of the claim. Keep equipment properly maintained to avoid the following:

- Dirty print elements with filled character loops.
- Light print or print of different density.
- Breaks or gaps in characters.
- Ink blotches or smears in print.
- Worn out ribbons.

Dot matrix printers should not be used as they result in frequent misreads by the OCR.

Questions and problems with the compatibility of equipment with MDHHS scanners should be directed to MDHHS Provider Inquiry. (Refer to the Directory Appendix for contact information.)

Paper claims should appear on a remittance advice (RA) within 60 days of submission. Do not resubmit a claim prior to the 60-day period.

2.2.A. GUIDELINES TO COMPLETE PAPER CLAIM FORMS

To ensure that the scanner correctly reads claim information, adhere to the following guidelines in preparing paper claims. Failure to adhere to these guidelines may result in processing/payment delays or claims being returned unprocessed.

- Date of birth must be eight digits without dashes or slashes in the format MMDDCCYY (e.g., 03212002). All other dates must be six digits in the format MMDDYY. Be sure the dates are within the appropriate boxes on the form.
- Use only black ink.
- Do not write or print on the claim, except for the Provider Signature Certification.
- Handwritten claims are not acceptable.
- UPPER CASE alphabetic characters are recommended.
- Do not use italic, script, orator, or proportional fonts.
- 12-point type is preferred.
- Make sure the type is even (on the same horizontal plane) and within the boxes.
- Do not use punctuation marks (e.g., commas or periods).
- Do not use special characters (e.g., dollar signs, decimals, or dashes).
- Only service line data can be on a claim line. Do not squeeze comments below the service line.



- Do not send damaged claims that are torn, glued, taped, stapled, or folded. Prepare another claim.
- Do not use correction fluid or correction tape, including self-correction typewriters.
- If a mistake is made, the provider should start over and prepare a clean claim form.
- Do not submit photocopies.
- Claim forms must be mailed flat, with no folding, in 9" x 12" or larger envelopes.
- Put a return address on the envelope.
- Separate the claim form from the carbon.
- Separate each claim form if using the continuous forms and remove all pin drive paper completely. Do not cut edges of forms.
- Keep the file copy.
- Mail NUBC claim forms separate from any other type of form.

2.2.B. PROVIDING ATTACHMENTS WITH PAPER CLAIM FORMS

When a claim attachment(s) is required, it must be directly behind the claim it supports and be identified on each page with the beneficiary's name and Medicaid ID number. Attachments must be on 8 1/2" x 11" white paper and one-sided. Do not submit two-sided material. Multiple claims cannot be submitted with one attachment. Each claim form that requires an attachment must have a separate attachment. Do not staple or paperclip the documentation to the claim form.

Mail claim forms with attachments flat, with no folding, in a 9" x 12" or larger envelope and print "Ext. material" (for extraneous material) on the outside. Do not put claims that have no attachments in this envelope. Mail claims without attachments separately. Do not send attachments unless the attachment is required as unnecessary attachments delay claim processing.

Claim attachments, such as medical records and EOBs, may be associated to a paper claim via the Document Management Portal. (Refer to the Directory Appendix for website information.)

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 Document Management Portal" must be included in the Remarks section of the paper claim.

Refer to the MDHHS website for Document Management Portal instructions, including fax requirements. (Refer to the Directory Appendix for website information.)

2.2.C. MAILING PAPER CLAIM FORMS

All paper claim forms and claim forms with attachments must be mailed to MDHHS. (Refer to the Directory Appendix for contact information.)



2.3 REPORTING PROVIDER NPI

MDHHS requires that NPI numbers be reported in any applicable provider loop or field (e.g., attending, billing, referring, and rendering) on the claim. A provider's Taxpayer Identification Number (TIN) will also be used for claim adjudication. Both the NPI and the TIN or Employer Identification Number (EIN) must be reported at the billing provider loop for all electronic claims. For the UB-04 paper claim form, the TIN must be reported in Form Locator 5.

A Type 1 (Individual) NPI is the number associated with an individual healthcare professional (e.g., MD, DDS, CRNA, etc.). The individual may be a sole proprietor or be employed by a clinic, group practice, or other organization. If a sole proprietor, the Type 1 NPI must be reported in the billing provider loop or field of the claim for payment.

A Type 2 (Group) NPI is the number required for organizations (such as clinics, group practices, and incorporated individuals) who provide healthcare services and receive payment. For MDHHS, the Group NPI must be reported in the billing provider loop or field. Also for dental and professional claims, the appropriate Type 1 (Individual) NPI of the specific provider performing the service must be reported in the rendering provider loop or field for proper claim adjudication. Do not enter the Type 2 (Group) NPI as the rendering provider.

MDHHS NPI claim editing will be applied to the attending, billing, referring and rendering provider as applicable. A claim cannot be paid if the NPI is missing or the reported NPI is invalid as it does not check digit and/or correctly crosswalk to the Provider Enrollment files for these provider loops or fields.

2.3.A. BILLING PROVIDER

The billing provider loop or field is mandatory to complete on all claims. The billing provider must be enrolled with the program for payment. If the billing provider NPI reported is an invalid number and/or represents a non-enrolled provider, the entire claim will be denied for payment.

2.3.B. ATTENDING PROVIDER

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 must be Medicaid enrolled. If the attending physician information is not reported on the claim or if the provider is not enrolled in the Michigan Medicaid program, the claim cannot be paid.

Rendering providers should ensure their referral sources are aware of this requirement.

2.3.C. REFERRING PROVIDER

If a referring provider is required to be submitted, use the appropriate Form Locator field for claim completion.



SECTION 3 – REPLACEMENT, VOID/CANCEL CLAIMS AND REFUND OF PAYMENT

3.1 REPLACEMENT CLAIMS (ADJUSTMENTS)

Replacement claims are submitted when all or a portion of the claim was paid incorrectly or a third-party payment was received after MDHHS made payment. When replacement claims are received, MDHHS deletes the original claim and replaces it with the information from the replacement claim. It is very important to include all service lines on the replacement claim, whether they were paid incorrectly or not. All money paid on the first claim will be recouped and payment will be based on information reported on the replacement claim only. Examples of when a claim may need to be replaced:

- To return an overpayment (report "returning money" in Remarks section);
- To correct information submitted on the original claim (other than to correct the provider NPI number and/or the beneficiary ID number). Refer to the Void/Cancel subsection below;
- To report payment from another source after MDHHS paid the claim (report "returning money" in Remarks section); and/or
- To correct information that the scanner may have misread (state reason in Remarks section).

To replace a previously paid claim, indicate 7 (xx7) as the third digit in the Type of Bill Form locator frequency. Providers must enter the 18-digit Transaction Control Number (TCN) of the last approved claim being replaced and the reason for the replacement in Remarks. The provider NPI number and beneficiary ID number on the replacement claim must be the same as on the original claim. Providers must enter in Remarks the reason for the replacement. Refer to the Void/Cancel subsection below for additional information. To replace a previously paid claim adjudicated with a Claim Reference Number (CRN) prior to October 1, 2007, both the Medicaid legacy provider ID number and the NPI must be reported on the replacement claim for successful adjudication.

3.2 VOID/CANCEL A PRIOR CLAIM

If a claim was paid under the wrong provider NPI or beneficiary ID Number, providers must void/cancel the claim. To void/cancel the claim, indicate an 8 in the Type of Bill (xx8) as the third digit frequency. The 8 indicates that the bill is an exact duplicate of a previously paid claim, and the provider wants to void/cancel that claim. The provider must enter the 18-digit TCN of the last approved claim or adjustment being cancelled and enter in the Remarks section the reason for the void/cancel. A new claim may be submitted immediately using the correct provider NPI or beneficiary ID number.

A void/cancel claim must be completed exactly as the original claim. To void/cancel an original claim adjudicated with a Claim Reference Number (CRN) prior to October 1, 2007, both the correct Medicaid legacy provider ID number and NPI must be reported along with the correct beneficiary ID number.

3.3 REFUND OF PAYMENT

Return of overpayments made by MDHHS, due to either payment from a third party resource or due to an error, must be done through the use of a replacement claim or void/cancel claim. This process will result in a debit against future payment.



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This requirement does not apply to inactive providers or monies being returned to MDHHS due to settlements or lawsuits. In these situations, checks must:

- be made payable to the State of Michigan in the amount of the refund;
- include the provider EIN (tax) number; and
- be sent to the MDHHS Cashier's Unit. (Refer to the Directory Appendix for contact information.)

Do not submit either a replacement claim or a void/cancel claim and manually send a refund to the Cashier's Unit as this will result in an incorrect amount.



SECTION 4 – CHANGES IN ELIGIBILITY/ENROLLMENT (FFS/MHP/CSHCS)

It is the provider's responsibility to determine eligibility/enrollment status of patients at time of treatment and obtain the appropriate authorizations for payment.

Medicaid or CSHCS beneficiaries may lose eligibility or change enrollment status on a monthly basis. Enrollment status changes include beneficiaries changing from FFS (FFS Medicaid or CSHCS) to a Medicaid Health Plan (MHP), from one health plan to another health plan, or from a health plan to FFS. Normally the change occurs at the beginning of a month; however, some changes may occur during the month. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.) It is important that providers check beneficiary eligibility before each service is provided to determine who is responsible for payment and whether PA is necessary.

4.1 MDHHS ADMISSION NOTIFICATION – HOSPITALS

It is vital that hospital providers complete admission/enrollment and discharge/disenrollment information in a timely manner in CHAMPS in order to maintain an accurate roster, as well as to ensure that beneficiaries have the correct PET and benefit plans assigned for correct payments.

Hospitals must submit facility admissions via CHAMPS for the following beneficiaries:

- Medicaid deductible beneficiaries (regardless of the length of stay).
- Medicaid eligible beneficiaries if their stay is expected to be 30 days or greater.
- Private Pay admission if applying for Medicaid (regardless of length of stay).

Refer to the Beneficiary Eligibility Chapter for additional information about the admission process through CHAMPS.

4.2 AUTHORIZATION OF ADMISSIONS AND SERVICES

The following guidelines are intended to assist providers and health plans with common concerns regarding authorization of services and payment responsibility, particularly when a change in enrollment status has occurred.

- All admissions (other than emergency admissions) require PA. MDHHS or its Admissions and Certification Review Contractor (ACRC) must authorize medical/surgical (non-psychiatric) admissions for FFS beneficiaries. If the beneficiary is enrolled in a MHP, the health plan must prior authorize the admission. All psychiatric admissions must be authorized by the local Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP).
- Services provided during the inpatient admission may also require PA for health plan enrollees. Providers must be aware of the beneficiary's enrollment status and of health plan requirements and processes for authorization. Consultations, surgical procedures, and diagnostic tests are not reimbursed unless a health plan's PA process is followed.
- If a beneficiary is admitted by the local PIHP/CMHSP, the admission and all psychiatric services are the responsibility of the PIHP/CMHSP. However, for beneficiaries enrolled in a MHP, any non-psychiatric medical/surgical services needed during a psychiatric admission are the responsibility of the health plan and must be authorized by the health plan. For FFS beneficiaries, the non-



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psychiatric medical/surgical services should be billed to MDHHS. This includes transportation to another facility for medical/surgical services. If a beneficiary is admitted for medical/surgical services authorized by the health plan and needs psychiatric consultation or care, the initial mental health assessment will be the responsibility of the health plan. The PIHP/CMHSP must be contacted for authorization of subsequent psychiatric services and is then responsible for payment for the psychiatric services.

- If a beneficiary is admitted to an acute care inpatient hospital facility and the enrollment status changes during the admission (e.g., a FFS beneficiary enrolls in a MHP), the payer at the time of admission is responsible for payment for all services provided until the date of discharge. Services provided after discharge are the responsibility of the new payer. The discharge planning process should include the new payer for authorization of any medically necessary services or treatments required after discharge from the hospital.
- If a beneficiary is transferred from one acute care inpatient hospital to another acute care inpatient hospital, this does not constitute a discharge. The payer at admission is the responsible party until the beneficiary is discharged from the acute care inpatient hospital setting to a non-acute care inpatient hospital setting.
- If a beneficiary is transferred from an acute care inpatient hospital to an inpatient rehabilitation hospital or a long term acute care hospital (LTACH), this constitutes a discharge. The new payer assumes payment responsibility upon admission to the inpatient rehabilitation hospital or LTACH.

Change in Setting	Payer Responsibility in New Setting
Acute care inpatient hospital to another acute care inpatient hospital	Payer at admission remains the responsible party while the beneficiary is in the acute care inpatient hospital level setting. Exception: CSHCS enrollment.
Acute care inpatient hospital to inpatient rehabilitation hospital or LTACH	New payer is responsible party upon admission to the inpatient rehabilitation hospital or LTACH.
Inpatient rehabilitation hospital or LTACH to acute care inpatient hospital	New payer is responsible party upon admission to the acute care inpatient hospital.

The following examples illustrate payment responsibilities:

FFS to Health Plan	A FFS beneficiary is admitted on 9-15, enrolled in a health plan on 10-1, and discharged from the hospital on 10-5. The health plan is not responsible for services until 10-5, after discharge. FFS is responsible for the entire admission and physician services provided during the admission. The health plan must be contacted at discharge to transition care needs and authorize services needed after discharge, such as rental of equipment, ongoing medical supply needs, ongoing treatment (e.g., home health care, physical therapy, chemotherapy, IV infusion), etc.
Health Plan to Health Plan	If a beneficiary is in health plan "A" during September and changes to health plan "B" for October, health plan "A" is responsible for the admission. Health plan "B" must be contacted during the discharge planning process and is responsible for authorizing all services needed after discharge.



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Health Plan to Health Plan with Transfer to Tertiary Hospital	A beneficiary enrolled in health plan "A" is admitted for authorized surgery in June. The beneficiary is enrolled in health plan "B" on July 1. After surgery, the beneficiary develops complications necessitating a transfer to a tertiary hospital on July 2. The beneficiary is subsequently discharged to home on July 6. Plan "A" is responsible for all hospital and physician services through July 6, and plan "B" is responsible for all services needed after discharge.
Hospitalization for Medical Reasons During an Inpatient Psychiatric Stay	A health plan beneficiary is admitted for inpatient psychiatric care by a PIHP/CMHSP. During the admission, the patient requires surgery for medical reasons at another facility. The beneficiary's health plan must authorize the surgery and is responsible for paying for transport between the facilities and for charges related to the surgery.

CSHCS Exceptions:

- Prior to October 1, 2012, beneficiaries with CSHCS coverage were excluded from enrollment in a MHP and the following applied:
 - When a beneficiary was enrolled in CSHCS, he/she was disenrolled from the MHP.
 - Upon review, MDHHS may have initiated a retroactive disenrollment from the MHP effective the first day of the month in which CSHCS medical eligibility was determined.
 - Responsibility of payment transferred from the MHP to FFS on the effective date of the disenrollment.
- After October 1, 2012, Medicaid beneficiaries who become eligible for CSHCS who are enrolled in an MHP will no longer be disenrolled from the MHP.

Providers are advised to check the eligibility response for changes in enrollment status prior to billing. (Refer to the Beneficiary Eligibility Chapter for additional information.)

4.3 ONGOING SERVICES AND EXTENDED TREATMENT PLANS

Providers are responsible for verifying a beneficiary's eligibility/enrollment status before each service is rendered, particularly on the first day of a new month. Even though a beneficiary may be involved in an ongoing treatment or care plan, a change in enrollment status requires new authorization from the new responsible party. Enrollment in a health plan always triggers an authorization process through the new or "current" health plan. There is no requirement for a new health plan to reimburse providers for services that were authorized under a previous health plan. The new health plan must assess the need for continuing services and authorize, as appropriate. Health plans should facilitate the transition between providers to ensure continuity of care for the beneficiary.

The following are examples of situations that may occur while providing care to an eligible beneficiary:

FFS to Health Plan	A beneficiary is in FFS in June. On June 15, MDHHS authorizes a breast reconstruction after mastectomy for breast cancer. The surgery is scheduled for July 20. On July 1, the beneficiary is enrolled in a health plan with the same primary care provider and surgeon. The surgeon must follow the health plan process for authorization of the reconstructive surgery, as the health plan is now the payer, not FFS. MDHHS authorization would be void.
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Voluntary Health Plan Change During a Course of Treatment

A beneficiary is in health plan "A" in July and is involved in a course of physical therapy (PT). The therapy program was authorized for six weeks. On August 1, the beneficiary changes enrollment to health plan "B" and still has two more scheduled weeks of PT. Before PT can continue, the provider must obtain a new authorization from health plan "B." Ideally, as a plan-to-plan change occurs at the request of the beneficiary, the provider would coordinate the transition to the new plan, maintain continuity of care, and have an authorization in place from plan "B" so the ongoing PT is not interrupted. However, if PT continues without new plan "B" authorization, plan "A" is not responsible and plan "B" may or may not honor the treatment. Providers cannot bill the beneficiary as the services are covered and it is the provider's responsibility to verify eligibility/enrollment changes and obtain any necessary authorization.

4.4 DURABLE ITEMS OR EQUIPMENT

MDHHS policy directs providers to bill the date of delivery for durable items or equipment. However, when a beneficiary has a change in enrollment status and the responsible payer is different on the date of delivery than on the date of order, providers must bill the date of order and specify the date of delivery in the comments/remarks section. This is especially important when a person changes from FFS to a health plan.



SECTION 5 - PROVIDER PREVENTABLE CONDITIONS (PPCs)

5.1 REPORTING AND NON-PAYMENT FOR PROVIDER PREVENTABLE CONDITIONS (PPCs)

Provider Preventable Conditions (PPCs) addresses both hospital and non-hospital conditions identified by MDHHS for non-payment. PPCs are defined as Health Care Acquired Conditions (HCACs) and Other Provider Preventable Conditions (OPPCs). Medicaid providers are required to report the occurrence of a PPC and are prohibited from payment.

5.2 HEALTH CARE ACQUIRED CONDITIONS (HCAC) – INPATIENT HOSPITAL

MDHHS follows Medicare's policy on reporting Present on Admission (POA) indicators on inpatient hospital claims and non-payment for HCACs. Acute care hospitals and Critical Access Hospitals (CAHs) are required to report whether a diagnosis on a Medicaid claim is present on admission. Claims submitted without the required POA indicators are denied. For claims containing secondary diagnoses that are included on Medicare's most recent list of HCACs and for which the condition was not present on admission, the HCAC secondary diagnosis is not used for DRG grouping. That is, the claim is paid as though any secondary diagnoses (HCAC) were not present on the claim.

POA is defined as "present" at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered Present on Admission. A POA indicator must be assigned to principal and secondary diagnoses.

Providers should refer to the CMS Medicare website for the most up to date POA reporting instructions and list of HCACs ineligible for payment.

5.3 OTHER PROVIDER PREVENTABLE CONDITIONS (OPPCs) – OUTPATIENT

Medicaid follows the Medicare guidelines and national coverage determinations (NCDs), including the list of HAC conditions, diagnosis codes and OPPCs.

Conditions currently identified by CMS include:

- wrong surgical or other invasive procedure performed on a patient;
- surgical or other invasive surgery performed on the wrong body part; and
- surgical or other invasive procedure performed on the wrong patient.

5.4 NON-PAYMENT AND REPORTING REQUIREMENTS PROVIDER PREVENTABLE CONDITIONS (PPCs) – INPATIENT

MDHHS follows the Medicare billing guidelines on how to bill a no-pay claim, reporting the appropriate Type of Bill (TOB 110) when the surgery/procedure related to the NCDs service/procedure (as a PPC) is reported.



If covered services/procedures are also provided during the same stay, MDHHS follows Medicare's billing guidelines requiring hospitals submit two claims: one claim with covered services, and the other claim with the non-covered services/procedures as a non-pay claim. Inpatient hospitals must appropriately report one of the designated ICD diagnosis codes for the PPC on the no-pay TOB claim. MDHHS follows the Medicare billing guidelines on how to bill a no-pay claim, reporting the appropriate Type of Bill (TOB 110) when the surgery/procedure related to the NDC service/procedure (as a PPC) is reported.

5.5 NON-PAYMENT AND REPORTING REQUIREMENTS OTHER PROVIDER PREVENTABLE CONDITIONS (OPPCs) – OUTPATIENT

Medicaid follows the Medicare guidelines and NCDs, including the list of HAC conditions, diagnosis codes and OPPCs. Outpatient providers must use the appropriate claim format, TOB and follow the applicable NCD/modifier(s) to all lines related to the surgery(s).



SECTION 6 – HOSPITAL CLAIM COMPLETION – INPATIENT

Information in this section should be used in conjunction with the National Uniform Billing Committee (NUBC) Manual when preparing hospital claims. The MDHHS website contains additional billing information (i.e., MDHHS Institutional Billing Resource document). (Refer to the Directory Appendix for website information.)

The following references unique billing requirements for completing inpatient claims.

6.1 ACCOMMODATIONS

Hospitals must use the appropriate revenue code that best indicates the type of room the beneficiary occupied.

Personal comfort and convenience items (e.g., telephone, television) are not covered by Medicaid and cannot be used to offset the beneficiary-pay amount. Charges for these services must not be included on the claim.

6.1.A. INTENSIVE CARE

Refer to the NUBC Manual for the specific cost center for a specific type of intensive care unit and the definitions and report the most appropriate revenue code. The MDHHS website contains additional billing information (i.e., MDHHS Institutional Billing Resource document). (Refer to the Directory Appendix for website information.)

6.2 SPECIAL BILLING

6.2.A. GENERAL INFORMATION

Coding	<p>All unlisted or not otherwise classified (NOC) codes require an explanation of the service/item provided. The explanation may be entered in the Remarks Section or may be provided as a claim attachment. Do not recode procedure codes submitted to Medicare or other insurers to unlisted or NOC codes when billing Medicaid unless MDHHS does not cover the procedure code. When Medicaid covers the procedure code, providers must submit the same procedure code to Medicaid that was submitted to the other payer to ensure proper reimbursement.</p> <div data-bbox="565 1507 1273 1625" style="border: 1px solid black; background-color: yellow; padding: 5px; text-align: center;"> <p>Claims will be rejected for inappropriate recoding even if PA was issued by MDHHS.</p> </div>
Diagnosis Coding	<p>Use ICD coding conventions to report the diagnosis code(s) at the highest level of specificity and with the correct number of digits. If a code requires additional digits, the claim will reject.</p>



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<p>Prior Authorization</p>	<p>For elective services requiring PA, authorization must be obtained prior to providing services. Do not submit the letter with your claim; however, you must report the PA number appropriately (form locator, segment) when billing for the PA services.</p>
<p>National Uniform Billing Committee Manual</p>	<p>This manual may be purchased from the American Hospital Association, National Uniform Billing Committee. (Refer to the Directory Appendix for contact information.) Data elements used in the paper UB-04 are also used in the electronic claim standard required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). (Refer to the Directory Appendix for contact information.)</p>

6.2.B. CHANGES IN FACILITY OWNERSHIP DURING A BENEFICIARY’S INPATIENT STAY

When a change in facility ownership occurs during a beneficiary's inpatient stay, the owner on the date of admission should submit a claim for all inpatient hospital services for the beneficiary regardless of when the admission began and ended. The National Provider Identifier (NPI) of the hospital facility on the date of admission is the applicable billing NPI for claims to Medicaid.

Claims must include necessary information for Medicaid to compute the payment amount, whether or not some of the services occurred during a period when a different party legally owned the hospital. Payments are not prorated between the buyer and seller.

6.2.C. SPECIAL CIRCUMSTANCES FOR HOSPITAL READMISSIONS AND TRANSFERS

<p>Readmissions (DRG Hospitals Only)</p>	<p>Under the fee for service DRG reimbursement system, payment is intended to include all services required to treat the beneficiary. The DRG system is designed to carefully monitor and control readmissions.</p> <p>MDHHS defines a readmission as any admission within 15 days of a previous discharge, whether the readmission is to the same or a different hospital.</p> <p>Example: If a beneficiary is discharged on November 13, 2009 and is readmitted before November 28, 2009, this is considered a readmission within 15 days. (Count the day of the original discharge and the day of readmission.) If the beneficiary is discharged on November 13, 2009 and is readmitted on November 28, 2009, this is considered a new admission. (The beneficiary is discharged and is readmitted after 15 days have elapsed.)</p> <p>MDHHS reviews hospital claims on a pre-payment basis and, through its ACRC contractor, on a post-payment basis to determine the appropriateness of readmissions. If MDHHS determines that a readmission within 15 days was inappropriate, monies are recovered from the hospital.</p>
<p>Readmission within 15 days to the Same Hospital (Unrelated Readmission)</p>	<p>If a beneficiary is readmitted to the same hospital within 15 days for a condition(s) unrelated to the previous admission (e.g., gall bladder removal, injuries due to a car accident), Medicaid considers the case a new admission for payment purposes.</p> <ul style="list-style-type: none"> ▪ The provider must submit two separate claims to assure appropriate processing. ▪ A claim for the first admission must be submitted and paid prior to submission of the readmission claim. ▪ When completing the second (readmission) claim, the hospital must indicate the PACER number in the treatment authorization field and Occurrence Span Code 71 with "from" and "through" dates from the previous admission.



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Readmission within 15 days to the Same Hospital (Related Admission)	<p>If a beneficiary is readmitted to the same hospital within 15 days for a related (required as a consequence of the original admission) condition, Medicaid considers the admission and the related readmission as one episode for payment purposes. The related admissions must be combined on a single claim. No PACER number is issued for continuation of care.</p> <ul style="list-style-type: none"> ▪ Revenue code 0180 is used for the days the beneficiary was not in the hospital. ▪ Enter the number of leave days in the service units field. ▪ Leave the rate and total charges blank. ▪ Include the leave day units in the total units field. ▪ Report Occurrence Span Code 74 with "from" and "through" dates of the leave of absence. ▪ If the original admission has been submitted and paid, a replacement claim must be submitted that contains the combined services for the original admission and the readmission.
Readmission within 15 days to a Different Hospital	<p>Enter the PACER number in the treatment authorization field and Occurrence Span Code 71 with "from" and "through" dates from the previous admission.</p>
Transfers	<p>Authorization for a transfer is granted only if the transfer is medically necessary and the care/treatment is not available at the transferring hospital. Transfer for convenience is not considered. Authorization should be obtained by the next business day for emergent/urgent transfers.</p> <ul style="list-style-type: none"> ▪ The receiving hospital enters the PACER number of the approved transfer in the treatment authorization field. ▪ Submission of documentation with the claim is not required when billing transfers.

6.2.D. FISCAL YEAR-END/INTERIM BILLING (DRG HOSPITALS ONLY)

Hospitals reimbursed under the DRG system generally cannot submit interim billings. The hospital must wait until the beneficiary is discharged and then bill for all services on one claim. However, if a beneficiary has been continuously hospitalized for at least one year and is expected to remain hospitalized for at least another six months, the hospital may submit a claim as if the beneficiary has been discharged. At least every three months thereafter, the hospital should submit a replacement claim which alters the date of discharge and increases the charges. The Remarks Section of the replacement claim must indicate the reason for filing (i.e., interim billing due to extended length of stay).

6.2.E. HYSTERECTOMY

To encourage electronic billing and reduce administrative burden, MDHHS allows for submission of the Acknowledgement of Receipt of Hysterectomy Information form (MSA-2218) via fax. (Refer to the Forms Appendix for additional information.) This form must be submitted to Medicaid before reimbursement can be made for any hysterectomy procedure. Submitting this form via fax can eliminate submitting paper attachments for hysterectomy claims and pre-confirms the acceptability of the completed acknowledgement form, as well as reduces costly claim rejections.



The provider who obtains the required acknowledgement and completes the MSA-2218 may fax the completed form, along with a cover sheet, to the Medicaid Payments Division. The form is reviewed within five working days. Either an explanation of errors or notice that the form has been accepted and is on file is returned to the submitting provider. When the provider receives notice that the form is accepted and on file, all invoices related to the service may be submitted without attachments.

The procedure for approval of the acknowledgement form is:

- Complete a cover sheet (typed or printed) which must include beneficiary name, beneficiary Medicaid ID number, provider's contact person, provider fax number, and provider phone number.
- Fax the cover sheet and completed acknowledgement form to Hysterectomy Acknowledgement Form Approval. (Refer to the Directory Appendix for contact information.) Do not fax claims.
- Wait for a response. When notified that the acknowledgement form has been accepted and is on file, inform the other providers via a copy of the response.
- If there is no response within five working days, confirm that the fax is working. Be sure that the cover sheet included the necessary information for Medicaid staff to contact the provider. Resend the information if necessary.
- All providers may then submit claims (either electronic or hard copy) to Medicaid. The Remarks Section or Comment Record must include the statement "Acknowledgement on File."
- When hysterectomy claims are received with this information in the Remarks, acknowledgement form edit requirements are forced if the submitted invoice matches the acknowledgement form on file.

This process is an option. Providers may continue to attach a copy of the acknowledgement form to the claim without going through this pre-approval process. If a paper copy of the MSA-2218 is attached with the claim, indicate "submitted attachment" in the Remarks Section.

When billing for a hysterectomy performed during a beneficiary's period of retroactive eligibility, indicate in the Remarks section "MSA-2218 not completed. Not eligible on date of service." Also indicate the beneficiary was informed prior to the hysterectomy that the service would render her incapable of reproducing.

When billing for a beneficiary that was sterile prior to the hysterectomy, the Acknowledgement of Receipt of Hysterectomy Information form is not required. The Remarks field of the claim must indicate "Beneficiary sterile prior to hysterectomy" along with the cause/procedure that rendered her sterile.

6.2.F. LOSS/GAIN MEDICAID ELIGIBILITY

Under the DRG system, hospitals must wait until a beneficiary is discharged and then bill all services on one claim. Hospitals generally cannot split-bill DRG claims. If a



beneficiary loses or gains Medicaid eligibility during a hospital stay, the hospital must bill only for the Medicaid eligible days as follows:

- The "from" and "through" dates must reflect only the days of Medicaid eligibility.
- The patient status code must reflect the actual status of the entire admission.
- The Remarks section must indicate that the beneficiary was Medicaid eligible for a portion of the hospital stay.
- The admission date must reflect the date the order to admit the beneficiary was written.

When Medicaid eligibility is determined retroactively, "Retroactive Eligibility" must be entered in the Remarks section of the inpatient hospital claim.

6.2.G. MEDICARE

For Medicare Parts A and B/Medicaid claims, Medicaid only pays up to a Medicare-enrolled beneficiary's obligation to pay (i.e., coinsurance, deductible) or the Medicaid DRG, whichever is less. Medicaid payment does not include capital and direct medical education.

Due to the nature of DRG calculations, the following instructions must be used when completing an inpatient hospital claim:

- All Medicare and other insurance payment information should be indicated on the claim which contains the Patient Status code that indicates the beneficiary has been discharged from the facility. If the inpatient service requires two claims, payment information (e.g., total other insurance payment, Medicare coinsurance and deductible) must be included on the claim for the last date of service for the inpatient stay. Interim claims should not reflect a payment.
- Medicare Part A and Part B charges must be combined on one claim.
- When a beneficiary has Medicare Part B only, this must be reflected in the Remarks section of the claim. Additionally, the claim must reflect the 20 percent amount due from Medicaid. The Medicare Part A and Part B payment is the 80 percent of the allowable charges covered by Medicare for Part B services.

For Medicaid reimbursement, the amount billed for services does not equal the sum of the coinsurance and deductible items. It must be calculated as the gross hospital charges **minus** all Medicare payments, **minus** other insurance payments, and **minus** any patient-pay and/or copayment amount. If a claim is submitted with the amount billed equal to zero, other payment greater than or equal to Medicaid's payment, or a negative amount, Medicaid does not make a payment. If there is a balance to be billed to Medicaid, the hospital may bill Medicaid for covered services only.

For Medicare Part B/Medicaid claims where Medicare Part A is exhausted, Medicaid pays up to the beneficiary's financial obligation to pay or the Medicaid DRG (or per diem rate) less the total amount paid by all other payers, whichever is less. Medicaid reimbursement includes capital and direct medical education (made at final settlement).



Medicare Part A Exhausted Prior to Stay	<ul style="list-style-type: none"> ▪ Report Type of Bill 0111 and enter occurrence code A3 and the date when Medicare Part A is exhausted. ▪ Noncovered days must be reflected on the claim to be paid correctly. ▪ Medicare Part B payment must be reflected on the claim.
Medicare Part A Exhausted During Stay	<ul style="list-style-type: none"> ▪ Report Type of Bill 0111 and enter occurrence code A3 and the date when Medicare Part A is exhausted. ▪ Noncovered days must be reflected on the claim to be paid correctly. ▪ The Medicare payment must be reflected on the claim. ▪ Report value code A2 (coinsurance).
Medicare Part A Becomes Effective During Stay	<ul style="list-style-type: none"> ▪ Enter occurrence code A2 and the date when Medicare Part A becomes effective. ▪ Noncovered days must be reflected on the claim to be paid correctly. ▪ The Medicare payment must be reflected on the claim. ▪ Report amount applied to coinsurance, copay or deductible [OI and Medicare (Inpatient, Outpatient, LTC, Home Health, Hospice)]. <ul style="list-style-type: none"> ➢ For DOS prior to July 1, 2007 – electronic/paper claims: Value Code A1, B1, C1, A2, B2, C2, A7, B7, C7 and amount ➢ For DOS on/after July 1, 2007: <ul style="list-style-type: none"> ◆ Electronic claims: use CAS segments only ◆ Paper claims: use only Value Codes (A1, B1, C1, A2, B2, C2, A7, B7, C7 and amount)

6.2.H. MULTI-PAGE CLAIM (PAPER CLAIM)

Inpatient hospitals can report charges on multiple pages when services exceed more than 22 lines. MDHHS is unable to accept multiple-page paper claims for all institutional providers (Inpatient, Outpatient, LTC, Home Health, Hospice). Providers are encouraged to bill electronically whenever possible for faster payment.

6.2.H.1. INITIAL CLAIM

Refer to the NUBC Manual for reporting multiple pages (on line 23) and total charges.

6.2.H.2. CLAIM REPLACEMENT

Refer to the NUBC Manual for submitting a claim replacement TOB. Enter the 18-digit Transaction Control Number (TCN) of the last approved claim being replaced in the appropriate FL or loop/segment if billing electronically.

When information which affects the entire claim needs to be corrected (i.e., diagnosis coding, other insurance payments, etc.), replace only the claim with an approved dollar amount greater than zero. The DRG assignment and/or amount approved may be changed.



6.2.I. NEWBORN ELIGIBILITY

All newborn services must be billed under the newborn's ID number. The hospital must not bill under the mother's ID number. If an ID number has not been assigned prior to or at the time of delivery, the State's Electronic Birth Certificate (EBC) system is the preferred method of adding Medicaid coverage and assigning a MHP to newborns with mothers who are Medicaid beneficiaries. This process is the most efficient way for hospitals to obtain a Medicaid ID for newborns. If the facility is unable to submit the newborn birth through the EBC, the hospital may submit a Hospital Newborn Notice (form MSA-2565-C) to the local MDHHS office for Medicaid eligibility to be established and to obtain a Medicaid ID number. (Refer to the Forms Appendix for additional information.) If the MSA-2565-C form is used, the local MDHHS office will open the newborn's MA case and return the form to the provider with the necessary billing information. Providers must not bill until the eligibility response shows the newborn's ID number, date of birth, and the sex. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information regarding verifying beneficiary eligibility. Refer to the General Information for Providers Chapter of this manual for PACER requirements for newborns.)

If the mother is enrolled with a MHP at the time of birth, all newborn charges must be billed to the MHP.

6.2.J. INPATIENT HOSPITAL CLAIM REQUIREMENTS FOR NEWBORNS

Providers are required to adhere to NUBC guidelines for reporting newborn priority (type of) admission or visit, newborn birth weight, and cesarean sections/inductions related to gestational age. Birth weight should be reported as a whole number. For example, if the birth weight is 2764.5 grams, then the NUBC value code should be reported as "2765". Claims that fail to report newborn priority (type of) admission or visit and newborn birth weight will be denied.

6.2.K. PATIENT-PAY AMOUNT

- Value code D3 followed by the dollar amount is used to reflect the patient-pay amount.
- The facility must submit a claim to Medicaid even though the patient-pay amount is sufficient to cover the cost of the entire admission.
- The facility must not bill the beneficiary for any balance between the facility charges and the patient-pay amount.
- If a beneficiary is discharged and/or transferred to another facility within the same calendar month, the first facility collects the patient-pay amount. If a patient-pay amount was deducted from the second admission in error, a claim replacement must be submitted.



- When an admission spans two or more months, the nursing facility must collect the patient-pay amount for each month the beneficiary is in the nursing facility (for PETS LTC-NFAC and LTC-CMCF) and in hospice (PET HOS-NFAC).
- When an admission spans two or more months, the facility only collects one spend-down amount for the entire hospital admission.

6.3 REHABILITATION UNITS

For Medicare recognized distinct part rehabilitation units, MDHHS recommends that providers report the appropriate taxonomy code on all claims submitted, either electronically or by paper, to ensure proper adjudication. Within the ASC X12 837 5010 institutional format, report the valid taxonomy code in provider loop 2000A (billing/pay-to-provider taxonomy code). For paper claims, use the Code-Code field within the UB-04 claim form. The PACER number must be entered on the claim in the treatment authorization field.

6.4 STERILIZATION

For coverage policy information, refer to the Hospital Chapter of this manual. Refer to the Forms Appendix of this manual for a copy of the Consent for Sterilization (MSA-1959/HHS-687), including completion instructions. If any field on the form is improperly completed, the claim is rejected.

The procedure for completion of the MSA-1959/HHS-687 form is:

- Complete a cover sheet (typed or printed) which must include: beneficiary name, beneficiary Medicaid ID number, provider's contact person, provider fax number, and provider phone number.
- Fax the cover sheet and completed MSA-1959/HHS-687. Do not fax claims.
- Wait for a response. When notified that the MSA-1959/HHS-687 has been accepted and is on file, inform the other providers via a copy of the response.
- If there is no response within five working days, confirm that the fax is working. Be sure that the cover sheet included the necessary information needed for Medicaid staff to contact the provider. Resend the information if necessary.
- All providers may then submit claims (either electronic or paper copy) to Medicaid. The Remarks Section or Comment Record must include the statement "Consent on File."
- The information on the sterilization claim must match the information on the MSA-1959/HHS-687. If it does not, the claim is rejected.

This process is optional. Copies of the MSA-1959/HHS-687 may be attached to a claim without going through the pre-approval process. If choosing to include a paper copy of the MSA-1959/HHS-687, indicate "submitted attachment" in the Remarks section.

6.5 TELEMEDICINE

To be reimbursed for the originating site facility fee, the hospital must bill the appropriate telemedicine NUBC revenue code with the appropriate telemedicine CPT/HCPSCS procedure code and modifier. Refer to the Telemedicine Section of the Practitioner Chapter for additional information. Refer to the Additional



Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

6.6 TRANSPLANTS [CHANGE MADE 4/1/20]

Heart, liver, lung, simultaneous pancreas/kidney, kidney (revised 4/1/20) and pancreas transplants are reimbursed at the hospital's Medicaid cost-to-charge ratio.

- Organ acquisition costs are reimbursed at 100% of charges when billed using either revenue code 0811 or 0812. This applies to heart, liver, lung, simultaneous pancreas/kidney, kidney, or pancreas transplants. (revised 4/1/20)
- The letter of authorization for the transplant from the Office of Medical Affairs (OMA) or MHP must be attached to all applicable transplant claims, otherwise payment is denied.
- Indicate "PA letter submitted" in the Remarks section of the submitted claim.
- For other transplant services not described by a specific DRG, identify in the Remarks Section the type of transplant that has been performed (i.e., small bowel transplant).
- If the donor and beneficiary are both Medicaid eligible, the services must be billed under each beneficiary's respective ID Number. If only the beneficiary is Medicaid eligible, bill services for both donor and beneficiary under the Medicaid beneficiary's ID Number.

All other insurance resources must be exhausted before Medicaid is billed. If Medicare eligibility is denied, the denial notice must be submitted with the claim.



SECTION 7 – HOSPITAL CLAIM COMPLETION – OUTPATIENT

Information in this section should be used in conjunction with the National Uniform Billing Committee (NUBC) Manual when preparing Outpatient Hospital claims. The MDHHS website contains additional billing information (i.e., MDHHS Institutional Billing Resource document). (Refer to the Directory Appendix for website information.)

7.1 OPPS/AMBULATORY PAYMENT CLASSIFICATION

7.1.A. PACKAGED/BUNDLED SERVICES

MDHHS follows Medicare guidelines for packaged/bundled service costs. Services having a status indicator (SI) of "N" are considered packaged/bundled into other services. The costs of these services are allocated to the APC but are not paid separately. Providers must report all HCPCS/CPT codes and charges for all services provided on a claim whether payment for the service(s) is made separately or is packaged in order for the claim to pay correctly. Charges related to the packaged services are used for the outlier calculation.

Packaged services revenue codes, when billed under OPPS, do not require a HCPCS code. Any other revenue codes billable on an outpatient hospital claim must contain the HCPCS code to assure payment under OPPS.

7.1.B. PAYMENT STATUS INDICATORS

For categories covered differently than Medicare under the MDHHS OPPS, refer to the MDHHS OPPS Wraparound Code List posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

Medicare assigns a payment status indicator (SI) to every HCPCS code and identifies whether the service described (by the HCPCS code) is paid under OPPS, and whether payment is made separately or packaged. The SI may also provide additional information about how the code is paid under OPPS or under another payment system or fee schedule. A list of Medicare SIs with their definitions is in Medicare's Addendum D. Medicare's Addendum B shows the status indicator for each HCPCS code. (The Addendums are available on the CMS website. Refer to the Directory Appendix for website information.)

7.1.C. TYPE OF BILL

The following Type of Bill (TOB) are accepted for outpatient claims under the MDHHS OPPS: 13x, 14x, 34x, 72x, 74x, 75x or 85x.

7.1.D. REPORTING CPT/HCPCS CODES

The OPPS payment calculations are dependent on CPT/HCPCS procedure codes and modifiers reported at the claim line level. Providers are advised to ensure the accuracy of procedure codes, the OPPS modifiers, and the appropriateness of the revenue codes.



MDHHS uses the Medicare HCPCS/Revenue Code Chart as a guide for how hospitals report services.

7.1.E. DATE OF SERVICE

OPPS requires a claim line date of service for each service billed. If a claim line date of service is not entered for each HCPCS code reported or, if the line item dates of service reported are outside of the "statement covers" period ("from" and "through" dates), the claim will be returned to the provider.

If the claim spans more than one calendar day, the Outpatient Code Editor (OCE) will subdivide the claim into separate days for the purpose of determining discounting and multiple visits on the same calendar day. Per Federal Regulations, the MDHHS OPPS uses Medicaid NCCI and MUE values for OPH claims processing. The Medicaid NCCI and MUE values are reviewed with the quarterly file updates.

All services for a single outpatient encounter must be reported on one claim, except for Medicare's allowable repetitively billed services and hospital-owned ambulance services. MDHHS aligns closely with Medicare's guidelines for monthly repetitive billing.

7.1.F. LATE CHARGES

Late charges do not apply for outpatient hospital (Type of Bill 135). A claim replacement must be submitted to report correct charges. (Refer to the Replacement, Void/Cancel Claims and Refund of Payment Section of this chapter for additional information.)

7.1.G. REPETITIVE SERVICES BILLING

MDHHS follows Medicare's Repetitive Services billing for Medicaid covered services when billed appropriately.

7.2 ABORTION

Physicians must certify on a completed Certification for Induced Abortion form (MSA-4240) that, for medical reasons, an abortion was necessary to save the life of the mother or the beneficiary's medical history indicates that the terminated pregnancy was the result of rape or incest. The physician who completes the MSA-4240 must also ensure completion of the Beneficiary Verification of Coverage form (MSA-1550) and is responsible for providing copies of the forms for billing purposes to any other provider (e.g., anesthesiologist, hospital, laboratory) that would submit claims for services related to the abortion.

Copies of the MSA-4240 and the MSA-1550 are not required for claims for ectopic pregnancies or spontaneous, incomplete, or threatened abortions. Providers may attach copies of the MSA-4240 and the MSA-1550 to the claim or submit them via fax.

Federal regulations require that these forms be submitted to Medicaid before reimbursement can be made for any abortion procedure. This process can eliminate submitting paper attachments for abortion claims and pre-confirms the acceptability of the completed forms, as well as reduces costly claim rejections.



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(Refer to the Forms Appendix for copies of MSA-4240 and MSA-1550.)

7.3 AMBULANCE

Claims for hospital-owned ambulance services must be billed using the current 837I or UB paper claim format and Medicare claim completion instructions except as noted below. 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.

For coverage policy information, refer to the Ambulance Chapter of this manual. Additional information related to appropriate coverage support codes and reimbursement is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

7.3.A. BILLING INSTRUCTIONS FOR HOSPITAL-OWNED AMBULANCES

- The appropriate NUBC Ambulance revenue code with the appropriate MDHHS covered ambulance CPT/HCPCS procedure code(s) must be reported for each ambulance trip on the individual service line(s).
- For proper claim payment, the appropriate taxonomy code must be reported along with the NPI to designate ambulance, land, air, or by water. (Report the valid taxonomy code in loop 2000A of the ASC X12 837 5010 electronic format or the Code-Code field within the UB-04 paper claim form.)
- A revenue code, HCPCS code(s) and a modifier(s) are required for billing ambulance services and mileage.
- The claim line date of service must be reported for each revenue code line in the Date of Service field for each revenue code used.
- A one-way ambulance trip is reported on two separate consecutive revenue code lines: one line represents the ambulance service provided, and one line represents the mileage.
- Units must be reported in the Service Units field. The number of units reported for the revenue line reflecting each ambulance trip should always equal "1".
- The appropriate origin and destination modifier(s) must be included on the service line when billing for mileage.

Origin and Destination Modifiers	Description
D	Diagnosis or therapeutic site other than "P" or "H" when these are used as origin codes
E	Residential domiciliary custodial facility (other than a Medicare/Medicaid facility)
G	Hospital based dialysis facility
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of transportation
J	Non hospital-based dialysis facility



Origin and Destination Modifiers	Description
N	Skilled Nursing Facility (SNF) (Medicare/Medicaid facility)
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	(Destination code only) Intermediate stop at a physician's office on the way to the hospital

7.3.B. MULTIPLE TRANSPORTS PER BENEFICIARY

When a beneficiary requires more than one ambulance transport on the same date of service, providers must report:

- the appropriate origin and destination modifier with both the base rate and the mileage procedure codes; and
- the quantity for each transport base rate as "1" and the quantity for each transport mileage as the number of loaded miles.

If a break in service occurs between transports, each transport must be billed as a separate service. A break in service occurs when the ambulance is available to respond to other requests. If there is no break in service between transports, the transport is considered a single run and is described under the Continuous or Round Trip Transports subsection of the Ambulance Chapter of this manual.

7.3.C. MULTIPLE PATIENT TRANSPORT

When billing for a transport when more than one patient is transported at one time, the appropriate modifier must be reported on the service line for the transport for the second or subsequent patient being transported.

Modifier	Description	Special Instructions
GM	Multiple patients on one ambulance trip	Enter on the transport service line for second or subsequent patient when more than one patient is transported. Reduces reimbursement for the second or subsequent patient transported. Do not report for the first patient.



7.3.D. MILEAGE

When billing a mileage code for trips totaling:

- Less than 100 miles, ambulance providers must report mileage units rounded up to the nearest tenth of a mile (e.g., 15.5 miles). For trips totaling less than one mile, ambulance providers must report a "0" prior to the decimal (e.g., 0.5 miles). For claims submitted with mileage units greater than one decimal place, Medicaid will truncate to accommodate its fractional billing policy (e.g., 15.99 reported miles will become 15.9 miles).
- 100 miles or more, ambulance providers must report mileage rounded up to the nearest whole mile. For claims submitted totaling 100 miles or more and that are reported using fractional mileage, Medicaid will truncate to accommodate this policy (e.g., 115.99 reported miles will become 115 miles). Medicaid will not round up to the nearest whole mile for ambulance runs totaling 100 miles or more that are truncated as a result of this policy.

NOTE: Because the National Uniform Billing Committee (NUBC) UB-04 paper claim form cannot accommodate fractional billing, hard copy ambulance billers submitting the UB-04 should report mileage units rounded up to the nearest whole mile.

7.3.E. WAIT TIME

When billing for wait time (if more than 30 minutes of waiting time occurs), report the procedure code and enter the appropriate number of time units in the Service Units field. Bill one time unit for each 30 minutes of wait time over and above the first 30 minutes.

If more than four hours of waiting time is required, providers must request individual consideration and provide documentation. Documentation is required when billing wait time regarding the circumstances, noting under Remarks or submitted as an attachment with the claim.

7.3.F. ZIP CODE

MDHHS does not require reporting the ZIP code of the geographic location for pricing.

7.4 ANESTHESIA

MDHHS aligns as closely as possible with Medicare's anesthesia billing guidelines. Under OPPS, anesthesia services are packaged services, with items and services considered an integral part of another service being included in the APC payment for that integral part. Anesthesia, routine supplies, recovery room, and most drugs are considered an integral part of a surgical procedure; therefore, payment of these items is packaged into the APC payment for the surgical procedure.

Providers must bill all packaged items and services appropriately.

CRNA, AA, and physician professional charges should not be included in the outpatient hospital bill. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for information related to billing professional services.)



7.5 APHERESIS

MDHHS aligns as closely as possible with Medicare's billing and reimbursement guidelines for Apheresis services.

7.6 BENEFICIARY EDUCATION

7.6.A. CHILDBIRTH EDUCATION

Childbirth education services must be billed upon completion of the course.

- Report the quantity as "1".
- Enter the last date the beneficiary was seen for childbirth education in "statement covers period".
- The "from" and "through" dates must be the same.

7.6.B. KIDNEY DISEASE EDUCATION (KDE)

MDHHS follows Medicare's billing and reimbursement requirements for covered Kidney Disease Education (KDE) services.

- Bill the appropriate NUBC Revenue Code.
- Bill the appropriate CPT/HCPCS code for KDE.
- Bill the appropriate diagnosis code.

7.7 BLOOD AND PRODUCTS

MDHHS aligns as closely as possible with Medicare's billing and reimbursement guidelines for billing blood or blood products.

7.7.A. TRANSFUSION SERVICES

MDHHS aligns as closely as possible with Medicare's billing and reimbursement guidelines for transfusion services.

7.7.B. UNUSED BLOOD

MDHHS aligns as closely as possible with Medicare's billing and reimbursement guidelines for blood bank unused blood, processing and storage costs. The OPPS provider must not bill the beneficiary for these storage costs.

7.8 CLINIC SERVICES

MDHHS aligns as closely as possible with Medicare's billing and reimbursement guidelines for billing Hospital Clinic services rendered in a clinic setting (that is part of the licensed, Medicaid enrolled hospital) and that satisfy Medicare requirements for provider-based status.



Clinic services rendered in the outpatient hospital include non-emergency outpatient services that are provided to ambulatory beneficiaries.

7.9 COSMETIC SURGERY

A copy of the authorization letter that was sent to the attending physician from the OMA or MHP must be submitted with the claim.

Indicate "PA letter submitted" in the Remarks section.

7.10 DENTAL SERVICES

PA is not required for the outpatient hospital setting for FFS beneficiaries. However, PA may be required for MHP enrollees.

The hospital must bill the appropriate supporting HCPCS code and the appropriate revenue code(s).

7.11 DIABETES SELF-MANAGEMENT EDUCATION (DSME) TRAINING PROGRAM

MDHHS follows Medicare's DSME Training (initial and follow-up) billing guidelines as closely as possible. Providers must bill appropriately. All documentation must support that services furnished are provided by a Medicaid enrolled provider who meets Michigan Medicaid DSME program requirements in the appropriate place of service.

Refer to the Hospital Chapter for information regarding DSME program requirements.

7.12 DIALYSIS (HEMODIALYSIS AND PERITONEAL)

MDHHS follows Medicare's billing requirements for chronic dialysis services (e.g., the appropriate diagnosis code, patient weight, height, etc.); however, coverage and reimbursement policies differ. Refer to the outpatient portion of the Hospital Chapter of this manual and the MDHHS OPPS Wraparound Code List on the MDHHS website for additional information. (Refer to the Directory Appendix for MDHHS website information.)

7.13 DONOR SEARCHES

Charges for donor searches which do not result in an organ acquisition and transplant should be billed as an outpatient service.

- A copy of the PA for the transplant that was sent to the attending physician from the OMA or MHP must be submitted with the claim.
- The appropriate NUBC revenue code should be used with the appropriate CPT/HCPCS procedure code. The MDHHS website contains additional billing information (i.e., MDHHS Institutional Billing Resource document). (Refer to the Directory Appendix for website information.)
- Indicate "PA letter submitted" in the Remarks Section.



7.14 DRUGS ADMINISTERED ON PREMISES

Medicaid does not cover the NUBC revenue code for self-administered drugs. Refer to the Revenue Code Requirements Table posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

7.15 EMERGENCY DEPARTMENT SERVICES

Emergency Department services are to be billed as follows:

EMTALA Screen	The hospital must bill the appropriate NUBC Emergency Department (ED) revenue code with the appropriate ED Evaluation and Management (E&M) code/CPT/HCPCS procedure code when billing the EMTALA screen without follow-up treatment/stabilization services. (Refer to the General Information for Providers and the Emergency Services Only Medicaid chapters for additional information.)
Emergency Department Stabilization/ Emergency Treatment Services	<ul style="list-style-type: none"> ▪ Use the appropriate ED revenue code or combination of codes. ▪ Use the appropriate ED E&M code/CPT/HCPCS code to indicate the level of service provided. ▪ The principle diagnosis code field must reflect the emergency diagnosis resulting from the EMTALA screen. The Admitting Diagnosis Code field should reflect the beneficiary's reason for the emergency room visit. ▪ Hospitals must apply current guidelines designated by the appropriate ED HCPCS code to reasonably relate the intensity of hospital resources to the different E&M levels represented by the codes. <p>Exception: The reason the encounter was considered an emergency must be entered in the Remarks Section if the principal diagnosis or the admitting diagnosis does not reflect the definition of an emergency as stated in the Balanced Budget Act of 1997 and its regulations. Information in the Remarks Section should include vital signs, medical problems or conditions noted during the ED visit, if an IV was started, and medications administered during the visit. This information must be adequate to confirm the emergent condition.</p> <ul style="list-style-type: none"> ▪ All outpatient hospital charges for ED services resulting in an inpatient admission must be billed on the inpatient claim. Payment is made through the inpatient reimbursement system (as part of the DRG).
Emergency Department Non-Emergency Treatment Services	<p>Medicaid covers all appropriate hospital charges for ED services, provided that the diagnosis supports procedures billed and/or documentation supports the facility charges.</p> <ul style="list-style-type: none"> ▪ Hospitals must bill the appropriate NUBC ED revenue code. ▪ Use appropriate ED E&M code/CPT/HCPCS code to indicate level of service provided. ▪ All other services (e.g., laboratory, x-ray, etc.) must be billed consistent with Medicaid's FFS policy. <p>For MHP enrollees, authorization must be obtained prior to provision of non-emergency services in the ED.</p>



7.16 HYPERBARIC OXYGEN THERAPY

MDHHS follows Medicare's Hyperbaric Oxygen Therapy billing guidelines as closely as possible when billed appropriately.

7.17 HYSTERECTOMY

Refer to the Hospital Claim Completion-Inpatient Section of this chapter for information related to hysterectomies.

7.18 INJECTIONS

Outpatient hospital providers who bill physician administered drugs (injectable and non-injectable) separately to Medicaid must report the National Drug Code (NDC) and its supplemental information in addition to the corresponding procedure code (CPT or HCPCS) to assist Medicaid in collecting rebates. Reporting of the NDC is not required for claims that are considered packaged or bundled (Medicare Pay Status = N) under the Outpatient Prospective Payment System (OPPS).

Providers can report decimals if they are part of the NDC supplemental information.

Coverage of a physician administered drug (except an immunization) is limited to a drug product from a manufacturer who has a signed rebate agreement with the CMS. A current listing of the rebate manufacturers can be found on the CMS website. (Refer to the Directory Appendix for website information.) Providers are required to review the website for any changes. MDHHS will not provide an updated listing of rebate manufacturers.

The NDC information must be reported on all Medicare crossover claims.

Do not re-code injectable drugs from a national procedure code covered by Medicare or other payers to a NOC code when billing MDHHS unless MDHHS does not cover that procedure code. When MDHHS covers the procedure code, the same procedure code must be submitted to MDHHS that was submitted to the other payer to ensure proper reimbursement.

When billing a code with a dose-specific description, enter the appropriate quantity. If the dose specified in the code description is exceeded, use modifier 22 and document the actual dosage given in the appropriate segment or form locator.

If an injectable or non-injectable drug is obtained at a lower than normal cost (e.g., through 340B program), the lower than normal cost (actual acquisition cost) must be reported on the claim in place of the cost of charge. In addition, drugs purchased through the 340B program must be indicated on the institutional claim using the MDHHS modifier U6 and CMS modifiers for OPPS 340B acquired drugs.

Invalid or missing NDC information or an NDC by a manufacturer who does not have a signed rebate agreement with CMS will reject at the claim line level.



7.18.A. ELECTRONIC CLAIMS

The following NDC information is reported in the appropriate segments of the electronic claim format:

- N4 (2-digit qualifier)
- NDC (11 digits, with 5-4-2 format)
- Unit of Measurement Value (2-digit qualifier)
- NDC Quantity

To report the NDC information in an 837 HIPAA-compliant format with the correct information in the 2410 Loop:

- Repeat the HCPCS code on multiple service line loops, allowing one NDC to be reported within each LIN segment.
- Within the LIN segment, report the 2-digit qualifier along with the 11-digit NDC.
- Within the CTP segment, report the quantity and unit of measurement.
- For the REF segment, the prescription number or Compound Drug Association Number must be reported on each service line to link this service together.

7.18.B. NUBC CLAIM FORMAT

The National Uniform Billing Committee (NUBC) provides instructions for reporting an NDC and its supplemental information on the NUBC claim format. These instructions can be found on the NUBC website. (Refer to the Directory Appendix for website information.)

To bill a procedure code (HCPCS or CPT) with multiple NDCs:

- Report the first NDC and its supplemental information in the appropriate Form Locator.
- Report the additional NDC and its supplemental information in the Remarks field.

7.18.C. NOT OTHERWISE CLASSIFIED CODE (NOC)

If a nonspecific or not otherwise classified code (NOC) is billed for a drug product, the NDC and its supplemental information must be reported in the appropriate segments of the electronic claim format and the appropriate Form Locator on the UB-04 claim format. The cost of the drug must be reflected in the charges submitted to MDHHS. If the drug is obtained at a lower than normal cost (e.g., through 340B program), the lower than normal cost must be reported on the claim. Enter a quantity of "1."

7.18.D. DRUGS AND BIOLOGICAL PRODUCTS NOT COVERED BY MEDICAID HEALTH PLANS

When multiple OPH or ASC services are provided in conjunction with a carved-out physician-administered drug, claims with the PA number, all services, the appropriate billing codes, and the appropriate National Drug Code (NDC) must be submitted to



Medicaid Fee For Service (FFS). Medicaid FFS will process payment of the carved-out drug service line only. All other claim lines will be denied with Claim Adjustment Reason Code (CARC) 24. Providers are to bill the FFS denied associated services to the beneficiary's health plan.

7.19 LABOR AND DELIVERY ROOM

Labor and delivery room charges must only be billed when labor progresses to delivery.

- Do not report fetal monitoring, a fetal contraction stress test, or a fetal non-stress test in addition to a labor and delivery or false labor room charge when there is no active labor.

False labor charges for a room used by a beneficiary in active labor who does not progress to delivery must be billed using the appropriate NUBC revenue code (i.e., Other Labor Room/Delivery) and the appropriate CPT/HCPCS procedure code.

- A fetal contraction stress test or a fetal non-stress test may be billed in addition to false labor (under the MDHHS OPPS) when medically necessary.
- No other room charges may be billed with the NUBC Revenue Code (Other Labor Room/Delivery) for the same date of service.

Refer to the MDHHS Institutional Billing Resource document (posted on the MDHHS website) for billing updates and additional information. (Refer to the Directory Appendix for website information.)

7.20 LABORATORY

Differences in coverage of lab services between MDHHS and Medicare have been identified and are included in the MDHHS OPPS Wraparound Code List available on the MDHHS website.

7.21 OUTPATIENT OBSERVATION SERVICES

MDHHS follows Medicare's observation care services coverage, claim submission, and reimbursement policies when billed appropriately.

7.22 PREADMISSION DIAGNOSTIC SERVICES

MDHHS policy/billing guidelines align with billing guidance referenced in the Medicare Claims Processing Manual and the applicable section (i.e., date specific) for "Outpatient Services Treated as Inpatient Services."

MDHHS does not differentiate any specialty hospitals or facilities referenced in the CMS policy (i.e., critical access hospital [CAH], cancer, etc.). (NOTE: This policy does not apply to ambulance providers, freestanding dialysis centers or inpatient rehabilitation hospitals.) MDHHS will use a hospital's tax identification number to align with the CMS definition of "any hospital entity that is wholly owned or wholly operated by" the hospital. Otherwise, MDHHS will align as closely as possible with Medicare policy and guidelines for all beneficiaries.



7.23 RADIATION THERAPY SERVICES

MDHHS follows Medicare's billing guidelines for repetitive billing on the same claim or separately by date of service. If reporting charges on a single claim, the provider must also report all charges for the radiation services (one episode of care) and supplies for the recurring radiation service on the same claim.

7.24 REHABILITATION SERVICES

MDHHS follows Medicare's billing requirements for Cardiac Rehabilitation (CR), Intensive Cardiac Rehabilitation (ICR), and Pulmonary Rehabilitation (PR).

Hospitals must bill appropriately following Medicare's billing guidelines.

7.25 SELF-CARE DIALYSIS TRAINING

Bill self-care dialysis training using the appropriate revenue code and HCPCS/CPT codes. Refer to the MDHHS OPPS Wraparound Code List on the MDHHS website for CPT HCPCS codes. (Refer to the Directory Appendix for MDHHS website information.)

If a beneficiary completes a course:

- Report the appropriate CPT/HCPCS procedure code for dialysis patient training, complete course.
- The quantity should be "1."

If a beneficiary does not complete a course:

- Report each session separately using the appropriate CPT/HCPCS procedure code for dialysis patient training, per session.
- The service date on the claim line must indicate the actual date that the session occurred.
- Report each session using the appropriate CPT/HCPCS procedure code for dialysis patient training, course not completed, per training session.

7.26 STERILIZATION

Refer to the Hospital Claim Completion-Inpatient Section of this chapter for additional information related to sterilization.

7.27 TELEMEDICINE

To be reimbursed for the originating site facility fee, the hospital must bill the appropriate telemedicine CPT/HCPCS procedure code and modifier. Refer to the Telemedicine Section of the Practitioner Chapter for additional information. Information about telemedicine services is contained in the Telemedicine Section of the Practitioner Chapter. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.



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7.28 THERAPIES (OCCUPATIONAL, PHYSICAL AND SPEECH-LANGUAGE) [CHANGE MADE 7/1/20]

Therapy services must be reported using the appropriate procedure code and therapy modifier to distinguish the discipline under which the service is delivered. In addition, when services are habilitative, they must be billed with the appropriate modifier that represents the nature of the therapy performed. (revised 7/1/20) For MHP enrollees, the provider should check with the MHP for PA requirements. Refer to the Therapy Services chapter for additional information related to therapies.

<p>Occupational Therapy (OT)</p>	<ul style="list-style-type: none"> ▪ OT does not require PA for a maximum of 144 units within a calendar year. ▪ OT must be billed with a revenue code along with the appropriate HCPCS code on the claim line. The quantity should reflect the appropriate quantity per code description. If the procedure is not defined by a specific time frame, report "1" as the quantity. ▪ Therapy must be provided by the evaluating discipline. Evaluation or reevaluation may be billed with other OT services on the same day. Therapy must be provided by the evaluating discipline. ▪ The fee for OT includes all services. Hospitals cannot bill a clinic room charge in addition to the therapy, unless the visit is unrelated to OT. ▪ OT may be provided to nursing facility beneficiaries by the outpatient department of a general hospital. ▪ PA is required for continuing therapy beyond the initial 12 consecutive calendar months of therapy.
<p>Physical Therapy (PT)</p>	<ul style="list-style-type: none"> ▪ PT does not require PA for maximum of 144 units within a calendar year. ▪ For PT services, use a revenue code with the appropriate HCPCS code on the claim line. The quantity should reflect the appropriate quantity per code description. If the procedure is not defined by a specific time frame, report "1" as the quantity. The fee screen for PT includes all services. Hospitals cannot bill a clinic room charge in addition to the therapy unless the visit is unrelated to PT. ▪ Evaluation or re-evaluation may be billed with other PT services on the same day. Therapy must be provided by the evaluating discipline. ▪ PA is required for continuing therapy beyond the initial 12 consecutive calendar months of therapy.



Speech-Language Therapy (ST)

- Speech-language therapy does not require PA for a maximum of 36 visits within the first 12 consecutive calendar months of therapy.
- Speech therapy must be billed with a revenue code along with the appropriate HCPCS code on the claim line. The quantity should reflect the appropriate quantity per code description. If the procedure is not defined by a specific time frame, report "1" as the quantity.
- Evaluation or re-evaluation may be billed with other speech pathology services on the same day. Therapy must be provided by the evaluating discipline.
- The fee for speech-language therapy includes all services. Hospitals cannot bill a clinic room charge in addition to the therapy unless the visit is unrelated to speech therapy.
- PA is required for continuing therapy beyond the initial 12 consecutive calendar months of therapy.

7.29 ULTRASONOGRAPHY

Claims for diagnostic ultrasound procedures which are performed more than once require documentation of medical necessity. Documentation with the claim should clearly state the reason for the repeat procedure (e.g., multiple gestation, breach presentation, pre-term labor, etc.). Claims are rejected if the documentation does not support the medical necessity for the repeat diagnostic procedure.

7.30 WEIGHT REDUCTION

A copy of the letter of authorization for the weight reduction that was sent to the attending physician from the OMA must be submitted with the claim.

Indicate "PA letter submitted" in the Remarks Section.



SECTION 8 – NURSING FACILITY CLAIM COMPLETION

This section contains information that should be used in conjunction with the NUBC Manual when preparing nursing facility claims.

Only one calendar month is to be billed on a nursing facility claim.

For Room and Board, the service line from and to date (if reported) must match that of the claim header from and through dates and be reflected in the units billed. The room and board revenue code billed must be for the appropriate room type. Both Revenue Codes 0110 and 0120 must not be billed on two separate claims for the same beneficiary and same/overlapping service dates. These claims will be denied or recouped if paid incorrectly.

8.1 SPLIT BILLING – STATEMENT COVERS PERIOD

The Statement Covers Period on the claim is used for reporting the beginning and ending dates of service for the entire period reflected on the claim. In instances where the facility is split billing the month, the From and Through dates must be for only the period reflected on the claim.

Example: Facility is split billing April. On the first claim, the From date would be 040105 and the Through date would be 041505 for 15 days. The second claim From date would be 041605 and the Through date would be 043005 for 15 days.

If a patient-pay amount is involved on both claims, the facility is reminded that the first claim must be paid before submitting the second claim. Refer to the Patient-Pay portion of this section for additional information.

Failure to follow the above claim completion instructions will result in unnecessary suspending of claims and delays in processing.

8.2 PATIENT-PAY AMOUNT

8.2.A. ONE FACILITY – TWO CLAIMS IN ONE MONTH

When a nursing facility must submit two claims within the same month for the same beneficiary who has a patient-pay amount, the following instructions must be followed:

- The claim for the first service dates in the month must be submitted before the claim for the remainder of the month, even if the patient-pay amount is equal to or greater than the amount billed; and



- The first claim must be paid before submitting the second claim. If the first claim is suspended or rejected, and the second claim is submitted and paid, the whole patient-pay amount is deducted incorrectly from the net amount due on the second claim, even if all or a portion of the patient-pay amount was to have been deducted from the first claim. A replacement claim is required for the second claim to correct the underpayment after both claims are paid.

Facilities must report the total patient-pay amount on the first claim. If there is any remaining patient-pay amount, the amount must be reported on the second claim. The total patient-pay amount is not to be reported on both the first and second claims.

8.2.B. TWO FACILITIES – TWO CLAIMS IN ONE MONTH

If a beneficiary with a patient-pay amount resides in more than one Medicaid-certified facility in the same month:

- The first facility must submit a claim:
 - For the days the beneficiary resided in the facility (even if the amount billed is zero because the amount due is covered by the patient-pay amount);
 - To be paid for any amount due that is more than the patient-pay amount; and
 - For the second facility to receive the correct payment.
- If the first claim has not been submitted or is suspended or rejected, and the second facility submits its claim, the whole patient-pay amount is deducted from the amount due on the second claim. The second facility needs to void their claim in order for the first facility to bill their claim so the PPA may be applicable. Once that is complete, the second facility can rebill a new claim to receive its proper payment.

Note: Nursing facilities must not contact the beneficiary's Michigan Department of Health and Human Services (MDHHS) case worker as the case worker cannot change the patient-pay amount in these situations nor is it warranted. Facilities must bill as outlined above.

8.2.C. OFFSET TO PATIENT-PAY AMOUNT FOR NONCOVERED SERVICES

Notes:

- Pre-Eligibility Medical Expenses: This section does not pertain to Pre-Eligibility Medical Expenses (PEME). PEME must not be reported on the claim. (Refer to the Directory Appendix for PEME contact information.)
- Private Insurance Premiums: Premiums for private insurance cannot be reported on a claim to Medicaid as an offset to the patient-pay amount. The cost of insurance premiums must be handled by the beneficiary's local MDHHS office worker. The MDHHS worker will determine if the cost of the insurance is an allowable expense/offset. Any cost of a premium is not permissible on a claim submitted to Medicaid.



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Claims containing an offset to the patient-pay amount cannot be split-billed. The facility must submit one claim for the particular month of service. The offset must be reported for the month that the services were provided.

The offset for the noncovered service must be reported on the claim using the appropriate value code and FL 39 and the related dollar amount. Only value codes for Michigan Medicaid noncovered services will be activated for approval through CHAMPS.

The dollar amount of Value Code D3 minus Estimated Responsibility Patient (patient-pay amount) is the beneficiary's monthly patient-pay amount MINUS the dollar amount of the offset.

The total of D3 and the offset must equal the beneficiary patient-pay amount for that given month.

Offsetting the patient-pay amount may involve more than one month. For example, the beneficiary may have a patient-pay amount of \$200 per month. The amount to be offset is \$500. The amount to be offset would involve a three-month period. The first month claim would indicate \$200 as an offset with D3 as zero. The second month claim would indicate \$200 as an offset with D3 as zero. The third month claim would indicate \$100 as an offset with D3 as \$100.

8.2.C.1. CLAIM DOCUMENTATION REQUIREMENTS WHEN OFFSETTING THE PATIENT-PAY AMOUNT

Documentation must accompany the claim when offsetting the patient-pay amount with Value Codes 25, 26, 27, 28, 29, 33, or 34. Refer to the NUBC website for additional information. (Refer to the Directory Appendix for website information.)

Documentation Requirements	<p>The documentation that must accompany the claim includes the specific reason that the patient-pay amount is being offset, a detailed description of the specific item or service that is offset, and receipt showing that the beneficiary paid for the Medicaid non-covered service.</p> <p>The nursing facility must upload the documentation to the Document Management Portal (DMP). The nursing facility is responsible for a successful upload of the documentation. This tool enables providers to electronically submit supporting documentation for Medicaid claims. A review guide for the DMP is available on the MDHHS website. (Refer to the Directory Appendix for website information.)</p> <p>Note: The nursing facility must report in the Note section of the claim that documents have been uploaded to the DMP.</p>
Claims Processing	<p>There will be a change in the processing of claims when the above Value Codes are reported. Claims will suspend for review of the submitted documentation. Claims submitted with no documentation will be rejected.</p>



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MI Health Link	For beneficiaries enrolled in the MI Health Link program, nursing facilities must still collect and maintain patient-pay amount offset information according to policy. Nursing facilities will not be required to submit this information to MDHHS for the months in which a beneficiary is enrolled in MI Health Link. Nursing facilities should continue to abide by their individual contracts with the Integrated Care Organizations (ICOs) as it relates to reporting patient-pay amount offsets when a beneficiary is enrolled in MI Health Link.
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8.2.D. PATIENT -PAY AMOUNT GREATER THAN AMOUNT BILLED

Nursing facilities must bill Medicaid even if the patient-pay amount is greater than the amount billed to Medicaid. Medicaid requires that a claim be billed so it can obtain particular information off the claim for statistical purposes.

8.2.E. BILLED FACILITY DAYS

Day of Admission	Medicaid reimburses the day of admission if the beneficiary is counted in the facility census (e.g., if they are in the facility at midnight).
Day of Discharge	Medicaid does not reimburse the day of discharge unless the discharge is due to the resident's death. When billing, the facility must indicate "20" (expired) as the Patient Status Code. A discharge due to death is counted in the facility census.
Hospital Leave Days	<ul style="list-style-type: none"> ▪ If the resident is expected to be in the hospital for 10 days or fewer and dies while in the hospital, the nursing facility may bill for the hospital leave days up to the day before the resident died. ▪ For Medicaid to pay for hospital leave days, Medicaid must have been paying for the nursing facility stay before the beneficiary was admitted to the hospital. ▪ If the resident returns to the nursing facility under Medicare coverage, the facility may bill for the hospital leave days if the emergency hospitalization was for ten days or fewer. ▪ A resident is counted in the facility census if he is in the facility at midnight. If the resident is out of the facility on hospital leave at midnight, that day must be counted as a hospital leave day. If the resident returns to the nursing facility from the hospital, then is readmitted to the hospital for the same condition that he was hospitalized for previously, the 10-day period of Medicaid reimbursed hospital leave days continues if the resident was not counted in the facility census for that day. If, given the circumstances above, the resident was counted in the facility census, a new 10-day period of Medicaid reimbursed hospital leave days may begin.
One-Day Stay	A nursing facility is reimbursed for a one-day stay if a Medicaid beneficiary is admitted to the facility and, the same day, is discharged from the facility due to death, return home, or transfer to another institution that is not a Medicaid-enrolled provider. The one-day stay does not apply to a beneficiary admitted to a nursing facility if, later that day, the beneficiary is discharged and transferred to another nursing facility or an inpatient hospital and, at midnight, the second facility or hospital claims the beneficiary in its daily census.



Outpatient and Emergency Room	A beneficiary who goes to the hospital for outpatient or emergency room services is not discharged from the nursing facility because the beneficiary is not admitted to the inpatient hospital. The beneficiary should be included in the census of the nursing facility, and this day may be billed to Medicaid even if the beneficiary was being treated at midnight in the hospital outpatient or emergency room.
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8.3 HOSPITAL LEAVE DAYS

For Hospital Leave Days, Medicaid will pay to hold a beneficiary’s bed only when the facility’s total available bed occupancy is at 98 percent or more on the day the beneficiary leaves the facility. Facilities at 97.50 percent occupancy may round up to 98 percent. Facilities may not round up 97.45 percent – 97.49 percent to 98 percent. Hospital leave days are limited to a total of 10 days per admission to the hospital for emergency medical treatment. The patient must return to the nursing facility in 10 or fewer days in order for the nursing facility to bill for hospital leave days. When billing, the facility must use:

- Revenue Code 0185; and
- Occurrence Span Code 74, with dates representing the leave days.

8.4 THERAPEUTIC LEAVE DAYS

Therapeutic leave days are limited to a total of 18 days during a 365-day period. When billing, the facility must use:

- Revenue Code 0183; and
- Occurrence Span Code 74, with dates representing leave days.

8.5 VENTILATOR DEPENDENT CARE UNIT (VDCU) AND COMPLEX CARE

When billing for approved VDCU care or complex care:

- Facilities must enter the PA number from the Medicaid authorization form on the claim. If a beneficiary is approved for both complex care and therapy services, one PA number is issued for both complex care and therapy. If a beneficiary is approved for ventilator care and also requires therapy, prior authorization for the therapy must be obtained under the VDCU NPI. Both the therapy and VDCU prior authorization numbers may be reported on the same claim.
- Facilities must bill with the appropriate daily care accommodation revenue codes. For ventilator dependent care, revenue code 0110 must be used. For complex care, revenue code 0120 must be used. Providers should contact MDHHS Long Term Care Services for information on ventilator dependent care and/or complex care. (Refer to the Directory Appendix for contact information.)

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.



8.6 FACILITY UNDER NEW OWNERSHIP

If a facility changes ownership, the facility must register the NPI for the new owner through the on-line CHAMPS Provider Enrollment (PE) subsystem. If the provider tax identification number (TIN) did not change, the NPI can be reported through the CHAMPS PE maintenance function. If the change involves a new TIN, the provider must complete a new enrollment application. (Refer to the Provider Enrollment Section of the General Information for Providers Chapter for enrollment information.)

If the facility changes ownership in the middle of the month and the beneficiary was in continuous residency at the facility for the month, the facility must submit a claim using the old provider NPI number for the first part of the month and another claim for the second part of the month using the new provider NPI number. The process for two facilities and two claims in a month should be followed for beneficiaries with patient-pay amounts. (Refer to the Patient-Pay Amount subsection above for additional information.)

8.7 BENEFICIARY TRANSFER

When a beneficiary is transferred from one facility to another, MDHHS recommends that the second facility obtain the therapeutic leave day record and Medicare status for the year from the first facility. Maintenance of these records allows the second facility to bill properly and prevents unnecessary rejections.

8.8 HOSPITAL SWING BEDS

Providers of Medicaid swing bed services may not bill for swing bed days unless the combined length of stay in the acute care bed and swing bed exceeds the average length of stay for the Medicaid hospital diagnosis related group (DRG) of the admission.

- The admission date on the claim is the date the beneficiary was admitted to the swing bed. A beneficiary may not be admitted to the swing bed until discharged from an acute care bed.
 - The admission date to the swing bed is not included in the billing period if the admission date to the swing bed is within the DRG coverage period.
- The "from" date and "through" dates on the claim are the beginning and end dates of the billing period. No more than one calendar month may be billed on a claim. The billing period for a Medicaid covered swing bed stay begins when the combined length of stay in the acute care bed and swing bed exceeds the average length of stay for the Medicaid hospital DRG for the hospital admission.
- Hospitals that are exempt from the DRG system may bill for Medicaid covered swing bed days beginning the day of admission to the swing bed.
- The units of service entered on the claim is the number of swing bed care days provided. The day of admission to the swing bed may not be included in the billing period. To determine if the admission date is included in the billing period, refer to the instruction (above) for the "from" date.
- The total number of swing bed care days is limited to 100 days per beneficiary per stay.



8.9 COST SETTLED PROVIDER DETAIL REPORT (FD-622)

A Cost Settled Provider Detail Report (FD-622) is available to nursing facilities (nursing homes, county medical care facilities, hospital long-term care units, ventilator-dependent care units, and hospital swing beds). The FD-622 provides detailed information of a facility's charges paid by Medicaid. Since MDHHS acts as a fiscal agent for many different sources of payment, the FD-622 includes all of these sources.

This report can be used in conjunction with the Remittance Advice (RA) to reconcile the accounts receivable and used as the actual log that the facility must maintain for Medicaid, eliminating duplication of paperwork by the facility.

The FD-622 includes:

- Medicaid payroll information
- the facility's billing information
- the facility's current interim reimbursement rate
- an indicator if the facility is on Medicaid Interim Payments
- beneficiary information on services billed to Medicaid
- summary of cost settled services
- total charges billed to Medicaid
- amount paid by Medicare, other insurance, beneficiary
- Medicaid payments
- gross adjustments
- Medicaid claim statistic information

The detail portion of the FD-622 report is available in an electronic version. Additional information is available on the MDHHS website. (Refer to the Directory Appendix, Nursing Facility Resources, for website information.)

8.10 DAILY CARE

The following providers may bill for daily care and must enter the appropriate revenue code that identifies the specific daily care accommodation being billed:

- Nursing Home Facilities
- County Medical Care Facilities
- Hospital Long Term Care Units
- Hospital Swing Beds
- Ventilator Dependent Units
- State Veterans' Homes

The NUBC Manual provides the revenue codes to be used for Michigan Medicaid.



8.11 ANCILLARY PHYSICAL AND OCCUPATIONAL THERAPY, SPEECH PATHOLOGY

Ancillary services can be billed on the same claim as daily care (room and board).

The following providers may bill physical/occupational therapy and speech pathology:

- Nursing Home Facilities
- County Medical Care Facilities
- Hospital Long Term Care Units
- Outpatient County Medical Care Facilities
- Ventilator Dependent Units
- State Veterans' Homes

When billing on the NUBC claim form, facilities must use the revenue codes and HCPCS codes identified on the MDHHS Therapy Services Database available on the MDHHS website. (Refer to the Directory Appendix for website information.)

- Each ancillary service must be billed on a separate claim line. Series billing is not allowed.
- Each claim line requires a:
 - Date of service
 - Revenue code and a HCPCS code
 - PA number on the claim
 - Therapy discipline modifier
 - Therapy nature modifier (habilitative claims only)
- PA number must be on the claim.

When billing, facilities must enter the PA number from the Medicaid authorization form on the claim. If a beneficiary is approved for both complex care and therapy services, one PA number is issued for both complex care and therapy.

Therapy services must be reported using the appropriate therapy modifier to distinguish the discipline under which the service is delivered. In addition, when services are habilitative, they must be reported with the appropriate modifier that represents the nature of the therapy. Maintenance therapy visits should also include the MDHHS designated maintenance modifier. Refer to the Therapy Services chapter for additional information related to therapies.



- Occupational therapy modifier: GO
- Physical therapy modifier: GP
- Speech therapy modifier: GN
- Rehabilitative therapy modifier: 97
- Habilitative therapy modifier: 96
- Maintenance visit modifier: TS (Follow-up Service)

8.12 OUTPATIENT COUNTY MEDICAL CARE FACILITIES

- When billing for therapies, outpatient county medical care facilities must indicate the Type of Bill as 23X.
- Each service must be billed on a separate claim line. Series billing is not allowed.
- Each claim line requires a revenue code and a CPT/HCPCS code.
- Each claim requires a PA number to be reported in the appropriate form locator or electronic segment.

8.13 MEDICARE PART B COINSURANCE AND DEDUCTIBLE AMOUNTS

The following providers are allowed to bill Medicaid for Medicare Part B coinsurance and deductible:

- Nursing Home Facilities
- County Medical Care Facilities
- Hospital Long Term Care Units

For the following revenue codes, Medicaid reimburses for any Medicare Part B coinsurance and deductible amounts, based on Medicare's payment, up to Medicaid's maximum amount allowed. Also, Medicaid covers the coinsurance and deductible amounts on any Medicare covered services not normally covered by Medicaid. When billing, each claim line requires a CPT/HCPCS code and the date of service (DOS).

If a beneficiary has Medicare Part B coverage and Medicare does not cover the service(s), the service(s) is considered routine nursing care.

Allowed Revenue Codes: 0270, 0272, 0274, 0275, 0276, 0300 - 0359, 0400 - 0409, 0420 - 0449, 0460, 0469, 0480 - 0489, 0610 - 0619, 0636, 0730 - 0749, 0780, 0800 - 0809, 0920 - 0929, 0940 - 0949.

8.14 OTHER SERVICE REVENUE CODES

Other service revenue codes may be billed as indicated below:

- 0160 - For dually eligible beneficiaries who wish to return to their Medicaid NF bed and refuse their Medicare SNF benefit following a qualifying Medicare hospital stay.

Services for nursing facility beneficiaries requiring outpatient physical therapy, outpatient speech pathology, and outpatient occupational therapy must be provided and billed under Medicare



Part B where applicable, even if no payments are made under Medicare Part A for the nursing facility stay.

- 0410 - Oxygen (gas, equipment, and supplies) for frequent or prolonged oxygen on a daily basis (i.e., at least 8 hours per day - covered when billed by a county medical care facility or hospital long-term care unit).

The rental of a concentrator is billable by a Medical Supplier and should not be confused as needing to be billed under Revenue Code 0410.

Interim reimbursement is based on a percent of charge. Final reimbursement is calculated during the respective period's cost settlement and is based on that period's audited cost to charge ratio.

Medicare/Medicaid – If Medicare is being billed for the nursing facility stay, neither the nursing facility nor a medical supplier can bill Medicaid for oxygen services (i.e., gas, equipment, supplies). Oxygen services are included in the Medicare payment to the facility under Medicare's Prospective Payment System.

- Telemedicine – To be reimbursed for the originating site facility fee, the NF must bill the appropriate telemedicine NUBC revenue code with the appropriate telemedicine procedure code and modifier. Refer to the Telemedicine Section of the Practitioner Chapter for additional information. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

8.15 PART A CO-INSURANCE RATE FOR NURSING FACILITY CARE

Medicaid co-insurance payments for Part A are the lower of the co-insurance charge or the current maximum co-insurance rate established under the formula stated in the Social Security Act. The facility's total payments from Medicare, Medicaid and other insurance may be up to, but cannot exceed, the amount established by Medicare as reasonable (i.e., the amount allowed by Medicare).

8.16 MEDICARE - MEDICAID NURSING FACILITY CROSSOVER CLAIMS WITH GROUP HEALTH INCORPORATED (GHI) (COORDINATION OF BENEFITS)

MDHHS accepts institutional crossover claims from the Coordination of Benefits Contractor, Group Health Incorporated (GHI).

The institutional nursing facility crossover claim process allows nursing facilities to submit a single claim for residents dually eligible for Medicare and Medicaid. After processing the Medicare portion, GHI forwards the claim to Michigan Medicaid for processing and reimbursement.

A remittance advice (RA) is generated from Medicare with the details of the Medicare payment and Remark Code MA07 (the claim information has also been forwarded to Medicaid for review). If this remark code does not appear on the Medicare RA, a separate claim must be submitted to MDHHS.

Once Medicare payment is received by the facility and Remark Code MA07 appears on the Medicare RA, the claim should appear on the Medicaid RA within 30 days. The facility may check claim status online through CHAMPS. If the claim does not appear in CHAMPS within 30 days, a claim should be submitted directly to MDHHS showing all Medicare payment information.



Providers must resolve denied claims with Medicare when there is a denied Medicare service not covered by Medicaid. The excluded Medicare service covered by Medicaid should be billed directly to Medicaid.

The following claims are excluded from the crossover process:

- Original Medicare claims paid in full without deductible or co-insurance remaining
- Claims with private and commercial insurance
- Adjustment claims fully paid without deductible or co-insurance
- Original Medicare claims paid at greater than 100% of submitted charges without deductible or co-insurance remaining
- 100% denied original claims
- 100% denied adjustment claims, with no additional beneficiary liability
- 100% denied original claims, with additional beneficiary liability
- 100% denied adjustment claims, with additional beneficiary liability
- Adjustment claims
- Mass adjustment claims - other (monetary or non-monetary)
- Medicare secondary payer cost-avoided (fully denied) claims
- Claims reporting Revenue Code 0160 (Medicaid Reimbursement for a Nursing Facility Bed Following a Qualifying Medicare Hospital Stay)

NOTE:

- For any Medicare Part B services associated with this nursing facility claim, the facility would bill Medicare accordingly.
- Nursing facilities must continue to complete their claims as they have been doing for Medicare.
- Nursing facilities must report the beneficiary's patient-pay, any offset to the patient-pay amount, and voluntary payments on the claim submitted to Medicare.
- When reporting ancillary services, the facility must indicate the service date on the line level of the claim. (Refer to applicable subsections in this chapter for additional information regarding ancillary services.)

8.16.A. VENTILATOR-DEPENDENT CARE UNITS

Medicaid-enrolled ventilator-dependent care units have a distinct National Provider Identifier (NPI) number for Medicaid billing. The number is separate from the "regular" facility NPI number. The facility would use the "regular" NPI number to bill days 1 to 100 to Medicare. Starting on day 101, the facility would bill Medicaid directly using its ventilator-dependent care unit distinct NPI number.

Additional information regarding crossover claims is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

NOTE: A Level of Care Determination (LOCD) must be completed for each NPI.



8.17 REPORTING MEDICARE ON THE MEDICAID NURSING FACILITY CLAIM

When reporting Medicare, nursing facilities must bill as outlined below.

- **Covered Days**
 - Covered days must be reported using Value Code 80.
 - Covered days are the days in which Medicare approves payment for the beneficiary's skilled care. Covered days must be reported when the primary insurance makes a payment.
- **Non-Covered Days**
 - Non-covered days must be reported using Value Code 81.
 - Non-covered days are the days not covered by Medicare due to Medicare being exhausted or the beneficiary no longer requiring skilled care. Non-covered days must be reported in order to receive the proper Medicaid provider rate payment.
 - When Medicare non-covered days are reported because Medicare benefits are exhausted, facilities must report Occurrence Code A3 and the date benefits were exhausted, along with Claim Adjustment Reason Code (CARC) 96 (Non-Covered Charges) or 119 (Benefit Maximum for the Time Period has been Reached).
 - When Medicare non-covered days are reported because Medicare active care ended, facilities must report Occurrence Code 22 and the corresponding date Medicare active care ended, along with CARC 96 or 119.
- **Coinsurance Days**
 - Medicare coinsurance days must be reported using Value Code 82.
 - Coinsurance days are the days in which the primary payer (Medicare or Medicare Advantage Plan) applies a portion of the approved amount to coinsurance. Coinsurance days must be reported in order to receive the proper coinsurance rate payment.
 - When reporting Value Code 82, Occurrence Span Code 70 (Qualifying Stay Dates for SNF) and corresponding from/through dates (at least a three-day inpatient hospital stay which qualifies the resident for Medicare payment of SNF services) must also be reported.
 - Facilities billing for beneficiaries in a Medicare Advantage Plan must report CARC 2, and this must equal the Medicare Advantage Plan coinsurance rate times the number of coinsurance days. Facilities using CARC 2 must report it with the amount equal to the coinsurance rate times the number of coinsurance days reported.
 - Medicare Advantage Plan coinsurance rates vary and do not always equal the Medicare Part A coinsurance rate. Providers must verify the beneficiary's Medicare Advantage Plan coinsurance rate prior to billing Medicaid.
- **Prior Stay Date**
 - If a SNF or nursing facility stay ended within 60 days of the SNF admission, Occurrence Span Code 78 and the from/through dates must be reported along with Occurrence Span Code 70 and the from/through dates.



- Nursing Facilities with Medicaid-Only Certified Beds Not Billing Medicare
 - For nursing facilities with Medicaid-only certified beds not billing Medicare, claims submitted directly to Medicaid must be billed as outlined above. For example, for beneficiaries with Medicare coverage based on Medicaid's TPL file, covered days must be left blank if Medicare is not covering the service or benefits have exhausted as Medicare is the primary payer. The non-covered day must be completed and it must equal the service units billed for room and board revenue codes and/or leave days revenue codes.

The reason Medicare is not covering the service (e.g., benefits exhausted) must also be reported.

8.18 LONG-TERM CARE INSURANCE

Federal regulations require that all identifiable financial resources available for payment, including long-term care insurance, be billed prior to billing Medicaid. If a beneficiary has long-term care insurance, it must be reported as other insurance on the Medicaid claim. (Refer to the Coordination of Benefits chapter for additional information.)

8.19 MONIES RECEIVED FROM A BENEFICIARY AND REPORTED WITH VALUE CODE 22

When a nursing facility uses Value Code 22 – Surplus to report monies received from a beneficiary, beneficiary's family, or beneficiary's legal representative, the facility must also report these monies to the beneficiary's case worker at MDHHS. This must be reported in order for the case worker to evaluate whether or not the money is countable toward the Medicaid asset limit for Medicaid eligibility. When reporting Value Code 22, the facility must report in the "Note" portion of the claim a detailed description of the monies received. The date that the nursing facility contacted the case worker must also be reported in the "Note" portion of the claim.

8.20 STATE VETERANS' HOMES [CHANGES MADE 4/1/20]

In addition to customary billing requirements, a State Veterans' Home must report:

- revenue code 0022,
- the five-digit Health Insurance Prospective Payment System (HIPPS) code,
- the Assessment Reference Date (ARD),
- the number of covered days for each HIPPS code, and
- occurrence code 50.

Revenue code 0022 must be reported on the same service line as each HIPPS code. The five-digit HIPPS code reported on the claim represents (in this exact order) the PT/OT score, the Speech-Language Pathology (SLP) score, the Nursing score, the Non-Therapy Ancillary (NTA) score and the Minimum Data Set (MDS) assessment type. HIPPS codes for the PT/OT, SLP, Nursing and NTA scores can be found in the Medicare Claims Processing Manual. The MDS assessment type should always be an Omnibus Budget Reconciliation Act (OBRA) assessment which has a value of 6, so the fifth digit of the HIPPS code should always be 6 on the claim. The service units on the service line must contain the number of covered days for each HIPPS code. Patient Driven Payment Model (PDPM) (revised per bulletin MSA 19-24) categories



and AIs are determined by the MDS 3.0 and can be found in the MDS 3.0 Resident Assessment Instrument (RAI) Manual. (Refer to the Directory Appendix for RAI Manual information.)

The federally required OBRA MDS assessments listed in A0310A of the MDS 3.0 RAI Manual are the only assessments that may be used for billing PDPM. **(revised per bulletin MSA 19-24)**

There must be an occurrence code 50 for each assessment period represented on the claim. The date of service with occurrence code 50 must contain the ARD associated with the applicable MDS assessment. Occurrence code 50 is not required with the default HIPPS code.

Providers must report the HIPPS code(s) and ARD(s) based on the applicable MDS assessment(s) to the billing period. Example: The provider is billing for April 1 through April 30, and MDS assessments occurred on March 15 and May 15. The HIPPS code and ARD would be based on the March 15 assessment since that was the assessment in effect when services were rendered.

Submitted claims will reject in the Community Health Automated Medicaid Processing System (CHAMPS). MDHHS will review the rejected claims and make periodic gross adjustments to the provider based on the claims data. MDHHS will adjust the gross adjustments as necessary to correct for past payments that do not conform to MDHHS billing and reimbursement policies.

Non-routine OT, PT and SLP services are included in the PDPM **(revised per bulletin MSA 19-24)** rates paid to State Veterans' Homes. These providers are to bill for non-routine therapies on the same claims as daily care, and they are required to obtain prior authorization.

The revenue code, HIPPS code, number of covered days for each HIPPS code, occurrence code 50, and the MDS ARD may be reported in the claim notes. **(text added per bulletin MSA 19-24)**

These billing requirements apply to State Veterans' Homes billing for NF services and hospice providers billing for room and board in a State Veterans' Home.



SECTION 9 – HOME HEALTH CLAIM COMPLETION

This section contains information that should be used in conjunction with the NUBC Manual when preparing Home Health claims.

9.1 INTERMITTENT NURSING VISITS/AIDE VISITS/THERAPIES

Each visit must be reported on a separate claim line: Medicaid follows Medicare policy on the requirement that each home health agency visit (e.g., nursing, therapy) must be billed on an individual line. This policy includes two visits performed on the same day (i.e., two visits on the same day must be billed on individual lines of the same claim).

Report 15-minute time increments: Medicaid follows Medicare policy for reporting home health visits in 15-minute increments. When billing on the NUBC form, each home health visit revenue code that is reported must have a corresponding 15-minute increment HCPCS code along with the number of 15-minute increments reported in the Service Units as follows:

Units	Time Requirements
1	1 minute to < 23 minutes
2	23 minutes to < 38 minutes
3	38 minutes to < 53 minutes
4	53 minutes to < 68 minutes
5	68 minutes to < 83 minutes
6	83 minutes to < 98 minutes
7	98 minutes to < 113 minutes
8	113 minutes to < 128 minutes

If services continue for longer periods of time, the home health agency would follow the above pattern.

Time of Service Visit: The timing of the visit begins at the beneficiary's home when services actively begin and ends when services are completed. The time counted must be the time spent actively treating the beneficiary. For example:

- If a beneficiary interrupts a treatment to talk on the telephone for other than a minimal amount of time (less than three minutes), then the time the beneficiary spends on the telephone and not engaged in treatment does not count in the amount of service.
- The home health aide completed bathing and transferring the beneficiary into a chair, and now begins to wash the kitchen dishes before leaving. Washing the dishes is considered incidental and does not meet the definition of a home health aide service. Therefore, the time to perform this activity would not be included in the 15-minute incremental reporting to Medicaid.



Other nontreatment-related interruptions would follow the same principle. If the beneficiary is late returning home from a doctor's appointment, the waiting time of the home health agency personnel cannot be counted as treatment time.

However, if the professional spends time with family or other caretakers in the home teaching them to care for the beneficiary, this activity is counted as treatment time. Calls to the physician by the nurse while in the beneficiary's home to report on the beneficiary's condition can also be counted as treatment time.

If beneficiary assessment activities for completion of the Outcome and Assessment Information Set (OASIS) are a part of an otherwise covered and billable visit, time spent in beneficiary assessment may be included in the total count of 15-minute increments. Completion of the assessment activities must be incorporated into a visit providing otherwise necessary home health care to the beneficiary. A separate visit made only to collect information for the OASIS assessment but not to provide other covered home health services is not billable.

9.2 POSTPARTUM/NEWBORN FOLLOW-UP NURSE VISIT

- Medicaid allows one initial postpartum and one initial newborn visit per pregnancy. The initial postpartum visit must be billed using the mother's Medicaid ID number. The initial newborn visit must be billed using the newborn's Medicaid ID number.
- Medicaid allows one subsequent visit to the mother and newborn. This subsequent visit may be billed under either the mother's or newborn's ID number, based on with which beneficiary the nurse spent the majority of the time.

9.3 INTRAVENOUS INFUSIONS

If the beneficiary is in need of intravenous infusion and an Infusion Clinic or ancillary Medicaid provider (who has no nurse) does not cover the service, or a family member/caregiver will not accept this task, the HHA may perform this service and bill accordingly.

These services must be billed as an Infusion Nurse Visit:

- Use Revenue Codes 0550, 0551, or 0552
- Use Procedure Codes:
 - 99601 (per visit - up to two hours). Must be billed on the first claim line.
 - 99602 (each additional hour). Must be billed on each additional claim line for each additional hour.



9.4 HOME HEALTH PROCEDURE CODES

When billing on the NUBC claim form, home health agencies must use the HCPCS codes located in the Healthcare Common Procedure Coding System manual and the revenue codes in the UB-04 Manual. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.



SECTION 10 – PRIVATE DUTY NURSING AGENCY CLAIM SUBMISSION/COMPLETION

10.1 DIRECT BILLING TO MDHHS

Providers must bill MDHHS directly (either paper or electronically) using the codes listed in the MDHHS Private Duty Nursing Reimbursement Rates Database posted on the MDHHS website. (Refer to the Directory Appendix for website information.) When direct billing to MDHHS, note the following:

Service Dates	Each date of service must be reported on a separate service line.
Units	Each service line must contain the number of units of care in the "Serv. Units" for that date of service.
Prior Authorization	The PA number listed on the Medicaid authorization letter must be recorded on the claim.
Authorization Letter	The provider must retain the authorization letter for private duty nursing in the beneficiary's record. The authorization letter must not be mailed with the claim when billing.
Billable Units	PDN services are authorized, billed, and paid in 15-minute incremental units. The total number of units reported on the claim must not exceed the total units that were authorized for that month. Since 15-minute units of care are authorized, only those units of care that entail a full 15 minutes of care may be billed.
Adjustments	Adjustments to claims are made through a total claim replacement or void/cancel process.
Multiple Beneficiaries Seen At Same Location	<p>The total Medicaid reimbursement for multiple beneficiaries is time-and-one-half for two beneficiaries. The specific codes listed in the HCPCS Codes/Modifiers section of the MDHHS Private Duty Nursing Reimbursement Rates Database must be used if an RN or LPN is caring for more than one beneficiary at the same location for which this approach to staffing has been authorized. These codes must be used for each beneficiary provided care (i.e., first, second beneficiary). For example, if there is one RN caring for two children at the same location, the multiple beneficiary modifier code must be used for both children.</p> <p>When billing for services for one child (when two have been authorized), do not use the TT modifier along with the HCPCS code. Claims will not pay for one child unless the following comment is entered in the Remarks section of the claim: "Only one child present at time of service, documentation on file."</p>
Holidays	Medicaid allows additional reimbursement for holidays. Medicaid currently recognizes the following holidays: New Year's Day, Easter, Memorial Day, July 4th, Labor Day, Thanksgiving Day, and Christmas Day. A holiday begins at 12:00 am and ends at 12:00 midnight of that holiday day.
Other Insurance	If the beneficiary has other insurance, it must be reported on all claims to MDHHS.



10.1.A. REVENUE CODES/HCPCS CODES/MODIFIERS

When billing, the provider must use the appropriate codes. HCPCS codes/modifiers are located in the Healthcare Common Procedure Coding System manual. The Private Duty Nursing Reimbursement Rates Database, posted on the MDHHS website, outlines private duty nursing rates and applicable codes. (Refer to the Directory Appendix for website information.)

10.1.B. PAYMENT IN 15-MINUTE INCREMENTS

Private duty nursing is prior authorized and paid in 15-minute incremental units. When billing for services, the total number of units billed must not exceed the total number of units authorized for that month. Since 15-minute increments of care are authorized, only those units of care that entail a full 15 minutes of care may be billed.



SECTION 11 – HOSPICE CLAIM COMPLETION

This section contains information that should be used in conjunction with the NUBC Manual when preparing Hospice claims.

11.1 BILLING INSTRUCTIONS FOR HOSPICE CLAIM COMPLETION

- **Admission Date:** The Certification (start) date must be reported on every hospice claim. Use Occurrence Code 27 and the applicable date. Hospice claims submitted to MDHHS must be in date sequence order. Ensure payment is received for the initial hospice month prior to submitting claims for subsequent months.
- **Inpatient Respite Care:** "Occurrence Span Code" - include occurrence span code M2 and complete the "from and through" dates for an episode of inpatient respite care.
- **Core Based Statistical Area (CBSA):** "Value Codes" - include value code 61 in the value code field and report the CBSA number. Hospice claims must be reported with a valid CBSA code based on the location of the beneficiary receiving services.
- Use the Revenue Codes listed below:

Revenue Code	Description
0651	Routine Home Care I
0652	Continuous Home Care
0655	Inpatient Respite Care
0656	General Inpatient Care
0657	Physician Services
0658	Other Hospice I (Room & Board)
0659	Other Hospice Service – Facility Innovative Design Supplemental (FIDS) Bed

- Effective for dates of service on or after January 1, 2016, hospice routine home care is reimbursed as a two-tiered reimbursement rate:
 - A higher rate is paid for the first 60 days of hospice care
 - A decreased rate is paid for hospice days 61 and beyond

A day of hospice is counted when any level of hospice care is provided (i.e., Routine Home Care, Continuous Home Care, General Inpatient Care, and Inpatient Respite Care). If a beneficiary is discharged from hospice but the discharge is not due to death, and the individual returns to hospice within 60 days of the discharge, the hospice day count will resume from the point that the beneficiary left hospice. If a beneficiary is discharged from hospice but returns after more than 60 days have elapsed, the count will reset to day one and the higher hospice routine home care rate for days 1 to 60 will be reimbursed. The count of hospice days does not reset if the beneficiary transfers to a different hospice provider.



- To bill for room and board in a nursing facility, licensed hospice long-term care unit, or Ventilator Dependent Care Unit (VDCU), use Revenue Code 0658. Providers must bill their customary room and board rate and Medicaid pays the usual and customary rate or the Medicaid fee screen, whichever is less. Room and board is reimbursable on the day of discharge if the discharge is due to resident death or the resident is discharged from hospice but remains in the NF. NOTE: In order for the hospice provider to complete the hospice beneficiary's admission, the type of facility for the VDCU must be identified as a nursing facility in the Admission Information Section in CHAMPS and include the VDCU's NPI. When a beneficiary resides in a VDCU/Dialysis Unit under which the VDCU has a special agreement with Medicaid and elects hospice, a prior authorization (PA) number for hospice is not required.
- To bill for room and board in a nursing facility when the beneficiary resides in a Facility Innovative Design Supplemental (FIDS) bed, use Revenue Code 0659.
- Revenue Code 0657 Physician Services requires inclusion of a HCPCS code on the claim line. Each Physician service must be billed on a separate claim line.
- Revenue Code 0652 Continuous Home Care must be billed for each date of service on separate claim lines. To receive the Continuous Home Care rate under code 0652, a minimum of 8 hours of care, not necessarily consecutive, in a 24-hour period is required. Less than 8 hours is reported under code 0651. A portion of an hour counts as an hour for this determination.
- Hospital Leave Days must be billed using Revenue Code 0185 (must not exceed 10 consecutive days). Reimbursement is at 100 percent of class-wide Nursing Facility Hospital Leave Day rate for qualifying facilities.
- Therapeutic Leave Days must be billed using Revenue Code 0183 (must not exceed 18 total days for the year) or Revenue Code 0189, Therapeutic Leave Days, for a beneficiary in a Facility Innovative Design Supplemental (FIDS) bed. Reimbursement is at 95 percent of Nursing Facility rate for leave days.
- Hospice services are reimbursable for day of discharge if services were rendered, regardless of the setting in which the services were provided. (See first bullet for instructions regarding room and board.)
- When billing for a hospice/NF resident who has been approved for complex care, bill revenue code 0120 and include the assigned PA number in F.L. 84, as obtained from the NF.
- Billing for Service Intensity Add-on (SIA): Effective for dates of service on and after January 1, 2016, the SIA rate will be reimbursed for a minimum of 15 minutes but not more than four hours daily during the last seven days of a beneficiary's life for in-person visits made by a Registered Nurse (RN) and/or Social Worker when the beneficiary is receiving routine home care. However, the total of combined time rendered by an RN and Social Worker will not be reimbursed more than four hours per day. For example, if an RN provides three hours of care and a Social Worker provides two hours during a given day, four hours will be reimbursed. The following items must be documented on the claim in order for the SIA to be paid:
 - Occurrence Code 55 with date of death
 - Appropriate discharge status code for death



- Revenue Codes and Healthcare Common Procedure Coding System (HCPCS) combinations representative of the RN or Social Worker visit:
 - RN: 0551 and G0299
 - Social Worker: 0561 and G0155
- Time of visit(s) recorded in units for the respective RN or Social Worker visit(s); one unit equals 15 minutes

The Michigan Medicaid program, including Medicaid Health Plans (MHPs) and MICHild, as well as CSHCS, covers hospice care for children under 21 years of age concurrently with curative treatment of the child's terminal illness when the child qualifies for hospice as described in the Hospice Chapter of this manual. Hospice services and curative treatment are billed and reimbursed separately under this policy. Prior to billing, it is important that providers differentiate between services that are palliative and therefore included in hospice reimbursement, and those that are curative and separately reimbursable under Medicaid. Each child's circumstances will need to be taken into consideration when making this distinction. Caution should be taken to avoid billing both the hospice and Medicaid for the same service as this represents double billing and may constitute fraud.

11.2 APPLICATION OF THE PATIENT-PAY AMOUNT

CHAMPS handles the Patient-Pay Amount (PPA) in the following manner: When a beneficiary has a monthly PPA and a corresponding nursing facility and hospice PET (i.e., HOS-NFAC), the PPA will be deducted from the first claim received in CHAMPS. The PPA will be deducted from the first claim received in CHAMPS resulting in deduction of the higher PPA amount. If the PPA is greater than the amount of the first submitted claim, the difference will be applied to subsequent claims until the total PPA for that month is met. The PPA must be exhausted each month before any Medicaid payment will be made. The nursing facility and hospice must bill in sequence according to the location of the beneficiary at the first of the month. This will prevent the PPA from being deducted from the wrong claim.

Providers have the ability to verify the PPA on the Member Eligibility Detail page in CHAMPS.

The following examples are provided for application of the patient-pay amount (PPA).

Example 1: The beneficiary resides in a NF but is not receiving Medicaid hospice benefits. The beneficiary has a PPA of \$500. The room and board for the NF is \$125. The NF collects \$500 from the beneficiary and provides the beneficiary with a receipt.

Example 2: The beneficiary resides in a NF and elects the Hospice benefit at the beginning of the month. The beneficiary has a PPA of \$500. The hospice or the NF collects the \$500 PPA from the beneficiary and applies it to the hospice room and board rate which includes the daily QAS amount (\$150 which is \$125 [NF rate] + \$25 [QAS]). The hospice or the NF provides the beneficiary with a receipt.

Example 3: The beneficiary resides in a NF for the first two days of the month before electing the Hospice benefit. The beneficiary's PPA is \$500. The NF collects the \$500 from the beneficiary, applies \$250 from the PPA (the NF rate of \$125) toward the room and board owed the NF, and passes \$250 on to the hospice. The hospice then bills, showing on its claim the \$250 PPA balance available to be applied to the hospice room and board rate. The NF provides the beneficiary with a receipt.



11.3 OFFSET TO PATIENT-PAY AMOUNT FOR NONCOVERED SERVICES

NOTE: This section does not pertain to Pre-Eligibility Medical Expenses (PEME). PEME must not be reported on the claim. (Refer to the Directory Appendix for PEME contact information.)

Claims containing an offset to patient-pay amounts cannot be split-billed. The hospice must submit one claim for the particular month of service.

The offset for the noncovered service must be reported on the claim using the appropriate value code and F.L. 39 and the related dollar amount. Only value codes for Michigan Medicaid noncovered services will be activated for approval through CHAMPS.

The dollar amount of Value Code D3, minus Estimated Responsibility Patient (patient-pay amount), is the beneficiary's monthly patient-pay amount MINUS the dollar amount of the offset.

The total of D3 and the offset must equal the beneficiary patient-pay amount for that given month.

Offsetting the patient-pay amount may involve more than one month. For example, the beneficiary may have a patient-pay amount of \$200 per month. The amount to be offset is \$500. The amount to be offset would involve a three-month period. The first month claim would indicate \$200 as an offset with D3 as zero. The second month claim would indicate \$200 as an offset with D3 as zero. The third month claim would indicate \$100 as an offset with D3 as \$100.

11.3.A. CLAIM DOCUMENTATION REQUIREMENTS WHEN OFFSETTING THE PATIENT-PAY AMOUNT

Documentation must accompany the claim when offsetting the patient-pay amount with Value Codes 25, 26, 27, 28, 29, 33, or 34. Refer to the NUBC website for additional information. (Refer to the Directory Appendix for website information.)

Documentation Requirements	<p>The documentation that must accompany the claim includes the specific reason that the patient-pay amount is being offset, a detailed description of the specific item or service that is offset, and receipt showing that the beneficiary paid for the Medicaid non-covered service.</p> <p>The hospice provider must upload the documentation to the Document Management Portal (DMP). The hospice provider is responsible for a successful upload of the documentation. This tool enables providers to electronically submit supporting documentation for Medicaid claims. A review guide for the DMP is available on the MDHHS website. (Refer to the Directory Appendix for website information.)</p> <p>Note: The hospice provider must report in the Note section of the claim that documents have been uploaded to the DMP.</p>
Claims Processing	<p>There will be a change in the processing of claims when the above Value Codes are reported. Claims will suspend for review of the submitted documentation. Claims submitted with no documentation will be rejected.</p>



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MI Health Link	For beneficiaries enrolled in the MI Health Link program, the hospice provider must still collect and maintain patient-pay amount offset information according to policy. Hospice providers will not be required to submit this information to MDHHS for the months in which a beneficiary is enrolled in MI Health Link. Hospice providers should continue to abide by their individual contracts with the Integrated Care Organizations (ICOs) as it relates to reporting patient-pay amount offsets when a beneficiary is enrolled in MI Health Link.
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11.4 PATIENT-PAY AMOUNT GREATER THAN AMOUNT BILLED

Hospices must bill Medicaid even if the patient-pay amount is greater than the amount billed to Medicaid. Medicaid requires that a claim be billed so it can obtain particular information off the claim for statistical purposes.



SECTION 12 – REMITTANCE ADVICE

A Remittance Advice (RA) is produced to inform providers about the status of their claims. RAs are available in paper and electronic formats, and utilize the HIPAA-compliant national standard claim adjustment group codes, claim adjustment reason codes, and remarks codes, as well as adjustment reason codes, to report claim status. Code definitions are available from the Washington Publishing Company. (Refer to the Directory Appendix for contact information.)

12.1 PAYMENT PROCESS

MDHHS processes claims and issues payments (by check or EFT) every week unless special provisions for payments are included in the provider's enrollment agreement. A RA is issued with each payment to explain the payment made for each claim. If no payment is due or claims have rejected, an RA is also issued. If claims are not submitted for the current pay cycle or no gross adjustments are processed in the pay cycle, an RA is not generated.

If a claim does not appear on an RA within 60 days of submission, a new claim should be submitted. Providers should verify that the provider NPI number and beneficiary ID number are correct. Submitting claims prior to the end of the 60-day period may result in additional delays in claims processing for payment.

Payments to providers are issued by Tax Identification Number (TIN). All payments due to all providers enrolled with MDHHS under a specific TIN are consolidated and issued as one check or EFT.

Providers who would like to receive payments from MDHHS through EFT must register through the DTMB website. (Refer to the Directory Appendix for DTMB website information.)

12.2 ELECTRONIC REMITTANCE ADVICE

The electronic RA is produced in the HIPAA-compliant ASC X12N 835 5010 format. Providers opting to receive an electronic RA receive all information regarding adjudicated (paid or rejected) claims in this format.

The electronic RA (835) has many advantages:

- It can serve to input provider claim information into the provider's billing and accounting systems;
- It includes a MDHHS trace number to identify the associated warrant or electronic funds transfer (EFT) payment;
- It returns the provider's internal medical record number, line item control number, and patient control number when submitted on the original claim; and
- It contains additional informational fields not available on the paper RA.

The 835 transaction corresponds to one payment device (check or EFT). All claims associated with a single TIN processed in a weekly pay cycle report on a single 835, regardless of how the claims were submitted (e.g., some paper, some electronic, multiple billing agents, etc.). Providers choosing to receive the 835 transaction must authorize a billing agent to receive the 835 per TIN. An addition of and/or



change to the identification of the billing agent for the provider's 835 must be changed through their CHAMPS enrollment application.

For more information regarding the 835 transactions issued by MDHHS, refer to the MDHHS 835 Companion Documents (Data Clarification Documents) on the MDHHS website. For general information about the 835, refer to the Implementation Guides for these transactions. The guides are available through the Washington Publishing Company. (Refer to the Directory Appendix for contact information.)

12.3 PAPER REMITTANCE ADVICE

A paper RA is generated for all providers and/or billing agents who submit and process claims through CHAMPS. The RA is available online or is sent to providers only if requested through the CHAMPS PE subsystem. The RA contains three main sections: cover sheet, summary page, and detail page(s). Refer to the Forms Appendix for a sample copy of a Remittance Advice.

12.4 GROSS ADJUSTMENTS

Gross adjustments are initiated by MDHHS. A gross adjustment may pertain to one or more claims. Providers are notified in writing when adjustments are made to claims. Notification should be received before the gross adjustment appears on the RA.

The paper RA indicates gross adjustments have been made by:

- **Adjustment Reason Code:** Indicates the reason for the debit or credit memo or adjustment to payment. Standard Adjustment Reason Codes are used. Code definitions can be found in the 835 Implementation Guide.
- **Gross Adjustment Code:** This is the MDHHS gross adjustment code that corresponds to the gross adjustment description.

12.5 CLAIM ADJUSTMENT REASON/REMARK CODES

When a claim is initially processed, the Claim Adjustment Reason/Remark column on the RA identifies which service lines have been paid or rejected and lists edits which apply.

If a service line is rejected, a Claim Adjustment Reason/Remark code prints in the Claim Adjustment Reason/Remark column of the RA. Providers should review the definition of the codes to determine the reason for the rejection.



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SECTION 13 - JULIAN CALENDAR [CHANGE MADE 10/1/20]

Day Month	January	February	March	April	May	June	July	August	September	October	November	December
1	1	32	60	91	121	152	182	213	244	274	305	335
2	2	33	61	92	122	153	183	214	245	275	306	336
3	3	34	62	93	123	154	184	215	246	276	307	337
4	4	35	63	94	124	155	185	216	247	277	308	338
5	5	36	64	95	125	156	186	217	248	278	309	339
6	6	37	65	96	126	157	187	218	249	279	310	340
7	7	38	66	97	127	158	188	219	250	280	311	341
8	8	39	67	98	128	159	189	220	251	281	312	342
9	9	40	68	99	129	160	190	221	252	282	313	343
10	10	41	69	100	130	161	191	222	253	283	314	344
11	11	42	70	101	131	162	192	223	254	284	315	345
12	12	43	71	102	132	163	193	224	255	285	316	346
13	13	44	72	103	133	164	194	225	256	286	317	347
14	14	45	73	104	134	165	195	226	257	287	318	348
15	15	46	74	105	135	166	196	227	258	288	319	349
16	16	47	75	106	136	167	197	228	259	289	320	350
17	17	48	76	107	137	168	198	229	260	290	321	351
18	18	49	77	108	138	169	199	230	261	291	322	352
19	19	50	78	109	139	170	200	231	262	292	323	353
20	20	51	79	110	140	171	201	232	263	293	324	354
21	21	52	80	111	141	172	202	233	264	294	325	355
22	22	53	81	112	142	173	203	234	265	295	326	356
23	23	54	82	113	143	174	204	235	266	296	327	357
24	24	55	83	114	144	175	205	236	267	297	328	358
25	25	56	84	115	145	176	206	237	268	298	329	359
26	26	57	85	116	146	177	207	238	269	299	330	360
27	27	58	86	117	147	178	208	239	270	300	331	361
28	28	59	87	118	148	179	209	240	271	301	332	362
29	29	--	88	119	149	180	210	241	272	302	333	363
30	30	--	89	120	150	181	211	242	273	303	334	364
31	31	--	90	---	151	---	212	243	---	304	---	365



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For leap year, one day must be added to the number of days after February 28. The next three leap years are 2024, 2028 and 2032. **(revised 10/1/20)**

Example: Transaction Control Number (TCN) 211215010000189001 – Header TCN always ends in 000
Position 1: "2" – DDE Web Submission
Position 2: "1" – FFS Claim
Positions 3-7: "12150" – YY = 12 (for 2012) + 3-digit Julian date = "150" (May 29)
Position 8: "1" – Original Claim
Positions 9-15: "0000189" – Sequence Number
Positions 16-18: "001" – Line Number. Will begin with 001 for every new claim and increment by 1 for each claim line. Any replacement or voids claim, use the header TCN. Header TCN always ends in 000 (211215010000189000).



BILLING & REIMBURSEMENT FOR PROFESSIONALS

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SECTION 1 - GENERAL INFORMATION

This chapter applies to all providers billing the CMS-1500 or 837 Professional claim formats. It contains information needed to submit professional claims to the Michigan Department of Health and Human Services (MDHHS) for Medicaid programs and Children's Special Health Care Services (CSHCS). It also contains information about how claims are processed and how providers are notified of MDHHS actions.

The following providers must use the ASC X12N 837 5010 professional format when submitting electronic claims and the CMS 1500 claim form for paper claims.

- Advanced Practice Registered Nurses (APRNs), including Certified Nurse Practitioners (NPs), Certified Clinical Nurse Specialists (CNSs), Certified Nurse-Midwives (CNMs)
- Ambulance
- Ambulatory Surgical Centers
- Anesthesiologist Assistants
- Certified Registered Nurse Anesthetists
- Chiropractors
- Community Mental Health Services Programs/Prepaid Inpatient Health Plans
- Family Planning Clinics
- Federally Qualified Health Centers
- Hearing Aid Dealers
- Hearing Centers
- Independent Diagnostic Testing Facilities
- Independent Laboratories
- Indian Health Centers
- Maternal Infant Health Program
- Medical Clinics
- Medical Suppliers
- Optical Companies
- Optometrists
- Oral-Maxillofacial Surgeons
- Orthotists and Prosthetists
- Physician Assistants
- Physical Therapists
- Physicians (MD & DO)
- Podiatrists
- Portable X-ray Suppliers
- Private Duty Nurses (Individually Enrolled)
- Rural Health Clinics
- School Based Services
- Shoe Stores
- Urgent Care Centers

Claims for services rendered as a result of an order or referral must contain the name and individual NPI of the provider who ordered or referred the service/item. The following are the authorized health professionals who may order, prescribe or refer services to Medicaid beneficiaries:

- Physician
- Physician Assistant
- Advanced Practice Registered Nurse
- Dentist
- Podiatrist
- Optometrist
- Chiropractor (limited to spinal x-rays only)

Examples of services that require an order, prescription or referral include, but are not limited to,:

- Ambulance non-emergency transports



- Ancillary services for beneficiaries residing in nursing facilities (e.g., chiropractic, dental, podiatry, vision)
- Childbirth/parenting and diabetes self-management education
- Consultations
- Diagnostic radiology services, unless rendered by the ordering physician
- Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS)
- Hearing and hearing aid dealer services
- Home health services
- Hospice services
- Independent Diagnostic Testing Facilities
- Laboratory services
- Certain mental health and substance abuse children's waiver services
- Certain Maternal Infant Health Program (MIHP) services
- Pharmacy services
- Portable X-ray Suppliers
- Private Duty Nursing services
- Certain School Based Services
- Therapy services (occupational therapy (OT), physical therapy (PT) and speech)
- Certain vision supplies

1.1 CLAIMS PROCESSING SYSTEM

All claims submitted and accepted are processed through CHAMPS. Paper claims are scanned and converted to the same file format as claims submitted electronically.

Claims processed through CHAMPS are edited for many parameters, including provider and beneficiary eligibility, procedure validity, claim duplication, frequency limitations for services, and a combination of service edits. MDHHS uses the Medicaid National Correct Coding Initiative (NCCI) policies and edits. (Refer to the Directory Appendix for resource information.)

MDHHS encourages providers to send claims electronically. (Refer to the Electronic Submission Manual on the MDHHS website for additional information. Refer to the Directory Appendix for website information.) Electronic filing is more cost effective, more accurate, payment is received more quickly, and administrative functions can be automated. Electronic claims filed by Wednesday may be processed as early as the next weekly cycle.

1.2 PREDICTIVE MODELING

Predictive modeling, a pre-payment claims process in CHAMPS, uses advanced screening technology to identify Medicaid claims with billing irregularities. Claims flagged by the predictive modeling process will undergo a detailed analysis to determine the next step(s) to be taken. This may include a review of



medical records and/or past claims. Providers must submit the requested records within 45 days of the date on the request for documents letter to avoid denials for lack of documentation. Records should not be submitted prior to receiving a request for documentation letter.

Requested records must be submitted through the Document Management Portal available in CHAMPS. Refer to:

- the MDHHS website for information and tutorials on the Document Management Portal.
- the Directory Appendix for Document Management Portal website information.

1.3 CLAIM PAYMENT/CLAIM STATUS

Once claims have been submitted and processed through CHAMPS, an electronic health care claim payment/advice (ASC X12N 835 5010) is sent to the designated service bureau for providers choosing an electronic RA. The CHAMPS RA is also available to providers online or is sent to providers via paper if requested through the Provider Enrollment Subsystem. (Refer to the Remittance Advice Section of this chapter for additional information about both the electronic and paper RA.)

To receive information on suspended claims, a provider-initiated 276 claim status request must be submitted and a 277 claim status response will be returned. Providers have the option to receive information on suspended claims via the CHAMPS claims inquiry screens as well.

1.4 ELECTRONIC FUNDS TRANSFER

Electronic Funds Transfer (EFT) is the method of direct deposit of State of Michigan payments into a provider's bank account. This replaces a paper warrant. To initiate an EFT, the facility should go to the Department of Technology, Management & Budget (DTMB) website. (Refer to the Directory Appendix for website information.)



SECTION 2 - HOW TO FILE CLAIMS

Professional claims may be submitted electronically or on paper. Electronic claim submission is the preferred method for submitting claims to MDHHS.

2.1 ELECTRONIC CLAIMS

Claims submitted electronically and accepted are received directly into CHAMPS, which results in faster payments and fewer claims that suspend or reject. (Refer to the Electronic Submission Manual on the MDHHS website for additional information. Refer to the Directory Appendix for website information.) Providers submitting claims electronically must use the ASC X12N 837 5010 professional format. The payroll cut-off for electronic claims submission to MDHHS is Wednesday of each week.

Complete information on submission of electronic claims is available on the MDHHS website. (Refer to the Directory Appendix for website information.) The MDHHS Electronic Submission Manual and other resources, such as the Companion Guides, are on the website. Information on the website is updated as version changes occur at the national level and are adopted by MDHHS.

2.1.A. AUTHORIZED BILLING AGENTS

Any entity (service bureau or individual provider) wishing to submit claims electronically to MDHHS must enroll as an authorized billing agent. The Provider Enrollment Section of the General Information for Providers Chapter and the Trading Partners portion of the MDHHS website contain information related to the application and billing agent authorization process. (Refer to the Directory Appendix for website information.)

More than one billing agent per provider can be authorized to submit the provider's claims electronically. However, only one electronic billing agent may be the designated receiver of the electronic health care claim payment/advice ASC X12N 835 5010. Authorizations remain in effect until changed by the provider through the CHAMPS Provider Enrollment subsystem.

Any individual provider can submit claims electronically as long as the authorization process is completed and approved; however, many providers find it easier to use an existing authorized billing agent to submit claims to MDHHS. Billing agents prepare claims received from their clients, format to HIPAA compliant MDHHS standards, and submit the files to MDHHS for processing. Whether claims are submitted directly or through another authorized billing agent, providers receive a paper remittance advice (RA) that reflects their individual claims. Billing agents receive an RA that contains information on all the claims the agent submitted.

For more information on becoming an electronic biller or for a list of authorized billing agents, contact the Automated Billing Unit. (Refer to the Directory Appendix for contact information.)



2.1.B. ELECTRONIC CLAIMS WITH ATTACHMENTS

The Document Management Portal (DMP) 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 MDHHS website for information and tutorials on the Document Management Portal. Refer to the Directory Appendix for website information.)

If comments or additional information are required with an electronic claim, electronic submitters must enter the information in the appropriate segments of the electronic record. If an operative report or other paper attachment is required, providers must use the Document Management Portal to submit electronic attachments to MDHHS. Within the Document Management Portal, the appropriate documentation category must be chosen along with completing specified information to successfully enter the document. MDHHS does not accept paper documentation via mail for any electronic claim. The Document Management Portal allows MDHHS to communicate directly with providers to resolve claim attachment issues prior to finalizing claim adjudication.

Consent forms (Consent for Sterilization [MSA-1959/HHS-687] and Acknowledgement of Receipt of Hysterectomy Information [MSA-2218]) must be submitted through the Document Management Portal. (Refer to the Forms Appendix for copies of the forms and to the Directory Appendix for website information.) MDHHS will notify the submitter of the status of their consent review within seven business days. Once the consent forms are approved and entered, it is not necessary to submit additional copies when billing for sterilization or hysterectomy services. All consent forms must be submitted through the Document Management Portal.

Electronic submitters must:

- Include the notation "Documents uploaded in DMP" in the Claim Note area (NTE02 Segment, Loop 2300) and Reference Code "ADD" (NTE01 Segment, Loop 2300) within the electronic claim.
- Comply with all standard HIPAA reporting requirements, including using Claim Adjustment Segment (CAS) codes when submitting secondary or tertiary claims.

Refer to the MDHHS website for Document Management Portal instructions. (Refer to the Directory Appendix for website information.)

2.2 PAPER CLAIMS

The CMS-1500 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.)

Claims may be prepared on a typewriter or on a computer. Handwritten claims are not accepted. Because claims are optically scanned, print or alignment problems may cause misreads thus delaying processing of the claim. Keep equipment properly maintained to avoid the following:



- Dirty print elements with filled character loops
- Light print or print of different density
- Breaks or gaps in characters
- Ink blotches or smears in print
- Worn out ribbons

Dot matrix printers should not be used as they result in frequent misreads by the OCR.

Questions and/or problems with the compatibility of equipment with MDHHS scanners should be directed to MDHHS Provider Inquiry. (Refer to the Directory Appendix for contact information.)

Paper claims should appear on a remittance advice (RA) within 60 days of submission. Do not resubmit a claim prior to the 60-day period.

2.2.A. GUIDELINES TO COMPLETE PAPER CLAIM FORMS

To assure that the scanner correctly reads claim information, adhere to the following guidelines in preparing paper claims. Failure to do so can result in processing/payment delays or claims being returned unprocessed.

- Dates must be either the eight-digit format (MMDDCCYY) or the six-digit format (MMDDYY) without dashes or slashes as instructed by the NUCC manual. Be sure the dates are within the appropriate fields on the form.
- Use only black ink.
- Do not write or print on the claim, except for the Provider Signature Certification.
- Handwritten claims are not acceptable.
- UPPER CASE alphabetic characters are recommended.
- Do not use italic, script, orator, or proportional fonts.
- 12-point type is preferred.
- Make sure the type is even (on the same horizontal plane) and within the boxes.
- Do not use punctuation marks (e.g., commas or periods).
- Do not use special characters (e.g., dollar signs, decimals, or dashes).
- Only service line data can be on a claim line. Do not squeeze comments below the service line.
- Do not send damaged claims that are torn, glued, taped, stapled, or folded. Prepare another claim.
- Do not use correction fluid or correction tape, including self-correcting typewriters.



- If a mistake is made, start over and prepare a clean claim form.
- Do not submit photocopies.
- Claim forms must be mailed flat, without folding, in 9" x 12" or larger envelopes. Do not fold the form.
- Put your return address on the envelope.
- Separate the claim form from the carbon.
- Separate each claim form if using the continuous forms and remove all pin drive paper completely. Do not cut edges of forms.
- Keep the file copy.
- Mail CMS 1500 claim forms separately from any other claim form type.

2.2.B. PROVIDING ATTACHMENTS WITH PAPER CLAIMS

When a claim attachment is required, it must be directly behind the claim it supports and be identified with the beneficiary's name and Medicaid ID number. Attachments must be on 8 ½" x 11" white paper and one-sided. Do not submit two-sided materials. Multiple claims cannot be submitted with one attachment. Each claim form that requires an attachment must have a separate attachment. Do not staple or paperclip the documentation to the claim form.

Mail claim forms with attachments flat, with no folding, in a 9" x 12" or larger envelope and print "Ext. material" (for extraneous material) on the outside. Do not put claims without attachments in this envelope. Mail claims without attachments separately. Do not send attachments unless the attachment is required as unnecessary attachments delay processing of claims.

Claim attachments, such as medical records and EOBs, may be associated to a paper claim via the Document Management Portal. (Refer to the Directory Appendix for website information.)

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 Document Management Portal" must be included in the Remarks section of the paper claim.

Refer to the MDHHS website for Document Management Portal instructions, including fax requirements. (Refer to the Directory Appendix for website information.)

2.2.C. MAILING PAPER CLAIMS

All paper claim forms and claim forms with attachments must be mailed to MDHHS. (Refer to the Directory Appendix for contact information.)



2.3 REPORTING PROVIDER NPI

MDHHS requires that NPI numbers be reported in any applicable provider loop or field (e.g., billing, referring/ordering, rendering and supervising) on the claim. A provider's Taxpayer Identification Number (TIN) will also be used for claim adjudication. The TIN reported is either the provider's Employer Identification Number (EIN) or Social Security Number (SSN). The TIN reported is either the provider's Employer Identification Number (EIN) or Social Security Number (SSN). For a Type 2 (Group) NPI, both the NPI and EIN must be reported at the billing provider loop for all electronic claims. For a Type 1 (Individual) NPI, both the NPI and EIN/SSN are required at the billing provider loop for electronic claims when a Type 2 NPI does not apply.

A Type 1 (Individual) NPI is the number associated with an individual healthcare professional (e.g., MD, DDS, CRNA, etc.). The individual may be a sole proprietor or be employed by a clinic, group practice, or other organization. If a sole proprietor, the Type 1 NPI must be reported in the billing provider loop or field of the claim for payment.

A Type 2 (Group) NPI is the number required for organizations (such as clinics, group practices, and incorporated individuals) who provide healthcare services and receive payment. For MDHHS, the Group NPI must be reported in the billing provider loop or field. Also for dental and professional claims, the appropriate Type 1 (Individual) NPI of the specific provider performing the service must be reported in the rendering provider loop or field for proper claim adjudication. Do not enter the Type 2 (Group) NPI as the rendering provider.

MDHHS NPI claim editing will be applied to the billing, referring/ordering, rendering, and supervising provider, as applicable. A claim cannot be paid if the NPI is missing or the reported NPI is invalid as it does not check digit and/or correctly crosswalk to the Provider Enrollment files for these provider loops or fields.

2.3.A. BILLING PROVIDER

The billing provider loop or field is mandatory to complete on all claims. The billing provider must be enrolled with the program for payment. If the billing provider NPI reported is an invalid number and/or represents a non-enrolled provider, the entire claim will be denied for payment.

2.3.B. RENDERING PROVIDER

For claims requiring a rendering provider, the loop or field is mandatory. The rendering provider must be enrolled with the program for payment. If the rendering provider information is not reported on the claim, or if the provider is not enrolled in the Michigan Medicaid program, the claim cannot be paid. Claims for services rendered by non-physician practitioners (e.g., physician assistants and nurse practitioners) must be billed under the non-physician practitioner's NPI and include the NPI of the supervising physician as applicable.

School-Based Services providers are exempt from this requirement and are not required to provide rendering NPIs on their claims.



2.3.C. REFERRING/ORDERING PROVIDER

Referring/ordering provider information is a claim submission requirement for all services rendered as a result of a referral/order. The claim must contain the name and individual NPI of the provider who referred/ordered the service(s)/item(s).

If the referring/ordering provider information is not reported on the claim, or if the provider is not enrolled in the Michigan Medicaid program, the claim cannot be paid.

Rendering providers should ensure their referral sources are aware of this requirement.

2.3.D. SUPERVISING PROVIDER

The supervising physician NPI is a claim editing requirement which must be included on claims when physician services are rendered by an enrolled non-physician practitioner, such as a physician's assistant or advanced practice registered nurse. Physician supervision and oversight must be consistent with Michigan Public Act 368 of 1978, as amended. The supervising physician must be enrolled with the program.



SECTION 3 - CLAIM COMPLETION

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.)



SECTION 4 - REPLACEMENT, VOID/CANCEL CLAIMS AND REFUND OF PAYMENT

4.1 REPLACEMENT CLAIMS (ADJUSTMENTS)

A replacement claim must be submitted when all or a portion of the claim was paid incorrectly or a third party payment was received after MDHHS made payment. When a replacement claim is received, MDHHS deletes the entire original claim and replaces it with the information contained on the replacement claim. All money paid on the original claim is debited and a new payment is issued based solely on information reported on the replacement claim.

Replacement claims should be submitted to:

- return an overpayment. (Provide an explanation of the reason for the overpayment in Remarks section.)
- correct information submitted on the original claim (other than to correct a provider NPI and/or beneficiary ID number). (Provide an explanation of what information is being corrected. Refer to the Void/Cancel Claims subsection below to correct errors related to a provider NPI and/or beneficiary ID number.)
- report payment from another source after MDHHS paid the claim. (Report the source of the payment (e.g., OI, Medicare, etc.) in the Remarks section.)
- correct information that the scanner misread (except a provider NPI or beneficiary ID number). (State reason in the Remarks section. Refer to the Void/Cancel Claims subsection below to correct provider NPI or beneficiary ID number errors.)

All claim completion instructions apply to completing a replacement claim. In addition:

- The provider NPI number and the beneficiary ID number on the replacement claim must be the same as on the original claim.
- Resubmission code 7 must be entered in the left side of Item 22 and the 18-digit Transaction Control Number (TCN) of the previously paid claim in the right side of Item 22. If either the resubmission code of 7 or the original CRN is missing, the claim cannot be processed as a replacement claim.
- To replace a previously paid claim adjudicated with a Claim Reference Number (CRN) prior to October 1, 2007, both the Medicaid legacy provider ID number and the NPI must be reported on the replacement claim for successful adjudication.

If all service lines of a claim were rejected, the services must be resubmitted as a new claim, not a replacement claim.



4.2 VOID/CANCEL CLAIMS (ADJUSTMENTS)

A void/cancel claim must be submitted when a claim was paid under an incorrect provider NPI or beneficiary ID number. When void/cancel claims are received, MDHHS deletes the original claim and all money paid on the claim is debited.

When submitting a void/cancel claim:

- The provider NPI number and beneficiary ID number must be the same as on the original claim.
- To void/cancel an original claim adjudicated with a Claim Reference Number (CRN) prior to October 1, 2007, both the correct Medicaid legacy provider ID number and NPI must be reported along with the correct beneficiary ID number.
- Resubmission code 8 must be entered in the left side of Item 22 and the TCN of the previously paid claim in the right side of Item 22. If the resubmission code of 8 or the original TCN is missing, the claim cannot be processed as a void/cancel claim.

All claim completion instructions apply for completing a void/cancel claim except as noted below:

- Complete one service line and enter zero dollars (000) in all money fields. The entire payment made on the first claim will be debited. A new claim may then be submitted using the correct beneficiary ID.

After the void/cancel claim is submitted, a new claim containing the correct provider NPI and/or beneficiary ID number may be submitted.

The MDHHS 12-month timely filing billing limitation policy applies to void/cancel claims. Refer to the Timely Filing Billing Limitation subsection of the General Information for Providers Chapter for additional information.

4.3 REFUND OF PAYMENT

Return of overpayments made by MDHHS, due to either payment from a third-party resource or due to an error, must be done through the use of a replacement claim or void/cancel claim. This process will result in a debit against future payment.

This requirement does not apply to **inactive** providers or monies being returned to MDHHS due to settlements or lawsuits. In these situations, checks must:

- be made payable to the State of Michigan in the amount of the refund.
- include the provider EIN (tax) number.
- be sent to the MDHHS Cashier's Unit. (Refer to the Directory Appendix for contact information.)

A copy of the remittance advice corresponding to the original payment and/or a detailed statement explaining the reason for the return of the payment should accompany the check.



SECTION 5 - CHANGES IN ELIGIBILITY ENROLLMENT (FFS/MHP/CSHCS)

It is the provider's responsibility to determine eligibility/enrollment status of beneficiaries at the time services are provided and obtain the appropriate authorizations for payment.

Medicaid or Children's Special Health Care Services (CSHCS) beneficiaries may lose eligibility or change enrollment status on a monthly basis. Enrollment status changes include beneficiaries changing from FFS (Fee-For-Service Medicaid or CSHCS) to a MHP, from one health plan to another health plan, or from a health plan to FFS. Normally the change occurs at the beginning of a month; however, some changes may occur during the month. It is important that providers check beneficiary eligibility before each service is provided to determine who is responsible for payment and whether authorization is necessary. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.)

5.1 INPATIENT HOSPITAL ADMISSIONS AND SERVICES

The following guidelines are intended to assist providers and health plans regarding authorization of services and payment responsibility, particularly when a change in enrollment status has occurred.

- All admissions (other than emergency admissions) require authorization. All medical/surgical (nonpsychiatric) admissions must be authorized by MDHHS or its Admissions and Certification Review Contractor (ACRC) or by the Health Plan the beneficiary is enrolled in at the time of the admission. The local Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) must authorize all psychiatric admissions.
- Services provided during the admission may also require authorization for health plan enrollees. Providers must be aware of the beneficiary's enrollment status and of health plan requirements and processes for authorization. Consultations, surgical procedures, and diagnostic tests may not be reimbursed unless a health plan's authorization process is followed.
- If a beneficiary is admitted by the local PIHP/CMHSP, the admission and all psychiatric services are the responsibility of the PIHP/CMHSP. However, any nonpsychiatric medical/surgical services needed during a psychiatric admission are the responsibility of the health plan and must be authorized by the health plan. This includes transportation to another facility for medical/surgical services. If a beneficiary is admitted for medical/surgical services authorized by the health plan and needs psychiatric consultation or care, the PIHP/CMHSP must be contacted for authorization and is then responsible for payment for the psychiatric services once authorization has been obtained.
- If a beneficiary is admitted to an inpatient hospital facility and the enrollment status changes during the admission, payment for all services provided until the date of discharge are the responsibility of the payer at the time of admission. Services provided after discharge are the responsibility of the new payer. Discharge planning should include the new payer for authorization of any medically necessary services or treatments required after discharge from the hospital.
- If a beneficiary is transferred from one inpatient hospital to another inpatient hospital, this does not constitute a discharge. The payer at admission is the responsible party until the beneficiary is discharged from the inpatient hospital setting to a nonhospital setting.



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The following examples illustrate payment responsibilities:

FFS to Health Plan	A FFS beneficiary is admitted to the hospital on September 15, enrolled in a health plan on October 1, and discharged from the hospital on October 5. The health plan is not responsible for services until October 5, after discharge. FFS is responsible for the entire admission and physician services provided during the admission. The health plan must be contacted at discharge to transition care needs and authorize services needed after discharge such as rental of equipment, ongoing medical supply needs, ongoing treatment (e.g., home health care, physical therapy, chemotherapy, IV infusion), etc.
Health Plan to Health Plan	If a beneficiary is in health plan "A" during September and changes to health plan "B" for October, health plan "A" is responsible for the admission. Health plan "B" must be contacted during the discharge planning process and is responsible for authorizing all services needed after discharge.
Health Plan to Health Plan with Transfer to a Tertiary Hospital	A beneficiary enrolled in health plan "A" is admitted for authorized surgery in June. The beneficiary is enrolled in health plan "B" on July 1. After surgery, the patient develops complications necessitating a transfer to a tertiary hospital on July 2. The beneficiary is subsequently discharged to home on July 6. Plan "A" is responsible for all hospital and physician services through July 6, and plan "B" is responsible for all services needed after discharge.
Hospitalization for Medical Reasons During an Inpatient Psychiatric Stay	A health plan beneficiary is admitted for inpatient psychiatric care by a PIHP. During the admission, the beneficiary requires surgery for medical reasons at another facility. The beneficiary's health plan must authorize the surgery and is responsible for paying for transport between the facilities and for charges related to the surgery.

CSHCS Exceptions:

- Prior to October 1, 2012, beneficiaries with CSHCS coverage were excluded from enrollment in a MHP and the following applied:
 - When a beneficiary was enrolled in CSHCS, he/she was disenrolled from the MHP.
 - Upon review, MDHHS may have initiated a retroactive disenrollment from the MHP effective the first day of the month in which CSHCS medical eligibility was determined.
 - Responsibility of payment transferred from the MHP to FFS on the effective date of the disenrollment.
- After October 1, 2012, Medicaid beneficiaries who become eligible for CSHCS who are enrolled in an MHP will no longer be disenrolled from the MHP.

Providers are advised to check the eligibility response for changes in enrollment status prior to billing. (Refer to the Beneficiary Eligibility Chapter for additional information.)

5.2 ONGOING SERVICES AND EXTENDED TREATMENT PLANS

Providers are responsible for verifying a beneficiary's eligibility/enrollment status before each service is rendered, particularly on the first day of a new month. Even though a beneficiary may be involved in an ongoing treatment or care plan, a change in enrollment status requires new authorization from the new



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responsible party. Enrollment in a health plan always triggers an authorization process. There is no requirement for a new health plan to reimburse providers for services that were authorized under a previous health plan with an exception for CSHCS/Medicaid beneficiaries with a Prior Authorization (PA) in place at the time of enrollment in the current health plan.

In order to preserve continuity of care, MHPs and Fee-For-Service (FFS) must accept PAs in place when the CSHCS/Medicaid beneficiary has a change in enrollment status. For CSHCS/Medicaid beneficiaries who have been in the FFS system and who have FFS PA in place at the time the MHP receives the enrollment file, MHPs are expected to honor the PA in place for 30 days after the effective date of enrollment. Full reciprocity is required between the party that originally authorized the service and the new payer for the first 30 days following the enrollment change. This includes accepting the approved provider, services, quantity limits, Medicaid rates and special rates, as well as other terms that have been negotiated for the beneficiary's care.

- The servicing provider is responsible for transmitting a copy of the previously approved PA to the new payer when there is a change in the beneficiary's enrollment status.
- If the prior authorized provider is not in the MHP network, the MHP must pay the out-of-network provider at the prior authorized rate for the first 30 days following the enrollment change. Providers may not bill FFS or the beneficiary for services covered by the MHP; the provider must bill the MHP.
- Providers must be enrolled with Medicaid to bill FFS. Providers may not bill the MHP or the beneficiary for services covered by Medicaid FFS; the provider must bill FFS.

For all other purposes, the health plan in which the beneficiary is enrolled must assess the need for continuing services and authorize as appropriate. Health plans should facilitate the transition between providers for all beneficiaries to ensure continuity of care.

In situations where a change in enrollment status occurs during a hospital admission, physician services provided during the admission are the responsibility of the payer for the admission.

The following are examples of situations that may occur while providing care to an eligible beneficiary.

FFS to Health Plan	A beneficiary is in FFS in June. On June 15, MDHHS authorizes a breast reconstruction after mastectomy for breast cancer. The surgery is scheduled for July 20. On July 1, the beneficiary is enrolled in a health plan with the same primary care provider and surgeon. The surgeon must follow the health plan process for authorization of the reconstructive surgery as the plan is now the payer, not FFS. MDHHS authorization would be void.
Voluntary Health Plan Change During a Course of Treatment	A beneficiary is in health plan "A" in July and is involved in a course of physical therapy (PT). The therapy program was authorized for six weeks. On August 1, the beneficiary changes enrollment to health plan "B" and still has two more scheduled weeks of PT. Before PT can continue, the provider must obtain a new authorization from health plan "B." Ideally, as a plan-to-plan change occurs at the request of the beneficiary, the provider would coordinate the transition to the new plan, maintain continuity of care and have an authorization in place from plan "B" so the ongoing PT



	<p>is not interrupted. However, if PT continues without new plan "B" authorization, plan "A" is not responsible and plan "B" may or may not honor the treatment. The provider cannot bill the beneficiary as the services are covered and it is the provider's responsibility to verify eligibility/enrollment changes and obtain any necessary authorization.</p>
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5.3 DURABLE ITEMS OR EQUIPMENT

MDHHS policy directs providers to bill the date of delivery for durable items or equipment. However, when a beneficiary has a change in enrollment status and the responsible payer is different on the date of delivery than on the date of order, providers must bill the date of order and specify the date of delivery in the Comments/Remarks box on the claim. This is especially important when a beneficiary changes from FFS to a health plan.



SECTION 6 - SPECIAL BILLING

For professional claims, many of the coding conventions described in the CPT manual apply when submitting claims to MDHHS. Additionally, CMS guidelines apply in many instances. Some services may require additional billing information in order to receive correct reimbursement from Medicaid programs and CSHCS.

Do not send documentation with the claim unless it is a MDHHS requirement for processing the claim. The use of modifiers replaces documentation requirements in many instances.

If you have unusual circumstances to report, contact Provider Inquiry for assistance. (Refer to the Directory Appendix for contact information.)

6.1 GENERAL INFORMATION

Bundled Codes	MDHHS follows Medicare guidelines for bundled services. CPT procedure codes with a CMS status indicator of "B" indicate that payment for the covered service is always bundled into payment for other related services not specified. These bundled codes do not receive separate reimbursement. Status code indicators may be found in the RVU file on the CMS website. (Refer to the Directory Appendix for website information.)
Coding	<p>All unlisted or not otherwise classified (NOC) codes require an explanation of the service/item provided. The explanation may be entered in the Remarks Section or may be provided as a claim attachment. Do not recode procedure codes submitted to Medicare or other insurers to unlisted or NOC codes when billing Medicaid unless MDHHS does not cover the procedure code. When Medicaid covers the procedure code, providers must submit the same procedure code to Medicaid that was submitted to the other payer to ensure proper reimbursement.</p> <div style="border: 1px solid black; background-color: yellow; padding: 5px; text-align: center;"> <p>Claims will be rejected for inappropriate recoding even if PA was issued by MDHHS.</p> </div>
Diagnosis Coding	Use ICD coding conventions to report the diagnosis code(s) at the highest level of specificity and with the correct number of digits. An external cause code cannot be reported as a primary diagnosis. If an external cause code is reported as primary, or if a code requires additional digits, the claim will reject.
Place of Service Codes	<p>Use CMS approved two-digit place of service codes to report location for provision of covered services.</p> <p>MDHHS does not recognize the following place of service codes for reimbursement by the program:</p> <ul style="list-style-type: none"> ▪ 05 – Indian Health Service Freestanding Facility ▪ 06 – Indian Health Service Provider-Based Facility ▪ 08 – Tribal 638 Provider-Based Facility ▪ 09 – Prison Correctional Facility ▪ 25 – Birthing Center



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	<ul style="list-style-type: none"> ▪ 26 – Military Treatment Facility ▪ 53 – Community Mental Health Center ▪ 54 – Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) [Known as Intermediate Care Facility/Mentally Retarded (ICF/MR) by CMS] ▪ 60 – Mass Immunization Center <p>Additionally, some locations may be covered only for select providers. Refer to the appropriate provider-specific chapters of this manual for more information.</p>
Prior Authorization	For elective services requiring PA, authorization must be obtained before providing the service. A letter approving or denying the service will be sent to the requesting provider along with a PA number, if approved. Do not submit the letter with the claim when billing. Report the PA number in item 23.

6.2 THIRD PARTY COVERAGE

Identification of Third Party Resources	Providers must always identify third party resources and report third party payments in the appropriate item(s) on the claim. Third party resources must be identified even when the payer does not cover the services.
Medicare Services	<p>Medicare covered services must be submitted on one claim and any excluded services must be submitted on a separate claim. Do not mix covered and excluded services on the same claim.</p> <p>Providers must indicate Medicare’s allowable amount as the charge (item 24F) and report the actual payment and/or deductible as instructed.</p> <p>If the beneficiary is in a Medicare risk HMO, the fixed copay must be entered in item 24F.</p> <p>Refer to the Coordination of Benefits Chapter for information regarding Medicare crossover claims.</p>
Commercial Plan with Fixed Copay	If the beneficiary is in a commercial plan with fixed copays, the copay must be entered in item 24F.
Commercial Insurance Payments	If payments are made by a commercial insurance, the EOB must be submitted with the claim.
Medicaid Deductible	If the beneficiary's Medicaid deductible amount is met in the middle of a service so that part of the charge is the beneficiary's responsibility and part is Medicaid's responsibility, enter the remaining Medicaid liability for the service in item 24F of the service line.
Spend-down	See Medicaid Deductible.
Evidence of Other Insurance Response	<p>When billing on the CMS 1500 paper claim form, providers must submit evidence of other insurance responses (EOBs, denials, etc.) when billing MDHHS for covered services.</p> <p>If billing electronically, no EOB is necessary, as all required data are part of the electronic format. However, in all cases where a provider is billing on the CMS 1500 claim form, a copy of the Medicare EOB must be submitted with the claim.</p>



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Beneficiaries in a MHP or PIHP	<p>MDHHS cannot be billed for copays, deductibles, or any other fee for services provided to beneficiaries enrolled in a MHP or who are receiving services under PIHP/CMHSP capitation. Payment for services must be obtained from the MHP/PIHP/CMHSP.</p> <p>For detailed information related to third party billing, including Medicare and commercial insurance, refer to the Coordination of Benefits Chapter of this manual.</p>
Injectable Drugs Covered as a Pharmacy Benefit by Third Party Payers	<p>When billing for injectable drugs that are covered as a pharmacy benefit by a third party payer but covered as a physician service by Medicaid, the provider must reflect the payment from the carrier on the claim. The fixed copay/coinsurance/deductible must be reported in the appropriate field on the electronic claim form and in Item 24F on the CMS 1500 paper form.</p>

6.3 AMBULANCE

Wait Time	<p>The appropriate number of time units must be reflected in the Quantity field. One time unit represents each 30 minutes of waiting time after the first 30 minutes. No additional payment is made for the first 30 minutes of waiting time (i.e., total waiting time of 1 hour 30 minutes = 2 time units).</p> <p>The Remarks section or claim attachment must include the following information:</p> <ul style="list-style-type: none"> ▪ Total length of waiting time, including the first 30 minutes. ▪ Name and NPI of the physician ordering the wait. ▪ Reason for the wait.
Mileage	<p>When billing a mileage code for trips totaling:</p> <ul style="list-style-type: none"> ▪ Less than 100 miles, ambulance providers must report mileage units rounded up to the nearest tenth of a mile (e.g., 15.5 miles). For trips totaling less than one mile, ambulance providers must report a "0" prior to the decimal (e.g., 0.5 miles). For claims submitted with mileage units greater than one decimal place, Medicaid will truncate to accommodate its fractional billing policy (e.g., 15.99 reported miles will become 15.9 miles). ▪ 100 miles or more, ambulance providers must report mileage rounded up to the nearest whole mile. For claims submitted totaling 100 miles or more and that are reported using fractional mileage, Medicaid will truncate to accommodate this policy (e.g., 115.99 reported miles will become 115 miles). Medicaid will not round up to the nearest whole mile for ambulance runs totaling 100 miles or more that are truncated as a result of this policy.



6.4 ANCILLARY MEDICAL SERVICES

<p>National Drug Code (NDC) Reporting for Physician Administered Drugs</p>	<p>A provider is required to report the National Drug Code (NDC) supplemental information in addition to the procedure code (CPT or HCPCS) when billing for a physician administered drug on the electronic and paper claim formats. Coverage of a physician administered drug (except an immunization) is limited to a drug product from a manufacturer who has a signed rebate agreement with the Centers for Medicare & Medicaid Services (CMS). A current listing of the manufacturers who have signed rebate agreements with CMS can be found on the CMS website. (Refer to the Directory Appendix for website information.) Providers are required to review the website for any changes. MDHHS will not provide an updated listing of manufacturers with signed rebate agreements with CMS.</p> <p>Providers can report decimals if they are part of the NDC supplemental information.</p> <p>The NDC information must be reported on Medicare crossover claims.</p> <p>Claims submitted with invalid or missing NDC information or an NDC by a manufacturer who does not have a signed rebate agreement with CMS will reject at the claim line level.</p> <p>Examples in billing the NDC supplemental information and the NDC 5-4-2 format can be found on the MDHHS website. (Refer to the Directory Appendix for website information.)</p>
	<p><u>Electronic Claims:</u></p> <p>Providers must report the NDC supplemental information in the appropriate segments in the electronic format. Zero dollars (0.00) may also be reported as the NDC Unit Price. A provider who bills a procedure code with multiple NDCs (e.g., compound drug) must repeat the same HCPCS code on multiple service lines allowing each NDC to be reported. The prescription number must be listed on each service line (REF segment) to link this service as one compound drug.</p> <p>(Refer to the Directory Appendix for additional resources and website information.)</p> <p>DDE Claims:</p> <p>To report a procedure code with multiple NDCs (e.g., compound drug), the same HCPCS code must be repeated on multiple service lines, allowing each NDC to be reported. The prescription number must be reported on each service line to link this service together as one compound drug.</p> <p>CMS 1500:</p> <p>Providers must report the NDC supplemental information along with the procedure code in Items 24A - 24D on the CMS 1500. A provider can refer to the National Uniform Claim Committee (NUCC) 1500 Health Insurance Claim Form Reference Manual for Version 08/05 for further information. This manual is available on the NUCC website. (Refer to the Directory Appendix for website information.) Providers who bill a procedure code with multiple NDCs must report the first NDC supplemental information on the form in Items 24A - 24D and report subsequent NDC supplemental information in a claim attachment. Report "see attachment" in Item 19 on the CMS 1500 to indicate additional NDC supplemental information is being billed.</p>



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<p>Injectable Drugs</p>	<p>If an injectable drug, except a vaccine, is administered on the same day as another service, the administration of the drug is considered a part of the other service and cannot be billed separately. The procedure code, its NDC supplemental information, and the cost of the drug are billed. The cost of the drug must be reflected in the charge submitted to Medicaid. For example, if the drug is obtained at a lower than normal cost through the 340B Program, then the 340B price must be reported on the claim. In addition, injectable drugs purchased through the 340B program must be indicated on the CMS 1500 or in the appropriate field in the electronic format using the modifier U6.</p> <p>If a nonspecific or not otherwise classified (NOC) code is billed, the NDC supplemental information must be reported in Items 24A - 24D of the CMS 1500 or in the appropriate segments of the electronic format. Do not recode injectable drugs from a national procedure code covered by Medicare or other payers to a NOC code when billing Medicaid unless MDHHS does not cover that procedure code. When Medicaid covers the procedure code, providers must submit the same procedure code to Medicaid that was submitted to the other payer to ensure proper reimbursement.</p>
<p>Injectable Drugs and Biological Products Not Covered by Medicaid Health Plans</p>	<p>When multiple medical services are provided in conjunction with a carved-out physician-administered drug, FFS claims will process for payment of the carved-out drug service line only; all other claim lines will be denied with Claim Adjustment Reason Code (CARC) 24 – Charges are covered under a capitation agreement/managed care plan. The associated services that are denied by FFS are to be billed to the beneficiary’s health plan for payment.</p>
<p>Chemotherapy Drugs</p>	<p>Chemotherapy drugs and the administration of the chemotherapy drugs must be billed separately. Separate payment is also made for chemotherapy administration by push and by infusion techniques on the same day. The cost of the drug must be reflected in the charge submitted to Medicaid. For example, if the drug is obtained at a lower than normal cost through the 340B Program, the 340B price must be reported on the claim. In addition, chemotherapy drugs purchased through the 340B program must be indicated on the CMS 1500 or in the appropriate field in the electronic format using the modifier U6.</p> <p>If a chemotherapy drug is billed under a nonspecific or not otherwise classified (NOC) code, the NDC supplemental information must be reported in Items 24A - 24D of the CMS 1500 or in the appropriate segment of the electronic format. Do not recode chemotherapy drugs from a national procedure code covered by Medicare or other payers to a NOC code when billing unless Medicaid does not cover that procedure code. When Medicaid covers the procedure code, providers must submit the same procedure code to Medicaid that was submitted to the other payer to ensure proper reimbursement.</p>
<p>Immunizations</p>	<p>Immunizations must be reported using the administration fee code(s) and the code identifying the type of vaccine given. Each vaccine/toxoid given must be reported in addition to the appropriate CPT administration code(s). Immunization administration is covered in addition to the vaccine even if an Evaluation and Management (E/M) visit is reported on the same day. Immunizations included in the Vaccine For Children (VFC) Program are free to providers so the charge for these vaccines must be reported as 0.00 (zero dollars).</p> <p>Medicaid FFS or the appropriate Medicaid Health Plan can be billed directly for immunizations provided to a child even if other insurance resources are available. The preventive pediatric diagnosis code(s) must be included on a claim to avoid a rejection.</p>



Allergy Immunotherapy Services	For allergy immunotherapy services, only component services may be billed. Bill the number of doses of allergy extract or stinging insect venom prepared for and administered to the beneficiary on that date.
Component Billing	For diagnostic tests with global, professional and technical components, practitioners can bill the global service only in the non-facility setting. The professional component may be billed in any setting. Technical component procedures are institutional charges and are not to be billed separately by practitioners when performed in facility settings.

6.5 ANESTHESIA SERVICES

Coding	Report anesthesia services with the five-digit CPT anesthesia codes. Only one primary anesthesia service should be reported for a surgical session. Use the anesthesia code related to the major surgery.
Modifiers	Every anesthesia service must have an appropriate anesthesia modifier reported on the service line.
Anesthesia Add-on Codes	Anesthesia add-on codes may be billed in addition to the primary anesthesia code when appropriate. For all nonobstetrical anesthesia add-on codes, payment for the add-on code(s) is based on established anesthesia base unit values with all time units reported under the primary anesthesia code. For obstetrical anesthesia add-on codes, report the anesthesia time in minutes associated with the add-on code separately from the anesthesia time in minutes associated with the primary obstetrical anesthesia code.
Time Reporting	Report the total anesthesia time in minutes in item 24G. Convert hours to minutes and enter the total anesthesia minutes provided for the procedure. Do not include base units.
Concurrent Surgical and Anesthesia Services	If allowable surgical services are reported in addition to the anesthesia procedure, do not report time units for surgical services.

6.6 CHILDREN’S WAIVER PROGRAM

Holiday Pay	<p>Additional reimbursement is allowed under the Children’s Waiver Program for Community Living Supports (CLS) and Respite Services performed on a holiday.</p> <p>Information regarding the specific procedure codes and associated holiday rates is available on the MDHHS website in the MDHHS CMHSP Children’s Waiver Database. (Refer to the Directory Appendix for website information.)</p> <p>Current recognized holidays are: New Year’s Day, Easter, Memorial Day, July 4th, Labor Day, Thanksgiving Day and Christmas Day. A holiday begins at 12:00 a.m. and ends at 12:00 midnight.</p>
Modifiers	Use the appropriate HCPCS modifier that represents the level of the professional providing the service. Refer to the MDHHS CMHSP Children’s Waiver Database on the MDHHS website for the appropriate modifier/procedure code combination. Refer to other billing instructions in this chapter for special circumstances requiring the use of a modifier.



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Prior Authorization	Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, Children’s Waiver Section for information regarding prior authorization.
Respite Services to More Than One Beneficiary	When services are provided to more than one beneficiary at the same time, use the TT modifier on each claim. If services are performed for more than one beneficiary at the same time by an LPN or RN, use the LPN/RN modifier, as appropriate, in addition to the TT modifier.
Units of Service	Report the units of service/quantity based on the service that was performed. Some services by description are in 15-minute increments; if an hour of service was performed, this would be reported as 4 units of service. If the code description is per hour and 2 hours of service were performed, the reported units would be 2. Refer to the MDHHS CMHSP Children’s Waiver Database for the allowable units.

6.7 CHILDREN’S SERIOUS EMOTIONAL DISTURBANCE HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAM

Holiday Pay	<p>MDHHS allows additional reimbursement under the Children’s Serious Emotional Disturbance Home and Community-Based Services Waiver (SEDW) Program for Community Living Supports (CLS) and Respite Services performed on a holiday.</p> <p>Information regarding the specific procedure codes and associated holiday rates is available on the MDHHS website in the MDHHS CMHSP Serious Emotional Disturbance (SED) Waiver Database. (Refer to the Directory Appendix for website information.)</p> <p>Current recognized holidays are: New Year’s Day, Easter, Memorial Day, July 4th, Labor Day, Thanksgiving Day and Christmas Day. A holiday begins at 12:00 a.m. and ends at 12:00 midnight.</p>
Modifiers	Use the appropriate HCPCS modifier that represents the level of the professional providing the service. Refer to the MDHHS CMHSP Serious Emotional Disturbance (SED) Waiver Database on the MDHHS website for the appropriate modifier/procedure code combination.
Prior Authorization	Community Transition Services require prior authorization.
Services to More than One Beneficiary	A modifier is required to indicate that services were provided to more than one beneficiary at a time for Community Living Supports (CLS), Community Wraparound and Respite Services. When services are provided to more than one beneficiary at the same time, use the TT modifier on each claim.
Units of Service	Report the units of service/quantity based on the service that was performed. Some services by description are in 15-minute increments; if an hour of service was performed, this would be reported as 4 units of service. If the code description is per hour and 2 hours of service were performed, the reported units would be 2. Refer to the MDHHS CMHSP Serious Emotional Disturbance (SED) Waiver Database for the allowable units.



6.8 DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES (DMEPOS)

6.8.A. DATE(S) OF SERVICE

Medical Supplies	For medical supplies, the date supplied must be reported as the date of service.
Diaper and Incontinent Supplier	For the Diaper and Incontinent Supplier Contract, the date the order is transmitted by the contractor to the fulfillment house is the date of service.
DME/Prosthetics/Orthotics	For both custom and noncustom durable medical equipment (DME) and prosthetics and orthotics (P&O), the date of delivery must be reported as the date of service. For subsequent rental months, if applicable, the DOS must be the first day of the service month based on the original date of delivery.
Custom-Fabricated DME or P&O Appliances	For custom-fabricated DME or P&O appliances when there is a loss of eligibility or a change in eligibility status (e.g., from FFS to health plan enrollment or vice versa) between the time the item is ordered and is delivered, the order date rather than the delivery date must be reported as the date of service. For payment, the item must be delivered within 30 days after loss or change in eligibility.
Rented DMEPOS	For all rented DMEPOS, if a beneficiary's death occurs during a specific month in which payment has already been made, the prorating of actual days the items were used is not required.

6.8.B. DAYS OR UNITS

Continuous Passive Motion Device	For a passive motion device, the rental must be billed as a daily rate by reporting total number of days used as units. (Up to 21 days of rental may be considered for payment.)
Enteral Formula	For enteral formula (administered orally or by tube), the appropriate formula HCPCS code should be billed on a monthly basis with total caloric units reported as the quantity. To determine the number of caloric units, divide the total number of calories of all cans to be used by 100.
Gradient Compression Stockings/Surgical Stockings	<p>Gradient compression stockings are considered a "one item" service. The right (RT) and left (LT) modifiers must be used for these items when reporting HCPCS codes A6530 – A6549. When a gradient compression stocking is provided bilaterally, the same code is reported for both garments on one service line using modifiers LTRT with a quantity of "2".</p> <p>Surgical stockings and most gradient compression stockings are packaged by a pair and are billed with a quantity of "1" for each stocking. No RT or LT modifier is required for billing surgical stockings.</p>



Home Intravenous Infusion Therapy	For home intravenous infusion therapy, HCPCS "S" codes must be reported as a daily rate by reporting the total number of days used as units unless otherwise noted in the code description. A home infusion therapy code may be billed with modifier "SH" or "SJ" if multiple drugs are being administered concurrently (e.g., SH – 2 drugs, SJ – 3 drugs). Routine catheter care is included with the daily rate for the active infusion. For chemotherapy and pain management, the specific HCPCS code will designate either continuous or intermittent administration. If the therapy is provided without interruption for 24 hours or more, report the continuous therapy code. For less than 24 hours of therapy, use the intermittent code. For antibiotic, antiviral or antifungal therapy, report the code that best describes the frequency of administration. Only one therapy code of this series may be reported on the same date of service.
Parenteral Intravenous Infusion Therapy	For parenteral intravenous infusion therapy, the appropriate HCPCS "B" codes must be billed as a daily rate by reporting total number of days used as units. The parenteral lipids, the parenteral pre-mix solution, the infusion pump, supply kit, and the administration kit may be billed in combination with each other.
Powered Air Flotation Bed/Air-fluidized Bed	<p>For a powered air flotation bed or air-fluidized bed, the rental must be billed as a daily rate by reporting total number of days used as units. (Up to 10 months of rental may be considered for payment.)</p> <p>For a powered air flotation bed or air-fluidized bed, the "MS" modifier is reported only after 10 months of rental have occurred and an additional six months of continued maintenance and servicing of the item has been provided. A quantity of "1" must be reported for the entire six-month period of service.</p>

6.8.C. HOSPITAL DISCHARGE WAIVER SERVICES

To bypass the PA requirement when billing for standard DME covered under the hospital discharge waiver service, report the discharge date in item 18. (The discharge date must be entered in the eight-digit MMDDCCYY format.)

6.8.D. CONVERTING RENTAL TO PURCHASE

If the purchase of an item is requested after a previous rental month(s) has been paid, the provider must subtract all amounts previously paid from the total purchase price. Enter this amount in the charge field. Enter in the Remarks section that the item is converting from rental to a purchase. Do not enter any payment made by Medicaid in field 24k.



6.8.E. PLACE OF SERVICE CODES

<p>DMEPOS</p>	<p>Place of service codes acceptable to report for DMEPOS claims submitted by medical suppliers are as follows:</p> <ul style="list-style-type: none"> ▪ 01 – Pharmacy ▪ 04 – Homeless Shelter ▪ 12 – Home ▪ 13 – Assisted Living Facility ▪ 14 – Group Home ▪ 16 – Temporary Lodging ▪ 31 – Skilled Nursing Facility ▪ 32 – Nursing Facility ▪ 33 – Custodial Care Facility
<p>Nursing Facility Residents</p>	<p>For residents in a skilled nursing facility or a nursing facility, many medical supplies and/or items or DME are considered a part of the facility's per diem rate. For verification of specific procedure codes that may be billed by the medical supplier, refer to the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)</p>

6.9 EVALUATION AND MANAGEMENT SERVICES

<p>Coding</p>	<p>CPT E/M service guidelines apply for determining what level of care is appropriate. Generally, CPT descriptions for E/M services indicate "per day" and only one E/M service may be reported per date of service (DOS).</p>
<p>Preventive Medicine E/M Visit and Another E/M Visit on the Same Date</p>	<p>A preventive medicine E/M visit and another E/M visit on the same date are billed separately if, during the preventive visit, a problem or abnormality is detected which requires additional work which meets the key component requirements of a problem-oriented E/M visit. When this occurs, bill the office/outpatient E/M procedure code using modifier 25 and bill the preventive E/M visit without using a modifier. Refer to CPT guidelines for additional information.</p> <p>If the same level of care E/M visit is provided twice on the same day, report on one service line and use modifier 22. Indicate the time of day for each visit in item 19.</p>
<p>Procedures and New E/M Service</p>	<p>A procedure and a new patient E/M service on the same date should be reported using modifier 25 on the E/M service line.</p>
<p>EPSDT Developmental Screening</p>	<p>The developmental screening using an objective standardized tool is billed using the appropriate CPT E/M codes for the visit. A maximum of three screenings per beneficiary are allowed in one day by a single provider.</p>
<p>Consultations</p>	<p>Consultations require the referring/ordering provider's name and NPI in items 17 and 17b.</p>
<p>Office Emergency Services</p>	<p>To report emergency services in the office, report the applicable procedure (e.g., laceration repair) or the E/M office visit that represents the level of care provided.</p>



Hospital ED Reimbursement	E/M services provided in the hospital emergency department (ED) by the attending physician (MD, DO) are reimbursed on a two-tiered case rate based on whether the beneficiary was released or admitted. If the beneficiary was released from the ED, a single rate is used as the fee screen. If the beneficiary was admitted to the hospital or transferred to another hospital from the ED, a higher single rate is used as the fee screen. Physicians must bill the level of service identified in the CPT coding descriptions to ensure proper reimbursement.
Miscellaneous	Services such as telephone calls, missed appointments, interpretations of lab results, and services of an interpreter cannot be billed as separate services or billed to the beneficiary.

6.10 FAMILY PLANNING CLINICS

A Family Planning Clinic enrolled with a single billing NPI (representing both the Family Planning Clinic and any other enrolled provider specialty) must report the non-individual taxonomy code of 261QF0050X (Family Planning, Non-Surgical) to allow successful adjudication of family planning services. The taxonomy code must be reported at the header level of the claim, along with the billing provider NPI.

The taxonomy code must only be reported for family planning services. For non-family planning services, a separate claim must be submitted to MDHHS omitting the taxonomy code with the billing provider NPI.

6.11 FEDERALLY QUALIFIED HEALTH CENTERS

A Federally Qualified Health Center (FQHC) enrolled with a single billing NPI (representing both the FQHC and Family Planning Clinic) must report the non-individual taxonomy code of 261QF0050X (Family Planning, Non-Surgical) to allow successful adjudication of family planning services. The taxonomy code must be reported at the header level of the claim, along with the billing provider NPI.

The taxonomy code must only be reported for family planning services. For non-family planning services, a separate claim must be submitted to MDHHS omitting the taxonomy code with the billing provider NPI.

6.12 HEARING AIDS

Delivery Date	The date of delivery of the hearing aid must be reported as the date of service. See Change in Eligibility below.
Change in Eligibility	When there is a loss of eligibility or a change in eligibility status (e.g., from FFS to health plan enrollment or vice versa) between the time a custom hearing aid is ordered and delivered, the date of service should be reported as the order date rather than the delivery date.

6.13 HYSTERECTOMY

Refer to the Surgery Section of this chapter for billing information.



6.14 LABORATORY SERVICES

Panels	CPT definitions for panels apply. All services in the panel must be provided and each test must be appropriate to the diagnosis or symptom for which the test was ordered. If a group of tests overlaps two or more panels, report the panel that incorporates the greater number of tests to fulfill the code definition and report the remaining tests as individual tests.
Blood Handling	On the CMS 1500 claim form, Box 19, Reserved for Local Use, must indicate the reason the blood was obtained as a separate service and the reason the laboratory that performed the testing could not also perform the venipuncture. For electronic claims, ANSI X12 837, Professional, documentation should be entered in the 2300 Loop, segment NTE02.
Referring/Ordering Provider	All clinical lab services billed to Medicaid must have a referring/ordering Medicaid provider name and NPI in items 17 and 17b.
CLIA Number	All clinical lab services billed to Medicaid must have a CLIA number in item 23.
Repeat Tests	If it is medically necessary to repeat the same clinical lab test on the same day for the same patient, report the first test on one line with no modifier and the second test on the next line with modifier 91. Medicaid does not pay for tests that are duplicated due to lab error.

6.15 MATERNITY CARE SERVICES

Coding	CPT guidelines for reporting prenatal care and delivery services apply. Bill the global obstetrical package or the antepartum, delivery, and postpartum components as appropriate per Medicaid NCCI guidelines.
Delivery	Delivery is part of the global maternity package and should not be billed separately if the global package is billed. If the beneficiary is seen for fewer than seven antepartum visits, delivery and postpartum care should be billed separately. Use appropriate CPT guidelines.
Global Service	The global maternity package should be billed if the beneficiary is seen for seven or more antepartum visits with delivery and postpartum performed by the same physician or physician group. The provider or group may choose to bill the antepartum, delivery, and postpartum components separately as allowed by Medicaid NCCI editing.



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<p>Multiple Gestation</p>	<p>Per Medicaid NCCI guidelines, if multiple infants were delivered vaginally, report the appropriate CPT code for the initial delivery (global maternity care or vaginal delivery-only) on line one. Code additional vaginal deliveries as vaginal delivery-only. It is appropriate to append the code with modifier 59 (Distinct procedural service).</p> <p>If one infant is delivered vaginally and one or more delivered by cesarean, report the appropriate CPT code for the cesarean delivery (global maternity or cesarean delivery-only) on line one and the appropriate CPT code for the vaginal delivery (delivery-only) on line two. It is appropriate to append modifier 51 (Multiple procedures) to the vaginal delivery code.</p> <p>If multiple infants were delivered by cesarean delivery, report the appropriate CPT code for the cesarean delivery (global maternity care or cesarean delivery-only) on line one. When the delivery was significantly more difficult than usual, modifier 22 (Increased procedural service) may be appended to the delivery code. When modifier 22 is appended, documentation must support the substantial additional work and the reason for the additional work such as:</p> <ul style="list-style-type: none"> ▪ Increased intensity or time ▪ Increased technical difficulty of performing the procedure ▪ Severity of the patient’s condition ▪ Increased physical and mental effort required <p>In instances of multiple births, providers should attach a copy of the medical records with the claim that supports the procedures performed. Providers must use a diagnosis code that represents the multiple birth.</p>
<p>Outpatient Lactation Support Provided by an Internationally Board Certified Lactation Consultant (IBCLC)</p>	<p>Claims are to be submitted utilizing the mother’s Medicaid beneficiary identification number.</p> <p>Medicaid will reimburse for evidence-based lactation support services provided up to and through 60 days post-delivery. A maximum of two visits per pregnancy will be reimbursed for either a single or multiple gestation pregnancy. One visit is reimbursable per date of service. Medicaid will reimburse for the first eligible claims submitted for these services.</p> <p>IBCLC services may be billed as a separate and distinct service on the same date as which other services are rendered by a provider. Documentation must support a separately identifiable visit.</p>
<p>Physician Change During Antepartum Care</p>	<p>If the beneficiary changes physicians during the antepartum care (other than physicians within the same group), use the appropriate maternity CPT codes and guidelines for the services performed. The global package should not be billed by either physician regardless of the number of antepartum visits provided.</p>
<p>Postpartum Care</p>	<p>Postpartum care is included in the global maternity package and in the global surgical delivery period when the services are provided by the same physician or physician group. When the postpartum exam is performed by a physician not billing the global package or performing the delivery, the postpartum exam may be billed as a separate service.</p>
<p>Prenatal/Antepartum Care</p>	<p>If the beneficiary receives fewer than seven but greater than three antepartum visits, use the appropriate antepartum CPT code. Individual E/M codes should be used when three or fewer antepartum visits are performed.</p>



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6.16 NEWBORN CARE

When billing for medical services provided to the newborn, providers must use the newborn's Medicaid ID number, **except** if the delivering physician performs the newborn care and circumcision during the mother's inpatient stay, the delivering physician may bill for the newborn care and circumcision on the same claim as the delivery under the mother's Medicaid ID number.

6.17 PRIVATE DUTY NURSING (PDN)

6.17.A. DIRECT BILLING TO MDHHS

Providers must bill MDHHS directly (either paper or electronically) using the codes listed in the MDHHS Private Duty Nursing Reimbursement Rates Database posted on the MDHHS website. (Refer to the Directory Appendix for website information.) When direct billing to MDHHS, note the following:

Place of Service	The Place of Service Code on the claim must indicate "Home".
Service Dates	Each date of service must be reported on a separate service line.
Units	Each service line must contain the number of units of care in the "Days or Units" item for that date of service.
Prior Authorization	The PA number listed on the Medicaid authorization letter must be recorded on the claim.
Authorization Letter	The provider must retain the authorization letter for private duty nursing in the beneficiary's record. The authorization letter should not accompany the claim when billing.
Billable Units	PDN services are authorized, billed, and paid in 15-minute incremental units. The total number of units reported on the claim must not exceed the total units that were authorized for that month. Since 15-minute units of care are authorized, only those units of care that entail a full 15 minutes of care may be billed.
Adjustments	Adjustments to claims are made through a total claim replacement or void/cancel process.
Multiple Beneficiaries Seen at Same Location	The appropriate code must be used if an RN or LPN is caring for more than one beneficiary at the same location for which this approach to staffing has been authorized. This code must be used for each beneficiary provided care (i.e., first, second beneficiary). For example, if there is one RN caring for two children at the same location, the multiple beneficiary modifier code must be used for both children. When billing for services for one child (when two have been authorized), do not use the TT modifier along with the HCPCS code. Claims will not pay for one child unless the following comment is entered in the Remarks section of the claim: "Only one child present at time of service, documentation on file."
Holidays	Additional reimbursement for holidays on which private duty nursing services are provided is allowed. Current recognized holidays are: New Year's Day, Easter, Memorial Day, July 4 th , Labor Day, Thanksgiving Day, and Christmas Day. A holiday begins at 12:00 a.m. and ends at 12:00 midnight of that holiday day.



Other Insurance	If the beneficiary has other insurance, it must be reported on all claims to MDHHS.
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6.17.B. HCPCS CODES/MODIFIERS

When billing, the provider must use the appropriate codes. HCPCS codes/modifiers are located in the Healthcare Common Procedure Coding System manual. The Private Duty Nursing Reimbursement Rates Database, posted on the MDHHS website, outlines private duty nursing rates and applicable codes. (Refer to the Directory Appendix for website information.)

6.17.C. PAYMENT IN 15-MINUTE INCREMENTS

Private duty nursing is prior authorized and paid in 15-minute incremental units. When billing for services, the total number of units billed must not exceed the total number of units authorized for that month. Since 15-minute increments of care are authorized, only those units of care that entail a full 15 minutes of care may be billed.

6.18 PROVIDER PREVENTABLE CONDITIONS (PPCs)

Coding	Providers must refer to the current CPT and HCPCS code books for the full descriptions of the national procedure codes and for additional explanatory information that may affect billing.
Modifiers	Every PPC service must have an appropriate HCPCS modifier reported on the service line. (Refer to the Modifiers section of this chapter for additional information.)

6.19 RADIOLOGY SERVICES

Bilateral	If bilateral x-rays are performed on extremities, report on two service lines with modifier RT on one and modifier LT on the other.
Multiple X-Rays	If the same x-ray is performed multiple times on the same beneficiary on the same day, (e.g., before and after fracture care) report the appropriate quantity in item 24G.
Component Billing	For radiology services with global, professional and technical components, practitioners can bill the global service only in the non-facility setting. The professional component may be billed in any setting. Technical component procedures are institutional charges and are not to be billed separately by practitioners when performed in facility settings.
Referring/Ordering Provider	Diagnostic radiology services that are a result of a physician's order or referral require the submission of the referring/ordering Medicaid provider name and NPI in items 17 and 17b.



6.20 SCHOOL BASED SERVICES

Units/Time	<p>Procedure codes that specify time intervals cannot be billed until and unless the time unit specified is reached. Providers cannot bill less than a full unit or a partial unit and cannot round up to the next unit of service.</p> <p>For procedure codes billed by time units, such as per 15 minutes, the time specified in the procedure code description equals one unit of service.</p> <p>Procedure codes that are not billed by time units are billed per encounter.</p>
Coding	<p>Qualified staff may bill for assessments, tests and evaluations performed for the Individuals with Disabilities Education Act (IDEA) assessment using the appropriate procedure code with the HT modifier. The date of service is the date of the determination of eligibility for special education or early-on services. The determination date must be included in the assessment, test or evaluation.</p>
IEP/IFSP	<p>Qualified staff may bill for the multidisciplinary team assessment to develop, review and revise an IEP/IFSP treatment plan using the appropriate procedure code and the TM modifier. The date of service is the date of the multidisciplinary team assessment.</p>
Evaluations/ Assessments	<p>Evaluations/assessments may be provided that are not related to the IDEA assessment or IEP/IFSP development, review, and revision. When this occurs, bill the appropriate evaluation/assessment procedure code for that profession with no modifier. The date of service is the date the evaluation/assessment is completed.</p>
Multiple Disciplines on Same DOS	<p>The psychologist, counselor, and social worker can bill for their evaluations/ assessments using the same procedure code for the same date of service. When this occurs, bill on one service line and indicate the total number of units provided for that date of service. The evaluations/assessments that are performed on the same day for the same student must be for different purposes and not duplicative. The date of service is the date the evaluations/assessments are completed.</p>

6.21 SURGERY

Bilateral Procedures	<p>When a bilateral procedure is performed and there is a bilateral CPT code available, the bilateral code must be used. When there is no code describing bilateral services, report the service on one line and use modifier 50. Use CPT guidelines for reporting modifier 50.</p>
Coding	<p>CPT surgery guidelines for add-on codes, separate procedures, and bilateral services generally apply.</p>
Global Surgery	<p>CMS global surgery guidelines apply. Use the appropriate modifiers to identify the service provided.</p>



Hysterectomy and Sterilization Procedures	<p>Hysterectomy and sterilization consent forms may be faxed to MDHHS for acknowledgement of proper completion and signatures before the service is billed. (Refer to the Directory Appendix for contact information.) If completed properly, there is no need to submit a copy of the form with the claim. Indicate "consent on file" in the Remarks section. For MHP enrollees, providers must contact that health plan for specific requirements related to these consent forms.</p> <p>The charge submitted to Medicaid for devices used in the sterilization process, permanent implantable contraceptive intra-tubal occlusion device and delivery system, must reflect the acquisition cost of the device and delivery system, including advertised discounts, special promotions, or other programs initiated to reduce prices for product costs (340B program). In addition, drugs purchased through the 340B program must be indicated on the claim using the modifier U6</p>
Identical Surgery/ Procedures on Same DOS	<p>If two identical surgical or procedural services are provided on the same day to the same beneficiary and cannot be reported as a bilateral procedure, bill on two service lines with no modifier on the first line and modifier 51 on the second line. Multiple surgery rules apply. If more than two identical services are provided on the same day, the second and subsequent identical services must be combined on the second line. Report modifiers 51 and 22 and provide an explanation of the circumstances.</p>
Multiple Surgery	<p>For multiple surgical procedures performed during the same surgical session, report the primary surgery on the first service line with no modifier. Report the subsequent procedures performed during the same surgical session with modifier 51.</p>
Post-Operative Care	<p>When reporting post-operative care only for surgical procedures with 10-day or 90-day global periods, the provider assuming the post-operative care must bill the date of the surgery and the appropriate surgical code with modifier 55. The claim cannot be submitted until after the patient is seen. Report the date care was assumed/relinquished in the Remarks section.</p>

6.22 TELEMEDICINE

Procedure code and modifier information is contained in the MDHHS Telemedicine Services Database available on the MDHHS website. (Refer to the Directory Appendix for website information.)

6.22.A. ORIGINATING SITE

To be reimbursed for the originating site facility fee, the originating site provider must bill the appropriate telemedicine procedure code and modifier. MDHHS will reimburse the originating site provider the lesser of charge or the current Medicaid fee screen. Additional services provided at the originating site on the same date as the telemedicine service may be billed and reimbursed separately according to published policy.

6.22.B. DISTANT SITE

The modifier for interactive communication must be used in conjunction with the appropriate HCPCS procedure code to identify the professional telemedicine services provided by the distant site provider. To be reimbursed for services that are telemedicine specific (that can only be billed via telemedicine), the provider must use the interactive communication modifier. If the appropriate modifier is not supplied, the service cannot be paid.



6.23 VISION

<p>Routine Eye Examination</p>	<p>A routine eye examination includes, but is not limited to:</p> <ul style="list-style-type: none"> ▪ Case history ▪ Determination of visual acuity (each eye) ▪ Ophthalmoscopy ▪ Biomicroscopy ▪ Ocular motility ▪ Tonometry ▪ Refraction ▪ Diagnosis ▪ Treatment program ▪ Disposition <p>Ophthalmologists and optometrists must use appropriate CPT/HCPCS code(s) for the service</p>
<p>Nonroutine Eye Examination</p>	<p>Nonroutine eye examinations for the purpose of evaluation and treatment of chronic, acute, and/or sudden onset of abnormal ocular conditions must be billed using the appropriate CPT/HCPCS codes.</p>
<p>Glaucoma Screening</p>	<p>Glaucoma screening must be billed with the appropriate CPT/HCPCS procedure codes. This screening entails a dilated eye examination, tonometry, and direct ophthalmoscopy or slit lamp examination. If this screening is provided as part of another billable service, separate reimbursement for this screening is not allowed.</p> <p>If the beneficiary presents with a visual or ocular complaint, the glaucoma screening procedure code should not be used. A procedure code that best describes the encounter should be selected from the E/M or General Ophthalmological codes.</p>
<p>CPT/HCPCS Codes/Modifiers</p>	<p>Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding covered CPT/HCPCS codes.</p>
<p>Eyeglass Dispense Date</p>	<p>Report the date eyeglasses are dispensed as the date of service in item 24A. If eligibility or enrollment status changes after eyeglasses are ordered but before they are delivered, the order date of the eyeglasses must be reported as the date of service in item 24A.</p>
<p>Low Vision Services</p>	<p>When billing for low vision services, the low vision diagnosis must be designated as the primary diagnosis code on the claim service line. Covered low vision diagnosis codes are listed in the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)</p>



SECTION 7 – MODIFIERS

Procedure codes may be modified under certain circumstances to more accurately represent the service or item rendered. MDHHS recognizes two levels of modifiers:

- Level I modifiers are those included in CPT and updated annually by the American Medical Association (AMA).
- Level II modifiers are recognized nationally and updated annually by CMS.

Definitions and use of Level I modifiers can be found in the annual edition of the CPT manual. Definitions of Level II modifiers are found in the annual edition of the HCPCS procedure coding manual. Providers should refer to these manuals and MDHHS provider manuals for specific information on the use of these modifiers.

The modifiers listed below must be reported when applicable. Modifiers affect the processing and/or reimbursement of claims billed to MDHHS for Medicaid programs and CSHCS beneficiaries. Other Level I and Level II modifiers may be used to provide additional information about the service or may be required by other payers but do not affect the processing of the Medicaid claim.

7.1 GENERAL BILLING GUIDELINES

Modifier	Description	Special Instructions
22	Increased Procedural Services	Providers may report when the work required to provide a service is substantially greater than typically required. Documentation/remarks required.
99	Multiple Modifiers	Identifies that more modifiers are necessary than allowed by the format (2 on paper claims or 4 in the electronic format). The second or fourth modifier must be "99" and the additional modifiers must be indicated in item 19 or the appropriate electronic remark area.
EP	Service provided as part of Medicaid EPSDT program	Report to identify EPSDT services.
GC	Service performed by resident under direction of teaching physician	Report to identify services provided by resident in presence of teaching physician.
GE	Service performed by resident under primary care exception	Report to identify primary care services provided by a resident without the presence of the teaching physician under the primary care exception.
LT	Left side (used to identify procedures performed on the left side of the body)	Allows appropriate multiple line reporting of select procedures performed on the right and left side of the body on the same day.
Q5	Service furnished by substitute physician under a reciprocal billing arrangement	The name of the physician providing the service must be reported in item 19.



Modifier	Description	Special Instructions
Q6	Service furnished by a locum tenens physician	The name of the physician providing the service must be reported in item 19.
RT	Right side (used to identify procedures performed on the right side of the body)	Allows appropriate multiple line reporting of select procedures performed on the right and left side of the body on the same day.
TS	Follow-up service	Used with procedure code T1029 to determine reimbursement.
UN	Two patients served	Identifies the number of patients served to allow for adjustment to the reimbursement.
UP	Three patients served	Identifies the number of patients served to allow for adjustment to the reimbursement.
UQ	Four patients served	Identifies the number of patients served to allow for adjustment to the reimbursement.
UR	Five patients served	Identifies the number of patients served to allow for adjustment to the reimbursement.
US	Six or more patients served	Identifies the number of patients served to allow for adjustment to the reimbursement.

7.2 AMBULANCE

7.2.A. ORIGIN AND DESTINATION MODIFIERS

When billing for ambulance services, appropriate origin and destination modifiers must be included on any service line when billing for mileage. The first character of the modifier is the origin code and the second character of the modifier is the destination code (e.g., use modifier RH for a transport from the residence to the hospital).

Modifier	Description
D	Diagnosis or therapeutic site other than "P" or "H" when these are used as origin codes
E	Residential domiciliary custodial facility (other than a Medicare/Medicaid facility)
G	Hospital based dialysis facility
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of transportation
J	Non hospital-based dialysis facility
N	Skilled Nursing Facility (SNF) (Medicare/Medicaid facility)
P	Physician's office



Modifier	Description
R	Residence
S	Scene of accident or acute event
X	(Destination code only) Intermediate stop at a physician's office on the way to the hospital

7.2.B. MULTIPLE TRANSPORTS PER BENEFICIARY

When a beneficiary requires more than one ambulance transport on the same date of service, providers must report:

- the appropriate origin and destination modifier with both the base rate and the mileage procedure codes; and
- the quantity for each transport base rate as "1" and the quantity for each transport mileage as the number of loaded miles.

If a break in service occurs between transports, each transport must be billed as a separate service. A break in service occurs when the ambulance is available to respond to other requests. If there is no break in service between transports, the transport is considered a single run and is described under the Continuous or Round Trip Transport subsection of the Ambulance Chapter of this manual.

7.2.C. MULTIPLE PATIENTS TRANSPORT

When billing for a transport when more than one patient is transported at one time, the appropriate modifier must be reported on the service line for the transport for the second or subsequent patient being transported.

Modifier	Description	Special Instructions
GM	Multiple patients on one ambulance trip	Enter on the transport service line for second or subsequent patient when more than one patient is transported. Reduces reimbursement for the second or subsequent patient transported. Do not report for the first patient.

7.3 ANESTHESIA

Anesthesia services billed without an appropriate modifier are rejected.

Modifier	Description	Special Instructions
47	Anesthesia by Surgeon	Anesthesia procedure codes billed with this modifier are not paid. General anesthesia provided by the surgeon is not covered.
AA	Anesthesia Services Performed Personally by Anesthesiologist	Determines reimbursement for anesthesia services reported with codes 00100-01999.



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Modifier	Description	Special Instructions
AD	Medical Supervision By a Physician: More Than Four Concurrent Anesthesia Procedures	Determines reimbursement for anesthesia services reported with codes 00100-01999.
QK	Medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individuals	Determines reimbursement for anesthesia services reported with codes 00100-01999.
QS	Monitored anesthesia care service	Report in addition to the appropriate anesthesia modifier to identify monitored anesthesia care (MAC) services reported with codes 00100-01999.
QX	Certified Registered Nurse Anesthetist (CRNA) / Anesthesiologist Assistant (AA) service with medical direction by a physician / anesthesiologist	Determines reimbursement for anesthesia services reported with codes 00100-01999. Anesthesiologist Assistant must be medically directed by an anesthesiologist.
QY	Medical direction of one CRNA/AA by an anesthesiologist	Determines reimbursement for anesthesia services reported with codes 00100-01999.
QZ	CRNA service: without medical direction by a physician	Determines reimbursement for anesthesia services reported with codes 00100-01999.

7.4 CHILDREN’S WAIVER PROGRAM

Modifier	Description	Special Instructions
TD	RN	Report in addition to the appropriate procedure code for respite when a registered nurse provides the service.
TE	LPN/LVN	Report in addition to the appropriate procedure code for respite when the service is provided by a licensed practical nurse.
TT	Individualized service provided to more than one patient in the same setting	Report in addition to the appropriate procedure code for respite when more than one beneficiary is receiving the service at the same time from the same provider.

7.5 COMPONENT BILLING

Modifier	Description	Special Instructions
26	Professional Component	Must be reported when billing only the professional component of a procedure. Providers are limited to billing the professional component for certain services in a facility setting.



TC	Technical Component	Technical component procedures are institutional charges and are not to be billed separately by practitioners when performed in facility settings.
----	---------------------	--

7.6 DMEPOS

7.6.A. SURGICAL DRESSINGS

For surgical dressings, report modifiers A1 through A9 depending on number of wounds being treated.

Modifier	Description	Special Instructions
A1	Dressing for one wound	Use to report surgical dressings
A2	Dressing for two wounds	Use to report surgical dressings
A3	Dressing for three wounds	Use to report surgical dressings
A4	Dressing for four wounds	Use to report surgical dressings
A5	Dressing for five wounds	Use to report surgical dressings
A6	Dressing for six wounds	Use to report surgical dressings
A7	Dressing for seven wounds	Use to report surgical dressings
A8	Dressing for eight wounds	Use to report surgical dressings
A9	Dressing for nine or more wounds	Use to report surgical dressings

7.6.B. NEW/USED DME

Modifier	Description	Special Instructions
KH	DMEPOS item, initial claim, purchase or first month rental	Use with HCPCS code E0604 for first month of rental only.
NU	New DME equipment	Use for the purchase of a new DME item. (Refer to the Medical Supplier database and the Medicaid Code and Rate Reference Tool for codes that require the NU modifier.)
UE	Used durable medical equipment	Use for the purchase of used DME equipment. (Refer to the Medical Supplier database and the Medicaid Code and Rate Reference Tool for codes that require the UE modifier.)
RR	Rental (use the "RR" modifier when DME is to be rented)	For monthly rental rate of DME items.



7.6.C. LOWER EXTREMITY PROSTHESES

For all lower extremity prostheses, modifiers "K0" through "K4" must be reported to designate the potential functional ability of a beneficiary (before a prosthesis is furnished) based on the reasonable expectations of the prosthetist and treating physician.

Modifier	Description
K0	Lower extremity prosthesis functional level 0 – does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility.
K1	Lower extremity prosthesis functional level 1 – has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household ambulator.
K2	Lower extremity prosthesis functional level 2 – has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs or uneven surfaces. Typical of the limited community ambulator.
K3	Lower extremity prosthesis functional level 3 – has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to transverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
K4	Lower extremity prosthesis functional level 4 – has the ability or potential for prosthetic ambulation that exceeds the basic ambulation skills, exhibiting high impact, stress, or energy levels, typical of the prosthetic demands of the child, active adult, or athlete.

7.6.D. ORTHOTIC AND PROSTHETIC

For orthotic and prosthetic items, the "LT" or "RT" modifier is required to designate either the left or right side of the body, if applicable. When reporting bilateral orthotic or prosthetic items on the same DOS, the "LT" and "RT" modifiers must be listed on the same service line with the combined quantities of both items. To verify the specific HCPCS codes that require these modifiers, refer to the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)

Modifier	Description	Special Instructions
LT	Left Side of the Body (used to identify procedures performed on the left side of the body)	Must be reported with select prosthetic and orthotic items to identify the left side of the body for use. Also allows payment of bilateral RT and LT devices placed on the same date of service.
RT	Right Side of the Body (used to identify procedures performed on the right side of the body)	Must be reported with select prosthetic and orthotic items to identify the right side of the body for use. Also allows payment of bilateral RT and LT devices placed on the same date of service.



7.6.E. DME

Modifier	Description	Special Instructions
RA	Replacement of a DME item	Replacement of a DME when a significant change in the beneficiary's condition occurs prior to replacement limit.
RB	Replacement of a part of a DME furnished as part of a repair	Includes cost of the part and the labor associated with its replacement and finishing.

7.6.F. POWERED AIR FLOTATION/AIR-FLUIDIZED BED

Modifier	Description	Special Instructions
MS	Six month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty	Use with HCPCS code E0193 or E0194 after six months of continued maintenance and servicing following the initial 10 months of rental. A quantity of "1" must be entered in the quantity field for the full six-month period of service.

7.6.G. ENTERAL NUTRITION

Modifier	Description	Special Instructions
BO	Orally administered nutrition, not by feeding tube	Use to report oral administration of enteral nutrition.
U3	Medicaid State Defined Level 3 used with B4087 for low profile ext.	Refer to the MDHHS Medical Supplier/DME/Prosthetics and Orthotics Fee Schedule and the Medicaid Code and Rate Reference tool for additional information. (Refer to the Directory Appendix for website information.)

7.6.H. INFUSION THERAPY

Modifier	Description	Special Instructions
SH	Second concurrently administered infusion therapy	Must be reported with HCPCS "S" home infusion codes to specify two concurrently administered drugs.
SJ	Third or more concurrently administered infusion therapy	Must be reported with HCPCS "S" home infusion codes to specify three or more concurrently administered drugs.



7.6.I. MISCELLANEOUS SUPPLIES

Modifier	Description	Special Instructions
KX	Specific required documentation on file.	Append to each HCPCS code A4253/A4259 when submitting claims for over quantity for adults (age 21 and older) with medical need to test their blood glucose more frequently than established quantities. Append to specified HCPCS codes that require a face-to-face visit. Refer to the Medical Supplier Chapter and the Medicaid Code and Rate Reference tool in CHAMPS for all coverage requirements.
U4	Pediatric supply item	Use with HCPCS codes listed on the MDHHS Medical Supplier/DME/Prosthetics and Orthotics Fee Schedule that list the U4 modifier for pediatric pricing only. This information may also be found in the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)

7.7 EVALUATION AND MANAGEMENT (E/M) SERVICES [CHANGE MADE 7/1/20]

Modifier	Description	Special Instructions
		(obsolete information removed 7/1/20)
24	Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period	E/M services unrelated to the surgery and billed by the surgeon during the postoperative period of a global surgery are not payable without this modifier.
25	Significant, Separately Identifiable Evaluation and Management Services by Same Physician on Same Day of the Procedure	E/M services reported without modifier 25 and billed in addition to other procedures/services on the same day are not payable. Allows significant separately identifiable E/M services to be paid without review. Subject to post payment audit.
57	Decision for Surgery	Required for an E/M service provided the day of or the day before a procedure with a 90-day global period to indicate that the service was for the decision to perform the procedure.
UA	Admitted or transferred to inpatient hospital	Required for ED case rate paid to attending ED physician when beneficiary is admitted or transferred from the ED to the inpatient hospital.
UD	Released/Discharged from Emergency Department	Required for ED case rate paid to attending ED physician when beneficiary is treated and released/discharged from the ED.



7.8 LABORATORY

Modifier	Description	Special Instructions
90	Reference Lab	Identifies that services were referred to specialty lab. The NPI number of the reference lab must be included.
91	Repeat Clinical Diagnostic Laboratory Test	Use to identify a medically necessary repeat test done on same date.
QW	CLIA waived test	Identifies CLIA waived tests as required.

7.9 MEDICARE

Any service reported to Medicaid for a Medicare/Medicaid eligible beneficiary that is an excluded or noncovered Medicare benefit must be identified with modifier GY or GZ on the service line.

Modifier	Description	Special Instructions
GY	Excluded Medicare Benefit	Report this modifier to identify services that are excluded from Medicare coverage.
GZ	Medicare denied as not reasonable or necessary	Report this modifier to identify services determined not reasonable or necessary by Medicare.

7.10 PREVENTIVE SERVICES

Modifier	Description	Special Instructions
33	Preventive Services	When the primary purpose of the service is delivery of an evidence-based service in accordance with a United States Preventive Services Task Force (USPSTF) A or B rating in effect and other preventive services mandates (legislative or regulatory), the service may be identified by adding modifier 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.

7.11 PRIVATE DUTY NURSING

Modifier	Description	Special Instructions
TT	Individualized service provided to more than one patient in same setting	Use this modifier with HCPCS code T1000 and either modifier TD for RN or TE for LPN when private duty nursing services are being provided to more than one beneficiary at one time.



7.12 PROVIDER PREVENTABLE CONDITIONS (PPCs)

Any service reported to Medicaid for a PPC that has been identified for non-payment must be submitted with the appropriate modifier on the service line.

Modifier	Description	Special Instructions
PA	Surgery Wrong Body Part	Use this modifier to report that service is for surgery on wrong body part
PB	Surgery Wrong Patient	Use this modifier to report that service is for surgery on wrong patient
PC	Wrong Surgery on Patient	Use this modifier to report that service is for wrong surgery on patient

7.13 SCHOOL BASED SERVICES

Modifier	Description	Special Instructions
HT	Multi-disciplinary team	Use this modifier with the appropriate evaluation procedure codes to identify participation by each qualified profession in the Individuals with Disabilities Education Act (IDEA) assessment.
TL	Re-evaluation of Existing Data (REED)	Use this modifier 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.
TM	Individualized Education Program (IEP)	Use this modifier with the appropriate procedure codes to identify participation by each qualified staff in the development, review and revision of the IEP.

7.14 SURGICAL ASSISTANCE

Modifier	Description	Special Instructions
80	Assistant Surgeon	Reimbursement for services at the assistant surgeon rate. If reported with modifiers 54, 55, 58, 59, 78, 79, XE, XP, XS, XU, the claim is not paid.
82	Assistant Surgeon (when qualified resident surgeon not available)	Reimbursement for services at the assistant surgeon rate. If reported with modifiers 54, 55, 58, 59, 78, 79, XE, XP, XS, XU, the claim is not paid.
AS	PA, NP, CNS, or CNM services for assistant at surgery	Reimbursement for services adjusted to CMS limits for reimbursement for these practitioners.



7.15 SURGICAL SERVICES

Modifier	Description	Special Instructions
50	Bilateral Procedure	Report to identify that bilateral procedures were performed during the same operative session. Reimbursement is 150% of the fee for the procedure or the provider's charge if bilateral reporting is appropriate.
51	Multiple Procedure	Use to report multiple procedures during the same operative session. Report on each additional procedure, not on the primary procedure. Determines payment at 100%, 50%, 50%, etc. when appropriate.
52	Reduced Services	Report if a service or procedure is partially reduced or eliminated at the physician's discretion. A report or remarks are required to determine reimbursement. Refer to the Maternity Care Services section of this chapter for maternity care component billing instructions. Do not use for E/M services. Follow current CPT guidelines to determine the appropriate code to use for services performed.
53	Discontinued Procedure	Report if a surgical or diagnostic procedure is terminated after it was started. A report or remarks are required to determine reimbursement.
54	Surgical Care Only	Reported by the surgeon for surgical procedures with 10- or 90-day global periods when all or part of the post op care is relinquished to a physician who is not a member of the same group. Reimbursement is reduced to the surgical care rate only.
55	Postoperative Management Only	Reported by the physician furnishing post-op management only. Report the surgical procedure with the date of surgery and the date care was relinquished/assumed in Box 19.
58	Staged or Related Procedure or Service by the Same Physician During the Postoperative Period	Allows payment for subsequent surgical procedures performed during the global surgery period that meet certain requirements. Do not use in place of modifier 78.
59	Distinct Procedural Service	Report/remarks required. Do not report if another modifier is more appropriate.
62	Two Surgeons	Determines reimbursement when two surgeons were involved in the same surgery.
66	Surgical Team	Determines reimbursement for complex surgery requiring a surgical team. A report or remarks are required.
76	Repeat Procedure by Same Physician	Report when a procedure or service is repeated by the same physician subsequent to the original service.



Modifier	Description	Special Instructions
78	Return to the Operating Room for a Related Procedure During the Postoperative Period	When appropriate, allows payment for related services (complications) requiring a return to OR during the postoperative period. Payment is reduced to operative care only.
79	Unrelated Procedure or Service by Same Physician During Postoperative Period	When appropriate, allows payment for services during the postoperative period unrelated to the original surgery.
XE	Separate Encounter; a service that is distinct because it occurred during a separate encounter.	This modifier should only be used to describe separate encounters on the same date of service. May be used in lieu of modifier 59 where this description provides greater specificity.
XP	Separate Practitioner; a service that is distinct because it was performed by a different practitioner.	May be used in lieu of modifier 59 where this description provides greater specificity.
XS	Separate Structure; a service that is distinct because it was performed on a separate organ/structure.	May be used in lieu of modifier 59 where this description provides greater specificity.
XU	Unusual Non-Overlapping Service; the use of a service that is distinct because it does not overlap usual components of the main service.	May be used in lieu of modifier 59 where this description provides greater specificity.

7.16 THERAPY SERVICES

Therapy claims must be submitted using the appropriate procedure code and therapy modifier to distinguish the discipline under which the service is delivered. In addition, habilitative services must be reported with the appropriate modifier that represents the nature of therapy being performed. Maintenance therapy visit claims should also include the MDHHS designated maintenance modifier. Therapy services submitted without these modifiers may be denied.

Modifier	Description	Special Instructions
96	Habilitative Service	Used to identify therapy services habilitative in nature.
97	Rehabilitative Service	Used to identify therapy services rehabilitative in nature.
GP	Service delivered under an outpatient physical therapy plan of care.	Identifies services provided under a physical therapy treatment plan.
GO	Service delivered under an outpatient occupational therapy plan of care.	Identifies services provided under an occupational therapy treatment plan.



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Modifier	Description	Special Instructions
GN	Service delivered under an outpatient speech-language pathology plan of care.	Identifies services provided under a speech therapy treatment plan.
TS	Follow-up Service	Used to identify therapy services as maintenance related.

7.17 VISION

Modifier	Description	Special Instructions
U1	Polycarbonate lenses	Determines payment rate to contractor.
U2	High index lenses	Determines payment rate to contractor.
VP	Aphakic patient	Report to identify that service is for aphakic patient.
55	Postoperative management only	Reported by an optometrist (with Therapeutic Pharmaceutical Agent (TPA) certification) for select services when a physician performs the surgical procedure and relinquishes the follow-up care to the optometrist.



SECTION 8 - REMITTANCE ADVICE

A Remittance Advice (RA) is produced to inform providers about the status of their claims. RAs are available in paper and electronic formats, and utilize the HIPAA-compliant national standard claim adjustment group codes, claim adjustment reason codes, and remarks codes, as well as adjustment reason codes, to report claim status. Code definitions are available from the Washington Publishing Company. (Refer to the Directory Appendix for contact information.)

8.1 PAYMENT PROCESS

MDHHS processes claims and issues payments (by check or EFT) every week unless special provisions for payments are included in the provider's enrollment agreement. A Remittance Advice (RA) is issued with each payment to explain the payment made for each claim. If no payment is due or claims have been rejected, an RA is also issued. If claims are not submitted for the current pay cycle or no gross adjustments are processed in the pay cycle, an RA is not generated.

If a claim does not appear on an RA within 60 days of submission, a new claim should be submitted. Providers should verify that the provider NPI number and beneficiary ID number are correct. Submitting claims prior to the end of the 60-day period may result in additional delays in claims processing for payment.

Payments to providers are issued by Tax Identification Number (TIN). All payments due to all providers enrolled with MDHHS under a specific TIN are consolidated and issued as one check or EFT.

Providers who would like to receive payments from MDHHS through EFT must register through the DTMB website. (Refer to the Directory Appendix for website information.)

8.2 ELECTRONIC REMITTANCE ADVICE

The electronic RA is produced in the HIPAA-compliant ASC X12N 835 5010 format. Providers opting to receive an electronic RA receive all information regarding adjudicated (paid or rejected) claims in this format.

The electronic RA has many advantages:

- It can serve to input provider claim information into the provider's billing and accounting systems;
- It includes a MDHHS trace number to identify the associated warrant or electronic funds transfer (EFT) payment;
- It returns the provider's internal medical record number, line item control number, and patient control number when submitted on the original claim; and
- It contains additional informational fields not available on the paper RA.

The 835 transaction corresponds to one payment device (check or EFT). All claims associated with a single TIN processed in a weekly pay cycle report on a single 835, regardless of how the claims were submitted (e.g., some paper, some electronic, multiple billing agents, etc.). Providers choosing to receive the 835 transaction must authorize a billing agent to receive the 835 per TIN. An addition of and/or



change to the identification of the billing agent for the provider's 835 must be changed through their CHAMPS enrollment application.

For more information regarding the 835 transactions issued by MDHHS, refer to the MDHHS 835 Companion Documents (Data Clarification Documents) on the MDHHS website. For general information about the 835, refer to the Implementation Guides for these transactions. The guides are available through the Washington Publishing Company. (Refer to the Directory Appendix for contact information.)

8.3 PAPER REMITTANCE ADVICE

A paper RA is generated for all providers and/or billing agents who submit and process claims through CHAMPS. The RA is available online or is sent to providers only if requested through the CHAMPS PE subsystem. The RA contains three main sections: cover sheet, summary page, and detail page(s). Refer to the Forms Appendix for a sample copy of a Remittance Advice.

8.4 GROSS ADJUSTMENTS

Gross adjustments are initiated by MDHHS. A gross adjustment may pertain to one or more claims. Providers are notified in writing when adjustments are made to claims. Notification should be received before the gross adjustment appears on your RA.

The paper RA indicates gross adjustments have been made by:

- **Adjustment Reason Code:** Indicates the reason for the debit or credit memo or adjustment to payment. Standard Adjustment Reason Codes are used and defined in the 835 Implementation Guide.
- **Gross Adjustment Code:** This is the MDHHS gross adjustment code that corresponds to the gross adjustment description.

8.5 CLAIM ADJUSTMENT REASON/REMARK CODES

When a claim is initially processed the Claim Adjustment Reason/Remark column on the RA identifies which service lines have been paid or rejected and lists edits which apply.

If a service line is rejected, a Claim Adjustment Reason/Remark code prints in the Claim Adjustment Reason/Remark column of the RA. The provider should review the definition of the codes to determine the reason for the rejection.



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SECTION 9 - JULIAN CALENDAR [CHANGE MADE 10/1/20]

Day Month	January	February	March	April	May	June	July	August	September	October	November	December
1	1	32	60	91	121	152	182	213	244	274	305	335
2	2	33	61	92	122	153	183	214	245	275	306	336
3	3	34	62	93	123	154	184	215	246	276	307	337
4	4	35	63	94	124	155	185	216	247	277	308	338
5	5	36	64	95	125	156	186	217	248	278	309	339
6	6	37	65	96	126	157	187	218	249	279	310	340
7	7	38	66	97	127	158	188	219	250	280	311	341
8	8	39	67	98	128	159	189	220	251	281	312	342
9	9	40	68	99	129	160	190	221	252	282	313	343
10	10	41	69	100	130	161	191	222	253	283	314	344
11	11	42	70	101	131	162	192	223	254	284	315	345
12	12	43	71	102	132	163	193	224	255	285	316	346
13	13	44	72	103	133	164	194	225	256	286	317	347
14	14	45	73	104	134	165	195	226	257	287	318	348
15	15	46	74	105	135	166	196	227	258	288	319	349
16	16	47	75	106	136	167	197	228	259	289	320	350
17	17	48	76	107	137	168	198	229	260	290	321	351
18	18	49	77	108	138	169	199	230	261	291	322	352
19	19	50	78	109	139	170	200	231	262	292	323	353
20	20	51	79	110	140	171	201	232	263	293	324	354
21	21	52	80	111	141	172	202	233	264	294	325	355
22	22	53	81	112	142	173	203	234	265	295	326	356
23	23	54	82	113	143	174	204	235	266	296	327	357
24	24	55	83	114	144	175	205	236	267	297	328	358
25	25	56	84	115	145	176	206	237	268	298	329	359
26	26	57	85	116	146	177	207	238	269	299	330	360
27	27	58	86	117	147	178	208	239	270	300	331	361
28	28	59	87	118	148	179	209	240	271	301	332	362
29	29	--	88	119	149	180	210	241	272	302	333	363
30	30	--	89	120	150	181	211	242	273	303	334	364
31	31	--	90	---	151	---	212	243	---	304	---	365



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For leap year, one day must be added to the number of days after February 28. The next three leap years are 2024, 2028 and 2032. (revised 10/1/20)

Example: Transaction Control Number (TCN) 211215010000189001 – Header TCN always ends in 000
Position 1: "2" – DDE Web Submission
Position 2: "1" – FFS Claim
Positions 3-7: "12150" – YY = 12 (for 2012) + 3-digit Julian date = "150" (May 29)
Position 8: "1" – Original Claim
Positions 9-15: "0000189" – Sequence Number
Positions 16-18: "001" – Line Number. Will begin with 001 for every new claim and increment by 1 for each claim line. Any replacement or voids claim, use the header TCN. Header TCN always ends in 000 (211215010000189000).



AMBULANCE

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SECTION 1 - INTRODUCTION

1.1 GENERAL INFORMATION

This chapter applies to Ambulance providers and Hospital-Owned Ambulance Services.

The Michigan Department of Health and Human Services (MDHHS), which administers the Medicaid Program, reimburses for ambulance services as medically necessary and appropriate, regardless of whether there is a corresponding medical claim on the date of service, when:

- Medical/surgical or psychiatric emergencies exist; or
- No other effective and less costly mode of transportation for medical treatment can be used because of the beneficiary's medical condition.

Services that have been excluded from direct reimbursement to ambulance providers are:

- Services that are not medically necessary.
- Services that are included as a part of the base rate.
- Services for beneficiaries in a nursing facility (NF) that are reimbursed as part of the facility's per diem or are billed separately by the facility.
- Services reimbursed as part of the Diagnosis Related Groups (DRG) rate for beneficiaries who are inpatients at a hospital, are sent to another facility for services, and returned to the originating hospital without being discharged from the originating hospital.
- Services to Medicaid Health Plan (MHP) enrollees, except for medically necessary ambulance transports related to dental, substance abuse, and community mental health services.
- Nonambulance, non-emergency medical transportation that is provided by a MHP.
- Nonambulance, non-emergency medical transportation arranged by either the local MDHHS office or an MDHHS-contracted transportation broker who reimburses the beneficiary or the transportation provider directly.

The Covered Services Section of this chapter describes the coverages and limitations for payment of ambulance services by Medicaid.

Special billing instructions follow coverage sections, where applicable. These instructions assist the ambulance provider in obtaining reimbursement and must be used in conjunction with the completion instructions found in the Billing & Reimbursement for Professionals and the Billing & Reimbursement for Institutional Providers chapters of this manual and the Healthcare Common Procedure Coding System (HCPCS) manual.



1.2 COMMON TERMS

The following terms have specific meanings in the Ambulance Program:

Advanced Life Support (ALS) Assessment	An assessment performed by an ALS crew (minimum level Emergency Medical Technician-Specialist [EMT-S], Advanced Emergency Medical Technician [AEMT], or Paramedic) as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment to determine whether the patient's condition requires an ALS level of care. The completion of an ALS assessment does not necessarily result in a determination that the patient requires an ALS intervention.
Advanced Life Support Intervention	A procedure in accordance with state and local laws that is required to be performed by minimum level Emergency Medical Technician-Specialist [EMT-S], Advanced Emergency Medical Technician [AEMT], or Paramedic.
Ambulance	A motor vehicle or aircraft that is primarily used or designated as available to provide transportation and basic life support or advanced life support.
Base Rate	A payment rate associated with the level of service provided. Included in the base rate is oxygen, equipment and supplies essential to the provision of services, and accompanying personnel.
Continuous or Round Trip	An ambulance service in which the patient is transported to the hospital, the physician deems it medically necessary for the ambulance to wait, and the beneficiary is then transported to a more appropriate facility for care or back to the place of origin.
Emergency Medical Technician (EMT)	An individual licensed by the state of Michigan to provide BLS services.
Emergency Medical Technician Specialist (EMT-S)	An individual licensed by the state of Michigan to provide limited ALS services.
Emergency Response	A response that, at the time the ambulance provider is called, is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that in the absence of immediate medical attention could reasonably be expected to result in: <ul style="list-style-type: none"> ▪ placing the health of the beneficiary (or, with respect to pregnant women, the health of the woman or her unborn child) in serious jeopardy, ▪ serious impairment to bodily functions, or ▪ serious dysfunction to any bodily organ or part.
Fixed Wing Air Ambulance	An aircraft, such as an airplane, that is licensed as a fixed wing air ambulance and such ancillary services as may be medically necessary.
Loaded Mileage	The number of miles for which the Medicaid beneficiary is transported in the ambulance vehicle.
Medically Necessary Transport	An ambulance transport which is required because no other effective and less costly mode of transportation can be used due to the patient's medical condition.
Neonate	An infant less than four weeks old.



Neonate Return Transfer	An ambulance transport that returns a stabilized neonate from a Level III or Level IV NICU back to the Level I Well Born Nursery or Level II Special Care Nursery from which the neonate was originally transferred.
Neonatal Transport Team	A team of experienced, specialized, multidisciplinary health care providers (established and defined by a health care facility) who are trained for, and immediately available to respond to, calls for high risk neonatal transports.
Paramedic	An individual licensed by the state of Michigan to provide ALS services.
Rotary Wing Air Ambulance	An aircraft, such as a helicopter, that is licensed as a rotary wing air ambulance and such ancillary services as may be medically necessary.
Transfer	The movement of a beneficiary from one health care facility to another in a licensed ground or air ambulance because a medically necessary service was not available at the primary location.
Waiting Time	When an ambulance provider waits at a hospital while a beneficiary is being stabilized, with the intent of continuing transport to a more appropriate hospital for care, or back to the beneficiary's point of origin.

1.3 AMBULANCE SERVICES

MDHHS recognizes different levels of medical services provided by qualified ambulance staff according to the standards established by law and regulation through Michigan Public Act 368 of 1978 as amended. The standards established for each level of service are detailed in the Base Rate subsection of this chapter.

The beneficiary's attending physician must order all non-emergency, medically necessary ambulance transportation. The ambulance provider must retain all documentation supporting the nature of the service in the beneficiary's file regardless of the level of service provided. (Refer to the Emergency and Non-emergency subsections of this chapter for additional information.)

1.4 MEDICAL NECESSITY

Medical necessity is established when the beneficiary's condition is such that use of any other method of transportation is contraindicated. In cases where a mode of transportation other than an ambulance could be used without endangering the beneficiary's health, no payment may be made for ambulance services regardless of whether such other transportation is available.

The medical care personnel in attendance, including the Emergency Medical Technician (EMT) at the scene of an emergency, determine medical necessity and appropriateness of service within the scope of accepted medical practice and Medicaid guidelines. Medical necessity for non-emergency transports must be substantiated with a physician's written order. Ambulance providers must maintain documentation of the medical necessity and appropriateness of service in the beneficiary's file.

1.5 DOCUMENTATION REQUIREMENTS

Ambulance providers must maintain documentation of the medical necessity and appropriateness of service in the beneficiary's file. This documentation may be used to assess whether the transport meets medical necessity, eligibility, coverage, benefit category, and any other criteria necessary for payment. Documentation must be sufficiently detailed to allow reconstruction of what transpired for each service



billed. (Refer to the General Information for Providers chapter of this manual for information on documentation.) The level of service and assessment findings must be fully documented. An ambulance provider must document the medical necessity and clinical significance of an ALS assessment in the beneficiary's file. The ambulance service must meet all program coverage criteria for payment to be made.

1.6 DIAGNOSIS CODES

Providers must enter the appropriate ICD diagnosis code on all ambulance claims. Providers must report the most specific diagnosis code available that identifies the reason for the service. When billing for emergency transports, refer to the Covered Services Section, Emergency subsection of this chapter. For allowable diagnosis codes, refer to the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)

Documentation supporting the diagnosis code must be retained in the ambulance provider's records for audit purposes.

1.7 USUAL AND CUSTOMARY CHARGES

Providers must bill MDHHS the usual and customary (U&C) fee charged to the public. Customary charge means the amount the provider charges another third party payer or the general public (except in cases where the general public receives free or reduced charges) for the same or a similar service. This definition does not include negotiated or contracted payment rates. If the provider renders a covered service to a beneficiary that the provider offers for free or for a reduced fee to the general public, the provider may only bill Medicaid up to that customary charge as long as all other Medicaid requirements are met. If one charge is made to tax-paying residents in a given township, and a higher charge is made to nonresidents, the same charge formula should be applied for Medicaid beneficiaries.

Refer to the Billing & Reimbursement for Professionals, the Billing & Reimbursement for Institutional Providers, and the Coordination of Benefits chapters of this manual when the beneficiary also has Medicare or other insurance.

1.8 MEDICARE/MEDICAID COVERAGE

MDHHS reimburses the ambulance provider for the coinsurance and deductible amounts subject to Medicaid's reimbursement limitations on Medicare approved claims, even if Medicaid does not normally cover the service.

Refer to the Billing & Reimbursement for Professionals or the Billing & Reimbursement for Institutional Providers chapter of this manual, as appropriate, for instructions on completing the claim after Medicare has approved the services.

1.9 PRIOR AUTHORIZATION

For services requiring PA, the ambulance provider must request authorization from the MDHHS Program Review Division (PRD). (Refer to the Directory Appendix for contact information.) The request must include the following information:

- Beneficiary's name and Medicaid ID number



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- Diagnosis
- Point of pick-up and destination
- Services(s) to be provided
- Explanation as to why the ambulance transportation is medically necessary
- Explanation as to why the beneficiary cannot be transported by other means
- Name, address, and National Provider Identifier (NPI) of the ambulance provider
- PA requestor's name

Based on the documentation provided, PRD approves or denies the PA request. The ambulance provider may not bill MDHHS for prior authorized services until PRD approves the PA request. The PA requestor must notify PRD of any changes made to the approved authorization. Except as otherwise specified, the PA number must be entered on the claim before the ambulance provider is reimbursed for services.



SECTION 2 - COVERED SERVICES

2.1 AIR AMBULANCE

Air ambulance providers who are licensed by MDHHS to provide emergency medical services and are properly enrolled in the Medicaid program may be reimbursed for medically necessary air ambulance services. To become Medicaid-enrolled, Michigan-licensed air ambulance providers must submit a copy of their state-issued aircraft operations license number with their provider enrollment application. For prospective air ambulance providers who are not Michigan-licensed, a copy of their respective state-issued aircraft operations license must be submitted with their provider enrollment application, along with a copy of their Commission on Accreditation of Medical Transport Systems (CAMTS) accreditation or an affidavit of substantial CAMTS accreditation compliance. Providers must indicate on the enrollment application that they are requesting either fixed-wing air ambulance or rotary wing air ambulance status. Coverage of the air ambulance services includes the base rate, loaded mileage, and waiting time.

Medicaid reimburses air ambulance services only when a beneficiary requires medical or surgical (not diagnostic) procedures, and their condition requires rapid transportation to a treatment facility. One of the following requirements must be met:

- Great distance or obstacles preclude such delivery to the most appropriate facility; or,
- The beneficiary is inaccessible by either ground or water ambulance.

Hospital-to-hospital emergent transfers performed by either a rotary wing or fixed-wing air ambulance require clinical documentation (i.e., the History and Physical [H & P] report) from the beneficiary's attending physician validating the need for the air, rather than ground, transportation. (Refer to the Emergency subsection of this chapter for more information on emergent transports.)

The ambulance company must bill any ground ambulance transportation ordered to and from the airport in the normal manner.

Non-emergent air ambulance transports require an order from the beneficiary's attending physician and must be prior authorized. (Refer to the Ambulance Services subsection of this chapter for documentation requirements for emergency and medically necessary services.)

The ambulance company must bill any ground ambulance transportation ordered to and from the airport in the normal manner.

2.1.A. FIXED WING AIR AMBULANCE

The Medicaid Provider Enrollment file reflects enrollment as a fixed wing air ambulance provider.



2.1.B. ROTARY WING AIR AMBULANCE

The Medicaid Provider Enrollment file reflects enrollment as a rotary wing air ambulance provider.

2.2 BASE RATE

The ambulance provider may bill one base rate procedure code:

- Advanced Life Support 1 (ALS 1) Non-emergency;
- ALS 1 Emergency;
- Advanced Life Support 2 (ALS 2);
- Basic Life Support (BLS) Non-emergency;
- BLS Emergency;
- Neonatal Emergency Transport;
- Rotary Wing Air Ambulance; or
- Fixed Wing Air Ambulance Transport.

The determination to respond emergently with either an ALS or BLS ambulance vehicle is dependent upon local 911 or equivalent service dispatch protocol. Where the dispatch was inconsistent with this standard of protocol, or where no protocol was used, the beneficiary's condition at the time of ambulance arrival determines the appropriate level of reimbursement. Even if a local government or medical control authority requires an ALS response to all calls, the base rate billed must reflect the level of service rendered and not the type of vehicle in which the beneficiary was transported. Medicaid will only pay for the level of service required and provided.

Reimbursement for the base rate covers all services rendered except mileage that may be billed separately.

When treatment is rendered and no other care or transport is necessary, ambulance providers may bill the base rate procedure code for the level of service performed but not for mileage. (Refer to the Special Situations Section of this chapter for instructions regarding intercept situations.)

2.3 ADVANCED LIFE SUPPORT

Ambulance operations and ambulance staff must be licensed to render advanced life support (ALS) services by the State and properly enrolled with MDHHS.

2.3.A. ADVANCED LIFE SUPPORT, LEVEL 1 (ALS1) – NON-EMERGENCY

ALS1 is defined as the transportation by ground ambulance vehicle, and the provision of medically necessary supplies and services, which includes an ALS assessment or the furnishing of at least one ALS intervention within the context of a non-emergency response.



Ambulance providers must secure a physician's written order indicating the medical necessity of the elevated level of transport and retain it in their files. (Refer to the Non-emergency subsection of this chapter for additional information.)

2.3.B. ADVANCED LIFE SUPPORT, EMERGENCY TRANSPORT, LEVEL 1 (ALS1) – EMERGENCY

ALS1 is defined as the transportation by ground ambulance and the provision of ALS1 services within the context of an emergency response. The furnishing of an ALS assessment, without a medically necessary ALS intervention, is sufficient to bill the ALS base rate if the beneficiary's condition at the time of dispatch indicated an ALS level of service was required.

2.3.C. ADVANCED LIFE SUPPORT, LEVEL 2 (ALS2)

ALS2 is defined as the transportation by ground ambulance vehicle, and the provision of medically necessary supplies and services, including an ALS assessment, and:

- at least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusions (excluding crystalloid fluids); or
- one or more of the following ALS2 procedures:
 - Manual defibrillation/cardioversion
 - Endotracheal intubation, or the monitoring and maintenance of an endotracheal tube that was previously inserted prior to the transport
 - Central venous line
 - Cardiac pacing
 - Chest decompression
 - Surgical airway
 - Intraosseous line

Reimbursement for the ALS base rates includes those services listed under BLS and is the same whether or not special services were performed.

2.4 BASIC LIFE SUPPORT

Ambulance operations and ambulance staff must be licensed to render BLS services by the State of Michigan) and properly enrolled with MDHHS. Medicaid coverage of the BLS base rate includes transportation and medical services that an EMT is routinely trained to provide (e.g., the provision of oxygen and resuscitation). Reimbursement for accompanying personnel, suctioning, labor/delivery, emergency first aid, emergency/night call services, oxygen, and resuscitation is included in the BLS base rate.

BLS also includes equipment and supplies essential to providing such services (e.g., splints, backboards, obstetrical kits).



2.4.A. BASIC LIFE SUPPORT (BLS) – NON-EMERGENCY

BLS – Non-emergency is defined as the transportation by ground ambulance as defined above within the context of a non-emergency response. The BLS service must be provided by either a BLS or an ALS licensed provider.

Ambulance providers must secure a physician’s written order indicating the medical necessity of the transport and retain it in their files. (Refer to the Non-emergency subsection of this chapter for additional information.)

2.4.B. BASIC LIFE SUPPORT (BLS) – EMERGENCY

BLS is defined as the transportation by ground ambulance and when either a BLS or an ALS licensed provider renders BLS services as defined above within the context of an emergency response.

2.5 DRUGS AND SOLUTIONS

Drugs, intravenous solutions and needles, and syringes and hypodermic needles carried in ambulances require replacement by a cooperating hospital pharmacy and under the supervision of a licensed pharmacist. Only the hospital is reimbursed for these items.

2.6 EMERGENCY

Claims may be made to MDHHS for emergency transports that meet the criteria specified in the definitions of BLS Emergency, ALS 1 Emergency and ALS 2 transports in this section.

Claims for emergency ambulance transports must be coded with both an emergency procedure code and an appropriate ICD diagnosis code whenever the service results in transport to a hospital, or assessment and treatment/stabilization determines that no further transport is necessary. Claims for emergency transports without this information will be rejected. Documentation supporting the emergency diagnosis code must be retained in the ambulance provider's records for audit purposes.

To assure appropriate coverage and reimbursement for emergency ambulance services, MDHHS maintains a list of diagnosis codes for emergency ambulance transport. For allowable diagnosis codes, refer to the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)

2.7 MILEAGE

Mileage reimbursement is a Medicaid benefit when:

- A transport occurs.
- Loaded mileage is billed.
- Appropriate origin and destination modifier combinations are utilized.

Ambulance mileage reimbursement is a covered Medicaid benefit when a transport occurs and has been reimbursed. Transports that are denied for any reason, including lack of emergency criteria, will also be denied for the mileage reimbursement.



Refer to the Billing & Reimbursement for Professionals or the Billing & Reimbursement for Institutional Providers chapters of this manual, as appropriate, for a list of origin and destination modifiers.

When billing for mileage greater than 100 miles, enter the origin and destination addresses in the Remarks section.

2.8 NEONATAL

Coverage of neonatal transport includes the neonatal base rate, loaded mileage, and waiting time. The cost of the transfer isolette use is included in the neonatal base rate.

The intensive care transport of critically ill neonates to an approved, designated Level III or Level IV Neonatal Intensive Care Unit (NICU), as approved and designated by Certificate of Need (CON) review standards, is covered.

A neonatal transport team must accompany the neonate. The neonatal transport team has primary responsibility for the neonate and the hospital is reimbursed for these services. The designated ambulance provider may bill the neonatal base rate and mileage for the transport.

A neonate return transfer from a NICU to a Level I Well Newborn Nursery or a Level II Special Care Nursery (after the neonate's condition is stabilized) is covered if the transportation is ordered by the neonate's attending physician. A physician's order indicating the medical necessity of the return trip must be retained in the beneficiary's file as detailed in the Ambulance Services subsection of this chapter.

Waiting time that exceeds 30 minutes is reimbursable and must be billed consistent with the Waiting Time subsection of this section.

2.9 NON-EMERGENCY

A claim may be made to MDHHS for a scheduled, medically necessary non-emergency ambulance transport only when the beneficiary's attending physician orders the transportation and provides, to the ambulance provider, a written order (e.g., physician certification statement) certifying the medical necessity of the transport.

The ambulance provider must retain a copy of the physician's order in the beneficiary's file.

The written order must contain, at a minimum, the following information:

- beneficiary's name and Medicaid identification (ID) number;
- attending physician's NPI number and attending physician or provider signature;
- type of transport necessary;
- explanation of the medical necessity for ambulance transport (i.e., why other means of transport could not be used);
- origin and destination;
- diagnosis;
- frequency of needed transports (required for ongoing, planned treatment);



- type of ongoing treatment (required for ongoing, planned treatment); and
- an explanation of why ground transportation is not appropriate (required when transported by air ambulance).

A separate physician's order is required for each individual round trip transport, unless a beneficiary has a chronic medical condition that requires planned treatment. For chronic conditions, a physician may order non-emergency transportation for a maximum time period of up to 60 days in a single order. The physician's order for ongoing treatment must state the frequency of the transport and the type of ongoing treatment necessary.

If the ambulance provider is unable to obtain a written order signed by the beneficiary's attending physician, a physician's assistant, advanced practice registered nurse (including nurse practitioner, clinical nurse specialist and certified nurse midwife), registered nurse, or discharge planner who is knowledgeable about the beneficiary's condition and who is employed by the attending physician or facility to which the beneficiary was admitted may sign in the physician's place.

The ordering provider may be held responsible if a medically unnecessary ambulance transport is ordered. The ordering provider may be subject to corrective action related to these services, including recoupment of funds. Additionally, any instances in which the ordering provider fails to document all required information necessary for a written order (e.g., physician certification statement) may be subject to recoupment of funds. The ambulance provider may be subject to corrective action, including the recoupment of funds, if it submits a claim for a medically necessary non-emergency ambulance transport without record of a written order.

Non-emergency transport in a Medi-van or other wheelchair-equipped vehicle is not a covered service for ambulance providers. However, Medicaid beneficiaries or transportation providers may receive reimbursement for this type of transport directly from the local MDHHS office, an MDHHS contracted transportation broker or, if the beneficiary is enrolled, an MHP. Refer to the Non-Emergency Medical Transportation Chapter of this manual for additional information.

MDHHS pays for MHP enrolled beneficiaries on a fee-for service (FFS) basis only if the non-emergency transport was medically necessary and was for Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) related services. When submitting claims, providers are to enter in the Remarks section that the ambulance transport was to receive PIHP/CMHSP services.

2.10 UNLISTED AMBULANCE SERVICE

If a service is rendered that is not included in the coverages defined under the existing procedure codes, the ambulance provider may bill the procedure under the Unlisted Ambulance Service procedure code. The claim pends for manual review to determine whether the service is reimbursable under Medicaid guidelines.

Additional considerations:

- Items included in the base rate are not separately reimbursable.



- If no transport was provided, refer to the base rate billing instructions.
- A complete description of the service must be included in the Remarks section or as an attachment to the claim.

2.11 WAITING TIME

Waiting time is covered only when the beneficiary's attending physician deems it medically necessary. Waiting time is reimbursable after the first 30 minutes.

If more than four hours of waiting time is required, providers must request individual consideration and provide documentation. Providers should refer to the Billing & Reimbursement for Professionals or the Billing & Reimbursement for Institutional Providers chapters of this manual, as appropriate, for instructions.

2.12 INTERFACILITY TRANSFERS

Hospital transfers to the nearest hospital that has the necessary service may be covered when the beneficiary has been stabilized at the first hospital but needs a higher level of care available only at the second hospital. Examples of medically necessary transfers include, but are not limited to, services not available at the first facility such as rehabilitation, a burn unit, ventilator assistance, or other specialized care. The ambulance provider must maintain documentation that clearly describes what service(s) is not available at the first facility. Transport from a hospital capable of treating the beneficiary to another hospital for the convenience or preference of the ordering provider, beneficiary or beneficiary's family is not a covered benefit.



SECTION 3 - SPECIAL SITUATIONS

3.1 INTERCEPTS

In situations where a BLS vehicle intercepts with an ALS vehicle, each provider may bill for the appropriate base rate and for the loaded mileage they provided (if any).

3.2 BRIDGE/TUNNEL TOLL

Bridge and tunnel toll charges are reimbursable to the ambulance provider, both loaded and return trip.

Billing instructions:

- The Unlisted Ambulance Service code must be used.
- All toll charges must be combined on one claim line.
- The Remarks section must contain the bridge or tunnel name and the number of times used.

3.3 CONTINUOUS OR ROUND TRIP TRANSPORT

These types of transports are considered to be one run. The base rate code for the highest level of service performed during transport should be billed on one claim line. Loaded mileage is also billed on one claim line, with the total number of whole (loaded) miles indicated as the quantity.

Refer to the Waiting Time subsection of this chapter in cases where waiting time exceeds 30 minutes.

3.4 NURSING FACILITIES

When a resident requires physician ordered medically necessary non-emergency ambulance transportation, the ambulance provider may only bill MDHHS directly. This cost must not be claimed as a routine cost on Michigan's Medicaid cost report. The ambulance provider must maintain the physician's written order as documentation of medical necessity. (Refer to the Nursing Facility Coverages Chapter of this manual for additional information.)

If a resident's attending physician does not order non-emergency ambulance transport, arrangements for payment must be between the facility and the ambulance provider, and cannot be charged to the resident, the resident's family, or used to offset the patient-pay amount. This cost must not be claimed as a routine cost on Michigan's Medicaid cost report. The cost of non-emergency ambulance transports not ordered by the resident's physician must be identified and removed on Worksheet 1-B by the NF.

3.5 MULTIPLE ARRIVALS

When multiple units respond to a call for services, only the entity that actually provides services to the beneficiary may bill and be paid. The entity that rendered service/care should bill for all services furnished.



3.6 MULTIPLE BENEFICIARIES PER TRANSPORT

When more than one eligible beneficiary is transported at the same time, the only acceptable duplication of charges is half of the base rate.

Separate claims must be submitted for each beneficiary. The first claim is completed in the usual manner and the base rate billed must reflect the highest level of service performed.

Claims for additional beneficiaries must indicate the U&C base rate charge. The appropriate modifier must be reported. Providers should refer to the Billing & Reimbursement for Professionals or the Billing & Reimbursement for Institutional Providers chapters of this manual, as appropriate, for a list of modifiers. Payment is made at 50 percent of Medicaid's reimbursement rate or 50 percent of the provider's charge (whichever is less).

No mileage or waiting time is to be charged for additional beneficiaries. These services are included in the reimbursement of the first claim.

3.7 MULTIPLE TRANSPORTS PER BENEFICIARY

If more than two ambulance transports are needed for the same beneficiary on the same date of service, the third transport will require PA. When additional transports of an emergent nature are necessary, ambulance providers can secure PA after the transport has been rendered. (Refer to the Prior Authorization subsection of this chapter for additional information.) Additional information regarding billing is contained in the Billing & Reimbursement for Institutional Providers and the Billing & Reimbursement for Professionals Chapters of this manual.

3.8 OUT OF STATE/BEYOND BORDERLAND TRANSPORTS

Except in situations when an emergency response is required, out of state/beyond borderland ambulance transports require PA. (Refer to the General Information for Providers chapter of this manual for additional information on out of state/beyond borderland policy.) (Refer to the Prior Authorization subsection of this chapter for additional information.)

3.9 PRONOUNCEMENT OF DEATH

In situations where a Medicaid beneficiary dies, reimbursement to a Medicaid ambulance provider depends upon when the beneficiary's death occurs. If a beneficiary is pronounced dead by an individual legally authorized to pronounce death:

- Prior to the time that the ambulance is called, no payment is made.
- After the ambulance is called, either before or after the ambulance arrives at the scene, payment for an ambulance trip is made at the BLS rate, but no mileage is paid.
- On arrival to the receiving hospital after getting medically necessary care during the ambulance transport from the scene to the receiving facility, payment is made at the medically necessary level of service furnished.



SECTION 4 – AMBULANCE COVERAGE EXCLUSIONS

Circumstances under which Medicaid does not pay for ambulance transportation include, but are not limited to:

- Transport to services that are not Medicaid-covered.
- Transports that are not medically necessary, whether medical/surgical or psychiatric.
- Transport mileage when transports are denied for any reason, including lack of emergency criteria.
- Medi-car, Medi-van, or wheelchair transports.
- Transport to a funeral home.
- Trips made for services, such as drawing blood and catheterization that could have been provided at the beneficiary's location.
- Transportation of a beneficiary pronounced dead before the ambulance was called.
- Round trips when a beneficiary is taken from a hospital to another facility and returned to the same hospital. As long as the beneficiary is an inpatient, all ancillary services are the responsibility of the hospital.
- Transport of inmates to or from a correctional facility.



SECTION 5— AMBULANCE QUICK REFERENCE GUIDE

Transports rendered in an emergency situation are covered in all settings. Use the following table to determine if the service is covered, not covered or if covered but to be billed to another facility/entity.

	To Inpatient	To Emergency Department Outpatient	To Nursing Facility	To Ambulatory Setting (i.e., Lab, Office, Clinic, Therapy, Dialysis)	To Home
From Inpatient	If Medically Necessary	Emergency Only	If Medically Necessary	If Medically Necessary	If Medically Necessary
From Emergency Department Outpatient	If Medically Necessary	Emergency Only	If Medically Necessary	If Medically Necessary	If Medically Necessary
From Nursing Facility	If Medically Necessary	Emergency Only	If Medically Necessary	If Medically Necessary	If Medically Necessary
From Ambulatory Setting (i.e., lab, office, clinic, therapy, dialysis)	If Medically Necessary	Emergency Only	If Medically Necessary	If Medically Necessary	If Medically Necessary
From Home	Emergency Only	Emergency Only	If Medically Necessary	If Medically Necessary	Not Covered
From At Large (Example: Scene of accident)	Emergency Only	Emergency Only	Not Covered	Emergency Only	Not Covered



AMBULATORY SURGICAL CENTERS

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SECTION 1 - INTRODUCTION

Pursuant to Section 1642 of Public Act 131 of 2009, Michigan Department of Health and Human Services (MDHHS) recognizes and reimburses Ambulatory Surgical Center (ASC) facilities. An ASC is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services.

MDHHS follows Medicare ASC coverage and reimbursement policy, but applies the current Outpatient Prospective Payment System (OPPS)/ASC reduction factor to arrive at the Medicaid ASC reimbursement rate. To facilitate coordination of benefits, ASC policy follows, as closely as possible and appropriate, Medicare's current ASC coverage policies, editing, and claim submission requirements.

1.1 Medicare Certification

To be eligible for Michigan Medicaid enrollment and payment, ASCs must be certified as meeting the requirements for a Medicare ASC and must enter into an agreement with the Centers for Medicare & Medicaid Services (CMS).



SECTION 2 - COVERED SERVICES

MDHHS follows Medicare’s ASC coverage policies, with Medicaid-specific exceptions outlined by code. MDHHS-specific exceptions are outlined as part of the MDHHS Ambulatory Surgical Centers (ASC) Wraparound Code List. Updates are published quarterly on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.1 ASC Payment - Status Indicators

The Centers for Medicare & Medicaid Services (CMS) assigns a two-digit status indicator to each Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code identifying if a code will be paid and how it will be paid. MDHHS has adopted the CMS ASC status indicators.

For categories of codes that MDHHS covers differently than Medicare (wraparound codes), the following alpha/numeric status indicators are used:

Status Indicator	Description
AA1	MDHHS Covered /Medicare Non-Covered
AA2	MDHHS Covered
AA3	Vaccines for Children (VFC)
AA4	State Plan Reimbursement
RR1	MDHHS Non-Covered



SECTION 3 - ASC REIMBURSEMENT

The current OPPS/ASC reduction factor is applied to the current Medicare ASC reimbursement rate. The OPPS and ASC reduction rate is monitored and adjusted as necessary to assure payments do not exceed appropriated funding. Reimbursement for Ambulatory Surgical Center services will be monitored and adjustments will be made to the MDHHS reduction factor as necessary to ensure spending limits fall within the MDHHS appropriation. A wage index of 1.0 is applied for all Ambulatory Surgical Centers.

Additional billing and reimbursement information is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

3.1 Payment Calculation

Payments for ASC facility services are calculated utilizing the following formula:

Medicare ASC rate	X	Current OPPS/ASC reduction factor	=	Medicaid ASC Rate
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The MDHHS payment is the lesser of:

- the Medicaid fee screen/allowable amount, minus any Medicare or other insurance payments, and any applicable Medicaid copayment, patient-pay, and/or deductible; or
- (for fee schedule items) the provider's charge, reduced by any contractual adjustments, and minus any Medicare or other insurance payments, and any applicable Medicaid copayment, patient-pay, or deductible amount; or
- the beneficiary's liability for coinsurance, copayments, and/or deductibles.

3.2 Packaged Services

MDHHS follows Medicare guidelines for packaged/bundled service costs. ASC services having a status indicator of "N1" are considered a packaged service/item and do not receive separate payment.

3.3 Multiple Procedures

MDHHS follows Medicare payment rules for multiple procedures.

3.4 Bilateral Procedures

MDHHS follows Medicare payment rules for bilateral procedures. The multiple procedure reduction of 50 percent applies to all bilateral procedures subject to multiple procedure discounting.

3.5 Discounted Procedures

MDHHS follows Medicare payment rules for discounted procedures.



3.6 Application of Statewide Outpatient Cost-to-Charge Ratio

Services paid by Medicare at reasonable cost and contractor-priced items are paid by applying the Medicaid statewide outpatient hospital cost-to-charge ratio to the Medicare ASC rate. The OPPS/ASC reduction factor is not applied. Updates of hospital cost-to-charge ratios are done in conjunction with updates to the inpatient operating ratios.

3.7 Ambulatory Surgical Centers Wraparound Code List Fee Schedule

Services listed in the MDHHS Ambulatory Surgical Centers (ASC) Wraparound Code List are paid based on a MDHHS-specific fee schedule. CMS updates are published quarterly on the MDHHS website (revisions are made to align with Medicare). The OPPS/ASC reduction factor is not applied to MDHHS Ambulatory Surgical Centers Wraparound Code List services. (Refer to the Directory Appendix for website information.)

3.8 Injections/Intravenous Infusions

MDHHS covers intramuscular, subcutaneous or intravenous injections, and intravenous (IV) infusions when medically necessary. A list of outpatient physician-administered drugs and biological products carved out from the Michigan Medicaid Health Plans (MHPs) is maintained on the MDHHS website. (Refer to the Directory Appendix for website information.)

Refer to the Injectable Drugs and Biological Products section of the Practitioner chapter of this manual for additional information regarding prior authorization (PA) requirements. Refer to the Drugs and Biological Products Not Covered by Medicaid Health Plans section of the Billing & Reimbursement for Institutional Providers chapter of this manual for additional information regarding billing instructions.



SECTION 4 - ASC BILLING

Medicaid-enrolled ASCs are required to bill using the ASC X12 837 5010 professional claim format when submitting electronic claims. Paper claims must be billed on the CMS 1500 paper claim form. Providers are encouraged to bill electronically.



Michigan Department of Health and Human Services
Medicaid Provider Manual



BEHAVIORAL HEALTH AND INTELLECTUAL AND DEVELOPMENTAL DISABILITY SUPPORTS AND SERVICES

This chapter is comprised of two parts:

The **[BEHAVIORAL HEALTH AND INTELLECTUAL AND DEVELOPMENTAL DISABILITY SUPPORTS AND SERVICES](#)** portion of the chapter outlines the PIHP requirements and services for specialty behavioral health and intellectual and developmental disability supports and services.

The **[NON-PHYSICIAN BEHAVIORAL HEALTH APPENDIX](#)** portion of the chapter includes requirements for psychologists, social workers and professional counselors providing behavioral health services for fee for service beneficiaries.



BEHAVIORAL HEALTH AND INTELLECTUAL AND DEVELOPMENTAL DISABILITY SUPPORTS AND SERVICES

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SECTION 1 – GENERAL INFORMATION

This chapter applies to Mental Health providers. Information contained in this chapter is to be used in conjunction with other chapters of this manual including the Billing & Reimbursement Chapters and the Practitioner Chapter, as well as the related procedure code databases and fee schedules located on the Michigan Department of Health and Human Services (MDHHS) website. (Refer to the Directory Appendix for website information.)

1.1 MDHHS APPROVAL

Pursuant to Michigan’s Medicaid State Plan and federally approved 1915(b) waiver and 1915(c) Habilitation Supports Waiver (HSW), community-based mental health, substance abuse and developmental disability specialty services and supports are covered by Medicaid when delivered under the auspices of an approved Prepaid Inpatient Health Plan (PIHP). To be an approved Medicaid provider, a PIHP must be certified as a Community Mental Health Services Program (CMHSP) by MDHHS in accordance with Section 232a of the Michigan Mental Health Code. A PIHP may be either a single CMHSP, or the lead agency in an affiliation of CMHSPs approved by the Specialty Services Selection Panel. Service providers may contract with the PIHP or an affiliate of the PIHP. PIHPs must be enrolled with MDHHS as Medicaid providers. (Refer to the General Information for Providers Chapter of this manual for additional information.) The PIHP must offer, either directly or under contract, a comprehensive array of services, as specified in Section 206 of the Michigan Mental Health Code, being Public Act 258 of 1974, as amended, and all of those specialty services/supports included in this manual.

For the Specialty Services and Supports Program, Centers for Medicare & Medicaid Services gave Michigan permission to use Section 1915(b)(3) of the Social Security Act which allows a state to use Medicaid funds to provide services that are in addition to the state plan services. Those services are described in the Additional Mental Health Services (B3s) section of this chapter. Services selected during the person-centered planning process may be a mix of state plan, HSW, and additional/B3 services, or state plan or HSW or additional/B3 services only, depending on what services best meet a beneficiary’s needs and will assist in achieving his goals.

The 1915(c) Children’s Waiver services are delivered under the auspices of a CMHSP that has been enrolled as a Children’s Waiver provider. Children’s Waiver services are reimbursed by MDHHS through a fee-for-service (FFS) payment system. The Children’s Waiver program is described in the Children’s Home and Community-Based Services Waiver Section of this chapter.

1.2 STANDARDS

The PIHP shall comply with the standards for organizational structure, fiscal management, administrative record keeping, and clinical record keeping specified in this section. In order for a state plan or HSW service to be reported as a Medicaid cost, it must meet the criteria in this chapter.

1.2.A. NETWORK ADEQUACY STANDARDS FOR THE SPECIALTY BEHAVIORAL HEALTH SYSTEM

The Code of Federal Regulations at 42 CFR Parts 438.68 and 457.1218 charges states holding managed care contracts with the development and implementation of Network Adequacy Standards, including behavioral health and substance use disorder services for both adults and children. As such, MDHHS developed Network Adequacy Standards for



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the Prepaid Inpatient Health Plan system of care, including an authorizing policy and a companion procedural document that will be updated as necessary. The policy and procedural document can be found on the MDHHS website. (Refer to the Directory Appendix; Mental Health/Substance Abuse Resources section, for website information.)

1.3 ADMINISTRATIVE ORGANIZATION

The administrative organization shall assure effective and efficient operation of the various programs and agencies in a manner consistent with all applicable federal and state laws, regulations, and policies. Effective and efficient operation includes value purchasing. As applied to services and supports, value purchasing assures appropriate access, quality, and the efficient and economic provision of supports and services. Quality is measured by meeting or exceeding the sets of outcome specifications in the beneficiary's individual plan of service, developed through the person-centered planning process or, for substance abuse services, the individualized treatment plan. Efficient and economic is the lowest cost of the available alternatives that has documented capacity to meet or exceed the outcome quality specifications identified in the beneficiary's plan. There shall be clear policy guidelines for decision-making and program operations and provision for monitoring same. The PIHP must offer direct assistance to explore and secure all applicable first- and third-party reimbursements, and assist the beneficiary to make use of other community resources for non-Medicaid services, or Medicaid services administered by other agencies. MDHHS encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service.

1.4 PROVIDER REGISTRY

The PIHPs must register with MDHHS any Medicaid state plan, HSW, or additional/B3 service they provide directly or through one of their contracted providers, or an affiliate as applicable, as specified in the MDHHS /PIHP contract. The PIHPs should contact the Division of Quality Management and Planning for more information about the provider registry, and the Bureau of Community Based Services for MDHHS approval of special programs. (Refer to the Directory Appendix for contact information.) PIHPs must update the registry whenever changes (address, scope of program, additions, deletions) occur, according to the format and schedule specified by MDHHS.

Children's Waiver providers must be registered by the CMHSPs.

1.5 PROGRAMS REQUIRING SPECIAL APPROVAL

Certain programs and sites require the PIHP to request specific approval by MDHHS prior to service delivery. Programs must be approved by MDHHS prior to service provision in order to be reported as a Medicaid cost. (Refer to the Directory Appendix for contact information.) Programs previously approved by MDHHS and delivered by CMHSPs that are now affiliates do not need to be approved again. Programs requiring specific approval are:



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- Assertive Community Treatment Programs
- Clubhouse Psychosocial Rehabilitation Programs
- Crisis Residential Programs
- Day Program Sites
- Drop-in Programs
- Home-Based Services
- Intensive Crisis Stabilization
- Wraparound

The PIHP shall notify MDHHS of changes in providers of these programs or sites, including change of address or discontinuation.

1.6 BENEFICIARY ELIGIBILITY

A Medicaid beneficiary with mental illness, serious emotional disturbance or developmental disability who is enrolled in a Medicaid Health Plan (MHP) is eligible for specialty mental health services and supports when his needs exceed the MHP benefits. (Refer to the Medicaid Health Plans Chapter of this manual for additional information.) Such need must be documented in the individual’s clinical record.

The following table has been developed to assist health plans and PIHPs in making coverage determination decisions related to outpatient care for MHP beneficiaries. Generally, as the beneficiary’s psychiatric signs, symptoms and degree/extent of functional impairment increase in severity, complexity and/or duration, the more likely it becomes that the beneficiary will require specialized services and supports available through the PIHP/CMHSP. For all coverage determination decisions, it is presumed that the beneficiary has a diagnosable mental illness or emotional disorder as defined in the most recent Diagnostic and Statistical Manual of the Mental Disorders published by the American Psychiatric Association.

In general, MHPs are responsible for outpatient mental health in the following situations:	In general, PIHPs/CMHSPs are responsible for outpatient mental health in the following situations:
<ul style="list-style-type: none"> ▪ The beneficiary is experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments (self-care/daily living skills, social/interpersonal relations, educational/vocational role performance, etc.) and minimal clinical (self/other harm risk) instability. ▪ The beneficiary was formerly significantly or seriously mentally ill at some point in the past. Signs and symptoms of the former serious disorder have substantially moderated or remitted and prominent functional disabilities or impairments related to the condition have largely subsided (there has been no serious exacerbation of the condition within the last 12 months). The beneficiary currently needs ongoing routine 	<ul style="list-style-type: none"> ▪ The beneficiary is currently or has recently been (within the last 12 months) seriously mentally ill or seriously emotionally disturbed as indicated by diagnosis, intensity of current signs and symptoms, and substantial impairment in ability to perform daily living activities (or for minors, substantial interference in achievement or maintenance of developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills). ▪ The beneficiary does not have a current or recent (within the last 12 months) serious condition but was formerly seriously impaired in the past. Clinically significant residual symptoms and impairments exist and the beneficiary requires specialized services and supports to address residual symptomatology and/or functional impairments, promote recovery and/or prevent relapse.



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<p>medication management without further specialized services and supports.</p>	
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The "mental health conditions" listed in the table above are descriptions and are intended only as a general guide for PIHPs and MHPs in coverage determination decisions. These categories do not constitute unconditional boundaries and hence cannot provide an absolute demarcation between health plan and PIHP responsibilities for each individual beneficiary. Cases will occur which will require collaboration and negotiated understanding between the medical directors from the MHP and the PIHP. The critical clinical decision-making processes should be based on the written local agreement, common sense and the best treatment path for the beneficiary.

Medicaid beneficiaries who are not enrolled in a MHP, and whose needs do not render them eligible for specialty services and supports, receive their outpatient mental health services through the fee-for-service (FFS) Medicaid Program when experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior, with minor or temporary functional limitations or impairments (self-care/daily living skills, social/interpersonal relations, educational/vocational role performance, etc.) and minimal clinical (self/other harm risk) instability. Refer to the Practitioner Chapter of this manual for coverages and limitations of the FFS mental health benefit.

Medicaid beneficiaries are eligible for substance abuse services if they meet the medical eligibility criteria for one or more services listed in the Substance Abuse Services Section of this chapter.

Medicaid-covered services and supports selected jointly by the beneficiary, clinician, and others during the person-centered planning process and identified in the plan of service must meet the medical necessity criteria contained in this chapter, be appropriate to the individual's needs, and meet the standards herein. A person-centered planning process that meets the standards of the Person-centered Planning Practice Guideline attached to the MDHHS/PIHP contract must be used in selecting services and supports with mental health program beneficiaries who have mental illness, serious emotional disturbance, or developmental disabilities.

1.7 DEFINITION OF TERMS

This list of terms is not exhaustive, but rather the most commonly used terms, listed alphabetically:

<p>Amount</p>	<p>The number of units (e.g., 25 15-minute units of community living supports) of service identified in the individual plan of service or treatment plan to be provided.</p>
<p>Child Mental Health Professional</p>	<ul style="list-style-type: none"> ▪ A person who is trained and has one year of experience in the examination, evaluation, and treatment of minors and their families and who is either a physician, psychologist, licensed professional counselor or registered professional nurse; or ▪ A person with at least a bachelor's degree in a mental health-related field from an accredited school who is trained, and has three years of supervised experience in the examination, evaluation, and treatment of minors and their families; or ▪ A person with at least a master's degree in a mental health-related field from an accredited school who is trained, and has one year of experience in the examination, evaluation, and treatment of minors and their families.



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Covered Services or Medicaid Covered Services	For the purposes of this manual, Medicaid State Plan Services and Additional Mental Health Services (B3s).
Duration	The length of time (e.g., three weeks, six months) it is expected that a service identified in the individual plan of service or treatment plan will be provided.
Health Care Professional	A physician, registered nurse, physician assistant, nurse practitioner, clinical nurse specialist, or dietitian. Services provided must be relevant to the health care professional's scope of practice. Refer to the Staff Provider Qualifications in the Program Requirements Section of this chapter.
Individual Plan of Services (also referred to as the "plan" or "plan of services and supports" or "treatment plan" for beneficiaries receiving substance abuse treatment)	The document that identifies the needs and goals of the individual beneficiary and the medical necessity, amount, duration, and scope of the services and supports to be provided. For beneficiaries receiving mental health or developmental disabilities services, the individual plan of services must be developed through a person-centered planning process. In the case of minors with developmental disabilities, serious emotional disturbance or mental illness, the child and his family are the focus of service planning, and family members are an integral part of the planning process.
Medical Necessity	Determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. Medical necessity of a service shall be documented in the individual plan of services.
Mental Health Professional	A physician, psychologist, licensed master's social worker, licensed professional counselor, licensed marriage and family therapist, or registered nurse. (Refer to Staff Provider Qualifications in the Program Requirements Section of this chapter.)
Prescription	<p>A written order for a service or item by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under Michigan law that contains all of the following:</p> <ul style="list-style-type: none"> ▪ Beneficiary's name; ▪ Prescribing practitioner's name, address and telephone number; ▪ Prescribing practitioner's signature (a stamped signature is not acceptable); ▪ The date the prescription was written; ▪ The specific service or item being prescribed; ▪ The expected start date of the order (if different from the prescription date); and ▪ The amount and length of time that the service or item is needed. <p>A verbal order from a physician or other licensed practitioner of the healing arts within their scope of practice may be used to initiate occupational therapy (OT), physical therapy (PT), or Speech, Hearing and Language services or to dispense medically necessary equipment or supplies when a delay would be medically contraindicated. The written prescription must be obtained within 14 days of the verbal order. The qualified therapist (OT, PT or Speech) responsible for furnishing or supervising the ordered service, supports coordinator or case manager must receive and document the date of the verbal order in the individual plan of service. Upon receipt of the signed prescription, it shall be verified with the verbal order and entered into the individual plan of service.</p>



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<p>Qualified Mental Health Professional (QMHP)</p>	<p>An individual who has specialized training or one year of experience in treating or working with a person who has mental illness; and is a psychologist, physician, educator with a degree in education from an accredited program, licensed or limited licensed master's or bachelor's social worker, physical therapist, occupational therapist, speech pathologist or audiologist, registered nurse, therapeutic recreation specialist, rehabilitation counselor, licensed or limited licensed professional counselor or individual with a human services degree hired and performing in the role of QMHP prior to January 1, 2008. (Refer to Staff Provider Qualifications in the Program Requirements Section of this chapter for specific requirements of the professionals.)</p> <p>NOTE: If an individual was hired and performed the role of a QMHP prior to January 1, 2008 and later transfers to a new agency, his/her QMHP status will be grandfathered into the new agency.</p>
<p>Qualified Intellectual Disability Professional (QIDP)</p>	<p>An individual who meets the qualifications under 42 CFR 483.430. A QIDP is a person who has specialized training or one year of experience in treating or working with a person who has an intellectual disability; and is a psychologist, physician, educator with a degree in education from an accredited program, licensed or limited licensed master's or bachelor's social worker, physical therapist, occupational therapist, speech pathologist or audiologist, registered nurse, therapeutic recreation specialist, rehabilitation counselor, licensed or limited licensed professional counselor or individual with a human services degree hired and performing in the role of QIDP prior to January 1, 2008. (Refer to Staff Provider Qualifications in the Program Requirements Section of this chapter for specific requirements of the professionals.)</p> <p>NOTE: If an individual was hired and performed the role of a QIDP prior to January 1, 2008 and later transfers to a new agency, his/her QIDP status will be grandfathered into the new agency.</p>
<p>Scope of Service</p>	<p>The parameters within which the service will be provided, including:</p> <ul style="list-style-type: none"> ▪ Who (e.g., professional, paraprofessional, aide supervised by a professional); ▪ How (e.g., face-to-face, telephone, taxi or bus, group or individual); and ▪ Where (e.g., community setting, office, beneficiary's home).
<p>Substance Abuse Treatment Specialist</p>	<ul style="list-style-type: none"> ▪ An individual who has licensure in one of the following areas, and is working within their scope of practice: <ul style="list-style-type: none"> ➢ Clinical Nurse Specialist (CNS) ➢ Licensed Bachelor's Social Worker (LBSW) ➢ Licensed Marriage and Family Therapist ➢ Licensed Master's Social Worker (LMSW) ➢ Licensed Practical Nurse (LPN) ➢ Licensed Professional Counselor (LPC) ➢ Licensed Psychologist (LP) ➢ Limited Licensed Bachelor's Social Worker (LLBSW) ➢ Limited Licensed Marriage and Family Therapist ➢ Limited Licensed Master's Social Worker (LLMSW) ➢ Limited Licensed Professional Counselor (LLPC)



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	<ul style="list-style-type: none"> ➤ Limited Licensed Psychologist (LLP) ➤ Nurse Practitioner (NP) ➤ Physician (MD, DO) ➤ Physician Assistant (PA) ➤ Registered Nurse (RN) ➤ Temporary Limited Licensed Psychologist (TLLP) <p>and who has a registered development plan leading to certification and is timely in its implementation (Development Plan – Counselor (DP-C) – approved development plan in place); or who is functioning under a time-limited exception plan approved by the regional PIHP; or</p> <ul style="list-style-type: none"> • An individual who has one of the following Michigan Certification Board of Addiction Professionals (MCBAP) or International Certification and Reciprocity Consortium (IC & RC) credentials: <ul style="list-style-type: none"> ➤ Certified Advanced Alcohol and Drug Counselor – IC & RC (CAADC) ➤ Certified Alcohol and Drug Counselor – IC & RC (CADC) ➤ Certified Alcohol and Drug Counselor – Michigan (CADC-M) ➤ Certified Co-Occurring Disorders Professional – IC & RC (CCDP) ➤ Certified Co-Occurring Disorders Professional Diplomat – IC & RC (CCDP-D) ➤ Certified Criminal Justice Professional – IC & RC - Reciprocal (CCJP-R) <p>or;</p> <ul style="list-style-type: none"> ▪ An individual who has one of the following approved alternative certifications: <ul style="list-style-type: none"> ➤ for medical doctors: American Society of Addiction Medicine (ASAM) ➤ for psychologists: American Psychological Association (APA) specialty in addiction ➤ for counselors/therapists: Certification through the Upper Midwest Indian Council on Addiction Disorders (UMICAD) ➤ for Licensed Professional Counselors: National Certified Counselor (NCC) with concurrent Master Addictions Counselor (MAC) certification <p>A physician (MD, DO), physician assistant, nurse practitioner, registered nurse, clinical nurse specialist, or licensed practical nurse who provides substance use disorder treatment services within the scope of their practice is considered to be specifically-focused treatment staff and is not required to obtain MCBAP credentials. If one of these professionals provides substance use disorder treatment services outside their scope of practice, the appropriate MCBAP/IC & RC credential applies.</p>
<p>Substance Abuse Treatment Practitioner</p>	<p>An individual who has a registered MCBAP certification development plan (Development Plan – Counselor (DP-C) – approved development plan in place), is timely in its implementation, and is supervised by a Certified Clinical Supervisor – Michigan (CCS-M) or Certified Clinical Supervisor – IC & RC (CCS); or who has a registered development plan to obtain the supervisory credential (Development Plan – Supervisor (DP-S) – approved development plan in place) while completing the requirements of the plan (6000 hours).</p>



1.8 CONFIDENTIALITY

MDHHS complies with Health Insurance Portability and Accountability Act (HIPAA) privacy requirements and recognizes the concern for the confidential relationship between the provider and the beneficiary, and protects this relationship using the minimum amount of information necessary for purposes directly related to the administration of Medicaid.

All records are of a confidential nature and should not be released, other than to a beneficiary or their representative, unless the provider has a signed release from the beneficiary/parent/guardian/legal representative or the disclosure is for a permitted purpose under all applicable confidentiality laws.

If the provider questions the appropriateness of releasing beneficiary records, the provider is encouraged to seek legal counsel before doing so.

1.8.A. STANDARD CONSENT FORM

In cases when such consent is required, the Consent to Share Behavioral Health Information (form MDHHS-5515) must be used for all providers requesting release of information for behavioral health and/or substance use disorder related information. The consent is required to be accepted, honored and used for all Fee for Service (FFS), Managed Care and Prepaid Inpatient Health Plan (PIHP) beneficiaries both from and to any of those providers or entities. The MDHHS-5515 is maintained and updated on the MDHHS website. (Refer to the Directory Appendix for website information.)

An interpreter must be provided to assist the individual if the individual does not understand the language used on the consent form or the language used by the person obtaining the consent. Services of an interpreter cannot be billed as separate services or billed to the beneficiary.

Providers receiving federal funding under the Victims of Crime Act, Violence Against Women Act, and/or Family Violence Prevention and Services Act should not use the MDHHS-5515 because they are subject to stringent consent requirements under these federal laws that are not satisfied by the form. These requirements are in place to address the heightened safety and privacy concerns that victims of domestic violence, sexual assault, stalking, or other crimes may have. These individuals may need additional safeguards for their behavioral health information.

For guidance on addressing issues related to consent and the provision of services for domestic violence, sexual assault, stalking, or other crimes, refer to the MDHHS website.



SECTION 2 – PROGRAM REQUIREMENTS

2.1 MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES SERVICES

Mental health and developmental disabilities services (state plan, HSW, and additional/B3) must be:

- Provided under the supervision of a physician, or other licensed health professional whose profession is relevant to the services being provided. This includes professionals who are licensed or certified in Michigan in a human services field typically associated with mental health or developmental disabilities services. (Refer to Staff Provider Qualifications later in this section.)
- Provided to the beneficiary as part of a comprehensive array of specialized mental health or developmental disabilities services.
- Coordinated with other community agencies (including, but not limited to, Medicaid Health Plans [MHPs], family courts, local health departments [LHDs], MI Choice waiver providers, school-based services providers, and local MDHHS offices).
- Provided according to an individual written plan of service that has been developed using a person-centered planning process and that meets the requirements of Section 712 of the Michigan Mental Health Code. A preliminary plan must be developed within seven days of the commencement of services or, if a beneficiary is hospitalized, before discharge or release. Pursuant to state law and in conjunction with the Balanced Budget Act of 1997, Section 438.10 (f)(6)(v), each beneficiary must be made aware of the amount, duration, and scope of the services to which he is entitled. Therefore, each plan of service must contain the expected date any authorized service is to commence, and the specified amount, scope, and duration of each authorized service. The beneficiary must receive a copy of his plan of services within 15 business days of completion of the plan.
- The individual plan of service shall be kept current and modified when needed (reflecting changes in the intensity of the beneficiary's health and welfare needs or changes in the beneficiary's preferences for support). A beneficiary or his/her guardian or authorized representative may request and review the plan at any time. A formal review of the plan with the beneficiary and his/her guardian or authorized representative shall occur not less than annually to review progress toward goals and objectives and to assess beneficiary satisfaction. The review may occur during person-centered planning.
- Provided without the use of aversive, intrusive, or restrictive techniques unless identified in the individual plan of service and individually approved and monitored by a behavior treatment plan review committee.



2.2 SUBSTANCE ABUSE SERVICES

Substance abuse services must be furnished by service providers licensed by the State of Michigan to provide each type of substance abuse services for which they contract. Substance abuse service providers also must be accredited as an alcohol and/or drug abuse program by one of the following national accreditation bodies:

- The Joint Commission;
- Commission on Accreditation of Rehabilitation Facilities (CARF);
- American Osteopathic Association (AOA);
- Council on Accreditation of Services for Families and Children (COA);
- National Committee on Quality Assurance (NCQA); or
- Accreditation Association for Ambulatory Health Care (AAAHC).

Substance abuse services must be coordinated with other community services as appropriate to an individual's needs and circumstances. Services must also be provided according to an individualized treatment plan. All standard requirements of the Michigan Public Health Code, Article 6 - Substance Abuse apply.

2.3 LOCATION OF SERVICE [CHANGES MADE 7/1/20]

Services may be provided at or through PIHP service sites or contractual provider locations. Unless otherwise noted in this manual, PIHPs are encouraged to provide mental health and developmental disabilities services in integrated locations in the community, including the beneficiary's home, according to individual need and clinical appropriateness. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's residence.

Substance abuse covered services must generally be provided at state licensed sites. Licensed providers may provide some activities, including outreach, in community (off-site) settings. Mental health case management may be provided off-site, as necessary, to meet individual needs when case management is purchased as a component of a licensed service. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's home.

For beneficiaries residing in nursing facilities, only the following clinic services may be provided:

- Nursing facility mental health monitoring;
- Psychiatric evaluation;
- Psychological testing, and other assessments;
- Treatment planning;
- Individual therapy, including behavioral services;
- Crisis intervention; and
- Services provided at enrolled day program sites.



Refer to the Nursing Facility Chapter of this manual for PASARR information as well as mental health services provided by Nursing Facilities.

Medicaid does not cover services delivered in Institutions for Mental Diseases (IMD) for individuals between ages 22 and 64, as specified in §1905(a)(B) of the Social Security Act. Medicaid does not cover services provided to children with serious emotional disturbance in Child Caring Institutions (CCI) unless it is licensed as a "children's therapeutic group home" as defined in Section 722.111 Sec.1(f) under Act No. 116 of the Public Acts of 1973, as amended, or it is for the purpose of transitioning a child out of an institutional setting (CCI). Medicaid may also be used for the purpose of transitioning a child out of Hawthorn Center. For both the CCI and Hawthorn Center, the following mental health services initiated by the PIHP (the **child** needs to be open to the PIHP/CMHSP) may be provided within the designated timeframes:

- The assessment of a child's **eligibility and (revised 7/1/20)** needs for the purpose of determining the community based services necessary to transition the child out of a CCI or Hawthorn Center. This should occur up to 180 days prior to the anticipated discharge from a CCI or Hawthorn Center.
- Wraparound planning, case management or supports coordination. This should occur up to 180 days prior to discharge from a CCI or Hawthorn Center.

Medicaid-funded behavioral health services may be provided to support children with intellectual and developmental disabilities (I/DD) in a CCI that exclusively serves children with I/DD when authorized by the respective PIHP/CMHSP. Authorization by the PIHP/CMHSP includes special considerations, services and/or funding arrangements. Enrollment of the CCI provider is the responsibility of the PIHP/CMHSP to ensure providers rendering services adhere to all state and federal regulations on the use of seclusion and restraint and are appropriately credentialed to perform I/DD services. **(revised 7/1/20)**

Medicaid does not cover services provided to persons/children involuntarily residing in non-medical public facilities (such as jails, prisons or juvenile detention facilities).

Refer to the Amount and Scope of Service subsection for additional information regarding Wraparound program expectations.

2.3.A. DAY PROGRAM SITES

The PIHP may organize a set of state plan, HSW or additional/B3 services at a day program site, but the site and the set of services must be approved by MDHHS. Some services (e.g., inpatient or respite) may not be provided at a day program site. (Refer to individual program descriptions in this chapter for more information on those limitations.)

Mental health and developmental disabilities day program sites are defined as places other than the beneficiary's/family's home, nursing facility, or a specialized residential setting where an array of mental health or developmental disability services and supports are provided:

- To assist the beneficiary in achieving goals of independence, integrated employment and/or community inclusion, as specified in his individual plan of services.
- Through a predetermined schedule, typically in-group modalities.



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- By staff under the immediate and on-site supervision of a professional possessing at least a bachelor's degree in a human service field, and at least two years work experience providing services to beneficiaries with serious mental illness and developmental disabilities.

Medicaid providers wishing to provide mental health and/or developmental disability services and supports at a day program site must obtain approval of the day program site by MDHHS. (Refer to the Directory Appendix for contact information.) MDHHS approval will be based upon adherence to the following requirements:

- Existence of a program schedule of services and supports.
- Existence of an individual beneficiary schedule of state plan, HSW, and additional/B3 services and supports with amount, duration and scope identified.
- The beneficiary's services and supports must be based upon the desired outcomes and/or goals of the individual defined through a person-centered planning process.
- Direct therapy services must be delivered by professional staff, or aides under the supervision of professional staff, who are licensed, certified, or registered to provide health-related services within the scope of practice for the discipline.
- If an aide under professional supervision delivers direct therapy services, that supervision must be documented in the beneficiary's clinical record.

Approval of new program sites will be contingent upon submission of acceptable enrollment information to MDHHS by the PIHP, and upon a site visit by MDHHS.

2.4 STAFF PROVIDER QUALIFICATIONS

Providers of specialty services and supports (including state plan, HSW, and additional/B3) are chosen by the beneficiary and others assisting him/her during the person-centered planning process, and must meet the staffing qualifications contained in program sections in this chapter. In addition, qualifications are noted below for provider staff mentioned throughout this chapter, including the Children's Waiver. The planning team should also identify other competencies that will assure the best possible outcomes for the beneficiary. Credentialing and re-credentialing standards located in the Quality Assessment and Performance Improvement Program in the MDHHS/PIHP contract must be followed. Michigan laws regarding licensing and registration of professionals are found in the Public Health Code, the Mental Health Code and the Michigan Administrative Rules. These regulations define the scope of practice for each professional as well as requirements for supervision.

All providers must be:

- At least 18 years of age.
- Able to prevent transmission of any communicable disease from self to others in the environment in which they are providing supports.
- Able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and report on activities performed.
- In good standing with the law according to the MDHHS/PIHP contract.



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Aides	Must be able to perform basic first aid procedures. Children’s Waiver aides must also successfully complete training in recipient rights and implementation of the child’s individual plan of services.
Audiologist	A licensed individual; has the equivalent educational requirements and work experience necessary for the license; or has completed the academic program and is acquiring supervised work experience to qualify for the license.
Clinical Nurse Specialist	An individual licensed as a registered professional nurse who has been granted a specialty certification as a clinical nurse specialist by the Michigan Board of Nursing under section 17210.
Dietitian	An individual who is a Registered Dietitian or an individual who meets the qualification of Registered Dietitian established by the Academy of Nutrition and Dietetics.
Licensed Practical Nurse (LPN)	An individual who is licensed by the State of Michigan to practice as a licensed practical nurse under the supervision of a registered nurse, physician, or dentist. LPNs include licensed psychiatric attendant nurses per MCL§ 333.17209.
Nurse Practitioner (NP)	An individual licensed to practice as a registered nurse and certified in a nursing specialty by the State of Michigan.
Occupational Therapist (OT)	An individual who is licensed by the State of Michigan to practice as an occupational therapist.
Occupational Therapy Assistant (OTA)	An individual who is licensed by the State of Michigan to practice as an occupational therapy assistant and who is supervised by a qualified occupational therapist.
Physical Therapist (PT)	An individual licensed by the State of Michigan as a physical therapist.
Physical Therapy Assistant	An individual who is a graduate of a physical therapy assistant associate degree program accredited by an agency recognized by the Commission on the Accreditation in Physical Therapy Education (CAPTE), and who is supervised by the physical therapist licensed by the State of Michigan. The individual must be supervised by the physical therapist licensed by the State of Michigan.
Physician (MD or DO)	An individual who possesses a permanent license to practice medicine in the State of Michigan, a Michigan Controlled Substances license, and a Drug Enforcement Administration (DEA) registration.
Physician Assistant	An individual licensed by the State of Michigan as a physician assistant. Practice as a physician assistant means the practice of medicine with a participating physician under a practice agreement.
Professional Counselor	An individual who is fully licensed or limited-licensed by the State of Michigan to practice professional counseling. This includes Rehabilitation Counselors.
Psychologist	An individual who possesses a full license by the State of Michigan to independently practice psychology; or a master’s degree in psychology (or a closely related field as defined by the state licensing agency) and licensed by the State of Michigan as a limited-licensed psychologist (LLP); or a master’s degree in psychology (or a closely related field as defined by the state licensing agency) and licensed by the State of Michigan as a temporary-limited-licensed psychologist.
Registered Nurse (RN)	An individual licensed by the State of Michigan to practice nursing (MCL 333.17201).



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Social Worker	An individual who possesses Michigan licensure as a master's social worker, or Michigan licensure as a bachelor's social worker, or has a limited license as a bachelor's social worker or master's social worker. Limited licensed social workers must be supervised by a licensed MSW (MCL 333.18501 - 507).
Speech Pathologist (SLP)	An individual engaged in the practice of Speech-Language Pathology and is licensed by the State of Michigan to provide such services.

Refer to the Provider Qualifications on the MDHHS website for specific provider qualifications for each covered service. (Refer to the Directory Appendix for website information.)

2.5 MEDICAL NECESSITY CRITERIA

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

2.5.A. MEDICAL NECESSITY CRITERIA

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary;
- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;
- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;
- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;
- Made within federal and state standards for timeliness;



- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and
- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;
- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;
- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;
- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and
- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services:
 - that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;
 - that are experimental or investigational in nature; or
 - for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or
- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.



SECTION 3 – COVERED SERVICES

The Mental Health Specialty Services and Supports program is limited to the state plan services listed in this section, the services described in the Habilitation Supports Waiver for Persons with Developmental Disabilities Section of this chapter, and the additional/B3 services described in the Additional Mental Health Services (B3s) section of this chapter. The PIHP is not responsible for providing state plan covered services that MDHHS has designated another agency to provide (refer to other chapters in this manual for additional information, including the Chapters on Medicaid Health Plans, Home Health, Hospice, Pharmacy and Ambulance), nor is the PIHP responsible for providing the Children’s Waiver Services or Serious Emotional Disturbance Waiver Services described in this chapter. However, it is expected that the PIHP will assist beneficiaries in accessing these other Medicaid services. (Refer to the Substance Abuse Section of this chapter for the specific program requirements for substance abuse services.) It is expected that PIHPs will offer evidence based and promising practices as part of the Medicaid covered specialty services where applicable. PIHPs shall assure that these practices are provided by staff who have been appropriately trained in the model(s) and are provided to the population for which the model was intended. 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.

3.1 BEHAVIORAL HEALTH TREATMENT SERVICES/APPLIED BEHAVIOR ANALYSIS

Refer to the Behavioral Health Treatment Services/Applied Behavior Analysis Section of this chapter for specific program requirements.

3.2 ASSERTIVE COMMUNITY TREATMENT

Refer to the Assertive Community Treatment Program (ACT) Section of this chapter for specific program requirements.

3.3 ASSESSMENTS [CHANGE MADE 7/1/20]

Health Assessment	Health assessment includes activities provided by a registered nurse, physician assistant, nurse practitioner, clinical nurse specialist, or dietitian to determine the beneficiary's need for medical services and to recommend a course of treatment within the scope of practice of the nurse or dietitian.
Psychiatric Evaluation	A comprehensive evaluation performed face-to-face by a psychiatrist, psychiatric mental health nurse practitioner, or appropriately trained clinical nurse specialist that investigates a beneficiary's clinical status, including the presenting problem; the history of the present illness; previous psychiatric, physical, and medication history; relevant personal and family history; personal strengths and assets; and a mental status examination. This examination concludes with a written summary based on a recovery model of positive findings, a biopsychosocial formulation and diagnostic statement, an estimate of risk factors, initial treatment recommendations, estimate of length of stay when indicated, and criteria for discharge.



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Psychological Testing	Standardized psychological tests and measures rendered by full, limited-licensed, or temporary-limited-licensed psychologists. The beneficiary's clinical record must indicate the name of the person who administered the tests, the results of the tests, the actual tests administered, and any recommendations. The protocols for testing must be available for review.
All Other Assessments and Testing	<p>Generally accepted professional assessments or tests, other than psychological tests, that are conducted by a mental health care professional within their scope of practice for the purposes of determining eligibility for specialty services and supports, and the treatment needs of the beneficiary. For children/youth who have experienced trauma or have an elevated score on a trauma screener, a standardized, validated trauma assessment tool, appropriate for the age of the child, is utilized to inform the treatment needs of the beneficiary. (text added 7/1/20)</p> <p>The Child and Adolescent Functional Assessment Scale (CAFAS) must be used for the assessment of children 7 to 18 years of age with suspected serious emotional disturbance, and must be performed by staff who have been trained in the implementation of CAFAS. The Preschool and Early Childhood Functional Assessment Scale (PECFAS) must be used for the assessment of young children, 4 to 7 years of age, with suspected serious emotional disturbance, and must be performed by staff who have been trained in the implementation of the PECFAS. The Devereux Early Childhood Assessment (DECA) must be used for the assessment of infants and young children, 1 month to 47 months, with suspected serious emotional disturbance, and must be performed by staff who have been trained in the implementation of the DECA.</p>

3.4 BEHAVIOR TREATMENT REVIEW

The 1997 federal Balanced Budget Act requires states to assure that enrollees in their PIHPs will "be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints or seclusion" [42 CFR 438.100 (b)(2)(v)].

A behavior treatment plan, where needed, is developed through the person-centered planning process that involves the beneficiary. The person-centered planning process should determine whether a comprehensive assessment should be done in order to rule out any physical or environmental cause for the behavior. Any behavior treatment plan that proposes aversive, restrictive or intrusive techniques, or psycho-active medications for behavior control purposes and where the target behavior is not due to an active substantiated psychotic process, must be reviewed and approved by a specially constituted body comprised of at least three individuals, one of whom shall be a fully- or limited-licensed psychologist and one of whom shall be a licensed physician/psychiatrist. The psychologist or physician must be present during the review and approval process. At least one of the committee members shall not be the developer or implementer of the behavior treatment plan. The approved behavioral plan shall be based on a comprehensive assessment of the behavioral needs of the beneficiary. Review and approval (or disapproval) of such treatment plans shall be done in light of current research and prevailing standards of practice as found in current peer-reviewed psychological/psychiatric literature. Any proposed aversive, intrusive or restrictive technique not supported in current peer-reviewed psychological/psychiatric literature must be reviewed and approved by MDHHS prior to implementing. Acceptable behavioral treatment plans are designed to reduce maladaptive behaviors, to maximize behavioral self-control, or to restore normalized psychological functioning, reality orientation, and emotional adjustment, thus enabling the beneficiary to function more appropriately in interpersonal and social relationships. Such reviews shall be completed prior to the beneficiary's signing and implementation of the plan and as expeditiously as possible. Staff implementing the individual's behavior treatment plan must be trained in how to



implement the plan. This coverage includes the monitoring of the behavior treatment plan by the committee or a designee of the committee which shall occur as indicated in the individual plan of service.

3.5 CHILD THERAPY [CHANGE MADE 7/1/20]

Treatment activity designed to prevent deterioration, reduce maladaptive behaviors, maximize skills in behavioral self-control, or restore or maintain normalized psychological functioning, reality orientation and emotional adjustment, thus enabling the child to function more appropriately in interpersonal and social relationships. A child mental health professional may provide child therapy on an individual or group basis with a family-driven, youth-guided approach.

Telepractice/Telehealth is approved for Individual Therapy or Family Therapy using approved children's evidence-based practices (i.e., Trauma Focused Cognitive Behavioral Therapy, Parent Management Training-Oregon, Parenting Through Change) and utilizes the GT modifier when reporting the service. Qualified providers of children's evidence-based practices have completed their training in the model, its implementation via telehealth, and are able to provide the practice with fidelity.

Telepractice/Telehealth is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of services (e.g., access or travel to needed therapy services may be prohibitive). Telepractice/Telehealth must be obtained through real-time interaction between the child's/family's physical location and the provider's physical location. Telepractice/Telehealth services are provided to patients through hardware or internet connection. It is the expectation that providers involved in telepractice/telehealth are trained in the use of equipment and software prior to servicing children/families.

The technology used must meet the requirements of audio and visual compliance in accordance with current regulations and industry standards. Refer to the General Information for Providers Chapter of this manual for the complete Health Insurance Portability and Accountability Act (HIPAA) compliance requirements. **(text added 7/1/20)**

3.6 CLUBHOUSE PSYCHOSOCIAL REHABILITATION PROGRAMS

Refer to the Clubhouse Psychosocial Rehabilitation Programs Section of this chapter for specific program requirements.

3.7 CRISIS INTERVENTIONS

Unscheduled activities conducted for the purpose of resolving a crisis situation requiring immediate attention. Activities include crisis response, crisis line, assessment, referral, and direct therapy.

The standard for whether or not a crisis exists is a "prudent layperson" standard. That means that a prudent layperson would be able to determine from the beneficiary's symptoms that crisis services are necessary. Crisis situation means a situation in which an individual is experiencing a serious mental illness or a developmental disability, or a child is experiencing a serious emotional disturbance, and one of the following applies:

- The individual can reasonably be expected within the near future to physically injure himself, or another individual, either intentionally or unintentionally.



- The individual is unable to provide himself food, clothing, or shelter, or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the individual or to another individual.
- The individual's judgment is so impaired that he is unable to understand the need for treatment and, in the opinion of the mental health professional, his continued behavior as a result of the mental illness, developmental disability, or emotional disturbance can reasonably be expected in the near future to result in physical harm to the individual or to another individual.

If the beneficiary developed a crisis plan, the plan is followed with permission from the beneficiary.

3.8 CRISIS RESIDENTIAL SERVICES

Refer to the Crisis Residential Services Section of this chapter for specific program requirements.

3.9 FAMILY THERAPY [CHANGE MADE 7/1/20]

Family Therapy is therapy for a beneficiary and family member(s), or other person(s) significant to the beneficiary, for the purpose of improving the beneficiary/family function. For children and youth, a family-driven, youth-guided planning process should be utilized. Family therapy does not include individual psychotherapy or family planning (e.g., birth control) counseling. Family therapy is provided by a mental health professional or limited licensed master's social worker supervised by a fully licensed master's social worker. When providing trauma specific intervention for infants, toddlers (birth through 47 months) and their family member(s) or other person(s) significant to the beneficiary (i.e., Child Parent Psychotherapy), the mental health professional, or limited licensed master's social worker supervised by a fully licensed master's social worker, must minimally have endorsement as an Infant Family Specialist by the Michigan Association of Infant Mental Health; Infant Mental Health Specialist is preferred. (text added 7/1/20)

3.10 HEALTH SERVICES

Health Services are provided for purposes of improving the beneficiary's overall health and ability to care for health-related needs. This includes nursing services (on a per-visit basis, not on-going hourly care), dietary/nutritional services, maintenance of health and hygiene, teaching self-administration of medication, care of minor injuries or first aid, recognizing early symptoms of illness and teaching the beneficiary to seek assistance in case of emergencies. Health assessments are covered under the Assessments subsection above. A registered nurse, nurse practitioner, clinical nurse specialist, physician assistant, or dietician must provide these services, according to their scope of practice. Health services must be carefully coordinated with the beneficiary's health care plan so that the PIHP does not provide services that are the responsibility of the MHP.

3.11 HOME-BASED SERVICES

Refer to the Home-Based Services Section of this chapter for specific program requirements.

3.12 INDIVIDUAL/GROUP THERAPY

Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control, or restore normalized psychological functioning, reality orientation, remotivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. Evidence-



based practices such as integrated dual disorder treatment for co-occurring disorders (IDDT/COD) and dialectical behavior therapy (DBT) are included in this coverage. Individual/group therapy is performed by a mental health professional within their scope of practice or a limited licensed master's social worker supervised by a full licensed master's social worker.

3.13 INPATIENT PSYCHIATRIC HOSPITAL ADMISSIONS

Refer to the Inpatient Psychiatric Hospital Admissions Section of this chapter for specific program requirements.

3.14 INTENSIVE CRISIS STABILIZATION SERVICES

Refer to the Intensive Crisis Stabilization Services Section of this chapter for specific program requirements.

3.15 INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID) SERVICES

Health and rehabilitative services provided in a state-licensed facility of 16 beds or less that is certified to meet ICF/IID standards that are specified in 42 CFR 483.400 and 42 CFR 442 Subpart C. Beneficiaries must meet ICF/IID level of care criteria and require a continuous active treatment program that is defined in their individual plan of services and coordinated and monitored by a qualified intellectual disability professional (QIDP). The active treatment program includes specialized and generic training, treatment, health and related services that are directed toward acquisition of behaviors necessary for the beneficiary to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status (42 CFR 483.440 (a)(1)(i & ii)). Treatment services are provided by qualified professionals within their scope of practice. Direct care staff must meet aide level qualifications.

3.16 MEDICATION ADMINISTRATION

Medication Administration is the process of giving a physician-prescribed oral medication, injection, intravenous (IV) or topical medication treatment to a beneficiary. This should not be used as a separate coverage when other health services are utilized, such as Private Duty Nursing or Health Services, which already include these activities. A physician, physician assistant, nurse practitioner, clinical nurse specialist, or registered nurse may perform medication administration under the direction of the physician. A licensed practical nurse who is assisting a physician may perform medication administration as long as the physician is on-site.

For injections administered through the CMHSP clinic, refer to the Injectable Drugs and Biologicals subsection of the Practitioner Chapter of this manual.

3.17 MEDICATION REVIEW

Medication Review is evaluating and monitoring medications, their effects, and the need for continuing or changing the medication regimen. A physician, physician assistant, nurse practitioner, clinical nurse specialist, registered nurse, licensed pharmacist, or a licensed practical nurse assisting the physician may perform medication reviews. Medication review includes the administration of screening tools for the



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presence of extra pyramidal symptoms and tardive dyskinesia secondary to untoward effects of neuroactive medications.

3.18 NURSING FACILITY MENTAL HEALTH MONITORING

This service is the review of the beneficiary’s response to mental health treatment, including direct beneficiary contact and, as appropriate, consultation with nursing facility staff to determine whether recommendations from mental health assessments are carried out by the nursing facility. Nursing facility mental health monitoring is intended to allow follow-up for treatment furnished in response to emerging problems or needs of a nursing facility resident. It is not intended to provide ongoing case management, nor is it for monitoring of services unrelated to the mental health needs of the beneficiary. Nursing facility mental health monitoring can be provided by a physician, physician assistant, clinical nurse specialist, or nurse practitioner. If nursing facility mental health monitoring is provided by a limited licensed master's social worker or limited licensed bachelor's social worker, they must be supervised by a licensed master's social worker. If monitoring is provided by a licensed bachelor's social worker or a registered nurse, they need to be supervised by a professional. A "professional" is a physician, physician assistant, clinical nurse specialist, nurse practitioner, licensed master's social worker, professional counselor, QIDP or QMHP.

3.19 OCCUPATIONAL THERAPY

Evaluation	Therapy
<p>Physician/licensed physician assistant/family nurse practitioner/clinical nurse specialist prescribed activities provided by an occupational therapist licensed by the State of Michigan to determine the beneficiary's need for services and to recommend a course of treatment. An occupational therapy assistant may not complete evaluations.</p>	<p>It is anticipated that therapy will result in a functional improvement that is significant to the beneficiary’s ability to perform daily living tasks appropriate to his chronological developmental or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable).</p>
	<p>Therapy to make changes in components of function that do not have an impact on the beneficiary’s ability to perform age-appropriate tasks is not covered.</p> <p>Therapy must be skilled (requiring the skills, knowledge, and education of a licensed occupational therapist). Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed physical therapist, family member, or caregiver) would not be considered as a Medicaid cost under this coverage.</p>



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Evaluation	Therapy
	<p>Services must be prescribed by a physician/licensed physician assistant/family nurse practitioner/clinical nurse specialist and may be provided on an individual or group basis by an occupational therapist or occupational therapy assistant, licensed by the State of Michigan or by an occupational therapy aide who has received on-the-job training. The occupational therapist must supervise and monitor the assistant's performance with continuous assessment of the beneficiary's progress, but on-site supervision of an assistant is not required. An aide performing an occupational therapy service must be directly supervised by a qualified occupational therapist who is on site. All documentation by an occupational therapy assistant or aide must be reviewed and signed by the appropriately credentialed supervising occupational therapist.</p>

3.20 OUTPATIENT PARTIAL HOSPITALIZATION SERVICES

Refer to the Outpatient Partial Hospitalization Services Section of this chapter for specific program requirements.

3.21 PERSONAL CARE IN LICENSED SPECIALIZED RESIDENTIAL SETTINGS

Refer to the Personal Care in Licensed Specialized Residential Settings Section for specific program requirements.

3.22 PHYSICAL THERAPY

Evaluation	Therapy
<p>Physician/licensed physician's assistant-prescribed activities provided by a physical therapist currently licensed by the State of Michigan to determine the beneficiary's need for services and to recommend a course of treatment. A physical therapy assistant may not complete an evaluation.</p>	<p>It is anticipated that therapy will result in a functional improvement that is significant to the beneficiary's ability to perform daily living tasks appropriate to his chronological, developmental or functional status.</p>
	<p>These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable). Therapy to make changes in components of function that do not have an impact on the beneficiary's ability to perform age-appropriate tasks is not covered.</p>



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Evaluation	Therapy
	<p>Physical therapy must be skilled (it requires the skills, knowledge, and education of a licensed physical therapist). Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed occupational therapist, family member or caregiver) would not be considered as a Medicaid cost under this coverage.</p> <p>Services must be prescribed by a physician/licensed physician's assistant and may be provided on an individual or group basis by a physical therapist or a physical therapy assistant currently licensed by the State of Michigan, or a physical therapy aide who is receiving on-the-job training. The physical therapist must supervise and monitor the assistant's performance with continuous assessment of the beneficiary's progress. On-site supervision of an assistant is not required. An aide performing a physical therapy service must be directly supervised by a physical therapist that is on-site. All documentation by a physical therapy assistant or aide must be reviewed and signed by the appropriately credentialed supervising physical therapist.</p>

3.23 SPEECH, HEARING, AND LANGUAGE

Evaluation	Therapy
<p>Activities provided by a licensed speech-language pathologist or licensed audiologist to determine the beneficiary's need for services and to recommend a course of treatment. A speech-language pathology assistant may not complete evaluations.</p>	<p>Diagnostic, screening, preventive, or corrective services provided on an individual or group basis, as appropriate, when referred by a physician (MD, DO).</p> <p>Therapy must be reasonable, medically necessary and anticipated to result in an improvement and/or elimination of the stated problem within a reasonable amount of time. An example of medically necessary therapy is when the treatment is required due to a recent change in the beneficiary's medical or functional status affecting speech, and the beneficiary would experience a reduction in medical or functional status were the therapy not provided.</p>



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Evaluation	Therapy
	<p>Speech therapy must be skilled (i.e., requires the skills, knowledge, and education of a licensed speech-language pathologist) to assess the beneficiary's speech/language function, develop a treatment program, and provide therapy. Interventions that could be expected to be provided by another entity (e.g., teacher, registered nurse, licensed physical therapist, licensed occupational therapist, family member, or caregiver) would not be considered as a Medicaid cost under this coverage.</p> <p>Services may be provided by a licensed speech-language pathologist or licensed audiologist or by a speech pathology or audiology candidate (i.e., in his clinical fellowship year or having completed all requirements but has not obtained a license). All documentation by the candidate must be reviewed and signed by the appropriately licensed supervising speech-language pathologist or audiologist.</p>

3.24 SUBSTANCE ABUSE

Refer to the Substance Abuse Services Section of this chapter for specific program requirements relating to substance abuse services.

3.25 TARGETED CASE MANAGEMENT

Refer to the Targeted Case Management Section of this chapter for specific program requirements.

3.26 TELEMEDICINE

A CMH/PIHP can be either an originating or distant site for telemedicine services. Practitioners must meet the provider qualifications for the covered service provided via telemedicine.

Refer to the Telemedicine Section of the Practitioner Chapter for additional information regarding telemedicine services.

Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

3.27 TRANSPORTATION

PIHPs are responsible for transportation to and from the beneficiary's place of residence when provided so a beneficiary may participate in a state plan, HSW or additional/B3 service at an approved day program site or in a clubhouse psychosocial rehabilitation program. MHPs are responsible for assuring their enrollees' transportation to the primary health care services provided by the MHPs, and to (non-mental health) specialists and out-of-state medical providers. MDHHS is responsible for assuring transportation to medical appointments for Medicaid beneficiaries not enrolled in MHPs; and to dental, substance abuse, and mental health services (except those noted above and in the HSW program



described in the Habilitation Supports Waiver for Persons with Developmental Disabilities Section of this chapter) for all Medicaid beneficiaries. (Refer to the local MDHHS office or MHP for additional information, and to the Ambulance Chapter of this manual for information on medical emergency transportation.)

PIHP's payment for transportation should be authorized only after it is determined that it is not otherwise available (e.g., MDHHS, MHP, volunteer, family member), and for the least expensive available means suitable to the beneficiary's need.

3.28 TREATMENT PLANNING

Activities associated with the development and periodic review of the plan of service, including all aspects of the person-centered planning process, such as pre-meeting activities, and external facilitation of person-centered planning. This includes writing goals, objectives, and outcomes; designing strategies to achieve outcomes (identifying amount, scope, and duration) and ways to measure achievement relative to the outcome methodologies; attending person-centered planning meetings per invitation; and documentation. Monitoring of the individual plan of service, including specific services when not performed by the case manager or supports coordinator, is included in this coverage. For children and youth, a family-driven, youth-guided planning process should be utilized.

Case managers and supports coordinators perform these functions as part of the case management and supports coordination services; therefore, they should not report this activity as "Treatment Planning." Other mental health and health professionals who attend the beneficiary's person-centered planning should report the activity as "Treatment Planning."

For the Children's Waiver, the attendance of all clinicians and case managers during treatment planning is included in the monthly case management coverage.

3.29 WRAPAROUND SERVICES FOR CHILDREN AND ADOLESCENTS [CHANGE MADE 7/1/20]

NOTE: This service is a State Plan EPSDT service when delivered to children under 21 years of age. **(text added 7/1/20)**

Wraparound services for children and adolescents is a highly individualized planning process facilitated by Wraparound facilitators.

Wraparound utilizes a Child and Family Team, with team members determined by the family often representing multiple agencies and informal supports. The Child and Family Team creates a highly individualized Wraparound plan with the child/youth and family that consists of mental health specialty treatment, services and supports covered by the Medicaid mental health state plan, waiver, B3 services and other community services and supports.

The Wraparound plan may also consist of other non-mental health services and supports that are secured from, and funded by, other agencies in the community. The Wraparound plan is the result of a collaborative team planning process that focuses on the unique strengths, values and preferences of the child/youth and family, and is developed in partnership with other community agencies. This planning process tends to work most effectively with children/youth and their families who, due to safety and



other risk factors, require services from multiple systems and informal supports. The Community Team, which consists of parents/guardians/legal representatives, agency representatives, and other relevant community members, oversees Wraparound from a system level.

Children/youth and families served in Wraparound shall meet two or more of the following criteria:

- Children/youth who are involved in multiple child/youth serving systems.
- Children/youth who are at risk of out-of-home placements or are currently in out-of-home placement.
- Children/youth who have received other mental health services with minimal improvement in functioning.
- The risk factors exceed capacity for traditional community-based options.
- Numerous providers are working with multiple children/youth in a family and the identified outcomes are not being met.

Children/youth receiving Wraparound would not also receive, at the same time, the Supports Coordination coverage or the state plan coverage Targeted Case Management. In addition, PIHPs shall not pay for the case management function provided through home-based services and Wraparound at the same time.

Medicaid providers delivering Wraparound services (provided either as a 1915(b) Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service or an SEDW service) must request approval to provide Wraparound from MDHHS through an enrollment process defined by MDHHS, and re-enrollment must occur every three years. Programs are to be re-enrolled to ensure policy and Wraparound model fidelity adherence.

3.29.A. ORGANIZATIONAL STRUCTURE

The required organizational structure of Wraparound programs must include a Wraparound facilitator, supervisor, and Community Team; define the roles and responsibilities of those staff and the Community Team; and delineate expectations regarding child and family team capacity.

- Wraparound facilitators may not have more than one provider role with any one family (i.e., may not be both the home-based therapist and Wraparound facilitator for the same child/youth and family).
- The responsibility for directing, coordinating, and supervising the staff/program shall be assigned to a specific staff position who meets the requirements of a Child Mental Health Professional (CMHP).
- Services and supports identified in the Wraparound planning process shall be available to the child/youth and family and provided as outlined in the Wraparound plan.
- The child and family team ratio shall be reflective of the needs of individual children/youth and families being served and shall not exceed a ratio of one facilitator to 10 child/youth and family teams. The number of child and family teams for one facilitator may increase to a maximum of 12 when two child/youth and family teams are transitioning from Wraparound.



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- If facilitators are assigned to other programs as well as Wraparound, the number of Wraparound child/youth and family teams they facilitate shall correlate to the percentage of their position dedicated to providing Wraparound facilitation. For example, if a worker is a .50 FTE Wraparound facilitator, the number of teams assigned to that Wraparound facilitator shall not exceed six when one team is in transition. In addition, facilitators who have other roles shall not exceed a total of 15 families across programs.

3.29.B. QUALIFIED STAFF [CHANGES MADE 7/1/20]

Wraparound facilitators must:

- Complete the MDHHS three-day new facilitator training within 90 days of hire. The Medicaid encounter cannot be reported until after completion of the initial training unless provisional approval has been applied for and granted by MDHHS.
- Complete a minimum of two MDHHS Wraparound trainings per calendar year.
- Demonstrate proficiency in facilitating the Wraparound process, as monitored by their supervisor.
- Participate in and complete MDHHS-required evaluation and fidelity tools.
- Possess a bachelor's degree and be a CMHP or be supervised by a CMHP.

Wraparound supervisors shall:

- Complete the MDHHS three-day Wraparound new facilitator training within 90 days of hire and one additional MDHHS supervisory training in their first year of supervision. If the supervisor is working directly with children and families, they must complete the initial training prior to reporting Medicaid encounters.
- Attend two MDHHS Wraparound trainings annually, one of which shall be a Wraparound supervisor-specific training.
- Participate on the Community Team.
- Provide individualized supervision and coaching to the Wraparound staff weekly based on their individual needs and experience, and maintain a supervision log. Supervision logs will be available at site reviews and re-enrollment.
- Ensure documentation of attendance at required trainings is maintained for all Wraparound staff and available for review upon request.

The Community Team shall:

- **(text deleted 7/1/20)**
- **(text deleted 7/1/20)**
- **Include representation from system partners, other child serving agencies and local community agencies. (text added 7/1/20)**
- Provide support to Wraparound staff, supervisors, and child/youth and family teams and problem-solve barriers/needs to improve outcomes for children/youth and families.



- Work as a collaborative body to improve community service delivery to children, youth and families. **(text added 7/1/20)**
- **(text deleted 7/1/20)**
- **(text deleted 7/1/20)**
- Provide support to other child serving community agencies who are experiencing challenges meeting the needs of children, youth and families with complex needs. **(text added 7/1/20)**
- Implement additional activities and responsibilities that reflect the individual needs of the community. **(text added 7/1/20)**

3.29.C. PLANS OF SERVICE

The Wraparound plan shall reflect a family-driven/youth-guided approach, and shall include the following:

- Evidence that the child/youth and family team completed each step/phase of the Wraparound process, including completion of the strengths/culture discoveries, needs assessments, crisis/safety support plans, Wraparound plans, outcomes, and the development of the team mission statement.
- Individualized child/youth and family outcomes that are developed and measured by each child/youth and family team.
- A strength-based, needs-driven, and culturally-relevant Wraparound plan that is stated in the language of the child/youth and family.
- Evidence of regular updates as the needs of the child/youth and family change (annual updates alone are not sufficient).
- Any services, supports, and interventions that are provided to the family.
- A mixture of formal and informal support and services.
- An individualized crisis/safety support plan that reflects the child's/youth's and family's strengths and culture, and seeks to build skills/competencies that reduce risk.
- Measurement of outcomes identifying when transition plans should be developed. Transition plans will address any barriers to graduation, and identify how services and supports will be maintained after Wraparound has ended.
- Evidence that the child/youth and family team review and measure outcomes at least monthly and present outcomes and measurement to the Community Team for their review at least quarterly.

3.29.D. AMOUNT AND SCOPE OF SERVICE

- All Wraparound team meetings shall be documented in the form of minutes.
- All collateral contacts shall be documented in the form of contact/progress notes.
- Meeting frequency is guided by the family's needs and level of risk. Child/youth and family teams shall meet weekly until the Wraparound plan has been developed and is being implemented.



- Exceptions to Wraparound model expectations regarding the frequency of meetings can occur to fit the family's need and availability, and must be documented in the case file.
- When the Wraparound plan is successfully implemented and the child/youth and family have stabilized, meeting frequency may decrease to twice monthly.
- Wraparound child/youth and family teams begin to transition from the formal process when the outcomes identified by child/youth and family teams are met and shall not exceed three months in duration. Monthly meetings may occur during the transition phase.
- When the transition phase is successfully completed, the child/youth and family will graduate from the process.
- Upon graduation, documentation will be developed that will include the strengths and needs identified by the child/youth and family team, progress toward outcomes, continuing services and supports, and who will provide them. The family will receive a copy of this document.

3.29.E. EVALUATION AND OUTCOMES MEASUREMENT

The enrolled provider will comply with the State of Michigan Wraparound evaluation requirements. Current evaluation requirements are:

- Completion of the Family Status Report form at intake and every three months until the family graduates from Wraparound. Upon graduation, the facilitator will complete the post-graduation/follow-up Family Status Report.
- Additional evaluation tools will be completed as identified and requested by MDHHS.
- Ensure completion of the Child and Adolescent Functional Assessment Scale (CAFAS), the Preschool and Early Childhood Functional Assessment Scale (PECFAS), or the Devereux Early Childhood Assessment (DECA) at intake, quarterly, and at graduation.
- Adherence to Wraparound model fidelity may be reviewed at enrollment, re-enrollment, and at technical assistance visits through file review, family interviews, and evaluation and fidelity tools.



SECTION 4 – ASSERTIVE COMMUNITY TREATMENT PROGRAM

Assertive Community Treatment (ACT) is a therapeutic set of intensive clinical, medical and psychosocial services provided by a mobile multi-disciplinary treatment team that includes case/care management, psychiatric services, counseling/psychotherapy, housing support, Substance Use Disorders treatment, and employment and rehabilitative services provided in the beneficiary's home or community.

ACT provides basic services and supports essential to maintaining the beneficiary's ability to function in community settings, including assistance with accessing basic needs through available community resources (such as food, housing, medical care and supports) to allow beneficiaries to function in social, educational, and vocational settings.

ACT is an individually tailored combination of services and supports that may vary in intensity over time and is based on individual need. ACT includes availability of multiple daily contacts and 24-hour, 7-days-per-week crisis availability provided by the multi-disciplinary ACT team which includes psychiatric and skilled medical staff. ACT services are based on the principles of recovery and person-centered practice and are individually tailored to meet the needs of each beneficiary. Services are provided in the beneficiary's residence or other community locations by all members of the ACT team staff.

The Prepaid Inpatient Health Plans (PIHPs) and the Community Behavioral Health Services Programs (CMHSPs) offer a continuum of adult services including case/care management, outpatient therapy, and psychiatric services that can be used in varying intensities and combinations to assist beneficiaries in a recovery-oriented system of care. The beneficiary's level of need and preferences must be considered in the admission process. ACT is the most intensive non-residential service in the continuum of care within the service array of the public behavioral health system.

4.1 TEAM APPROVAL

Medicaid providers wishing to become providers of ACT services must obtain approval from MDHHS and meet the program components outlined below. Provider programs with more than one ACT team must have individually approved and registered ACT teams. All ACT teams are subject to MDHHS re-approval every three years.

4.2 TARGET POPULATION

The intensity of ACT services is intended for the beneficiary with a primary diagnosis of serious mental illness and who, without ACT, would require more restrictive services and/or settings. ACT is not an appropriate service for a beneficiary with a primary diagnosis of a personality disorder, a primary diagnosis of a Substance Use Disorder, or a primary diagnosis of intellectual or developmental disability. A beneficiary with a primary diagnosis of a serious mental illness may also be diagnosed with a personality disorder or co-occurring Substance Use Disorder and benefit from ACT services.

ACT services are targeted to beneficiaries demonstrating acute or severe psychiatric symptoms that are seriously impairing the beneficiary's ability to function independently, and whose symptoms impede the return of normal functioning as a result of the diagnosis of a serious mental illness. Areas of impairment are significant and are considered individually for each beneficiary.



These areas of difficulty may include:

- Maintaining or having interpersonal relationships with family and friends;
- Accessing needed mental health and physical health care;
- Addressing issues relating to aging, especially where symptoms of serious mental illness may be exacerbated or confused by complex medical conditions or complex medication regimens;
- Performing activities of daily living or other life skills;
- Managing medications without ongoing support;
- Maintaining housing;
- Avoiding arrest and incarceration, navigating the legal system, and transitioning back to the community from jail or prison;
- Coping with relapses or return of symptoms given an increase in psychosocial stressors or changes in the environment resulting in frequent use of hospital services, emergency departments, crisis services, crisis residential programs or homeless shelters;
- Maintaining recovery to meet the challenges of a co-occurring Substance Use Disorder;
- Encountering difficulty in past or present progress toward recovery despite participation in long-term and/or intensive services.



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4.3 ESSENTIAL ELEMENTS [CHANGES MADE 4/1/20 & 7/1/20]

<p>Team-Based Service Delivery</p>	<p>ACT is a team-based behavioral health service that includes shared service delivery responsibility that provides consistent continuity of care. Case/care management, psychiatric services, counseling/psychotherapy, peer support services, housing support, substance use disorder treatment, employment and rehabilitative services are interwoven with treatment and rehabilitative services, and services are provided by all members of the ACT team in the beneficiary’s home or community.</p> <p>All ACT staff must obtain a basic knowledge of ACT programs and principles acquired through participation in MDHHS-approved ACT-specific initial training, and subsequent participation in at least one MDHHS-approved ACT-specific training annually thereafter. All initial training of ACT staff must occur within six months of hire for work in ACT. Physicians/Nurse Practitioners/Physician’s Assistants/Clinical Nurse Specialists must participate in the MDHHS-approved Physicians/Nurse Practitioners/Physician’s Assistants/Clinical Nurse Specialists training one time, with additional ACT training/participation for Physicians/Nurse Practitioners/Physician’s Assistants/Clinical Nurse Specialists encouraged, but not mandatory.</p> <p>Team meetings occur Monday through Friday on business days and are attended by all ACT staff members on duty. Physicians, Nurse Practitioners, Physician’s Assistants or Clinical Nurse Specialists are expected to participate in ACT team meetings at least weekly. Agendas for daily team meetings include the status of all beneficiaries, updates from on-call, clinical and case/care management needs, crisis management, schedule organization, and finalized plans for ACT staff deployment into the community.</p> <p>A minimum of 80% of ACT contacts provided by the team are in the beneficiary’s home or other agreed upon community location. Treatment groups identified in the Individual Plan of Service (IPOS), such as Family Psychoeducation, Alcoholics Anonymous, etc., are excluded from the 80% community visit standard regardless of where the group is held.</p> <p>The average number of visits per day/week/month/etc. provided by the whole team, not individual ACT team members, to an individual consumer will comprise 80% of home or community contacts.</p>
<p>Team Composition and Size</p> <p><i>A minimum of 80% of ACT contacts provided by the team are in the beneficiary’s home or other agreed-upon community location.</i></p>	<p>The ACT team requires a sufficient number of qualified staff to assure the provision of an intensive array of services on a 24-hour basis. The minimum ACT staffing requirements are below. The scope of services for individual ACT staff members requires that some staff will work in the community more often than others. An ACT team operates minimally with 4 FTE staff and with no more than 9 FTE staff members. Teams average 6-7 FTE staff. If an ACT team believes it is necessary to operate outside of team requirements, consult with MDHHS regarding feasibility. If appropriate, a waiver request may be submitted to the PIHP. If approved, the PIHP will submit the request to MDHHS for consideration of approval.</p> <ul style="list-style-type: none"> ▪ A full-time team leader whose experience includes at least two years post-degree clinical work with adults who have a serious mental illness, and is fully licensed, minimally possessing a master’s degree in a relevant discipline, with appropriate licensure to provide clinical supervision to the ACT team staff. The ACT team leader leads the team, provides clinical supervision to team members, and provides direct services to beneficiaries in the community within their individual scope of practice. The fully licensed ACT team leader also meets the requirements of a MHP. (revised 4/1/20)



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The average number of visits per day/week/month/etc. provided by the whole team, not individual ACT team members, to an individual consumer will comprise 80% of home or community contacts.

Telepractice is the use of telecommunications and information technologies for the provision of psychiatric services to ACT consumers and is subject to the same service provisions as psychiatric services provided in person. The telepractice modifier, 95, must be used in conjunction with ACT encounter reporting code H0039 when telepractice is used.

All telepractice interactions shall occur through real-time interactions between the ACT consumer and the physician/nurse practitioner/physician's assistant/clinical nurse specialist from their respective physical location. Psychiatric services are the only ACT services that are approved to be provided in this manner.

- A full-time registered nurse (RN) is required on the ACT team. The RN provides integrated behavioral and physical healthcare, including managing medication, assessing and coordinating physical/medical care, and providing direct services to the beneficiary in the community.
- A physician who provides psychiatric coverage for all beneficiaries served by the ACT team is required. The physician is considered a part of the ACT team, but is not counted in the staff-to-beneficiary ratio. The physician participates in the team meeting at least weekly and is assigned to the ACT team at least 15 minutes per beneficiary per week in a capacity that allows for immediate access to the physician so that emergency, urgent or emergent situations may be addressed. The expectation is that some beneficiaries will need more physician time and some beneficiaries will need less time during any given week. The physician may delegate psychiatric activities to a nurse practitioner, physician's assistant or clinical nurse specialist, but the nurse practitioner, physician's assistant or clinical nurse specialist must be supervised by that physician. Typically, although not exclusively, physician activities may include team meetings, beneficiary appointments during regular office hours, psychiatric evaluations, psychiatric meetings/consultations, medication reviews, home visits, telephone consultations and telepractice. The physician (MD or DO) must possess a valid license to practice medicine in Michigan, a Michigan Controlled Substance License, and a Drug Enforcement Administration (DEA) registration.
- A physician assistant may perform clinical tasks under the terms of a practice agreement with a participating physician. The physician assistant must hold a current physician assistant license and a controlled substance license in Michigan. The physician assistant is not counted in the staff-to-beneficiary ratio. Typically, although not exclusively, physician assistant activities may include team meetings, beneficiary appointments during regular office hours, evaluations, psychiatric meetings/consultations, medication reviews, home visits, telephone consultations and telepractice.
- A nurse practitioner or clinical nurse specialist may perform clinical tasks delegated by and under the supervision of the physician. The nurse practitioner/clinical nurse specialist must hold a specialty certification as a nurse practitioner/clinical nurse specialist in Michigan, a current license to practice nursing in Michigan, and a master's degree in psychiatric mental health nursing. If the ACT team includes a nurse practitioner/clinical nurse specialist, he/she may substitute for a portion of the physician time, but may not substitute for the ACT RN. The nurse practitioner/clinical nurse specialist is not counted in the staff-to-beneficiary ratio. Typically, although not exclusively, nurse practitioner/clinical nurse specialist activities may include team meetings, beneficiary appointments during regular office hours, evaluations, psychiatric meetings/consultations, medication reviews, home visits, telephone consultations and telepractice.
- A case or care manager, possessing minimally a bachelor's degree in a human services discipline, who possesses appropriate licensure to provide the core elements of case or care management with at least one year of experience providing services to adults with a mental illness, and is a QMHP. If the case or care manager has a bachelor's degree but is without one year of experience working with adults with serious mental illness or co-occurring disorders and otherwise meets the requirements of the QMHP, documentation of clinical supervision is provided in the beneficiary record. **(revised 4/1/20)**



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<p><i>Refer to the General Information for Providers Chapter of this manual for the complete Health Insurance Portability and Accountability Act (HIPAA) compliance requirements for the provision of telepractice services.</i></p> <p><i>Treatment Groups identified in the IPOS, such as Family Psychoeducation, Alcoholics Anonymous, etc., are excluded from the 80% community visit standard regardless of where the group is held.</i></p> <p><i>The scope of services for individual ACT staff members require that some staff will work in the community more often than others.</i></p>	<ul style="list-style-type: none"> ▪ Individual/family/group counseling provided by a MHP, including a limited-licensed master’s degree social worker who is supervised by a licensed master’s degree social worker. (revised 4/1/20) ▪ Up to one Full Time Equivalent (FTE) Peer Support Specialist (PSS) may substitute for one QMHP to achieve the 1:10 required staff-to-beneficiary ratio. Under the supervision of the ACT team leader, a PSS may provide documentation in beneficiary records. This supervision is documented in the beneficiary record. ▪ Up to one FTE paraprofessional staff to work with ACT teams may be counted in the staff-to-beneficiary ratio. Paraprofessional staff may have a bachelor’s degree or related training in a field other than behavioral sciences (e.g., certified occupational therapy assistance, home health care); or have a high school equivalency and work or life experience with adults with severe mental illness or co-occurring substance use disorders. ▪ If the ACT team provides substance use disorder services, there must be a designated Substance Abuse Treatment Specialist who has one or more credentials through the Michigan Certification Board of Addiction Professionals (MCBAP). If the ACT team provides co-occurring treatment or substance use disorder treatment, the Organization must have a substance use disorder treatment license issued by the State of Michigan. <p>Additional staff positions reflect the needs of the population, such as the ability to obtain housing, employment services and rehabilitative services for beneficiaries who request them, and shall minimally be a QMHP.</p>
<p>Staff-to-Beneficiary Ratio</p>	<p>The ACT team’s staff-to-beneficiary ratio shall be at least one FTE ACT staff to a maximum of 10 ACT beneficiaries, a 1:10 staff-to-beneficiary ratio. Teams serving large service areas, highly complex beneficiaries, or very high acuity beneficiaries may find a lower staff-to-beneficiary ratio better meets beneficiary needs and retains team capacity to quickly address emerging or acute treatment needs and adjust service contacts. With the exceptions of the limitations on paraprofessionals and certified peer support specialists described above, the staff ratio includes all ACT team members, excluding the clerical support staff and physicians, nurse practitioners, physician assistants, (revised 4/1/20) and clinical nurse specialists.</p>
<p>Fixed Point of Responsibility</p> <p><i>H0039 indicates provision of ACT service; place of service is indicated as hospital. (text added 7/1/20)</i></p>	<p>The ACT team is the fixed point of responsibility for the development of the individual plan of service (IPOS) using the person-centered planning process and for supporting beneficiaries in all aspects of community living. The process addresses all services and supports to be provided to or obtained for the beneficiary by the team, including consultation with other disciplines and/or coordination of other supportive services as appropriate. Care continuity is maintained with pre-admission screening, team contact during inpatient psychiatric hospitalizations, and team participation in transition and discharge planning. (text added 7/1/20)</p>



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<p>Availability of Services</p> <p><i>Pre-admission screens for ACT beneficiaries must be reported by including the TG modifier with the ACT encounter code of H0039.</i></p>	<p>Availability of ACT services must include:</p> <ul style="list-style-type: none"> ▪ 24-hour/7-day crisis response coverage (including psychiatric availability) that is handled directly by members of the ACT team. ▪ The ACT team is responsible for performing the required pre-admission screen for all beneficiaries enrolled in an ACT program seeking inpatient psychiatric admission. ▪ The capacity to provide a rapid response to early signs of relapse, including the capability to provide multiple contacts daily with beneficiaries in acute need or with emergent conditions. ▪ The ACT team has the ability to provide needed services to the beneficiary 7 days a week as per the IPOS.
<p>Individual Plan of Service (IPOS)</p>	<p>ACT services and interventions must be consistent and balanced through medical necessity and the preferences of the beneficiary while embracing person-centered principles, wellness and behavioral health recovery with a goal of maximizing independence and a progression into less intensive services.</p> <p>Beneficiaries with co-occurring substance use disorders must have both behavioral health and substance use disorders addressed in the IPOS.</p> <p>Beneficiaries who need a less intensive service than ACT, such as case/care management, have documentation in the IPOS detailing the transition plan to the new service and a plan to return to ACT should the need occur.</p>
<p>In Vivo Settings</p>	<p>ACT teams provide a wide array of clinical, medical and rehabilitative services during face-to-face interactions designed to promote the beneficiary’s growth in recovery. ACT services and supports are focused on acquiring needed behavioral health services, substance misuse services, physical health care, performing activities of daily living, obtaining and/or maintaining employment, developing leisure activities, developing and maintaining meaningful relationships, maintaining housing, avoiding arrest and incarceration, navigating the legal system, transitioning successfully into the community from jail or prison, and relapse prevention.</p> <p>Services for ACT beneficiaries may include those defined elsewhere in this chapter, as well as others that are consistent with individual preferences, professionally accepted standards of care, and that are medically necessary.</p> <p>ACT services may be used as an alternative to hospitalization as long as beneficiary health and safety issues can be reasonably well-managed with ACT supports that do not require 24-hour-per-day supervision.</p>

4.4 ELIGIBILITY CRITERIA

Utilization of ACT in high acuity conditions and situations allows beneficiaries to remain in their community of residence and may prevent the use of more restrictive alternatives which may be detrimental to a beneficiary’s existing natural supports and occupational roles. This level of care is appropriate for beneficiaries with a history of serious mental illness who may be at risk for inpatient hospitalization or intensive crisis residential or partial hospitalization services, but can remain safely in their communities with the considerable support and intensive interventions of ACT. In addition to meeting the following criteria, these beneficiaries may also be likely to require or benefit from continuing psychiatric rehabilitation.



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The ACT acute service selection guideline covers criteria in the following domains:

Diagnosis	The beneficiary must have a serious mental illness, as reflected in a primary, validated, current version of Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).
Severity of Illness	<p>Psychiatric Status</p> <ul style="list-style-type: none">▪ Prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness) which may manifest as intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions, ruminations, severe phobias, depression, etc., and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions, rituals, impaired reality testing and/or impairments in functioning and role performance. <p>Self-Care/Independent Functioning</p> <ul style="list-style-type: none">▪ Disruptions of self-care, limited ability to attend to basic physical needs (nutrition, shelter, etc.), seriously impaired interpersonal functioning, and/or significantly diminished capacity to meet educational/occupational/parental role performance expectations.▪ Drug/Medication Conditions - Drug/medication adherence and/or a co-existing general medical condition which needs to be simultaneously addressed along with the psychiatric illness and which cannot be carried out at a less intensive level of care. Medication use requires monitoring or evaluation for adherence to achieve stabilization, to identify atypical side effects or concurrent physical symptoms and medical conditions.▪ Risk to Self or Others - Symptom acuity does not pose an immediate risk of substantial harm to the beneficiary or others, or if a risk of substantial harm exists, protective care (with appropriate medical/psychiatric supervision) has been arranged. Harm or danger to self, self-mutilation and/or reckless endangerment or other self-injurious activity is an imminent risk.



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Intensity of Service	<p>ACT team services are medically necessary to provide treatment in the least restrictive setting, to allow beneficiaries to remain in the community, to improve the beneficiary's condition and /or allow the beneficiary to function without more restrictive care, and the beneficiary requires at least one of the following:</p> <ul style="list-style-type: none">▪ An intensive team-based service is needed to prevent elevation of symptom acuity, to recover functional living skills and maintain or preserve adult role functions, and to strengthen internal coping resources; ongoing monitoring of psychotropic regimen and stabilization necessary for recovery.▪ The beneficiary's acute psychiatric crisis requires intensive, coordinated and sustained treatment services and supports to maintain functioning, arrest regression and forestall the need for inpatient care in a 24-hour protective environment.▪ The beneficiary has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but requires intensive coordinated services and supports.▪ Consistent observation and supervision of behavior are needed to compensate for impaired reality testing, temporarily deficient internal controls, and/or faulty self-preservation inclinations.▪ Frequent monitoring of medication regimen and response is necessary and adherence is doubtful without ongoing monitoring and support.▪ Routine medical observation and monitoring are required to affect significant regulation of psychotropic medications and/or to minimize serious side effects.
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<p>Discharge</p> <p><i>For beneficiaries who have progressed forward on their journey toward recovery and are ready for a less intensive service, the IPOS should document the transition from ACT to a less intensive service, such as case/care management.</i></p>	<p>Cessation or control of symptoms is not sufficient for discharge from ACT. For beneficiaries who have progressed forward on their journey toward recovery and are ready for a less intensive service, the IPOS should document the transition from ACT to a less intensive service, such as case/care management. Recovery must be sufficient to maintain functioning without the support of ACT as identified through the person-centered planning process as described below:</p> <ul style="list-style-type: none">▪ The beneficiary no longer meets severity-of-illness criteria and has demonstrated the ability to meet all major role functions for a period of time sufficient to show clinical stability. <p>Beneficiaries who meet medical-necessity criteria for ACT services usually require and benefit from long-term participation in ACT. ACT is not a service that is appropriate for short-term stabilization and then transition into another program.</p> <p>If a beneficiary requests transition to other service(s) because he/she believes maximum benefit has been reached in ACT, consideration for transition into less intensive services must be reviewed during the person-centered planning process. If clinical evidence supports the beneficiary's desire to transition, this evidence and the transition plan must be detailed in a revised IPOS developed through the person-centered planning process. The plan must identify what supports and services will be made available, and contain a provision for re-enrollment into ACT services, if needed.</p> <ul style="list-style-type: none">▪ Engagement of the beneficiary in ACT is not possible as deliberate, persistent and frequent assertive team outreach, including face-to-face engagement attempts and legal mechanisms when necessary, have been consistent, unsuccessful, and documented over many months, and an appropriate alternative plan has been established with the beneficiary.▪ Beneficiary has moved outside of the geographic service area. Contact continues until service has been established in the new location.
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SECTION 5 – CLUBHOUSE MODEL PROGRAMS

A Clubhouse is a community-based program organized to support individuals living with mental illness. Participants are known as Clubhouse members, and member choice is a key feature of the model. Clubhouses are vibrant, dynamic communities where meaningful work opportunities drive the need for member participation, thereby creating an environment where empowerment, relationship-building, skill development and related competencies are gained. Through what is referred to as the work-ordered day, the Clubhouse provides opportunities for member involvement and ownership in all areas of Clubhouse operation. Members and staff work side-by-side in the program as colleagues. Comprehensive opportunities are provided within the Clubhouse, including supports and services related to employment, education, housing, community inclusion, wellness, community resources, advocacy, and recovery. In addition, members participate in the day-to-day decision-making and governance of the program. Through Clubhouse involvement, members achieve or regain the confidence and skills necessary to lead satisfying, meaningful lives and successfully manage their mental illness. The Clubhouse model is included in the National Registry of Evidence-based Programs and Practices (NREPP), which can be found on the NREPP website. (Refer to the Directory Appendix for website information.)

5.1 PROGRAM APPROVAL

- PIHPs must seek approval for providers of Clubhouse services from the MDHHS Behavioral Health Developmental Disabilities Administration (BHDDA).
- To ensure fidelity to the model of the evidence-based practice of Psychosocial Rehabilitation, Clubhouses must acquire and maintain Clubhouse International accreditation. Additional information regarding Clubhouse International accreditation is available on the International Center for Clubhouse Development (ICCD) website. (Refer to the Directory Appendix for website information.)
- All new Clubhouses must participate in the Clubhouse International's New Clubhouse Development Training.
- MDHHS approval will be based on adherence to the requirements outlined below.

Requests for approval of Clubhouse services may be submitted to the MDHHS-BHDDA Community Practices and Innovation Section, Division of Quality Management & Planning. (Refer to the Directory Appendix for contact information.)

5.2 TARGET POPULATION

Clubhouse programs are appropriate for adults with a serious mental illness who wish to participate in a structured community with staff and peers and who desire to work on the goal areas reflected in the Core Psychiatric Rehabilitation Components subsection of this document. The beneficiary must be able to participate in, and benefit from, the activities necessary to support the program and its members.



5.3 ESSENTIAL ELEMENTS OF THE CLUBHOUSE MODEL

Member Choice/ Involvement	<p>Member choice and involvement are an ongoing essential process imbedded in all aspects of the Clubhouse model.</p> <ul style="list-style-type: none">▪ Membership is voluntary.▪ Clubhouse Membership is without time-limits; access to an intentional community supports the recovery process.▪ All members have access to the services/supports and resources with no differentiation based on diagnosis or level of functioning.▪ Members establish their own schedule of attendance and choose a work unit that they will regularly participate in during the work-ordered day.▪ Members are actively engaged and supported on a regular basis by Clubhouse staff in the activities and tasks that they have chosen.▪ Membership in the program and access to supportive services reflects the beneficiary's preferences and needs, building on the person-centered planning process.▪ Both formal and informal decision-making opportunities are part of the Clubhouse work units and program structures. Members can influence and shape program operations. Clubhouse decisions are generally made by consensus.▪ Staff and members work side-by-side to generate and accomplish individual/team tasks and activities necessary for the development, support, and maintenance of the program.
Work-Ordered Day	<ul style="list-style-type: none">▪ The work-ordered day is a primary component of the program and provides an opportunity for members to regain self-worth, purpose, and confidence. It consists of tasks and activities necessary for the operation of the Clubhouse and typically occurs during normal business hours.▪ Although participation in the work-ordered day provides opportunities to develop a variety of interpersonal and vocationally related skills, it is not intended to be job-specific training.▪ Member participation in the work-ordered day provides experiences that will support members' recovery, and is designed to assist members to acquire personal, community and social competencies and to establish and navigate environmental support systems.▪ The program's structure and schedule identifies when the various program components occur (e.g., work-ordered day, vocational/educational). Other activities, such as self-help groups and social activities, are scheduled before or after the work-ordered day.▪ The work done in the Clubhouse is exclusively the work generated by the Clubhouse in the operation and enhancement of the Clubhouse community. No work for outside individuals or agencies, whether for pay or not, is acceptable work in the Clubhouse. Members are not paid for any Clubhouse work, nor are there any artificial reward systems.▪ The amount, scope, and variety of tasks are sufficient enough to engage the membership in meaningful activities throughout the work-ordered day.



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	<ul style="list-style-type: none"> ▪ All staff are Clubhouse generalists. Their responsibilities are housed in a unit and they routinely work side-by-side with members to complete unit work. ▪ Staff help to identify meaningful work opportunities for members and are able to facilitate workgroups. ▪ Staff are dynamic and skilled at developing relationships with members. Staff utilizes a strengths-based approach and promotes an equal culture with members, thereby allowing members to experience themselves as valued colleagues in the Clubhouse community.
Employment Services	<ul style="list-style-type: none"> ▪ The Clubhouse provides its own employment services, including Transitional Employment (TE), Supported Employment (SE), and Independent Employment (IE), consistent with Clubhouse International standards and guidelines, which are available on the ICCD website. (Refer to the Directory Appendix for website information.) ▪ Additional resources for benefits planning are available.
Educational Services	<ul style="list-style-type: none"> • The Clubhouse provides resources and connections to assist members with goals to return to formal educational settings. This should include some of the following supports: <ul style="list-style-type: none"> ➢ connections with local colleges and General Educational Development (GED) centers, ➢ assistance with admission and financial aid applications, ➢ tutoring assistance with fellow members when appropriate, ➢ formal education groups, and ➢ other activities that support member success. <p>Educational programming should be individualized and should enhance the Clubhouse work-ordered day.</p>
Community Supports	<ul style="list-style-type: none"> • Community support services are provided by members and staff of the Clubhouse. Community support activities are centered in the work unit structure of the Clubhouse and include outreach, entitlements, housing, advocacy, promoting wellness, as well as assistance in finding quality medical, psychological, pharmacological and substance use disorder treatment services in the community. • The Clubhouse has an advisory board that meets regularly to provide support. Advisory board composition includes individuals from the local community who are able to assist with connections and/or advice in areas such as employment, education, legal assistance, finances, and advocacy. The board also includes member leaders. • The Clubhouse must engage with the local community. Activities may include speaking engagements, connections with media outlets, awareness-raising, political advocacy, community service projects, open houses, participating with the statewide Clubhouse coalition, and relevant conferences. ▪ The Clubhouse ensures that access to the building, Clubhouse-sponsored community activities, and employment sites are available through public transportation or other alternative modes of transportation. The Clubhouse provides or arranges for effective alternatives whenever access to public transportation is limited.



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<p>Social Supports</p>	<ul style="list-style-type: none"> • Opportunities are available for members to develop a sense of a community through planning and organizing Clubhouse social activities. This may include opportunities to explore recreational resources and activities in the community. The interests and desires of the membership determine both spontaneous and planned activities. ▪ Members may have access to the Clubhouse programming during times other than the work-ordered day, including evenings, weekends, and holidays (New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day). Access during these times should be based on the needs of the Clubhouse community and decided by members and staff.
<p>Wellness Supports</p>	<ul style="list-style-type: none"> ▪ The Clubhouse supports and encourages physical wellness. This may include enhanced nutrition, weight loss, exercise, smoking cessation, and promoting wellness throughout the Clubhouse. Wellness opportunities occur both within the Clubhouse and through connections with community resources. ▪ The voluntary nature of the Clubhouse is respected for all wellness activities. Wellness programming should enhance the Clubhouse work-ordered day rather than detract from it.
<p>Community Setting</p>	<ul style="list-style-type: none"> ▪ The program is designed as an intentional community, rather than a clinical setting. The Clubhouse does not include clinical personnel such as psychiatrists, nurses, or therapists, nor does it include classes or groups that are of a clinical nature. ▪ The Clubhouse is located in its own physical space. It is separate from any mental health center or institutional settings, and is impermeable to other programs. The Clubhouse is designed to facilitate the work-ordered day and at the same time be attractive, adequate in size, and convey a sense of respect and dignity. ▪ To promote pride and ownership, the Clubhouse has its own identity, including its own name, mailing address, fax, e-mail, and telephone number. ▪ All Clubhouse space is member and staff accessible. There are no staff-only or members-only spaces. ▪ There are no staff-only or members-only meetings where program decisions are made.

5.4 CORE PSYCHIATRIC REHABILITATION COMPONENTS

The Clubhouse model is not limited to a narrow set of components. A broad contextual perspective is present throughout the Model.

<p>Broad Context</p>	<ul style="list-style-type: none"> ▪ The Clubhouse model is embedded in the overarching goals of psychiatric rehabilitation. The aims and objectives of Clubhouse communities are to support the access to preferred living, learning, working, and socialization roles for members in their communities. ▪ Outcomes that move beyond the clinical condition and facilitate the recovery process from mental illness are more relevant, such as social role functioning (e.g., meaningful roles in society; social inclusion), establishing relationships, social support networks and social capital, work, recreation, and improved quality of life.
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<p>Personal Goal Development</p>	<p>Each Clubhouse member has goals based on his or her Individual Plan of Service (IPS) developed through the Person-Centered planning process and carried out throughout the member’s participation in the Clubhouse. Staff may also work informally with members on individual recovery goals while working side-by-side in the Clubhouse.</p>
<p>Psychiatric Rehabilitation Components, Goals and Objectives</p>	<p>Clubhouse environments support recovery in a variety of ways. Generally, expected outcomes associated with accredited Clubhouse participation include greater personal and interpersonal competencies, links with community resources, access to social support networks, increased illness and symptom management, vocational and educational competencies and opportunities, and overall increased personal independence and psychosocial functioning.</p> <ul style="list-style-type: none"> • Competency Building <ul style="list-style-type: none"> Community living competencies (e.g., self-care, cooking, money management, personal grooming, maintenance of living environment) are built and include: <ul style="list-style-type: none"> ➤ Social and interpersonal competencies (e.g., conversational competency, developing and/or maintaining positive self-image, interpersonal problem-solving, regaining the ability to evaluate the motivation and feelings of others to establish and maintain positive relationships). ➤ Personal adjustment competencies (e.g., developing and enhancing intrapersonal abilities and problem-solving in everyday experiences, resolving crises, or managing stress with the goal of facilitating self-efficacy and personal independence). ➤ Vocational competencies (e.g., focused tasks that teach how to apply for jobs, conduct employment interviews, provide opportunities of graded steps to promote job entry or reentry, improve co-worker communication and relationships, and task focus and completion). ➤ Cognitive competency (e.g., task-oriented activities to develop and maintain cognitive abilities, maximize independent functioning such as increased attention, improved concentration, better memory, and enhanced empathy). • Community Support, Inclusion, and Participation <ul style="list-style-type: none"> Identification of support, inclusion and participation through existing natural supports is necessary to: <ul style="list-style-type: none"> ➤ Achieve optimal levels of community membership ➤ Increase satisfaction with living environment ➤ Support community participation and integration/inclusion ➤ Reduce stigma through education, community awareness, and community networking ➤ Facilitate social capital via peer and social networks, both internal and external to Clubhouse ➤ Promote utilization of organizational support, community resources, and other collateral support systems, as well as linking with community resources, supports, and services for continuity of care.



	<ul style="list-style-type: none">▪ Illness Management and Recovery The identification and management of situations and prodromal symptoms to reduce the frequency, duration, and severity of psychiatric relapses include the following:<ul style="list-style-type: none">➤ Gaining competence regarding how to respond to and manage a psychiatric crisis (includes working in partnership with members who express desire to develop a recovery plan and incorporate natural supports in crisis planning).➤ Gaining competence in understanding the role psychotropic medication plays in the stabilization of the members' well-being or recovery.➤ Working in partnership to increase confidence and personal self-efficacy through Clubhouse participation.➤ Gaining access to holistic approaches to recovery that includes education, information and support for health and personal wellness.➤ Gaining access to information to support decision making and increased empowerment through Clubhouse participation.• Recovery Enhancing Environment An environment that fosters strength and resilience and practices the inclusion of the following:<ul style="list-style-type: none">➤ Is collaborative and non-hierarchical;➤ Supports work and high levels of activity;➤ Respects choice and control; and➤ Provides access to social and peer support.
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5.5 DOCUMENTATION

Documentation of members' progress in the Clubhouse modality differs from documentation requirements in individual treatment modalities and is demonstrated in the following process.

- Recovery progress can be documented in a variety of ways and, at a minimum, should be documented on at least a monthly basis.
- The documentation process, regardless of the established frequency or process, should be streamlined to minimally disrupt the work-ordered day.
- Progress note processing should be integrated into unit work.
- Members have the opportunity to write his or her own progress notes.
- Generally, all notes should be signed by both members and staff.

5.6 ELIGIBILITY

Clubhouse services are intended for beneficiaries with a primary diagnosis of serious mental illness. Clubhouse is not an appropriate service for beneficiaries with a primary intellectual/developmental disability.



Clubhouse services are not appropriate for beneficiaries who exhibit:

- Behaviors that would threaten or pose a current health and safety risk to themselves or others.
- A severity of symptoms requiring a more intensive level of treatment.
- Behaviors that disrupt the daily work of the Clubhouse.
- Behaviors that require excessive redirection and/or monitoring.

The Clubhouse director has the responsibility to ensure the safety of the Clubhouse.

All changes to a member's service provision must follow due process and all policies and procedures at local, state, and federal levels.

Discharge criteria are only met if the member moves on voluntarily or if one or more of the above criteria are met. Cessation or control of symptoms alone is not sufficient criteria for discharge from the Clubhouse.

5.7 STAFF CAPACITY

Clubhouse staff effectively facilitate the program with direct, inclusive and collegial member involvement. Sufficient staffing ratios allow for employment development, Transitional Employment management/coverage, supported education, and consistent engagement of the membership throughout the work-ordered day.

Clubhouse staff shall include:

- One full-time on-site Clubhouse director who has a minimum of:
 - A bachelor's degree in a health or human services field and is licensed, certified or registered by the State of Michigan or a national organization to provide health care services, with two years' experience working at a Clubhouse accredited by Clubhouse International; or
 - A master's degree in a health or human services field with appropriate licensure and one year experience working at a Clubhouse.
- Other diverse and uniquely qualified professional staff, typically with a bachelor's education level. If staff are not licensed, certified or registered by the State of Michigan or a national organization to provide health care services, they shall operate under a qualified professional.

All Clubhouse staff function as generalists sharing Clubhouse duties such as employment, social recreation, evening, weekend, and holiday coverage. All Clubhouse generalist staff should be paid at a level commensurate with like staff at the auspice agency. The Clubhouse director is responsible for all aspects of Clubhouse operations. Members are actively involved in the hiring process for both directors and generalists. Exceptions may be requested to the above staffing requirements and/or qualifications and must be submitted in writing to MDHHS for review and potential approval.



5.8 TRAINING REQUIREMENTS

All Clubhouse staff must have a basic knowledge of the Clubhouse Model acquired through MDHHS approved Clubhouse-specific training within six months of hire, and then at least one MDHHS-approved Clubhouse specific training annually. In addition, as part of the accreditation process, the Clubhouse director, members, staff and other appropriate persons participate in a comprehensive training program in the Clubhouse Model at an accredited training base. This team will also schedule a six-month follow-up site visit with the Training Base Clubhouse.

- This training requires the development of an action plan for developing the Clubhouse; and upon returning from training, all Clubhouses will submit their action plan to MDHHS.
- Exceptions may be requested to the above training requirements and must be submitted in writing to MDHHS for review and potential approval.



SECTION 6 – CRISIS RESIDENTIAL SERVICES

Crisis residential services are intended to provide a short-term alternative to inpatient psychiatric services for beneficiaries experiencing an acute psychiatric crisis when clinically indicated. Services may only be used to avert an inpatient psychiatric admission, or to shorten the length of an inpatient stay.

6.1 POPULATION

Services are designed for a subset of beneficiaries who meet psychiatric inpatient admission criteria or are at risk of admission, but who can be appropriately served in settings less intensive than a hospital. The goal of crisis residential services is to facilitate reduction in the intensity of those factors that lead to crisis residential admission through a person-centered/Family Driven, Youth-Guided, and recovery/resiliency-oriented approach.

6.2 COVERED SERVICES

Services must be designed to resolve the immediate crisis and improve the functioning level of the beneficiaries to allow them to return to less intensive community living as soon as possible.

The covered crisis residential services include:

- Psychiatric supervision;
- Therapeutic support services;
- Medication management/stabilization and education;
- Behavioral services;
- Milieu therapy; and
- Nursing services.

Individuals who are admitted to the crisis residential services must be offered the opportunity to explore and learn more about crises, substance abuse, identity, values, choices and choice-making, recovery and recovery planning. Recovery and recovery planning is inclusive of all aspects of life including relationships, where to live, training, employment, daily activities, and physical well-being.

6.2.A. CHILD CRISIS RESIDENTIAL SERVICES

Child Crisis Residential Services may not be provided to children with serious emotional disturbances in a Child Caring Institution (CCI) unless it is licensed as a "children's therapeutic group home" as defined in Section 722.111 Sec. 1(f) under Act No. 116 of the Public Acts of 1973, as amended. The program must include on-site nursing services (RN or LPN under appropriate supervision). On-site nursing must be provided at least one hour per day, per resident, seven days per week, with 24-hour availability on-call.



6.2.B. ADULT CRISIS RESIDENTIAL SERVICES

The program must include on-site nursing services (RN or LPN under appropriate supervision).

- For settings of six beds or fewer: on-site nursing must be provided at least one hour per day, per resident, seven days per week, with 24-hour availability on-call.
- For 7-16 beds: on-site nursing must be provided eight hours per day, seven days per week, with 24-hour availability on-call.

6.3 PROVIDER CRITERIA [CHANGE MADE 10/1/20]

The PIHP must seek and maintain MDHHS approval through an enrollment process (text added 10/1/20) for the crisis residential program in order to use Medicaid funds for program services.

6.4 QUALIFIED STAFF

Treatment services must be clinically-supervised by a psychiatrist. A psychiatrist need not be present when services are delivered but must be available by telephone at all times. The psychiatrist shall provide psychiatric evaluation or assessments at the crisis residential home or at an appropriate location in the community. A psychiatric evaluation completed by a treating psychiatrist that resulted in the admission to the program fulfills this requirement as long as the program psychiatrist has consulted with that physician as part of the admission process. Medication reviews performed at the crisis residential home must be performed by appropriately licensed medical personnel acting within their scope of practice and under the clinical supervision of the psychiatrist. The covered crisis residential services (refer to Covered Services subsection) must be supervised on-site eight hours a day, Monday through Friday (and on call at all other times), by a mental health professional possessing at least a master's degree in human services and one year of experience providing services to beneficiaries with serious mental illness, or a bachelor's degree in human services and at least two years of experience providing services to beneficiaries with serious mental illness.

Treatment activities may be carried out by paraprofessional staff who have at least one year of satisfactory work experience providing services to beneficiaries with mental illness, or who have successfully completed a PIHP/MDHHS-approved training program for working with beneficiaries with mental illness.

Peer support specialists may be part of the multidisciplinary team and can facilitate some of the activities based on their scope of practice, such as facilitating peer support groups, assisting in transitioning individuals to less intensive services, and by mentoring towards recovery.

6.5 LOCATION OF SERVICES

Services must be provided to beneficiaries in licensed crisis residential foster care or group home settings not exceeding 16 beds in size. Homes/settings must have appropriate licensure from the state and must be approved by MDHHS to provide specialized crisis residential services. Services must not be provided in a hospital or other institutional setting.



6.6 ADMISSION CRITERIA

Crisis residential services may be provided to adults or children who are assessed by, and admitted through, the authority of the local PIHP. Beneficiaries must meet psychiatric inpatient admission criteria but have symptoms and risk levels that permit them to be treated in such alternative settings. Services are designed for beneficiaries with mental illness or beneficiaries with mental illness and another concomitant disorder, such as substance abuse or developmental disabilities. For beneficiaries with a concomitant disorder, the primary reason for service must be mental illness.

6.7 DURATION OF SERVICES

Services may be provided for a period up to 14 calendar days per crisis residential episode. Services may be extended and regularly monitored, if justified by clinical need, as determined by the interdisciplinary team.

6.8 INDIVIDUAL PLAN OF SERVICE

Services must be delivered according to an individual plan based on an assessment of immediate need. The plan must be developed within 48 hours of admission and signed by the beneficiary (if possible), the parent or guardian, the psychiatrist, and any other professionals involved in treatment planning, as determined by the needs of the beneficiary. If the beneficiary has an assigned case manager, the case manager must be involved in the treatment as soon as possible, and must also be involved in follow-up services.

The plan must contain:

- Clearly stated goals and measurable objectives, derived from the assessment of immediate need, stated in terms of specific observable changes in behavior, skills, attitudes, or circumstances, structured to resolve the crisis.
- Identification of the activities designed to assist the beneficiary to attain his/her goals and objectives.
- Discharge plans, the need for aftercare/follow-up services, and the role of, and identification of, the case manager.

If the length of stay in the crisis residential program exceeds 14 days, an interdisciplinary team must develop a subsequent plan based on comprehensive assessments. The team is comprised of the beneficiary, the parent or guardian, the psychiatrist, the case manager and other professionals whose disciplines are relevant to the needs of the beneficiary, including the individual ACT team, outpatient services provider or home-based services staff, when applicable. If the beneficiary did not have a case manager prior to initiation of the intensive crisis residential service, and the crisis episode exceeds 14 days, a case manager must be assigned and involved in treatment and follow-up care. (The case manager may be assigned prior to the 14 days, according to need.)

For children's intensive crisis residential services, the plan must also address the child's needs in context with the family's needs. Educational services must also be considered and the plan must be developed in consultation with the child's school district staff.



SECTION 7 – HOME-BASED SERVICES

Mental health home-based services programs are designed to provide intensive services to children and their families with multiple service needs who require access to an array of mental health services. The primary goals of these programs are to support families in meeting their child's developmental needs, to support and preserve families, to reunite families who have been separated, and to provide effective treatment and community supports to address risks that may increase the likelihood of a child being placed outside the home. Treatment is based on the child's needs, with the focus on the family unit. The service style must support a family-driven and youth-guided approach, emphasizing strength-based, culturally relevant interventions, parent/youth and professional teamwork, and connection with community resources and supports.

NOTE: This service is a State Plan EPSDT service when delivered to children under 21 years of age.

7.1 PROGRAM APPROVAL [CHANGES MADE 7/1/20]

Applications for enrollment must identify home-based providers, either internal or contractual, who will serve children under 21 years of age. Home-based services can be provided by one or more providers who serve one or more age groups. Once enrolled, a program must re-enroll every three years. (Refer to the Directory Appendix for contact information.) MDHHS approval will be based on adherence to the requirements outlined below.

Applications for enrollment must identify the target population to be served by the program. Providers must assure that staff providing home-based services meet the required qualifications. Information submitted to MDHHS must include basic program information submitted in a format prescribed by MDHHS. If necessary during an initial period, the provider may receive provisional approval that will allow them to provide services. However, any necessary additional actions must be completed within the timeframe specified by MDHHS or provisional approval will be withdrawn.



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Organizational Structure

The organizational structure through which the mental health home-based services program shall be delivered must be specified. The following requirements must be met:

- Enrolled home-based services providers are available and sufficient to ensure that home-based services are provided to children **beginning prenatally to age 17 (revised 7/1/20)** and meet the need across the entire catchment area.
- Responsibility for directing, coordinating, and supervising the staff/program must be assigned to a specific staff position. The supervisor of the staff/program must meet the qualifications of a Qualified Mental Health Professional and be a child mental health professional with three years of clinical experience.
- One staff member or a team of staff may provide these services. Home-based services programs are designed to provide intensive services to children and families in their home and community. The degree of intensity will vary to meet the needs of families.
- The maximum full-time home-based services worker-to-family ratio is 1:12. This can be adjusted to accommodate families transitioning out of home-based services. The maximum worker-to-family ratio in those circumstances is 1:15 (12 active/3 transitioning).
- If providers wish to utilize clinicians who have more than one role in the agency (home-based services plus other services, e.g., outpatient, case management, etc.), the percentage of each position dedicated to home-based services must be specified. The number of home-based services families assigned to each partial position cannot exceed the same percentage of the maximum active home-based services families. For example, a 50% home-based position could serve no more than 6 home-based families. The total maximum number of families, including home-based and other services families, for a full-time clinician with multiple roles is 20 families.
- To determine the appropriate number of families for any home-based services worker, the intensity of service need presented by each family should be considered. The worker-to-family ratio can always be lower than the maximum to accommodate families with very high service needs.
- Home-based services staff must receive weekly clinical supervision (one-on-one and/or group) to help them navigate the intense needs of the families receiving home-based services. Evidence of the provision of this clinical supervision must be recorded via supervision logs, sign-in sheets, or other methods of documentation.
- The organization must have a policy or policies in place that support providing a comprehensive crisis/safety training curriculum that is required for all home-based services staff that includes de-escalation skills among other relevant trainings.
- There must be an internal mechanism for coordinating and integrating the home-based services with other mental health services, as well as general community services relevant to the needs of the child and family.



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Qualified Staff	<p>Properly credentialed staff must deliver home-based services. Home-based services professional staff must meet the qualifications of a child mental health professional. The initial training curriculum and 24 hours of annual child-specific training for home-based services staff should be relevant to the age groups served and the needs of the children and families receiving home-based services. For home-based services programs serving infants/toddlers (birth through age three) and their families, staff must be trained in infant mental health interventions and must minimally have Endorsement as Infant Family Specialist by the Michigan Association of Infant Mental Health; Infant Mental Health Specialist is preferred. (revised 7/1/20) For home-based services programs serving children with developmental disabilities, the child mental health professional must meet the qualifications, as defined above, and also be a Qualified Intellectual Disability Professional (QIDP).</p> <p>Trained paraprofessional assistants may assist home-based services professional staff with implementation of treatment plan behavioral goals related to positive skill development and development of age-appropriate social behaviors. Services to be provided by the home-based services assistant must be identified in the family plan of service, must relate to identified treatment goals, and must be under the supervision of relevant professionals. Home-based services assistants must be trained regarding the beneficiary's treatment plan and goals, including appropriate intervention and implementation strategies, prior to beginning work with the beneficiary and family. Activities of home-based services assistants do not count as part of the minimum four hours of face-to-face home-based services provided by the primary home-based services worker per month. The home-based services assistant's face-to-face time would be in addition to hours provided by the primary home-based services worker.</p>
Plan of Service	<p>Home-based services must be provided in accordance with a plan of service that focuses on the child and his family. The plan of service is a comprehensive plan that identifies child and family strengths and individual needs, determines appropriate interventions, and identifies supports and resources. It is developed in partnership with family members and other agencies through an equitable (text added 7/1/20) person-centered, family-driven and youth-guided planning process. The plan of service should include evidence of a blending of perspectives and information from the child/youth, family, home-based services worker, assessment tools, and other relevant parties. Goals should be based on family needs and priorities and reflect the family culture and voice. Refer to the Family-Driven and Youth-Guided Policy and Practice Guideline (attached to the MDHHS/PIHP contract) for more explicit information on this topic.</p> <p>The plan of service for youth receiving home-based services must also include individualized crisis and safety plans that explicitly outline responses to family-specific crisis situations and safety risks and delineate who, including the family and others, is accountable for the various responses identified.</p>



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<p>Amount and Scope of Service</p>	<p>Home-based services programs combine services to restore or enhance social, psychological, or biophysical functioning and promote resilience and optimal mental health (text added 7/1/20) of individuals, couples, or families and/or individual therapy, family therapy, group therapy, crisis intervention, case management, and collateral contacts. The family is defined as immediate or extended family or individual(s) acting in the role of family.</p> <p>Services provided in a home-based services program range from assisting beneficiaries to link to other resources that might provide food, housing, and medical care, as well as providing more therapeutic interventions such as family therapy or individual therapy, or services to restore or enhance functioning and promote resilience and optimal mental health (text added 7/1/20) for individuals, couples, or families.</p> <p>A minimum of four hours of individual and/or family face-to-face home-based services per month will be provided by the primary home-based services worker or, if appropriate, the evidence-based practice therapist. In addition, it is expected that adequate collateral contacts, including non-face-to-face collateral contacts, with school, caregivers, child welfare, court, psychiatrist, etc., will be provided to implement the plan of service.</p> <p>The amount and scope of home-based services to families as they transition out of home-based services into a less intensive service or to closure can be determined by family-driven and youth-guided decision making to maintain continuity of treatment and ensure stability. Variation from the required intensity of services for families transitioning out of home-based services must be documented in the plan of service. This transition period is not to exceed three months.</p> <p>Crisis intervention services must be available 24 hours a day, 7 days a week, via availability of home-based services staff or agency on-call staff. If after-hours crisis intervention services are provided to a family by staff other than the primary home-based services worker, procedures must be in place which provide the on-call staff access to information about any impending crisis situations and the family's crisis and safety plans.</p>
<p>Location of Service</p>	<p>Services are provided in the family home or community. Any contacts that occur other than in the home or community must be clearly explained in record documentation as to the reason, the expected duration, and the plan to address issues that are preventing the services from being provided in the home or community.</p>

7.2 ELIGIBILITY CRITERIA [CHANGE MADE 7/1/20]

The criteria for home-based services are described below for children birth through age three, children age four through age six, and children age seven through age seventeen. These criteria do not preclude the provision of home-based services to an adult beneficiary prenatally or (text added 7/1/20) who is a parent for whom it is determined home-based services would be the treatment modality that would best meet the needs of the adult beneficiary and the child. This would include a parent who has a diagnosis within the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) that results in a care-giving environment that places the child at-risk for serious emotional disturbance. These criteria do not preclude the provision of home-based services when it is determined through a person-centered, family-driven and youth-guided planning process that these services are necessary to meet the needs of the child and family. For continuing eligibility reviews during the transition to less intensive services, the child and family may be maintained in home-based services, even if they do not meet these criteria. Variation from the required



criteria for families transitioning out of home-based services must be documented in the plan of service. This transition period is not to exceed three months.

7.2.A. PRENATAL/BIRTH THROUGH AGE THREE [TITLE REVISED & CHANGES MADE 7/1/20]

Unique criteria must be applied to define serious emotional disturbance for the prenatal/birth (revised 7/1/20) to age three population, given:

- The magnitude and speed of developmental changes through pregnancy and infancy;
- The limited capacity of the very young to symptomatically present underlying disturbances;
- The extreme dependence of infants and toddlers upon caregivers for their survival and well-being; and
- The exceptional vulnerability of the very young to other relationship and environmental factors.

Operationally, the above parameters dictate that the mental health professional must be cognizant of the primary indicators of emotional disorder in very young children, and of the importance of assessing the constitutional/physiological and/or care-giving/ environmental factors which reinforce the severity and intractability of the child's disorder. Furthermore, the rapid development of very young children results in transitory disorders and/or symptoms, requiring the professional to regularly re-assess children in the appropriate developmental context.

The following is the recommended procedure for determining when a beneficiary is considered seriously emotionally disturbed or at high risk for serious emotional disturbance, qualifying for Mental Health Home-Based Services. All of the dimensions must be considered when determining if a child is eligible for home-based services.

Diagnosis	A child has an intellectual, behavioral, or emotional disorder sufficient to meet diagnostic criteria (specified within the current version of the DSM or ICD consistent with the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood; Revised Edition) not solely the result of an intellectual disability or other developmental disability, drug abuse/alcoholism or those with an ICD-9 V-code or ICD 10 Z-code diagnosis, and the beneficiary meets the criteria listed below for degree of disability/functional impairment and duration/service history.
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<p>Functional Impairment</p>	<p>Substantial interference with, or limitation of, the child’s proficiency in performing age-appropriate skills as demonstrated by at least one indicator drawn from one of the following areas:</p> <ul style="list-style-type: none"> General and/or specific patterns of reoccurring behaviors or expressiveness indicating affect/modulation problems, e.g., uncontrollable crying or screaming, sleeping and eating disturbances, and recklessness; the absence of developmentally expectable affect, such as pleasure, displeasure, joy, anger, fear, curiosity; apathy toward caregiver, absence of or inhibited exploration of environment, inability to maintain consistent placement in child care or other organized groups. (revised 7/1/20) Distinct behavioral patterns coupled with sensory, sensory motor, or organizational processing difficulty (homeostasis concerns) that inhibits the child’s daily adaptation and interaction/relationships. For example, absence or restricted range of exploration and/or play and assertiveness, (revised 7/1/20) dislike for changes in routine, and/or a tendency to be frightened and clinging in new situations, coupled with over-reactivity to loud noises or bright lights, inadequate visual-spatial processing ability, etc. Incapacity to obtain critical nurturing (often in the context of attachment-separation concerns), as determined through the assessment of child, caregiver and environmental characteristics. For example, the infant shows a lack of motor skills and/or language expressiveness; appears diffuse, unfocused and undifferentiated; expresses anger/obstinacy and whines, in the presence of a caregiver who often interferes with and/or suppresses (text added 7/1/20) the infant’s goals and desires, dominates the infant through over-control, does not reciprocate to the child’s gestures, and/or whose anger, depression or anxiety results in inconsistent care giving. <p>An assessment tool specifically targeting social-emotional functioning which can assist in determining functional impairment is the Devereux Early Childhood Assessment, Infant/Toddler or Clinical (revised 7/1/20) Version.</p> <p>Observational tools to assist in the assessment of infants, toddlers and their caregiver include the Massie Campbell Attachment During Stress (birth to 18 months of age) and Parenting Interactions with Children: Checklist of Observations Linked to Outcomes (PICCOLO) (for young children from 6 to 36 (revised 7/1/20) months).</p> <p>Other assessment tools (e.g., Trauma Assessment) (text added 7/1/20) may be utilized by the practitioner based on the needs of the infant/toddler or parent(s).</p>
<p>Duration/History</p>	<p>The very young age and rapid transition of infants and toddlers through developmental stages makes consistent symptomatology over time unlikely. However, indicators that a disorder is not transitory and will endure without intervention include:</p> <ul style="list-style-type: none"> The infant/toddler disorder(s) is affected by persistent multiple barriers to normal development (regulatory disorders, inconsistent care giving, chaotic environment, exposure to traumatic events, (text added 7/1/20) etc.); or Infant/toddler did not respond to less intensive, less restrictive intervention.

7.2.B. AGE FOUR THROUGH SIX [CHANGES MADE 7/1/20]

Decisions regarding whether a child age four through six is seriously emotionally disturbed and in need of home-based services and supports utilize similar dimensions to older children. The dimensions include a diagnosable behavioral or emotional disorder,



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substantial functional impairment/limitation of major life activities, and duration of condition. However, as with younger children birth through age three, assessment must be sensitive to the critical indicators of development and functional impairment for the age group. Significant impairments in functioning are revealed across life domains in the child’s expression of affect/self-regulation, social development (generalization of attachment beyond parents, capacity for peer relationships and play, etc.), physical and cognitive development, and the emergence of a sense of self. All of the dimensions must be considered when determining if a child is eligible for home-based services.

Diagnosis	A child has an intellectual, behavioral or emotional disorder sufficient to meet diagnostic criteria specified within the current version of the DSM or ICD not solely the result of an intellectual disability or other developmental disability, drug abuse/alcoholism or those with an ICD-9 V-code or ICD-10 Z-code diagnosis, and the beneficiary meets the criteria listed below for degree of disability/functional impairment and duration/service history.
Functional Impairment	<p>Substantial interference with, or limitation of, the child’s proficiency in performing age-appropriate skills across domains and/or consistently within specific domains as demonstrated by at least one indicator drawn from at least two of the following areas:</p> <ul style="list-style-type: none"> ▪ Impaired physical development, sensory, sensory motor or organizational processing difficulty, failure to control bodily functions (e.g., bed wetting). ▪ Limited cognitive development, as indicated by restricted vocabulary, memory, cause and effect thinking, ability to distinguish between real and pretend, transitioning from self-centered to more reality-based thinking, etc. ▪ Limited capacity for self-regulation, inability to control impulses and modulate emotions and/or (text added 7/1/20) anxieties as indicated by frequent tantrums or aggressiveness toward others, prolonged listlessness or depression, inability to cope with separation from primary caregiver, inflexibility and low frustration tolerance, etc. ▪ Impaired or delayed social development, as indicated by an inability to engage in interactive play with peers, inability to maintain consistent placements in child care (revised 7/1/20) or other organized groups, failure to display social values or empathy toward others, absence of imaginative play or verbalizations commonly used by preschoolers to reduce anxiety or assert order/control on their environment, etc. ▪ Care-giving factors which reinforce the severity or intractability of the childhood disorder and the need for multifaceted intervention strategies (e.g., home-based services) such as a chaotic household/constantly changing care-giving environments (e.g., child care), (text added 7/1/20) inappropriate caregiver expectations, abusive/neglectful or inconsistent care-giving, occurrence of traumatic events, subjection to others’ violent or otherwise harmful behavior. <p>The standardized assessment tool specifically targeting social-emotional functioning for children 4 through 6 years of age (text deleted 7/1/20) for use in determining degree of functional impairment is the Pre-School and Early Childhood Functional Assessment Scale (PECFAS).</p> <p>Additional assessment tools (e.g., Trauma Assessment) (text added 7/1/20) may be utilized based on the needs of the child and/or parent(s).</p>



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Duration/History	<p>The following specify length of time criteria for determining when the child’s functional disabilities justify his referral for enhanced support services:</p> <ul style="list-style-type: none"> ▪ Evidence of three continuous months of illness; ▪ Three cumulative months of symptomatology/dysfunction in a six-month period; or ▪ Conditions that are persistent in their expression and are not likely to change without intervention.
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7.2.C. AGE SEVEN THROUGH SEVENTEEN

NOTE: For EPSDT, this same criteria should be utilized to determine eligibility for home-based services for young adults ages 18-21.

Decisions regarding whether a child or adolescent has a serious emotional disturbance and is in need of home-based services is determined by using the following dimensions: the child has a diagnosable behavioral or emotional disorder, substantial functional impairment/limitation of major life activities, and duration of the condition. For children age seven through seventeen, the Child and Adolescent Functional Assessment Scale (CAFAS) is used to make discriminations within the functional impairment dimension. All of the dimensions, as well as family voice and choice, must be considered when determining if a child is eligible for home-based services.

Diagnosis	<p>The child/adolescent currently has, or had at any time in the past, a diagnosable behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the current version of the DSM or ICD, excluding those with a diagnosis other than, or in addition to, alcohol or drug disorders, a developmental disorder, or social conditions (ICD-9 V-codes and ICD-10 Z-codes).</p>
Functional Impairment	<p>For purposes of qualification for home-based services, children/adolescents may be considered markedly or severely functionally impaired if the minor has:</p> <ul style="list-style-type: none"> ▪ An elevated subscale score (20 or greater) on at least two elements of the Child/Adolescent Section of the CAFAS; or ▪ An elevated subscale score (20 or greater) on one element of the CAFAS Child/Adolescent Section, combined with an elevated subscale score (20 or greater) on at least one CAFAS element involving Caregiver/Care-giving Resources; or ▪ A total impairment score of 80 or more on the CAFAS Child/Adolescent Section.
Duration/History	<p>The following specify the length of time the youth’s functional disability has interfered with his daily living and led to his referral for home-based services:</p> <ul style="list-style-type: none"> ▪ Evidence of six continuous months of illness, symptomatology, or dysfunction; ▪ Six cumulative months of symptomatology/dysfunction in a 12-month period; or ▪ On the basis of a specific diagnosis (e.g., schizophrenia), disability is likely to continue for more than one year.



SECTION 8 – INPATIENT PSYCHIATRIC HOSPITAL ADMISSIONS

The PIHP is responsible to manage and pay for Medicaid mental health services in community-based psychiatric inpatient units for all Medicaid beneficiaries who reside within the service area covered by the PIHP. This means that the PIHP is responsible for timely screening and authorization/certification of requests for admission, notice and provision of several opinions, and continuing stay for inpatient services, defined as follows:

- **Screening** means the PIHP has been notified of the beneficiary and has been provided enough information to make a determination of the most appropriate services. The screening may be provided on-site, face-to-face by PIHP personnel, or over the telephone.
- **Authorization/certification** means that the PIHP has screened the beneficiary and has approved the services requested. Telephone screening must be followed-up by the written certification.

PIHP responsibilities include:

- Pre-admission screening to determine whether alternative services are appropriate and available. Severity of Illness and Intensity of Service clinical criteria will be used for such pre-screening. Inpatient pre-screening services must be available 24-hours-a-day, seven-days-a-week.
- Provision of notice regarding rights to a second opinion in the case of denials.
- Coordination with substance abuse treatment providers, when appropriate.
- Provision of, or referral to and linkage with, alternative services, when appropriate.
- Communication with the treating and/or referring provider.
- Communication with the primary care physician or health plan.
- Planning in conjunction with hospital personnel for the beneficiary's after-care services.

In most instances, the beneficiary will receive services in a community-based psychiatric unit in the PIHP service area where he resides. There may be instances when a PIHP is responsible for a resident that they have placed into a community program in another county or state. In these cases, the responsible PIHP, i.e., the one managing the case, is responsible for authorizing admission and/or continuing stay.

If a beneficiary experiences psychiatric crisis in another county, the PIHP in that county should provide crisis intervention/services as needed and contact the PIHP for the county of the beneficiary's residence for disposition.

8.1 ADMISSIONS

The PIHPs will make authorization and approval decisions for these services according to Level of Care guidelines established by MDHHS and appearing in this section. All admission and continuing stay responsibilities and procedures must be conducted in accordance with the terms of the contract between the hospital and the PIHP.



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Emergency Room Services	<p>When necessary, the beneficiary may seek services through the emergency room. Disposition of the psychiatric emergency will be the responsibility of the PIHP and may result in:</p> <ul style="list-style-type: none"> ▪ Inpatient admission; ▪ Referral to an alternative service when appropriate and available; or ▪ Disposition of the crisis through provision of immediate services/interventions, with follow-up as necessary. <p>The PIHP is involved in the psychiatric aspect of the emergency situation. Any medical treatment needed by the beneficiary is beyond the general purview of the PIHP.</p>
Admissions to In-State Out-of-Area Hospitals	<p>Medicaid beneficiaries may seek inpatient psychiatric services from hospitals located outside their county of residence/PIHP catchment area. If the out-of-area hospital has a contract with the beneficiary's county/catchment area PIHP, the hospital should contact that PIHP to obtain the required pre-admission authorization/approval for the beneficiary. If the out-of-area hospital does not have a contract with the beneficiary's designated county/catchment area PIHP, the hospital must contact the PIHP that serves the county in which the hospital is located to obtain pre-admission approval/authorization. The hospital-area PIHP will conduct the pre-admission review and will consult with the designated county/catchment area PIHP to determine the appropriate disposition of the request for admission authorization/approval. Payment responsibility for authorized days of care will rest with the PIHP that authorized the services.</p>
Admission to Out-of-State Non-Borderland Inpatient Psychiatric Hospitals	<p>The PIHP for the beneficiary's county of residency must prior authorize the admission for psychiatric inpatient care as medically necessary, as with in-state hospitals. The PIHP is responsible for continued stay reviews and payment to these hospitals.</p>

8.2 APPEALS

PIHPs will make authorization and approval decisions for services according to Level of Care guidelines. If the hospital disagrees with the decision of the PIHP, regarding either admission authorization/approval or the number of authorized days of care, the hospital may appeal to the PIHP according to the terms of its contract with the PIHP. If the hospital does not have a contract or agreement with the PIHP, any appeals by the hospital will be conducted through the usual and customary procedures that the PIHP employs in its contracts with other enrolled hospital providers.

If a beneficiary or his legal representative disagrees with a PIHP decision related to admission authorization/approval or approved days of care, he may request a reconsideration and second opinion from the PIHP. If the PIHP's initial decision is upheld, the beneficiary has further redress through the Medicaid fair hearing process. Medicaid beneficiaries can request the Medicaid fair hearing without going through local review processes.

8.3 BENEFICIARIES WHO DO NOT HAVE MEDICAID ELIGIBILITY UPON ADMISSION

For beneficiaries whose enrollment in Medicaid is determined after the end of an episode of inpatient psychiatric or partial hospitalization care (eligibility extends back and encompasses the dates of the episode of care), the PIHP will conduct a retrospective review of the episode of care to determine if services were medically necessary and appropriate for Medicaid reimbursement, unless the PIHP has previously reviewed and certified the admission and authorized days of care under other contractual and



payment arrangements with the hospital. If the PIHP has conducted the pre-admission authorization and continuing stay reviews for these beneficiaries during the episode of care, this will be considered as a certification that authorized services are eligible for reimbursement by the PIHP under the Medicaid program once the beneficiary's retroactive Medicaid eligibility has been established.

As noted above, the purpose of a retrospective review is to determine if services rendered were medically necessary and hence qualify for Medicaid reimbursement. Since the hospital will not receive reimbursement for any care rendered which does not meet the test of medical necessity, it is advantageous for hospitals to involve PIHPs during the episode of care for any beneficiary that the facility believes may be eligible for Medicaid.

8.4 MEDICARE

For Medicare-covered services, the PIHP may only pay up to a Medicare-enrolled beneficiary's obligation to pay (i.e., coinsurance and deductibles). (Refer to the Coordination of Benefits Chapter in this manual for more information.)

8.5 ELIGIBILITY CRITERIA

8.5.A. INPATIENT PSYCHIATRIC AND PARTIAL HOSPITALIZATION SERVICES

Medicaid requires that hospitals providing inpatient psychiatric services or partial hospitalization services obtain authorization and certification of the need for admission and continuing stay from PIHPs. A PIHP reviewer determines authorization and certification by applying criteria outlined in this document. The hospital or attending physician may request a reconsideration of adverse authorization/certification determinations made by the initial PIHP reviewer.

The criteria described below employ the concepts of Severity of Illness (SI) and Intensity of Service (IS) to assist reviewers in determinations regarding whether a particular care setting or service intensity is appropriately matched to the beneficiary's current condition.

- Severity of Illness (SI) refers to the nature and severity of the signs, symptoms, functional impairments and risk potential related to the beneficiary's psychiatric disorder.
- Intensity of Service (IS) refers to the setting of care, to the types and frequency of needed services and supports, and to the degree of restrictiveness necessary to safely and effectively treat the beneficiary.

Medicaid coverage for inpatient psychiatric services is limited to beneficiaries with a current primary psychiatric diagnosis, as described in the criteria below. It is recognized that some beneficiaries will have other conditions or disorders (e.g., developmental disabilities or substance abuse) that coexist with a psychiatric disturbance. In regard to developmental disabilities, if a person with developmental disabilities presents with signs or symptoms of a significant, serious, concomitant mental illness, the mental illness will take precedence for purposes of care and placement decisions, and the beneficiary may be authorized/certified for inpatient psychiatric care under these guidelines.

For beneficiaries who present with psychiatric symptoms associated with current active substance abuse, it may be difficult to determine whether symptoms exhibited are due to



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a primary mental illness or represent a substance-induced disorder, and to make an informed level of care placement decision. A beneficiary exhibiting a psychiatric disturbance in the context of current active substance use or intoxication may require acute detoxification services before an accurate assessment of the need for psychiatric inpatient services can be made. In these situations, the hospital and the PIHP must confer to determine the appropriate location (acute medical setting or psychiatric unit) for the detoxification services.

The crucial consideration in initial placement decisions for a beneficiary with psychiatric symptoms associated with current active substance abuse is whether the beneficiary's immediate treatment needs are primarily medical or psychiatric. If the beneficiary's primary need is medical (e.g., life-threatening substance-induced toxic conditions requiring acute medical care and detoxification), then detoxification in an acute medical setting (presuming the beneficiary's condition meets previously published acute care detoxification criteria) is indicated. If the beneficiary's primary need is psychiatric care (the person meets the SI/IS criteria for inpatient psychiatric care), they should be admitted to the psychiatric unit and acute medical detoxification provided in that setting.

Hospitals are reminded that they must obtain PIHP admission authorization and certification for all admissions to a distinct part psychiatric unit or freestanding psychiatric hospital.

8.5.B. INPATIENT ADMISSION CRITERIA: ADULTS

Inpatient psychiatric care may be used to treat a person with mental illness who requires care in a 24-hour medically structured and supervised facility. The SI/IS criteria for admission are based upon the assumption that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments, and manifesting a level of clinical instability (risk) that, either individually or collectively, are of such severity that treatment in an alternative setting would be unsafe or ineffective.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

The individual must meet all three criteria outlined in the following table:

Diagnosis	The beneficiary must be suffering from a mental illness reflected in a primary, validated, current version of DSM or ICD diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).
Severity of Illness (signs, symptoms, functional impairments and risk potential)	At least one of the following manifestations is present: <ul style="list-style-type: none"> ▪ Severe Psychiatric Signs and Symptoms <ul style="list-style-type: none"> ➢ Psychiatric symptoms - features of intense cognitive/perceptual/affective disturbance (hallucinations, delusions, extreme agitation, profound depression) severe enough to cause seriously disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor retardation, resulting in extensive interference with activities of daily living, so that the person cannot function at a lower level of care.



	<ul style="list-style-type: none">➢ Disorientation, seriously impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others.➢ A severe, life-threatening psychiatric syndrome or an atypical or unusually complex psychiatric condition exists that has failed, or is deemed unlikely, to respond to less intensive levels of care, and has resulted in substantial current dysfunction.▪ Disruptions of Self-Care and Independent Functioning<ul style="list-style-type: none">➢ The person is unable to attend to basic self-care tasks and/or to maintain adequate nutrition, shelter, or other essentials of daily living due to psychiatric disorder.➢ There is evidence of serious disabling impairment in interpersonal functioning (e.g., withdrawal from relationships; repeated conflictual interactions with family, employer, co-workers, neighbors) and/or extreme deterioration in the person's ability to meet current educational/occupational role performance expectations.▪ Harm to Self<ul style="list-style-type: none">➢ Suicide: Attempt or ideation is considered serious by the intention, degree of lethality, extent of hopelessness, degree of impulsivity, level of impairment (current intoxication, judgment, psychological symptoms), history of prior attempts, and/or existence of a workable plan.➢ Self-Mutilation and/or Reckless Endangerment: There is evidence of current behavior, or recent history. There is a verbalized threat of a need or willingness to self-mutilate, or to become involved in other high-risk behaviors; and intent, impulsivity, plan and judgment would suggest an inability to maintain control over these ideations.➢ Other Self-Injurious Activity: The person has a recent history of drug ingestion with a strong suspicion of overdose. The person may not need detoxification but could require treatment of a substance-induced psychiatric disorder.▪ Harm to Others<ul style="list-style-type: none">➢ Serious assaultive behavior has occurred, and there is a risk of escalation or repetition of this behavior in the near future.➢ There is expressed intention to harm others and a plan and/or means to carry it out, and the level of impulse control is non-existent or impaired (due to psychotic symptoms, especially command or verbal hallucinations, intoxication, judgment, or psychological symptoms, such as persecutory delusions and paranoid ideation).▪ Drug/Medication Complications or Coexisting General Medical Condition Requiring Care<ul style="list-style-type: none">➢ There has been significant destructive behavior toward property that endangers others.➢ The person has experienced severe side effects from using therapeutic psychotropic medications.
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	<ul style="list-style-type: none"> ➢ The person has a known history of psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the administration, adjustment or reinitiation of medications requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved. ➢ There are concurrent significant physical symptoms or medical disorders which necessitate evaluation, intensive monitoring and/or treatment during medically necessary psychiatric hospitalization, and the coexisting general medical condition would complicate or interfere with treatment of the psychiatric disorder at a less intensive level of care. <p>Special Consideration: Concomitant Substance Abuse - The underlying or existing psychiatric diagnosis must be the primary cause of the beneficiary's current symptoms or represent the primary reason observation and treatment is necessary in the psychiatric unit or hospital setting.</p>
Intensity of Service	<p>The person meets the intensity of service requirements if inpatient services are considered medically necessary for the beneficiary's treatment/diagnosis, and if the person requires at least one of the following:</p> <ul style="list-style-type: none"> ▪ Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications. ▪ Close and continuous skilled medical observation is necessary due to otherwise unmanageable side effects of psychotropic medications. ▪ Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) is needed to protect the beneficiary, others, and/or property, or to contain the beneficiary so that treatment may occur. ▪ A comprehensive multi-modal therapy plan is needed, requiring close medical supervision and coordination, due to its complexity and/or the severity of the beneficiary's signs and symptoms.

8.5.C. INPATIENT ADMISSION CRITERIA: CHILDREN THROUGH AGE 21

Inpatient psychiatric care may be used to treat a child or adolescent with mental illness or serious emotional disturbance who requires care in a 24-hour medically structured and supervised facility. The SI/IS criteria for admission are based on the assumption that the child, youth, or young adult is displaying signs and symptoms of a serious psychiatric disorder, demonstrating functional impairments and manifesting a level of clinical instability (risk) that are, either individually or collectively, of such severity that treatment in an alternative setting would be unsafe or ineffective.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

The individual must meet all three criteria outlined in the table below:

Diagnosis	The beneficiary must be suffering from a mental illness reflected in a primary, validated, current version of DSM or ICD diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).
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Severity of Illness
(signs, symptoms,
functional impairments
and risk potential)

At least **one** of the following manifestations is present:

- Severe Psychiatric Signs and Symptoms
 - Psychiatric symptoms - features of intense cognitive/perceptual/affective disturbance (hallucinations, delusions, extreme agitation, profound depression) - severe enough to cause disordered and/or bizarre behavior (e.g., catatonia, mania, incoherence) or prominent psychomotor retardation, resulting in extensive interference with activities of daily living, so that the person cannot function at a lower level of care.
 - Disorientation, impaired reality testing, defective judgment, impulse control problems and/or memory impairment severe enough to endanger the welfare of the person and/or others.
 - Severe anxiety, phobic symptoms or agitation, or ruminative/obsessive behavior that has failed, or is deemed unlikely, to respond to less intensive levels of care and has resulted in substantial current dysfunction.
- Disruptions of Self-Care and Independent Functioning
 - Beneficiary is unable to maintain adequate nutrition or self care due to a severe psychiatric disorder.
 - The beneficiary exhibits significant inability to attend to age-appropriate responsibilities, and there has been a serious deterioration/impairment of interpersonal, familial, and/or educational functioning due to an acute psychiatric disorder or severe developmental disturbance.
- Harm to Self
 - A suicide attempt has been made which is serious by degree of lethal intent, hopelessness, or impulsivity.
 - There is a specific plan to harm self with clear intent and/or lethal potential.
 - There is self-harm ideation or threats without a plan, which are considered serious due to impulsivity, current impairment or a history of prior attempts.
 - There is current behavior or recent history of self-mutilation, severe impulsivity, significant risk-taking or other self-endangering behavior.
 - There is a verbalized threat of a need or willingness to self-mutilate, or to become involved in other high-risk behaviors; and intent, impulsivity, plan and judgment would suggest an inability to maintain control over these ideations.
 - There is a recent history of drug ingestion with a strong suspicion of intentional overdose. The person may not need detoxification but could require treatment of a substance-induced psychiatric disorder.
- Harm to Others
 - Serious assaultive behavior has occurred and there is a clear risk of escalation or repetition of this behavior in the near future.



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	<ul style="list-style-type: none"> ➢ There is expressed intention to harm others and a plan and means to carry it out; the level of impulse control is non-existent or impaired. ➢ There has been significant destructive behavior toward property that endangers others, such as setting fires. ➢ The person has experienced severe side effects from using therapeutic psychotropic medications. <ul style="list-style-type: none"> ▪ Drug/Medication Complications or Coexisting General Medical Condition Requiring Care <ul style="list-style-type: none"> ➢ The person has a known history of psychiatric disorder that requires psychotropic medication for stabilization of the condition, and the administration, adjustment or reinitiation of medications requires close and continuous observation and monitoring, and this cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved. ➢ There are concurrent significant physical symptoms or medical disorders which necessitate evaluation, intensive monitoring and/or treatment during medically necessary psychiatric hospitalization, and the coexisting general medical condition would complicate or interfere with treatment of the psychiatric disorder at a less intensive level of care. <p>Special Consideration: Concomitant Substance Abuse - The underlying psychiatric diagnosis must be the primary cause of the beneficiary's current symptoms or represents the primary reason observation and treatment are necessary in the hospital setting.</p>
<p>Intensity of Service</p>	<p>The person meets the intensity of service requirements if inpatient services are considered medically necessary and if the person requires at least one of the following:</p> <ul style="list-style-type: none"> ▪ Close and continuous skilled medical observation and supervision are necessary to make significant changes in psychotropic medications. ▪ Close and continuous skilled medical observation is needed due to otherwise unmanageable side effects of psychotropic medications. ▪ Continuous observation and control of behavior (e.g., isolation, restraint, closed unit, suicidal/homicidal precautions) to protect the beneficiary, others, and/or property, or to contain the beneficiary so that treatment may occur. ▪ A comprehensive multi-modal therapy plan is needed, requiring close medical supervision and coordination, due to its complexity and/or the severity of the beneficiary's signs and symptoms.

8.5.D. INPATIENT PSYCHIATRIC CARE – CONTINUING STAY CRITERIA: ADULTS, ADOLESCENTS AND CHILDREN

After a beneficiary has been certified for admission to an inpatient psychiatric setting, services must be reviewed at regular intervals to assess the current status of the treatment process and to determine the continued necessity for care in an inpatient setting. Treatment within an inpatient psychiatric setting is directed at stabilization of incapacitating signs or symptoms, amelioration of severely disabling functional impairments, arrestment of potentially life-threatening self/other harm inclinations, management of adverse biologic reactions to treatment and/or regulation of complicated



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medication situations. The continuing stay recertification process is designed to assess the efficacy of the treatment regime in addressing these concerns, and to determine whether the inpatient setting remains the most appropriate, least restrictive, level of care for treatment of the beneficiary's problems and dysfunctions.

Continuing treatment in an inpatient setting may be certified when signs, symptoms, behaviors, impairments, harm inclinations or biologic/medication complications, similar to those which justified the beneficiary's admission certification, remain present, and continue to be of such a nature and severity that inpatient psychiatric treatment is still medically necessary. It is anticipated that in those reviews which fall near the end of an episode of care, these problems and dysfunctions will have stabilized or diminished.

Discharge planning must begin at the onset of treatment in the inpatient unit. Payment cannot be authorized for continued stays that are due solely to placement problems or the unavailability of aftercare services.

The individual must meet all three criteria outlined in the following table:

<p>Diagnosis</p>	<p>The beneficiary has a validated current version of DSM or ICD mental disorder (excluding ICD-9 V-codes and ICD-10 Z-codes) that remains the principal diagnosis for purposes of care during the period under review.</p>
<p>Severity of Illness (signs, symptoms, functional impairments and risk potential)</p>	<ul style="list-style-type: none"> ▪ Persistence/intensification of signs/symptoms, impairments, harm inclinations or biologic/medication complications which necessitated admission to this level of care, and which cannot currently be addressed at a lower level of care. ▪ Continued severe disturbance of cognition, perception, affect, memory, behavior or judgment. ▪ Continued gravely disabling or incapacitating functional impairments or severely and pervasively impaired personal adjustment. ▪ Continued significant self/other harm risk. ▪ Use of psychotropic medication at dosage levels necessitating medical supervision, dosage titration of medications requiring skilled observation, or adverse biologic reactions requiring close and continuous observation and monitoring. ▪ Emergence of new signs/symptoms, impairments, harm inclinations or medication complications meeting admission criteria.
<p>Intensity of Service</p>	<ul style="list-style-type: none"> ▪ The beneficiary requires close observation and medical supervision due to the severity of signs and symptoms, to control risk behaviors or inclinations, to assure basic needs are met or to manage biologic/medication complications. ▪ The beneficiary is receiving active, timely, treatment delivered according to an individualized plan of care. ▪ Active treatment is directed toward stabilizing or diminishing those symptoms, impairments, harm inclinations or biologic/medication complications that necessitated admission to inpatient care.



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	<ul style="list-style-type: none">▪ The beneficiary is making progress toward treatment goals as evidenced by a measurable reduction in signs/symptoms, impairments, harm inclinations or biologic/medication complications or, if no progress has been made, there has been a modification of the treatment plan and therapeutic program, and there is a reasonable expectation of a positive response to treatment.
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Discharge criteria and aftercare planning are documented in the beneficiary's record.



SECTION 9 – INTENSIVE CRISIS STABILIZATION SERVICES

9.1 ADULT SERVICES

Intensive crisis stabilization services are structured treatment and support activities provided by a multidisciplinary team and designed to provide a short-term alternative to inpatient psychiatric services. Services may be used to avert a psychiatric admission or to shorten the length of an inpatient stay when clinically indicated.

A crisis situation means a situation in which an individual is experiencing a serious mental illness or a developmental disability and one of the following applies:

- The individual can reasonably be expected within the near future to physically injure himself or another individual, either intentionally or unintentionally.
- The individual is unable to provide himself clothing, or shelter, or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the individual or to another individual.
- The individual's judgment is so impaired that he is unable to understand the need for treatment and, in the opinion of the mental health professional, his continued behavior, as a result of the mental illness, developmental disability, or emotional disturbance, can reasonably be expected in the near future to result in physical harm to the individual or to another individual.

9.1.A. APPROVAL

The PIHP must seek and maintain MDHHS approval for the intensive crisis stabilization services in order to use Medicaid funds for program services.

9.1.B. POPULATION

These services are for beneficiaries who have been assessed to meet criteria for psychiatric hospital admissions but who, with intense interventions, can be stabilized and served in their usual community environments. These services may also be provided to beneficiaries leaving inpatient psychiatric services if such services will result in a shortened inpatient stay.

Beneficiaries must have a diagnosis of mental illness or mental illness with a co-occurring substance use disorder or developmental disability.

9.1.C. SERVICES

Intensive crisis services are intensive treatment interventions delivered by an intensive crisis stabilization treatment team under the supervision of a psychiatrist. Component services include:

- Intensive individual counseling/psychotherapy;
- Assessments (rendered by the treatment team);



- Family therapy;
- Psychiatric supervision; and
- Therapeutic support services by trained paraprofessionals.

9.1.D. QUALIFIED STAFF

Intensive crisis services must be provided by a treatment team of mental health professionals under the supervision of a psychiatrist. The psychiatrist need not provide on-site supervision at all times but must be available by telephone at all times. The treatment team providing intensive crisis stabilization services must be mental health professionals. Nursing services/consultation must be available.

The treatment team may be assisted by trained paraprofessionals under appropriate supervision. The trained paraprofessionals must have at least one year of satisfactory work experience providing services to beneficiaries with serious mental illness. Activities of the trained paraprofessionals include assistance with therapeutic support services. In addition, the team may include one or more peer support specialists.

9.1.E. LOCATION OF SERVICES

Intensive crisis stabilization services may be provided where necessary to alleviate the crisis situation, and to permit the beneficiary to remain in, or return more quickly to, his usual community environment. Intensive crisis stabilization services must not be provided exclusively or predominantly at residential programs.

Exceptions: Intensive crisis stabilization services may not be provided in:

- Inpatient settings;
- Jails or other settings where the beneficiary has been adjudicated; or
- Crisis residential settings.

9.1.F. INDIVIDUAL PLAN OF SERVICE

Intensive crisis stabilization services may be provided initially to alleviate an immediate or serious psychiatric crisis. However, following resolution of the immediate situation (and within no more than 48 hours), an intensive crisis stabilization services treatment plan must be developed. The intensive crisis stabilization treatment plan must be developed through a person-centered planning process in consultation with the psychiatrist. Other professionals may also be involved if required by the needs of the beneficiary. The case manager (if the beneficiary receives case management services) must be involved in the treatment and follow-up services.

The individual plan of service must contain:

- Clearly stated goals and measurable objectives, derived from the assessment of immediate need, and stated in terms of specific observable changes in behavior, skills, attitudes, or circumstances, structured to resolve the crisis.



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- Identification of the services and activities designed to resolve the crisis and attain his goals and objectives.
- Plans for follow-up services (including other mental health services where indicated) after the crisis has been resolved. The role of the case manager must be identified, where applicable.

9.2 CHILDREN'S SERVICES

Intensive crisis stabilization services are structured treatment and support activities provided by a mobile intensive crisis stabilization team that are designed to promptly address a crisis situation in order to avert a psychiatric admission or other out of home placement or to maintain a child or youth in their home or present living arrangement who has recently returned from a psychiatric hospitalization or other out of home placement. These services must be available to children or youth with serious emotional disturbance (SED) and/or intellectual/developmental disabilities (I/DD), including autism, or co-occurring SED and substance use disorder (SUD).

A crisis situation means a situation in which at least one of the following applies:

- The parent/caregiver has identified a crisis and reports that their capacity to manage the crisis is limited at this time and they are requesting assistance.
- The child or youth can reasonably be expected within the near future to physically injure self or another individual, either intentionally or unintentionally.
- The child or youth exhibits risk behaviors and/or behavioral/emotional symptoms which are impacting their overall functioning; and/or the current functional impairment is a clearly observable change compared with previous functioning.
- The child or youth requires immediate intervention in order to be maintained in their home or present living arrangement or to avoid psychiatric hospitalization or other out of home placement.

The goals of intensive crisis stabilization services are as follows:

- To rapidly respond to any non-imminently life threatening emotional symptoms and/or behaviors that are disrupting the child's or youth's functioning;
- To provide immediate intervention to assist children and youth and their parents/caregivers in de-escalating behaviors, emotional symptoms and/or dynamics impacting the child's or youth's functioning ability;
- To prevent/reduce the need for care in a more restrictive setting (e.g., inpatient psychiatric hospitalization, detention, etc.) by providing community-based intervention and resource development;
- To effectively engage, assess, deliver and plan for appropriate interventions to minimize risk, aid in stabilization of behaviors, and improve functioning; and
- To enhance the child's or youth's and parent's/caregiver's ability to access any identified community-based supports, resources and services.



9.2.A. APPROVAL [CHANGE MADE 10/1/20]

The PIHP must seek and receive MDHHS approval **through an enrollment process, (text added 10/1/20)** initially and every three years thereafter, for the intensive crisis stabilization services in order to use Medicaid funds for program services.

9.2.B. POPULATION

These services are for children or youth ages 0 to 21 with SED and/or I/DD, including autism or co-occurring SED and SUD, and their parents/caregivers who are currently residing in the catchment area of the approved program, and are in need of intensive crisis stabilization services in the home or community as defined in this section. Mobile intensive crisis stabilization teams must be able to travel to the child or youth in crisis for a face to face contact in one hour or less in urban counties, and in two hours or less in rural counties, from the time of the request for intensive crisis stabilization services.

9.2.C. SERVICES

Component services include:

- Assessments (rendered by the treatment team)
- De-escalation of the crisis
- Family-driven and youth-guided planning
- Crisis and safety plan development
- Intensive individual counseling/psychotherapy
- Family therapy
- Skill building
- Psychoeducation
- Referrals and connections to additional community resources
- Collaboration and problem solving with other child- or youth-serving systems, as applicable
- Psychiatric consult, as needed

9.2.D. QUALIFIED STAFF

Intensive crisis stabilization services must be provided by a mobile intensive crisis stabilization team consisting of at least two staff who travel to the child or youth in crisis. One team member must be a Master's prepared Child Mental Health Professional (or Master's prepared Qualified Intellectual Disabilities Professional [QIDP], if applicable) and the second team member may be another professional or paraprofessional under appropriate supervision. Paraprofessionals must have at least one year of satisfactory work experience providing services to children with serious emotional disturbance and/or intellectual/developmental disabilities, as applicable. Team members must have access



to an on-call psychiatrist by telephone, as needed. At minimum, all team members must be trained in crisis intervention and de-escalation techniques.

9.2.E. LOCATION OF SERVICES

Intensive crisis stabilization services must be provided where necessary to alleviate the crisis situation, and to permit the child or youth to remain in their usual home and community environment.

Exceptions: Intensive crisis stabilization services may not be provided in:

- Inpatient settings;
- Jails or detention centers; or
- Residential settings (e.g., Child Caring Institutions, Crisis Residential).

9.2.F. INDIVIDUAL PLAN OF SERVICE

Intensive crisis stabilization services may be provided initially to alleviate an immediate crisis. However, following resolution of the immediate situation, an existing individual plan of service and crisis and safety plan must be updated or, for children or youth who are not yet recipients of CMHSP services but are eligible for such services, a family-driven and youth-guided follow-up plan must be developed.

If the child or youth is a current recipient of CMHSP services, mobile intensive crisis stabilization team members are responsible for notifying the primary therapist, case manager, or wraparound facilitator, as applicable, of the contact with the mobile intensive crisis stabilization team the next business day. It is the responsibility of the primary therapist, case manager, or wraparound facilitator to follow-up with the child or youth and parent/caregiver. The child or youth, parent/caregiver and the relevant treatment team members must revisit the current individual plan of service and crisis and safety plan and make adjustments where necessary to address current treatment needs.

If the child or youth is not yet a recipient of CMHSP services but is eligible for such services, the follow-up plan must include appropriate referrals to mental health assessment and treatment resources and any other resources the child or youth and parent/caregiver may require. The mobile intensive crisis stabilization team is responsible for providing necessary information and referrals. The follow-up plan must also include the next steps for obtaining needed services, timelines for those activities, and identify the responsible parties. Mobile intensive crisis stabilization team members must contact the parent/caregiver by phone or face-to-face within seven business days to determine the status of the stated goals in the follow-up plan.



SECTION 10 – OUTPATIENT PARTIAL HOSPITALIZATION SERVICES

The PIHP is responsible for authorizing and paying for Medicaid admissions and continued stays in partial hospitalization programs by Medicaid beneficiaries.

- Admissions - beneficiaries may be referred to a partial hospitalization program from psychiatric inpatient hospitals or psychiatric units, referring providers, or PIHPs, or they may present themselves at the outpatient hospital without a referral.
- Continued stays must be authorized by the PIHP.

Authorization for the partial hospitalization admission and continued stay includes authorization for all services related to that admission/stay, including laboratory, pharmacy, and radiology services. The outpatient partial hospitalization program must bill the PIHP for authorized services according to procedures and rates established between the facility and the PIHP.

10.1 PARTIAL HOSPITALIZATION ADMISSION CRITERIA: ADULT

Partial hospitalization services may be used to treat a person with mental illness who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services and supports are provided for six or more hours per day, five days a week. The use of partial hospitalization as a setting of care presumes that the beneficiary does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the beneficiary's present treatment needs. The SI/IS criteria for admission assume that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating significant functional impairments in self-care, daily living skills, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments and/or the estimation of risk (clinical instability) do not justify or necessitate treatment at a more restrictive level of care.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

The individual must meet all three criteria outlined in the table below:

Diagnosis	The beneficiary must be suffering from a mental illness, reflected in a primary, validated, current version of DSM or ICD Diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).
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Severity of Illness
(signs, symptoms,
functional impairments
and risk potential)

At least **two** of the following manifestations are present:

- Psychiatric Signs and Symptoms
 - Some prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness) or behavior exists (intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions/ruminations, severe phobias, depression, etc.) and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions/rituals, impaired reality testing and/or impairments in functioning and role performance. The disordered or aberrant conduct or activity and/or the level of agitation are not so severe, extreme or unstable so as to require frequent restraints or to pose a danger to others.
- Disruptions of Self-Care and Independent Functioning
 - The person seriously neglects self-care tasks (hygiene, grooming, etc.) and/or does not sufficiently attend to essential aspects of daily living (does not shop, prepare meals, maintain adequate nutrition, pay bills, complete housekeeping chores, etc.) due to a mental disorder.
 - Beneficiary is able to maintain adequate nutrition, shelter or other essentials of daily living only with structure and supervision for a significant portion of the day, and with family/community support when away from the partial hospitalization program.
 - The person's interpersonal functioning is significantly impaired (seriously dysfunctional communication, extreme social withdrawal, etc.).
 - There has been notable recent deterioration in meeting educational/occupational responsibilities and role performance expectations.
- Danger to Self
 - There is modest danger to self, reflected in: intermittent self-harm ideation, expressed ambivalent inclinations without a plan, non-intentional threats, mild and infrequent self-harm gestures (low lethality/intent) or self-mutilation, passive death wishes, or slightly self-endangering activities.
 - The beneficiary has not made any recent significant (by intent or lethality) suicide attempts, nor is there any well-defined plan for such activity or, if there have been recent significant actions, these inclinations/behaviors are now clearly under control and the person no longer needs/requires 24-hour supervision to contain self-harm risk.
- Danger to Others
 - Where assaultive tendencies exist, there have been no overt actions and there is reasonable expectation, based upon history and recent behavior, that the beneficiary will be able to curb these inclinations.
 - There have been destructive fantasies described and mild threats verbalized, but the beneficiary appears to have impulse control, judgment, and reality orientation sufficient to suppress urges to act on these imaginings or expressions.



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	<ul style="list-style-type: none"> ➤ There has been minor destructive behavior toward property without endangerment of others. ▪ Drug/Medication Complications <ul style="list-style-type: none"> ➤ The beneficiary has experienced side effects of atypical complexity resulting from psychotropic drugs, and regulation/correction/monitoring of these circumstances cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved. ➤ The beneficiary needs evaluation and monitoring due to significant changes in medication or because of problems with medication regimen compliance.
<p>Intensity of Service</p>	<p>The person meets the intensity of service requirements if partial hospitalization services are considered medically necessary and the person requires at least one of the following:</p> <ul style="list-style-type: none"> ▪ The person requires intensive, structured, coordinated, multi-modal treatment and supports with active psychiatric supervision to arrest regression and forestall the need for inpatient care. ▪ The beneficiary has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but continues to require active, intensive treatment and support to relieve/reverse disabling psychiatric symptomatology and/or residual functional impairments. ▪ Routine medical observation and supervision is required to effect significant regulation of psychotropic medications and/or to minimize serious side effects.

10.2 PARTIAL HOSPITALIZATION ADMISSION CRITERIA: CHILDREN AND ADOLESCENTS

Partial hospitalization services may be used to treat a child or adolescent with mental illness or serious emotional disturbance who requires intensive, highly coordinated, multi-modal ambulatory care with active psychiatric supervision. Treatment, services and supports are provided for six or more hours per day, five days a week. The use of partial hospitalization as a setting of care presumes that the beneficiary does not currently need treatment in a 24-hour protective environment. Conversely, the use of partial hospitalization implies that routine outpatient treatment is of insufficient intensity to meet the beneficiary's present treatment needs. The SI/IS criteria for admission assume that the beneficiary is displaying signs and symptoms of a serious psychiatric disorder, demonstrating significant functional impairments in self-care, daily living skill, interpersonal/social and/or educational/vocational domains, and is exhibiting some evidence of clinical instability. However, the level of symptom acuity, extent of functional impairments and/or the estimation of risk (clinical instability) does not justify or necessitate treatment at a more restrictive level of care.

Medicaid coverage is dependent upon active treatment being provided at the medically necessary level of care.

The individual must meet all three criteria outlined in the following table:

<p>Diagnosis</p>	<p>The beneficiary must be suffering from a mental illness, reflected in a primary, validated, current version of DSM or ICD diagnosis (not including ICD-9 V-codes and ICD-10 Z-codes).</p>
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Severity of Illness
(signs, symptoms,
functional impairments
and risk potential)

At least **two** of the following manifestations are present:

- Psychiatric Signs and Symptoms
 - Some prominent disturbance of thought processes, perception, affect, memory, consciousness, somatic functioning (due to a mental illness) or behavior exists (intermittent hallucinations, transient delusions, panic reactions, agitation, obsessions/ruminations, severe phobias, depression, etc.) and is serious enough to cause disordered or aberrant conduct, impulse control problems, questionable judgment, psychomotor acceleration or retardation, withdrawal or avoidance, compulsions/rituals, impaired reality testing and/or impairments in functioning and role performance. The disordered or aberrant conduct or activity and/or the level of agitation is not so severe, extreme or unstable so as to require frequent restraints or to pose a danger to others.
- Disruptions of Self-Care and Independent Functioning
 - The child/adolescent exhibits significant impairments in self-care skills (feeding, dressing, toileting, hygiene/bathing/grooming, etc.), in the ability to attend to age-appropriate responsibilities, or in self-regulation capabilities, due to a mental disorder or emotional illness.
 - The child/adolescent is able to maintain adequate self-care and self-regulation only with structure and supervision for a significant portion of the day, and with family/community support when away from the partial hospitalization program.
 - There is recent evidence of serious impairment/incapacitation in the child's/adolescent's interpersonal and social functioning (seriously dysfunctional communication, significant social withdrawal and isolation, repeated disruptive, inappropriate or bizarre behavior in social settings, etc.).
 - There is recent evidence of considerable deterioration in functioning within the family and/or significant decline in occupational/educational role performance due to a mental disorder or emotional illness.
- Danger to Self
 - There is modest danger to self, reflected in: non-accidental self-harm gestures or self-mutilation actions which are not life-threatening in either intent or lethal potential, intermittent self-harm ideation, expressed ambivalent inclinations without a plan, non-intentional threats, passive death wishes, or slightly self-endangering activities.
 - The beneficiary has not made any recent significant (by intent or lethality) suicide attempts, nor is there any well-defined plan for such activity or, if there have been recent significant actions, these inclinations/behaviors are now clearly under control and the person no longer needs/requires 24-hour supervision to contain self-harm risk.



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	<ul style="list-style-type: none"> ▪ Danger to Others <ul style="list-style-type: none"> ➢ Assaultive tendencies exist, and some assaultive behavior may have occurred, but any overt actions have been without any serious or significant injury to others, and there is reasonable expectation, based upon history and recent behavior, that the beneficiary will be able to curb any serious expression of these inclinations. ➢ There have been destructive fantasies described and mild threats verbalized, but the beneficiary appears to have adequate impulse control, judgment, and reality orientation sufficient to suppress urges to act on these imaginings or expressions. ➢ There has been minor destructive behavior toward property without endangerment of others. ▪ Drug/Medication Complications <ul style="list-style-type: none"> ➢ The beneficiary has experienced side effects of atypical complexity resulting from psychotropic drugs and regulation/correction/monitoring of these circumstances cannot be accomplished at a lower level of care due to the beneficiary's condition or to the nature of the procedures involved. ➢ The beneficiary needs evaluation and monitoring due to significant changes in medication or because of problems with medication regimen compliance.
Intensity of Service	<p>The person meets the intensity of service requirements if partial hospitalization services are considered medically necessary and the person requires at least one of the following:</p> <ul style="list-style-type: none"> ▪ The person requires intensive, structured, coordinated, multi-modal treatment and supports with active psychiatric supervision to arrest regression and forestall the need for inpatient care. ▪ The beneficiary has reached a level of clinical stability (diminished risk) obviating the need for continued care in a 24-hour protective environment but continues to require active, intensive treatment and support to relieve/reverse disabling psychiatric symptomatology and/or residual functional impairments. ▪ Routine medical observation and supervision is required to effect significant regulation of psychotropic medications and/or to minimize serious side effects.

10.3 PARTIAL HOSPITALIZATION CONTINUING STAY CRITERIA FOR ADULTS, ADOLESCENTS AND CHILDREN

After a beneficiary has been certified for admission to a partial hospitalization program, services will be reviewed at regular intervals to assess the current status of the treatment process and to determine the continued necessity for care in a partial hospitalization setting. Treatment within a partial hospitalization program is directed at resolution or stabilization of acute symptoms, elimination or amelioration of disabling functional impairments, maintenance of self/other safety and/or regulation of precarious or complicated medication situations. The continuing stay recertification process is designed to assess the efficacy of the treatment regime in addressing these concerns, and to determine whether the partial program remains the most appropriate, least restrictive, level of care for treatment of the beneficiary's problems and dysfunctions.

Continuing treatment in the partial program may be certified when symptoms, impairments, harm inclinations or medication complications, similar to those which justified the beneficiary's admission



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certification, remain present, and continue to be of such a nature and severity that partial hospitalization treatment is still medically necessary. It is anticipated that in those reviews which fall near the end of an episode of care, these problems and dysfunctions will have stabilized or diminished.

Discharge planning must begin at the onset of treatment in the program. Payment cannot be authorized for continued stays that are due solely to placement problems or the unavailability of aftercare services.

The individual must meet all three criteria outlined in the following table:

Diagnosis	The beneficiary has a validated current version of DSM or ICD mental disorder (excluding ICD-9 V-codes and ICD-10 Z-codes), which remains the principal diagnosis for purposes of care during the period under review.
Severity of Illness (signs, symptoms, functional impairments and risk potential)	<ul style="list-style-type: none">▪ Persistence of symptoms, impairments, harm inclinations or medication complications which necessitated admission to this level of care, and which cannot currently be addressed at a lower level of care.▪ Emergence of new symptoms, impairments, harm inclinations or medication complications meeting admission criteria.▪ Progress has been made in ameliorating admission symptoms or impairments, but the treatment goals have not yet been fully achieved and cannot currently be addressed at a lower level of care.
Intensity of Service	<ul style="list-style-type: none">▪ The beneficiary is receiving active, timely, intensive, structured multi-modal treatment delivered according to an individualized plan of care.▪ Active treatment is directed toward stabilizing or diminishing those symptoms, impairments, harm inclinations or medication complications that necessitated admission to the program.▪ The beneficiary is making progress toward treatment goals or, if no progress has been made, the treatment plan and therapeutic program have been revised accordingly and there is a reasonable expectation of a positive response to treatment.

Discharge criteria and aftercare planning are documented in the beneficiary's record.



SECTION 11 – PERSONAL CARE IN LICENSED SPECIALIZED RESIDENTIAL SETTINGS

Personal care services are those services provided in accordance with an individual plan of service to assist a beneficiary in performing their own personal daily activities. For children with serious emotional disturbance, personal care services may be provided only in a licensed foster care setting or in a Child Caring Institution (CCI) if it is licensed as a “children’s therapeutic group home” as defined in Section 722.111 Sec. 1(f) under Act No. 116 of the Public Acts of 1973, as amended. For children with intellectual/developmental disabilities, services may be provided only in a licensed foster care or CCI setting with a specialized residential program certified by the state. These personal care services are distinctly different from the state plan Home Help program administered by MDHHS.

Personal care services are covered when authorized by a physician or other health care professional in accordance with an individual plan of services and rendered by a qualified person. Supervision of personal care services must be provided by a health care professional who meets the qualifications contained in this chapter.

11.1 SERVICES

Personal care services include assisting the beneficiary to perform the following:

- Assistance with food preparation, clothing and laundry, and housekeeping beyond the level required by facility licensure, (e.g., a beneficiary requires special dietary needs such as pureed food);
- Eating/feeding;
- Toileting;
- Bathing;
- Grooming;
- Dressing;
- Transferring (between bed, chair, wheelchair, and/or stretcher);
- Ambulation; and
- Assistance with self-administered medications.

"Assisting" means staff performs the personal care tasks for the individual; or performs the tasks along with the individual (i.e., some hands-on); or otherwise assists the individual to perform the tasks himself/herself by prompting, reminding, or by being in attendance while the beneficiary performs the task(s).

11.2 PROVIDER QUALIFICATIONS

Personal care may be rendered to a Medicaid beneficiary in a Foster Care or CCI setting licensed and certified by the state under the 1987 Michigan Department of Health and Human Services Administrative Rule R330.1801-09 (as amended in 1995). For children birth to 21, personal care may be rendered to a Medicaid beneficiary in a Child Caring Institution setting with a specialized residential program facility



licensed by the State for individuals with I/DD under Act No. 116 of the Public Acts of 1973, as amended, and Act No. 258 of the Public Acts of 1974, as amended.

11.3 DOCUMENTATION

The following documentation is required in the beneficiary's file in order for reimbursement to be made:

- An assessment of the beneficiary's need for personal care.
- An individual plan of services that includes the specific personal care services and activities, including the amount, scope and duration to be delivered that is reviewed and approved at least once per year during person-centered planning.
- Documentation of the specific days on which personal care services were delivered consistent with the beneficiary's individual plan of service.



SECTION 12 – SUBSTANCE ABUSE SERVICES

12.1 COVERED SERVICES - OUTPATIENT CARE

Medicaid-covered services and supports must be provided, based on medical necessity, to eligible beneficiaries who reside in the specified region and request services.

Outpatient treatment is a non-residential treatment service that can take place in an office-based location with clinicians educated/trained in providing professionally directed alcohol and other drug (AOD) treatment or a community-based location with appropriately educated/trained staff. The treatment occurs in regularly scheduled sessions, usually totaling fewer than nine contact hours per week but, when medically necessary, can total over 20 hours in a week. Individual, family or group treatment services may be provided individually or in combination.

Treatment must be individualized based on a bio-psycho-social assessment, diagnostic impression and beneficiary characteristics, including age, gender, culture, and development. Authorized decisions on length of stay, including continued stay, change in level of care, and discharge, must be based on the American Society of Addiction Medicine (ASAM) Criteria. Beneficiary participation in referral and continuing care planning must occur prior to discharge and should be based on the needs of the beneficiary in order to support sustained recovery.

12.1.A. ELIGIBILITY

Outpatient care may be provided only when:

- The service meets medical necessity criteria.
- The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used to determine an initial diagnostic impression (also known as provisional diagnosis). The diagnostic impression must include all five axes.
- The service is based on individualized determination of need.
- The service is cost effective.
- The American Society of Addiction Medicine (ASAM) Criteria are used to determine substance abuse treatment placement/admission and/or continued stay needs.
- The service is based on a level of care determination using the six assessment dimensions of the current ASAM Criteria:
 - Withdrawal potential
 - Medical conditions and complications
 - Emotional, behavioral or cognitive conditions and complications
 - Readiness to change
 - Relapse, continued use or continued problem potential
 - Recovery/living environment.



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This service is limited to those beneficiaries who will benefit from treatment and have been determined to have:

- an acceptable readiness to change level;
- minimal or manageable medical conditions;
- minimal or manageable withdrawal risks;
- emotional, behavioral and cognitive conditions that will not prevent the beneficiary benefiting from this level of care;
- minimal or manageable relapse potential; and
- a minimally to fully supportive recovery environment.

12.1.B. COVERED SERVICES

Once the above criteria have been satisfied and the beneficiary has demonstrated a willingness to participate in treatment, the following services can be provided in the outpatient setting:

Individual Assessment	A face-to-face service for the purpose of identifying functional, treatment, and recovery needs and a basis for formulating the Individualized Treatment Plan.
Individual Treatment Planning	The beneficiary must be directly involved with developing the plan that must include Recovery Support Preparation/Relapse Prevention Activities.
Individual Therapy	Face-to-face counseling services with the beneficiary.
Group Therapy	Face-to-face counseling with three or more beneficiaries, and can include didactic lectures, therapeutic interventions/counseling, and other group related activities.
Family Therapy	Face-to-face counseling with the beneficiary and the significant other and/or traditional or non-traditional family members.
Crisis Intervention	A service for the purpose of addressing problems/issues that may arise during treatment and could result in the beneficiary requiring a higher level of care if intervention is not provided.
Referral/Linking/ Coordinating/ Management of Services	For the purpose of ensuring follow-through with identified providers, providing additional support in the community if primary services are to be provided in an office setting, addressing other needs identified as part of the assessment and/or establishing the beneficiary with another provider and/or level of care. This service may be provided individually or in conjunction with other services based on the needs of the beneficiary (frequently referred to as substance use disorder case management).
Peer Recovery and Recovery Support	To support and promote recovery and prevent relapse through supportive services that result in the knowledge and skills necessary for an individual's recovery. Peer recovery programs are designed and delivered primarily by individuals in recovery (Recovery Coach) and offer social, emotional, and/or educational supportive services to help prevent relapse and promote recovery.
Compliance Monitoring	For the purpose of identifying abstinence or relapse when it is a part of the treatment plan or an identified part of the treatment program (excludes laboratory drug testing).



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Early Intervention	Includes stage-based interventions for individuals with substance use disorders and individuals who may not meet the threshold of abuse or dependence but are experiencing functional/social impairment as a result of use.
Detoxification/Withdrawal Monitoring	For the purpose of preventing/alleviating medical complications as they relate to no longer using a substance.
Division of Pharmacologic Therapies/Center for Substance Abuse Treatment (DPT/CSAT) Approved Pharmacological Supports	Refer to the Treatment (DPT/CSAT) Approved Pharmacological Supports subsection.
Substance Abuse Treatment Services	Services that are required to include assessment, treatment planning, stage-based interventions, referral linking and monitoring, recovery support preparation, recovery support services, and treatment based on medical necessity. They may include individual, group and family treatment. These services are provided under the supervision of a SATS or SATP.

12.1.C. ADMISSION CRITERIA

Outpatient services should be authorized based on the number of hours and/or types of services that are medically necessary. Reauthorization or continued treatment should take place when it has been demonstrated that the beneficiary is benefiting from treatment but additional covered services are needed for the beneficiary to be able to sustain recovery independently.

Reauthorization of services can be denied in situations where the beneficiary has:

- not been actively involved in their treatment, as evidenced by repeatedly missing appointments;
- not been participating/refusing to participate in treatment activities;
- continued use of substances and other behavior that is deemed to violate the rules and regulations of the program providing the services.

Beneficiaries may also be terminated from treatment services based on these violations.



12.1.D. SERVICE INTENSITY

The medically necessary outpatient services correspond to the frequency and duration of services established by the ASAM levels of care and are referred to as follows:

- Level 0.5 – Early Intervention
- Level 1.0 – Outpatient
- Level 2.1 – Intensive Outpatient
- Level 2.5 – Expanded Intensive Outpatient

Outpatient services can include any variety of the covered services and are dependent on the individual needs of the beneficiary. The assessment, treatment plan and recovery support preparations are the only components that are consistent throughout the outpatient levels of care as each beneficiary must have these as part of the authorized treatment services. As a beneficiary’s needs increase, more services and/or frequency/ duration of services may be utilized if these are medically necessary. The ASAM levels correspond with established hours of services that take place during a week.

ASAM Level 0.5	Services are not subdivided by the number of hours received during a week. The amount and type of services provided are based on individual needs based on the beneficiary’s motivation to change and other risk factors that may be present.
ASAM Level 1.0	Services from one hour to eight hours during a week.
ASAM Level 2.1	Services from nine to 19 hours in a week. The services are offered at least three days a week to fulfill the minimum nine-hour commitment.
ASAM Level 2.5	Services that are offered 20 or more hours in a week.

12.2 TREATMENT (DPT/CSAT) APPROVED PHARMACOLOGICAL SUPPORTS

12.2.A. PROVISION OF SERVICES

Opiate-dependent beneficiaries may be provided chemotherapy using methadone as an adjunct to a treatment service. Provision of such services must meet the following criteria:

- Services must be provided under the supervision of a physician licensed to practice medicine in Michigan.
- The physician must be licensed to prescribe controlled substances, as well as licensed to work at a methadone program.
- The methadone component of the substance abuse treatment program must be:
 - licensed as such by the state;
 - certified by the Division of Pharmacologic Therapies/Center for Substance Abuse Treatment (DPT/CSAT);
 - licensed by the Drug Enforcement Administration (DEA); and



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- accredited by a DPT/CSAT and state-approved accrediting organization (The Joint Commission (TJC) and the Commission on Accreditation of Rehabilitation Facilities (CARF)).
- Methadone must be administered by an appropriately-licensed MD/DO, physician assistant, nurse practitioner, clinical nurse specialist, registered nurse, licensed practical nurse, or pharmacist.

12.2.B. COVERED SERVICES

Covered services for Methadone and pharmacological supports and laboratory services, as required by DPT/CSAT regulations and the Administrative Rules for Substance Use Disorder Service Programs in Michigan, include:

- Methadone medication
- Nursing services
- Physical examination
- Physician encounters (monthly)
- Laboratory tests (including health screening tests as part of the initial physical exam, pregnancy test at admission, and required toxicology tests)
- TB skin test (as ordered by physician)

12.2.C. ELIGIBILITY CRITERIA

Medical necessity requirements shall be used to determine the need for methadone as an adjunct treatment and recovery service.

All six dimensions of the American Society of Addiction Medicine (ASAM) Criteria must be addressed:

- Acute intoxication and/or withdrawal potential
- Biomedical conditions and complications.
- Emotional/behavioral conditions and complications (e.g., psychiatric conditions, psychological or emotional/behavioral complications of known or unknown origin, poor impulse control, changes in mental status, or transient neuropsychiatric complications)
- Treatment acceptance/resistance
- Relapse/continued use potential
- Recovery/living environment



12.2.D. ADMISSION CRITERIA

Decisions to admit an individual for methadone maintenance must be based on medical necessity criteria, satisfy the LOC determination using the six dimensions of the ASAM Criteria, and have an initial diagnostic impression of opioid dependency for at least one year based on current DSM criteria.

Admission procedures require a physical examination. This examination must include a medical assessment to confirm the current DSM diagnosis of opioid dependency of at least one year, as was identified during the screening process. The physician may refer the individual for further medical assessment as indicated.

Consistent with the LOC determination, individuals requesting methadone must be presented with all appropriate options for substance use disorder treatment, such as:

- Medical Detoxification
- Sub-acute Detoxification
- Residential Care
- Buprenorphine/Naloxone
- Non-Medication Assisted Outpatient Treatment

12.2.D.1. SPECIAL CIRCUMSTANCES FOR ADMISSIONS

There are special circumstances for the admission of pregnant women, pregnant adolescents, and adolescents.

Pregnant Women	<ul style="list-style-type: none"> ▪ Pregnant women requesting treatment are considered a priority for admission and must be screened and referred for services within 24 hours. ▪ Pregnant individuals who have a documented history of opioid addiction, regardless of age or length of opioid dependency, may be admitted to an Opioid Treatment Program (OTP) provided the pregnancy is certified by the OTP physician and treatment is found to be justified. ▪ For pregnant individuals, evidence of current physiological dependence is not necessary. ▪ Pregnant opioid-dependent individuals must be referred for prenatal care and other pregnancy-related services and supports, as necessary. ▪ OTPs must obtain informed consent from pregnant women, and all women admitted to methadone treatment who may become pregnant, stating that they will not knowingly put themselves and their fetus in jeopardy by leaving the OTP against medical advice. ▪ Because methadone and opiate withdrawal are not recommended during pregnancy due to the increased risk to the fetus, the OTP shall not discharge pregnant women without making documented attempts to facilitate a referral for continued treatment with another provider.
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<p>Pregnant Adolescents</p>	<ul style="list-style-type: none"> ▪ For an individual under 18 years of age, a parent, legal guardian, or responsible adult designated by the relevant state authority, must provide consent for treatment in writing. (In Michigan, the relevant state authority is Children's Protective Services.) <ul style="list-style-type: none"> ➢ A copy of this signed informed consent statement must be placed in the individual's medical record. ➢ This signed consent is in addition to the general consent that is signed by all individuals receiving methadone and must be filed in the medical record.
<p>Non-Pregnant Adolescents</p>	<ul style="list-style-type: none"> ▪ An individual under 18 years of age is required to have had at least two documented unsuccessful attempts at short-term detoxification and/or drug-free treatment within a 12-month period to be eligible for maintenance treatment. ▪ No individual under 18 years of age may be admitted to maintenance treatment unless a parent, legal guardian, or responsible adult (designated by the relevant state authority) consents, in writing, to such treatment. <p>Minors under 15 years of age must also have the permission of the State Opioid Treatment Authority and the Drug Enforcement Administration. (Refer to Administrative Rules for Substance Use Disorder Service Programs in Michigan, R 325.14409(5).)</p> <ul style="list-style-type: none"> ➢ A copy of this signed informed consent statement must be placed in the individual's medical record. ➢ This signed consent is in addition to the general consent that is signed by all individuals receiving methadone and must be filed in their medical record. (Refer to 42 CFR subpart 8.12(e)(2).)

12.2.E. MEDICAL MAINTENANCE PHASE

When the maximum therapeutic benefit of counseling has been achieved, it may be appropriate for the individual to enter the medical maintenance (methadone only) phase of treatment and recovery; that is if it has been determined that ongoing use of the medication is medically necessary and appropriate for the individual. The following criteria are to be considered when making the decision to move to medical maintenance:

- Two years of continuous treatment.
- Abstinence from illicit drugs and from abuse of prescription drugs for the period indicated by federal and state regulations (at least two years for a full 30-day maintenance dosage).
- No alcohol use problem.
- Stable living conditions in an environment free of substance use.
- Stable and legal source of income.
- Involvement in productive activities (e.g., employment, school, volunteer work).
- No criminal or legal involvement for at least three years and no current parole or probation status.



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- Adequate social support system and absence of significant non-stabilized co-occurring disorders.

12.2.F. DISCONTINUATION/TERMINATION CRITERIA

Discontinuation/termination from methadone treatment refers to the following situations:

- Beneficiaries must discontinue treatment with methadone when treatment is completed with respect to both the medical necessity for the medication and for counseling services.
- Beneficiaries may be terminated from services if there is clinical and/or behavioral non-compliance.
- If a beneficiary is terminated:
 - The OTP must attempt to make a referral for another LOC assessment or for placing the beneficiary at another OTP.
 - The OTP must make an effort to ensure that the beneficiary follows through with the referral.
 - These efforts must be documented in the medical record.
 - The OTP must follow the procedures of the funding authority in coordinating these referrals.
- Any action to terminate treatment of a Medicaid beneficiary requires a "notice of action" be given to the beneficiary and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS). The beneficiary and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS) has a right to appeal this decision. Services must continue and dosage levels maintained while the appeal is in process, unless the action is being carried out due to administrative discontinuation criteria outlined in the subsection titled Administrative Discontinuation.

Services are discontinued/terminated, either by Completion of Treatment or through Administrative Discontinuation. Refer to the following subsections for additional information.

12.2.F.1. COMPLETION OF TREATMENT

The decision to discharge a beneficiary must be made by the OTP's physician, with input from clinical staff, the beneficiary, and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS). Completion of treatment is determined when the beneficiary has fully or substantially achieved the goals listed in their individualized treatment and recovery plan and no longer needs methadone as a medication. As part of this process, a reduction of the dosage to a medication-free state (tapering) should be implemented within safe and appropriate medical standards.

12.2.F.2. ADMINISTRATIVE DISCONTINUATION

Administrative discontinuation relates to non-compliance with treatment and recovery recommendations, and/or engaging in activities or behaviors that impact the safety of the OTP environment or other individuals who are receiving treatment. The OTP must



work with the beneficiary and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS) to explore and implement methods to facilitate compliance.

Non-compliance is defined as actions exhibited by the beneficiary which include, but are not limited to:

- The repeated or continued use of illicit opioids and non-opioid drugs (including alcohol).
- Toxicology results that do not indicate the presence of methadone metabolites. (The same actions are taken as if illicit drugs, including non-prescribed medication, were detected.)

In both of the aforementioned circumstances, OTPs must perform toxicology tests for methadone metabolites, opioids, cannabinoids, benzodiazepines, cocaine, amphetamines, and barbiturates (Administrative Rules for Substance Use Disorder Service Programs in Michigan, R 325.14406).

OTPs must test the beneficiary for alcohol if use is prohibited under their individualized treatment and recovery plan or the beneficiary appears to be using alcohol to a degree that would make dosing unsafe.

- Repeated failure to submit to toxicology sampling as requested.
- Repeated failure to attend scheduled individual and/or group counseling sessions, or other clinical activities such as psychiatric or psychological appointments.
- Failure to manage medical concerns/conditions, including adherence to physician treatment and recovery services and use of prescription medications that may interfere with the effectiveness of methadone and may present a physical risk to the individual.
- Repeated failure to follow through on other treatment and recovery plan related referrals. (Repeated failure should be considered on an individual basis and only after the OTP has taken steps to assist beneficiaries to comply with activities.)

The commission of acts by the beneficiary that jeopardize the safety and well-being of staff and/or other individuals, or negatively impact the therapeutic environment, is not acceptable and can result in immediate discharge. Such acts include, but are not limited to, the following:

- Possession of a weapon on OTP property
- Assaultive behavior against staff and/or other individuals
- Threats (verbal or physical) against staff and/or other individuals
- Diversion of controlled substances, including methadone
- Diversion and/or adulteration of toxicology samples
- Possession of a controlled substance with intent to use and/or sell on agency property or within a one-block radius of the clinic
- Sexual harassment of staff and/or other individuals



- Loitering on the clinic property or within a one-block radius of the clinic

Administrative discontinuation of services can be carried out by two methods:

- **Immediate Termination** - This involves the discontinuation of services at the time of one of the above safety-related incidents or at the time an incident is brought to the attention of the OTP.
- **Enhanced Tapering Discontinuation** - This involves an accelerated decrease of the methadone dose (usually by 10 mg or 10 percent a day). The manner in which methadone is discontinued is at the discretion of the OTP physician to ensure the safety and well-being of the beneficiary.

It may be necessary for the OTP to refer beneficiaries who are being administratively discharged to the local access management system for evaluation for another level of care. Justification for non-compliance termination must be documented in the beneficiary's chart.

12.3 SUB-ACUTE DETOXIFICATION

Sub-acute detoxification is defined as supervised care for the purpose of managing the effects of withdrawal from alcohol and/or other drugs as part of a planned sequence of addiction treatment. Detoxification is limited to the stabilization of the medical effects of the withdrawal and to the referral to necessary ongoing treatment and/or support services. Licensure as a sub-acute detoxification program is required.

Sub-acute detoxification is part of a continuum of care for substance use disorders and does not constitute the end goal in the treatment process. The detoxification process consists of three essential components: evaluation, stabilization, and fostering client readiness for, and entry into, treatment. A detoxification process that does not incorporate all three components is considered incomplete and inadequate.

Detoxification can take place in both residential and outpatient settings, and at various levels of intensity within these settings. Client placement to setting and to level of intensity must be based on ASAM Criteria and individualized determination of client need.

The following combinations of sub-acute detoxification settings and levels of intensity correspond to the LOC determination based on the ASAM Criteria.

- Outpatient Setting
 - Ambulatory Detoxification without extended on-site monitoring corresponding to ASAM Level 1-WM, or ambulatory detoxification with extended on-site monitoring (ASAM Level 2-WM).
 - Outpatient setting sub-acute detoxification must be provided under the supervision of a Substance Abuse Treatment Specialist. Services must have arrangements for access to licensed medical personnel as needed. ASAM Level 2-WM ambulatory detoxification services must be monitored by appropriately credentialed and licensed nurses.



- Residential Setting
 - Clinically Managed Residential Detoxification - Non-Medical or Social Detoxification Setting: Emphasizes peer and social support for persons who warrant 24-hour support (ASAM Level 3.2-WM). These services must be provided under the supervision of a Substance Abuse Treatment Specialist. Services must have arrangements for access to licensed medical personnel as needed.
 - Medically Managed Residential Detoxification - Freestanding Detoxification Center: These services must be staffed 24-hours-per-day, seven-days-per-week by a licensed physician or by the designated representative of a licensed physician (ASAM Level 3.7-WM).

This service is limited to stabilization of the medical effects of the withdrawal, and referral to necessary ongoing treatment and/or support services. This service, when clinically indicated, is an alternative to acute medical care provided by licensed health care professionals in a hospital setting.

Authorization requirements:

- Symptom alleviation is not sufficient for purposes of admission. There must be documentation of current beneficiary status that provides evidence the admission is likely to directly assist the beneficiary in the adoption and pursuit of a plan for further appropriate treatment and recovery.
- Admission to sub-acute detoxification must be made based on:
 - Medical necessity criteria
 - LOC determination based on an evaluation of the six assessment dimensions of the current ASAM Criteria.
- Initial length-of-stay authorizations may be for up to three days, with additional days authorized if there is clinical evidence that detoxification is not successful or complete and authorization requirements continue to be met.

12.4 RESIDENTIAL TREATMENT

Residential Treatment is defined as intensive therapeutic service which includes overnight stay and planned therapeutic, rehabilitative or didactic counseling to address cognitive and behavioral impairments for the purpose of enabling the beneficiary to participate and benefit from less intensive treatment. A program director is responsible for the overall management of the clinical program, and treatment is provided by appropriate credentialed professional staff, including substance abuse specialists. Residential treatment must be staffed 24-hours-per-day. The clinical program must be provided under the supervision of a Substance Abuse Treatment Specialist with either full licensure or limited licensure as a psychologist, master's social worker, professional counselor, marriage and family therapist or physician. Services may be provided by a Substance Abuse Treatment Specialist or a non-degreed staff.

This intensive therapeutic service is limited to those beneficiaries who, because of specific cognitive and behavioral impairments, need a safe and stable environment in order to benefit from treatment.



Authorization requirements:

- The effects of the substance use disorder must be so significant and the resulting impairment so great that outpatient and intensive outpatient treatments have not been effective or cannot be safely provided, and when the beneficiary provides evidence of willingness to participate in treatment.
- Admissions to Residential Treatment must be based on:
 - Medical necessity criteria
 - LOC determination based on an evaluation of the six assessment dimensions of the current ASAM Criteria
- Additional days may be authorized when authorization requirements continue to be met, if there is evidence of progress in achieving treatment plan goals, and reauthorization is necessary to resolve cognitive and behavioral impairments which prevent the beneficiary from benefiting from less intensive treatment.

12.5 EXCLUDED SERVICES

- Room and board;
- All other services not addressed within Covered or Allowable Services; and
- Medicaid Substance Abuse Services funded Outside the PIHP Plan.

Some Medicaid-covered services are available to substance abuse beneficiaries but are provided outside of the PIHP Plan. The PIHPs are not responsible to pay for the following:

- Acute detoxification;
- Laboratory services related to substance abuse (with the exception of lab services required for Methadone);
- Medications used in the treatment/management of addictive disorders;
- Emergency medical care;
- Emergency transportation;
- Substance abuse prevention and treatment that occurs routinely in the context of providing primary health care; and
- Routine transportation to substance abuse treatment services which is the responsibility of the local MDHHS office.



SECTION 13 – TARGETED CASE MANAGEMENT

Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process. For children and youth, a family driven, youth guided planning process should be utilized. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.

Targeted case management services must be available for all children with serious emotional disturbance, adults with serious mental illness, persons with a developmental disability, and those with co-occurring substance use disorders who have multiple service needs, have a high level of vulnerability, require access to a continuum of mental health services from the PIHP, and/or are unable to independently access and sustain involvement with needed services.

Beneficiaries must be provided choice of available, qualified case management staff upon initial assignment and on an ongoing basis.

13.1 PROVIDER QUALIFICATIONS

Providers must demonstrate the capacity to provide all core requirements specified below and have a sufficient number of staff to meet the needs of the target population.

Providers must document initial and ongoing training for case managers related to the core requirements and applicable to the target population served.

Caseload size and composition must be realistic for the case manager to complete the core requirements as identified in the individual plan of service developed through the person-centered planning process.

13.2 DETERMINATION OF NEED

The determination of the need for case management must occur at the completion of the intake process and through the person-centered planning process for beneficiaries receiving services and supports. Justification as to whether case management is needed or not must be documented in the beneficiary's record.

13.3 CORE REQUIREMENTS

- Assuring that the person-centered planning process takes place and that it results in the individual plan of service.
- Assuring that the plan of service identifies what services and supports will be provided, who will provide them, and how the case manager will monitor (i.e., interval of face-to-face contacts) the services and supports identified under each goal and objective.



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- Overseeing implementation of the individual plan of service, including supporting the beneficiary's dreams, goals, and desires for optimizing independence; promoting recovery; and assisting in the development and maintenance of natural supports.
- Assuring the participation of the beneficiary on an ongoing basis in discussions of his plans, goals, and status.
- Identifying and addressing gaps in service provision.
- Coordinating the beneficiary's services and supports with all providers, making referrals, and advocating for the beneficiary.
- Assisting the beneficiary to access programs that provide financial, medical, and other assistance such as Home Help and Transportation services.
- Assuring coordination with the beneficiary's primary and other health care providers to assure continuity of care.
- Coordinating and assisting the beneficiary in crisis intervention and discharge planning, including community supports after hospitalization.
- Facilitating the transition (e.g., from inpatient to community services, school to work, dependent to independent living) process, including arrangements for follow-up services.
- Assisting beneficiaries with crisis planning.
- Identifying the process for after-hours contact.

Assessment	The provider must have the capacity to perform an initial written comprehensive assessment addressing the beneficiary's needs/wants, barriers to needs/wants, supports to address barriers, and health and welfare issues. Assessments must be updated when there is significant change in the condition or circumstances of the beneficiary. The individual plan of services must also reflect such changes.
Documentation	<p>The beneficiary's record must contain sufficient information to document the provision of case management, including the nature of the service, the date, and the location of contacts between the case manager and the beneficiary, including whether the contacts were face-to-face. The frequency of face-to-face contacts must be dependent on the intensity of the beneficiary's needs.</p> <p>The case manager must review services at intervals defined in the individual plan of service. The plan shall be kept current and modified when indicated (reflecting the intensity of the beneficiary's health and welfare needs). A beneficiary or his/her guardian or authorized representative may request and review the plan at any time. A formal review of the plan shall not occur less often than annually to review progress toward goals and objectives and to assess beneficiary satisfaction.</p>
Monitoring	The case manager must determine, on an ongoing basis, if the services and supports have been delivered, and if they are adequate to meet the needs/wants of the beneficiary. Frequency and scope (face-to-face and telephone) of case management monitoring activities must reflect the intensity of the beneficiary's health and welfare needs identified in the individual plan of services.

Targeted case management shall not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services. Targeted case managers are prohibited from exercising the agency's authority to authorize or deny the provision of services. Targeted case management shall not duplicate services that are the responsibility of another program.



13.4 STAFF QUALIFICATIONS

A primary case manager must be a qualified mental health or intellectual disability professional (QMHP or QIDP) or, if the case manager has only a bachelor's degree but without the specialized training or experience, they must be supervised by a QMHP or QIDP who does possess the training or experience. Services to a child with serious emotional disturbance must be provided by a QMHP who is also a child mental health professional. Services to children with developmental disabilities must be provided by a QIDP.



SECTION 14 – CHILDREN’S HOME AND COMMUNITY-BASED SERVICES WAIVER (CWP)

The Children’s Home and Community Based Services Waiver Program (CWP) provides services that are enhancements or additions to regular Medicaid coverage to children up to age 18 who are enrolled in the CWP.

The Children’s Waiver is a fee-for-service program administered by the CMHSP. The CMHSP will be held financially responsible for any costs incurred on behalf of the CWP beneficiary that were authorized by the CMHSP and exceed the Medicaid fee screens or amount, duration and scope parameters.

Services, equipment and Environmental Accessibility Adaptations (EAAs) that require prior authorization from MDHHS must be submitted to the CWP Clinical Review Team at MDHHS. The team is comprised of a physician, registered nurse, psychologist, and licensed master’s social worker with consultation by a building specialist and an occupational therapist.

14.1 KEY PROVISIONS

The CWP enables Medicaid to fund necessary home- and community-based services for children with developmental disabilities who reside with their birth or legally adoptive parent(s) or with a relative who has been named legal guardian under the laws of the State of Michigan, regardless of their parent's income.

The CMHSP is responsible for assessment of potential waiver candidates. The CMHSP is also responsible for referring potential waiver candidates by completing the CWP "pre-screen" form and sending it to the MDHHS to determine priority rating.

Application for the CWP is made through the CMHSP. The CMHSP is responsible for the coordination of the child’s waiver services. The case manager, the child and his family, friends, and other professional members of the planning team work cooperatively to identify the child’s needs and to secure the necessary services. All services and supports must be included in the Individual Plan of Services (IPOS). The IPOS must be reviewed, approved and signed by the physician.

A CWP beneficiary must receive at least one children’s waiver service per month in order to retain eligibility.

14.2 ELIGIBILITY

The following eligibility requirements must be met:

- The child must have a developmental disability (as defined in Michigan state law), be less than 18 years of age and in need of habilitation services.
- The child must have a score on the Global Assessment of Functioning (GAF) Scale of 50 or below.
- The child must reside with his birth or legally adoptive parent(s) or with a relative who has been named the legal guardian for that child under the laws of the State of Michigan, provided that the relative is not paid to provide foster care for that child.



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- The child is at risk of being placed into an ICF/IID facility because of the intensity of the child’s care and the lack of needed support, or the child currently resides in an ICF/IID facility but, with appropriate community support, could return home.
- The child must meet, or be below, Medicaid income and asset limits when viewed as a family of one (the parent's income is waived).
- The child’s intellectual or functional limitations indicate that he would be eligible for health, habilitative and active treatment services provided at the ICF/IID level of care. Habilitative services are designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Active treatment includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services. Active treatment is directed toward the acquisition of the behaviors necessary for the beneficiary to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status.

14.3 COVERED WAIVER SERVICES [CHANGE MADE 7/1/20]

Covered Medicaid services that continue to be available to CWP beneficiaries are listed in the Covered Services Section of this chapter. Refer to the Children's Waiver Community Living Support Services Appendix of this chapter for criteria for determining number of hours. Services covered under CWP include:

<p>Community Living Supports</p>	<p>Community Living Supports (CLS) provides assistance to a family in the care of their child while facilitating the child’s independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. The supports, as identified in the individual plan of services, are provided in the child’s home and may be provided in community settings when integration into the community is an identified goal. These supports may serve to reinforce skills or lessons taught in school, therapy or other settings, but are not intended to supplant services provided in school or other settings.</p> <p>Individuals who are identified in the individual plan of services to provide CLS to the child and family must meet provider qualifications.</p> <p>The CMHSP must maintain the following documentation:</p> <ul style="list-style-type: none"> ▪ A log of the CLS must be maintained in the child’s record, documenting the provision of activities outlined in the plan. ▪ Provider qualifications and standards must be maintained for all staff providing services and supports to the child and family. <p>All service costs must be maintained in the child’s file for audit purposes.</p>
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<p>Enhanced Transportation</p>	<p>Transportation costs may be reimbursed when separately specified in the individual plan of services and provided by people other than staff performing CLS, in order to enable a child served by the CWP to gain access to waiver and other community services, activities and resources. Transportation is limited to local distances, where local is defined as within the child’s county or a bordering county. This service is an enhancement of transportation services covered under Medicaid. Family, neighbors, friends, or community agencies that can provide this service without charge must be utilized before seeking funding through the CWP. The availability and use of natural supports should be documented in the record.</p> <p>Parents of children served by the waiver are not entitled to enhanced transportation reimbursement.</p>
<p>Environmental Accessibility Adaptations (EAAs)</p>	<p>Environmental Accessibility Adaptations (EAAs) include those physical adaptations to the home, specified in the individual plan of services, which are necessary to ensure the health, welfare and safety of the child, or enable him to function with greater independence in the home and without which the child would require institutionalization. Home adaptations may include the installation of ramps, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are essential to support the child’s medical equipment. Requests for EAAs must be prior authorized by the CWP Clinical Review Team following denial by all applicable insurance sources, e.g., private insurance, Children’s Special Health Care Services (CSHCS), Medicaid. All services shall be provided in accordance with applicable state or local building codes. A prescription is required and is valid for one year from the date of signature.</p> <p>Standards of value purchasing must be followed. The EAA must be the most reasonable alternative, based on the results of a review of all options, including a change in the use of rooms within the home or alternative housing. The existing structure must have the capability to accept and support the proposed changes. The infrastructure of the home involved in the funded EAA (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must be in compliance with any applicable local codes. EAAs shall exclude costs for improvements exclusively required to meet local building codes.</p> <p>The EAA must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values.</p> <p>The EAA must demonstrate cost-effectiveness. The family must apply, with the assistance of the case manager if needed, to all applicable funding sources, such as housing commission grants, MSHDA, and community development block grants, for assistance. Acceptances or denials by these funding sources must be documented in the child’s records. The CWP is a funding source of last resort.</p> <p>Excluded are those adaptations or improvements to the home that are of general utility, are considered to be standard housing obligations of parents, and are not of direct medical or remedial benefit to the child. EAAs that are required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in a child’s home.</p>



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	<p>All work must be completed while the child is enrolled in the CWP.</p> <p>Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner and the child's family must specify any requirements for restoration of the property to its original condition if the occupants move and must indicate that the CWP and MDHHS are not obligated for any restoration costs.</p> <p>If a family purchases a home, or builds a home or addition while the child is receiving waiver services, it is the family's responsibility to assure that the home will meet the child's basic needs, such as having a ground floor bath/bedroom if the child has mobility limitations. The CWP does not cover construction costs in a new home or addition, or a home purchased after the beneficiary is enrolled in the waiver. The CWP funds may be authorized to assist with the adaptation noted above (e.g., ramps, grab bars, widening doorways) for a home recently purchased.</p> <p>Additional square footage may be prior authorized following a MDHHS specialized housing consultation if it is determined that adding square footage is the only alternative available to make the home accessible and the most cost-effective alternative for housing. Additional square footage is limited to the space necessary to make the home wheelchair-accessible for a child with mobility impairments to prevent institutionalization; the amount will be determined by the direct medical or remedial need of the beneficiary. The family must exhaust all applicable funding options, such as the family's ability to pay, housing commission grants, MSHDA and community development block grants. Acceptances or denials by these funding sources must be documented in the child's records.</p>
<p>Family Training</p>	<p>This provides for training and counseling services for the families of children served on the CWP. For purposes of this service, "family" is defined as the people who live with or provide care to a child served on the CWP and may include a parent or siblings. Family does not include individuals who are employed to care for the child. Training includes instruction about treatment regimens and use of equipment specified in the plan of services, and must include updates as necessary to safely maintain the child at home.</p> <p>Family training is also a counseling service directed to the family and designed to improve and develop the family's skills in dealing with the life circumstances of parenting a child with special needs. All family training must be included in the child's individual plan of services and must be provided on a face-to-face basis.</p>
<p>Non-Family Training</p>	<p>This service provides coaching, supervision and monitoring of CLS staff by professional staff (LLP, MSW, or QIDP). The professional staff will work with parents and CLS staff to implement the plan that addresses services designed to improve the child's social interactions and self-control by instilling positive behaviors in the place of behaviors that are socially disruptive, injurious to the child or others, or that cause property damage.</p>
<p>Fencing</p>	<p>Fencing may be approved with documentation that it is essential to achieve the outcomes specified in the child's individual plan of services and necessary to meet a child's health and safety needs. Authorization for fencing is for a maximum of 200 feet of standard chain link fence and one gate. If it is determined that chain link fencing will not meet the child's health and safety needs, a standard stockade fence may be considered.</p>



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<p>Financial Management Services/Fiscal Intermediary Services</p>	<p>Healthcare Common Procedure Coding System (HCPCS) code "T2025" should be used to bill for this service. This is a "per month" service with a maximum unit of one per month.</p> <p>Financial Management Services/Fiscal Intermediary Services include, but are not limited to:</p> <ul style="list-style-type: none"> ▪ Facilitation of the employment of service workers by the child's parent or guardian acting as the consumer's representative, including federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements, and fiscal accounting; ▪ Assuring adherence to federal and state laws and regulations; and ▪ Ensuring compliance with documentation requirements related to management of public funds. <p>The fiscal intermediary may also perform other supportive functions that enable the consumer – through his/her parent or guardian - to self-direct needed services. These functions may include helping the consumer's representative recruit staff (e.g., developing job descriptions, placing ads, assisting with interviewing); contracting with or employing providers of services; verification of provider qualifications (including reference and background checks); and assisting the consumer and his/her representative to understand billing and documentation requirements.</p> <p>This is a service that handles the financial flow-through of Medicaid dollars for children enrolled in the CWP who are using Choice Voucher arrangements. This CWP waiver service is available only to CWP consumers whose parent or guardian, serving as the consumer's representative, chooses to self-direct selected services through Choice Voucher arrangements. A CMHSP may terminate self-direction of services (and therefore Financial Management Services) when the health and welfare of the consumer is in jeopardy due to the failure of the consumer's representative to direct services and supports or when the consumer's representative consistently fails to comply with contractual requirements.</p> <p>A fiscal intermediary is an independent legal entity – organization or individual - that acts as the fiscal agent of the CMHSP for the purpose of assuring fiduciary accountability for the funds authorized to purchase specific services identified in the consumer's individual plan of service (IPOS). The fiscal intermediary receives funds from the CMHSP and makes payments authorized by the consumer's parent or guardian, as the consumer's representative. The fiscal intermediary acts as an employer agent when the consumer's representative directly employs staff or other service providers.</p> <p>The fiscal intermediary can be an agency or organization (e.g., financial management services agency, accounting firm, local ARC or other advocacy organization) or individual (e.g., accountant, financial advisor/manager, attorney). The fiscal intermediary must meet requirements as identified in the MDHHS/CMHSP Managed Mental Health Supports and Services Contract – Attachment C3.4.4 Medicaid Managed Specialty Supports and Services Concurrent 1915(b)(c) Waiver Program FY12 (and subsequent years) – Attachment P3 4.4.</p>
<p>Overnight Health and Safety Supports</p>	<p>For information regarding Overnight Health and Safety Support (OHSS) Services, refer to the Covered Waiver Services section of the Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix of this chapter. (text added per bulletin MSA 20-04)</p>



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Respite Care	<p>Respite care services are provided to the child on an intermittent or short-term basis because of the absence or need for relief of the parent. Respite is intended to support the parent who is the primary caregiver. This service can be provided by a qualified provider under contract with the CMHSP in the child's home, foster home, group home, licensed respite care facility, licensed camp, or the home of a friend or relative. A parent or guardian may not be considered a provider, nor be reimbursed for this service. All respite services are billed under HCPCS code T1005 – Respite Care Service 15 Min. – with modifiers as appropriate. The maximum respite allocation is 4,608 units (1,152 hours) per fiscal year.</p> <p>The cost of room and board cannot be included as part of respite care, unless provided as part of the respite care in a facility that is not a private residence. Respite provided in an institution (i.e., ICF/IID, nursing facility, or hospital) is not covered by the CWP. When a child requires skilled nursing interventions for 24 hours, the maximum daily amount that one nurse can provide is 16 hours. When the family is not available to provide the additional eight hours of care, a second nurse will be required to provide services for the remainder of the 24-hour period. If a nurse provides respite to more than one child at the same time, the nurse can only provide skilled nursing interventions to one child at a time. Therefore, service for that child would be covered as RN or LPN respite, and services to the other child(ren) would be covered as aide-level respite.</p>
Specialized Medical Equipment and Supplies	<p>Specialized medical equipment and supplies includes durable medical equipment, environmental safety and control devices, adaptive toys, activities of daily living (ADL) aids, and allergy control supplies that are specified in the child's individual plan of services. This service is intended to enable the child to increase his abilities to perform ADLs or to perceive, control, or communicate with the environment in which the child lives. Generators may be covered for a beneficiary who is ventilator-dependent or requires daily use of oxygen via a concentrator. The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment. This service also includes vehicle modifications, van lifts and wheelchair tie-downs. Specialized medical equipment and supplies includes items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not covered by Medicaid or through other insurance. (Refer to the Medical Supplier Chapter for information regarding Medicaid-covered equipment and supplies.)</p> <p>Equipment and supplies must be of direct medical or remedial benefit to the child. "Direct medical or remedial benefit" is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that is essential to the implementation of the child's individual plan of services. The plan must include documentation that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the child will be prevented.</p> <p>A prescription is required and is valid for one year from the date of signature. All items must be determined to be essential to the health, safety, welfare, and independent functioning of the child as specified in the individual plan of services. There must be documented evidence that the item is the most cost-effective alternative to meet the child's need following value purchasing standards. All items must meet applicable standards of manufacture, design and installation. The CMHSP, or its contract agency, must maintain documentation to support that the best value in warranty coverage (e.g., the most coverage for the least cost, per industry standards) was obtained for the item at the time of purchase.</p>



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The following are examples of items not covered under this service:

- Items that are not of direct medical or remedial benefit or that are considered to be experimental. "Experimental" means that the validity of use of the item has not been supported in one or more studies in a preferred professional journal.
- Furniture, appliances, bedding, storage cabinets, whirlpool tubs, and other non-custom items that may routinely be found in a home.
- Items that would normally be available to any child and would ordinarily be provided by the family.
- Items that are considered family recreational choices (outdoor play equipment, swimming pools, pool decks and hot tubs).
- The purchase or lease of vehicles and any repairs or routine maintenance to the vehicle.
- Educational supplies and equipment expected to be provided by the school.

1. Local Authorization of Specialized Medical Equipment and Supplies

As defined below under the various Healthcare Common Procedure Coding System (HCPCS) codes, the CMHSP may locally authorize selected medical equipment and supplies covered under this service category. Medicaid payment will not be made for items that exceed quantity/frequency limits or established Medicaid fee screens as published in the MDHHS CMHSP Children's Waiver Database in effect at the time the equipment or supply is authorized.

- **Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "Remarks" (HCPCS T1999)**

This code is used to bill Medicaid for age-appropriate adaptive toys identified in the child's individual plan of services to address the adaptive or therapeutic need for the item and the specific habilitative outcome.

Items that are typically available in a home and ordinarily provided by families, schools, etc. (e.g., crayons, coloring books, regular board games, educational or non-adaptive toys/software, CD/DVD players, camera, film, computers) are not covered.

- **Personal care item, not otherwise specified, each; identify product in "Remarks" (HCPCS S5199)**

This code is used to bill Medicaid for ADL aids that enable the child to be as independent as possible in areas of self-care. The child's individual plan of services must describe the purpose and use of the ADL aid and any training that the child requires for its use. ADL aids must not be similar in function to items previously billed to Medicaid.

- **Specialized supply, not otherwise specified, waiver; identify product in "Remarks" (HCPCS T2028)**

This code is used to bill Medicaid for allergy control supplies used for the on-going management of a diagnosed severe reaction to airborne irritants and must be specified in the child's individual plan of services. Household items routinely found in a home are not covered (e.g., bed linens, mattress, pillow, vacuum cleaner).



2. State-Level Prior Authorization of Specialized Medical Equipment and Supplies

All other items and services covered under this category must be prior authorized by the MDHHS CWP Clinical Review Team following denial by all applicable insurance sources, e.g., private insurance, CSHCS, Medicaid. (Refer to the Children's Waiver Program [CWP] Prior Authorization subsection for details regarding the prior authorization process.) Prior authorization will not be given for items and services that exceed quantity/frequency limits as published in the MDHHS CMHSP Children's Waiver Database in effect at the time the service is authorized. Pursuant to prior authorization by the MDHHS CWP Clinical Review Team and provision of the items or service, Medicaid payment will be at the rate prior authorized.

- **Specialized medical equipment, not otherwise specified, waiver (HCPCS T2029)**

This code is used to bill Medicaid for environmental safety and control devices that enable the child to be as independent as possible. These devices may assist in controlling the environment or assuring safety in conjunction with programs designed to teach safety awareness or skills. The child's individual plan of services must address the use of the device and include any training that the child requires for its use. Environmental safety and control devices do not include items of general utility such as standard smoke detectors, fire extinguishers, home security systems, and storage cabinets.

This service is limited to five environmental safety and control devices or sets of devices per quarter. A set is considered a group of like items that must be purchased in a quantity to meet the child's needs, e.g., outlet plug covers.

- **Repair or non-routine service for durable medical equipment other than oxygen requiring the skill of a technician, labor component, per 15 minutes (HCPCS K0739)**

This code is used to bill Medicaid for repairs to specialized medical equipment that are not covered benefits through other insurances. There must be documentation in the child's individual plan of services that the specialized medical equipment continues to be of direct medical or remedial benefit to the child. All applicable warranty and insurance coverage must be sought and denied before requesting funding for repairs through the CWP. The CMHSP must document that the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the CMHSP must provide evidence of training in the use of the equipment to prevent future incidents.

- **Vehicle modifications, waiver; per service (HCPCS T2039)**

This code is used to bill Medicaid for modifications to full-size vans, van lifts and wheelchair tie-down systems. Modifications to the family-owned van must be necessary to ensure the accessibility of the child with mobility impairments, and the vehicle must be the child's primary means of transportation. The individual plan of services must specify the child's accessibility needs that will be addressed by these modifications.



Prior authorization for a van lift will be considered no more frequently than once every five years, which is the minimum life expectancy of a lift.

When purchasing new vehicles, many automobile manufacturers offer a rebate of up to \$1,000 to reimburse documented expenditures for modification of a vehicle for accessibility. The CMHSP must request that the family purchasing the vehicle obtain information regarding any rebate programs and apply the rebate toward the cost of the modifications.

Other modifications to a full-size van, such as raised doors, which are necessary to meet the child's accessibility needs will be considered. It is expected that the CMHSP will use prudence in considering and processing beneficiary requests for modifications to newly purchased vehicles (e.g., providing evidence that the child's needs were considered in purchasing a full-size van; purchasing a vehicle that has a raised roof). Conversions to mini-vans are limited to the same modification and would not include additional costs required to modify the frame (e.g., lower the floor) to accommodate a lift. Excluded are items such as automatic door openers, remote car starters, custom interiors, etc. The purchase of a vehicle or maintenance to the vehicle is the family's responsibility.

If the vehicle is stolen or damaged beyond repair within five years of the purchase, replacement would only be considered with documentation that the existing lift cannot be transferred to a new van and that no other funding source (e.g., automobile insurance, homeowner's insurance, personal liability, judgment settlement, etc.) is available to cover the replacement.

▪ **Durable medical equipment, miscellaneous (HCPCS E1399)**

This code is used to bill Medicaid for durable medical equipment as described below:

- Window air-conditioning unit for the room where the child spends the majority of his time (e.g., sleeping area). The child must have a documented medical diagnosis of one of the following specific medical diagnoses or conditions:
 - ◆ temperature regulation dysfunction due to brain injury or other medical diagnosis;
 - ◆ severe respiratory distress secondary to asthma, permanent lung damage, or other medical conditions which are exacerbated by heat and humidity;
 - ◆ severe dehydration resulting from a medical diagnosis (e.g., diabetes insipidus) which may result in hospitalization; or
 - ◆ severe cardiac problems which may result in hospitalization unless the environmental temperature is carefully controlled.



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	<ul style="list-style-type: none"> ➢ Generator for a child who is ventilator-dependent or requires daily use of oxygen via a concentrator. The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment (typically 5,000 watts) and is not intended to provide power for the entire home. The request for prior approval of a generator must include a documented history of power outages, including frequency and duration. The local power company must be notified in writing of the need to restore power on a priority basis due to the child’s needs. ➢ Therapeutic items, assistive technology, and other durable medical equipment for a child who has sensory, communication, or mobility needs when the item is reasonably expected to enable the child to perceive, control or communicate with the environment in which the child lives, to have a greater degree of independence than would be possible without the item or device, or to benefit maximally from a program designed to meet physical or behavioral needs.
Specialty Services	<p>Specialty Services include:</p> <ul style="list-style-type: none"> ▪ Music Therapies; ▪ Recreation Therapies; ▪ Art Therapies; and ▪ Massage Therapies. <p>Specialty Services may include the following activities: Child and family training; coaching and supervision of staff; monitoring of progress related to goals and objectives; and recommending changes in the plan. This may be used in addition to the traditional professional therapy model included in Medicaid.</p> <p>Services must be directly related to an identified goal in the individual plan of service and approved by the physician. Service providers must meet the CMHSP provider qualifications, including appropriate licensure/certification. Services are limited to four sessions per therapy per month.</p> <p>The CMHSP must maintain a record of all Specialty Service costs for audit purposes.</p> <p>Hourly care services are not covered under Specialty Services.</p>

14.4 CHILDREN'S WAIVER PROGRAM (CWP) PRIOR AUTHORIZATION

To determine if a specific service requires MDHHS CWP prior authorization, refer to the Covered Waiver Services subsection above. The CMHSP must complete and submit to the MDHHS CWP an original Prior Review and Approval Request (PRAR) form and the following documentation for each prior authorization request:

- Original current (within 365 days) prescription signed by a physician.
- Narrative justification of need completed by an appropriate professional.
- Documentation that the requested item, device, or modification is essential to the implementation of the child’s individual plan of services and is of direct medical or remedial benefit to the child.
- A copy of the habilitation program (i.e., goals, objectives and methodologies) as related to the request and identified in the individual plan of services.



- Written denial of funding from other sources, including private insurance, Medicaid or CSHCS when applicable, charitable or community organizations, and housing grant programs. If the private insurance carrier requires prior authorization to determine coverage, a request for prior authorization must be submitted to the carrier before submitting the PRAR to the MDHHS CWP.
- Three similar bids for requests costing equal to or more than \$1,000; only one bid is required for requests costing less than \$1,000. If fewer than three bids are obtained for requests costing equal to or more than \$1,000, documentation must describe what efforts were made to secure the bids, and why fewer than three bids were obtained.

The completed PRAR and supporting documentation must be submitted to the MDHHS Children's Waiver Program. (Refer to the Directory Appendix for contact information.)

14.5 PROVIDER QUALIFICATIONS

14.5.A. INDIVIDUALS WHO PROVIDE RESPITE AND CLS

Individuals who provide respite and CLS must:

- Be at least 18 years of age.
- Be able to practice prevention techniques to reduce transmission of any communicable diseases from themselves to others in the environment where they are providing support.
- Have a documented understanding and skill in implementing the individual plan of services and report on activities performed.
- Be in good standing with the law (i.e., not a fugitive from justice, a convicted felon, or an illegal alien).
- Be able to perform basic first aid and emergency procedures.
- Be trained in recipient rights.
- Be an employee of the CMHSP or its contract agency, or an employee of the parent who is paid through a Choice Voucher arrangement. The Choice Voucher System is the designation or set of arrangements that facilitate and support accomplishing self-determination through the use of an individual budget, a fiscal intermediary and direct consumer-provider contracting.

14.5.B. INDIVIDUALS PERFORMING CASE MANAGEMENT FUNCTIONS

Individuals performing case management functions must meet the requirements for a Qualified Intellectual Disability Professional (QIDP) and have:

- A minimum of a Bachelor's degree in a human services field.
- One year of experience working with people with developmental disabilities.



SECTION 15 – HABILITATION SUPPORTS WAIVER FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

Beneficiaries with developmental disabilities may be enrolled in Michigan’s Habilitation Supports Waiver (HSW) and receive the supports and services as defined in this section. HSW beneficiaries may also receive other Medicaid state plan or additional/B3 services. A HSW beneficiary must receive at least one HSW service per month in order to retain eligibility. Medical necessity criteria should be used in determining the amount, duration, and scope of services and supports to be used. The beneficiary’s services and supports that are to be provided under the auspices of the PIHP must be specified in his individual plan of services developed through the person-centered planning process.

HSW beneficiaries must be enrolled through the MDHHS enrollment process completed by the PIHP. The enrollment process must include annual verification that the beneficiary:

- Has a developmental disability (as defined by Michigan law);
- Is Medicaid-eligible;
- Is residing in a community setting;
- If not for HSW services, would require ICF/IID level of care services; and
- Chooses to participate in the HSW in lieu of ICF/IID services.

The enrollment process also includes confirmation of changes in the beneficiary’s enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. Termination from the HSW may occur when the beneficiary no longer meets one or more of the eligibility criteria specified above as determined by the PIHP, or does not receive at least one HSW service per month, or withdraws from the program voluntarily, or dies. Instructions for beneficiary enrollments and annual re-certification may be obtained from the MDHHS Bureau of Community Based Services. (Refer to the Directory Appendix for contact information.)

The PIHP shall use value purchasing for HSW services and supports. The PIHP shall assist beneficiaries to examine their first- and third-party resources to pursue all reimbursements to which they may be entitled, and to make use of other community resources for non-PIHP covered activities, supports or services.

Reimbursement for services rendered under the HSW is included in the PIHP capitation rate.

Beneficiaries enrolled in the HSW may not be enrolled simultaneously in any other §1915(c) waiver.

Habilitation services under the HSW are not otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973.



15.1 WAIVER SUPPORTS AND SERVICES [CHANGE MADE 7/1/20]

<p>Community Living Supports (CLS)</p>	<p>Community Living Supports (CLS) facilitate an individual’s independence, productivity, and promote inclusion and participation. The supports can be provided in the beneficiary’s residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.), and may not supplant other waiver or state plan covered services (e.g., out-of-home non-vocational habilitation, Home Help Program, personal care in specialized residential, respite). The supports are:</p> <ul style="list-style-type: none"> ▪ Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training the beneficiary with: <ul style="list-style-type: none"> ➢ Meal preparation; ➢ Laundry; ➢ Routine, seasonal, and heavy household care and maintenance (where no other party, such as a landlord or licensee, has responsibility for provision of these services); ➢ Activities of daily living, such as bathing, eating, dressing, personal hygiene; and ➢ Shopping for food and other necessities of daily living. ▪ Assisting, supporting and/or training the beneficiary with: <ul style="list-style-type: none"> ➢ Money management; ➢ Non-medical care (not requiring nurse or physician intervention); ➢ Socialization and relationship building; ➢ Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through MDHHS or health plan) from the beneficiary’s residence to community activities, among community activities, and from the community activities back to the beneficiary’s residence); ➢ Leisure choice and participation in regular community activities; ➢ Attendance at medical appointments; and ➢ Acquiring goods and/or services other than those listed under shopping and non-medical services. ▪ Reminding, observing, and/or monitoring of medication administration. <p>The CLS do not include the costs associated with room and board. Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.</p> <p>For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual’s needs for this assistance have been officially determined to exceed DHS’s allowable parameters. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage of Personal Care in Specialized Residential Settings.</p>
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	<p>If beneficiaries living in unlicensed homes need assistance with meal preparation, laundry, routine household care and maintenance, ADLs, and/or shopping, the beneficiary must request Home Help and, if necessary, Expanded Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP must assist with applying for Home Help or submitting a request for a Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not accurately reflect his or her needs. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision.</p> <p>Community Living Supports (CLS) provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.</p>
Enhanced Medical Equipment and Supplies	<p>Enhanced medical equipment and supplies include devices, supplies, controls, or appliances that are not available under regular Medicaid coverage or through other insurances. (Refer to the Medical Supplier Chapter of this manual for more information about Medicaid-covered equipment and supplies.) All enhanced medical equipment and supplies must be specified in the plan of service and must enable the beneficiary to increase his abilities to perform activities of daily living; or to perceive, control, or communicate with the environment.</p> <p>Items that are not of direct medical or remedial benefit, or that are considered to be experimental to the beneficiary, are excluded from coverage.</p> <ul style="list-style-type: none">▪ "Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that are essential to the implementation of the individual plan of service.▪ "Experimental" means that the validity of the use of the item has not been supported in one or more studies in a refereed professional journal. <p>The plan must document that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the beneficiary will be prevented. There must be documented evidence that the item is the most cost-effective alternative to meet the beneficiary's need. All items must be ordered on a prescription as defined in the General Information Section of this chapter. An order is valid one year from the date it was signed. This coverage includes:</p> <ul style="list-style-type: none">▪ Adaptations to vehicles;▪ Items necessary for life support;



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	<ul style="list-style-type: none"> ▪ Ancillary supplies and equipment necessary for proper functioning of such items; and ▪ Durable and non-durable medical equipment not available under the Medicaid state plan. <p>Generators may be covered for an individual who is ventilator dependent or requires daily use of an oxygen concentrator. The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment.</p> <p>Assessments and specialized training needed in conjunction with the use of such equipment, as well as warranted upkeep and repair, shall be considered as part of the cost of the services.</p> <p>Furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, and decorative items) that are routinely found in a home are not included.</p> <p>Items that are considered family recreational choices are not covered. The purchase or lease of a vehicle, as well as any repairs or routine maintenance to the vehicle, is not covered. Educational equipment and supplies are expected to be provided by the school as specified in the Individualized Education Plan and are not covered. Eyeglasses, hearing aids, and dentures are not covered.</p> <p>Covered items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase. The PIHP should have a process in place that gives notice to a medical equipment supplier that purchase of the equipment or supply has been authorized.</p> <p>Repairs to enhanced medical equipment that are not covered benefits through other insurances may be covered. There must be documentation in the individual plan of services that the enhanced medical equipment continues to be of direct medical or remedial benefit. All applicable warranty and insurance coverage must be sought and denied before paying for repairs. The PIHP must document the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the PIHP must provide evidence of training in the use of the equipment to prevent future incidents.</p> <p>The PIHP must assure that all applicable private insurance, Medicare and/or Medicaid requirements for the procurement of durable medical equipment and supplies have been met. The PIHP may not use the waiver service to purchase equipment or supplies that would have been covered by another program if the program's rules were followed, including using providers who participate with that program.</p>
Enhanced Pharmacy	<p>Physician-ordered, nonprescription "medicine chest" items as specified in the beneficiary's support plan. Items that are not of direct medical or remedial benefit to the beneficiary are not allowed. Only the following items are allowable:</p> <ul style="list-style-type: none"> ▪ Cough, cold, pain, headache, allergy, and/or gastrointestinal distress remedies; ▪ Vitamins and minerals; ▪ Special dietary juices and foods that augment, but do not replace, a regular diet;



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	<ul style="list-style-type: none"> ▪ Thickening agents for safe swallowing when the beneficiary has a diagnosis of dysphagia and either: <ul style="list-style-type: none"> ➢ A history of aspiration pneumonia, or ➢ Documentation that the beneficiary is at risk of insertion of a feeding tube without thickening agents for safe swallowing; ▪ First aid supplies (e.g., band-aids, iodine, rubbing alcohol, cotton swabs, gauze, antiseptic cleansing pads); ▪ Special oral care products to treat specific oral conditions beyond routine mouth care (e.g., special toothpaste, toothbrushes, anti-plaque rinses, antiseptic mouthwashes); and ▪ Special items (i.e., accommodating common disabilities -- longer, wider handles), tweezers and nail clippers. <p>Routine cosmetic products (e.g., make-up base, aftershave, mascara, and similar products) are not included. However, products necessary to ameliorate negative visual impact of serious facial disfigurements (e.g., massive scarring) and/or skin conditions (including exposed area eczema, psoriasis, and/or acne) will be covered. Refer to the Pharmacy Chapter in this manual for information about Medicaid-covered prescriptions.</p> <p>HSW funds cannot be used to pay for copays for other prescription plans the beneficiary may have.</p>
<p>Environmental Modifications</p>	<p>Physical adaptations to the home and/or workplace required by the beneficiary's support plan that are necessary to ensure the health, safety, and welfare of the beneficiary, or enable him to function with greater independence within the environment(s) and without which the beneficiary would require institutionalization.</p> <p>Adaptations may include:</p> <ul style="list-style-type: none"> ▪ The installation of ramps and grab bars; ▪ Widening of doorways; ▪ Modification of bathroom facilities; ▪ Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the beneficiary; and ▪ Environmental control devices that replace the need for paid staff and increase the beneficiary's ability to live independently, such as automatic door openers. <p>Excluded are those adaptations or improvements to the home that are of general utility, are considered to be standard housing obligations of the beneficiary and are not of direct medical or remedial benefit. Examples of exclusions include, but are not limited to, carpeting, roof repair, sidewalks, driveways, heating, central air conditioning (except under exceptions noted in the service definition), garages, raised garage doors, storage and organizers, hot tubs, whirlpool tubs, swimming pools, landscaping and general home repairs. The HSW does not cover construction costs in a new home or additions to a home purchased after the beneficiary is enrolled in the waiver.</p>



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"Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that are essential to the implementation of the individual plan of service. The plan must document that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the beneficiary will be prevented. There must be documented evidence that the item is the most cost-effective alternative to meet the beneficiary's need. An example of a reasonable alternative, based on the results of a review of all options, may include changing the purpose, use, or function of a room within the home or finding alternative housing. Assessments and specialized training needed in conjunction with the use of such environmental modifications are included as a part of the cost of the service. All items must be ordered on a prescription as defined in the General Information Section of this chapter. An order is valid for one year from the date it was signed.

Central air-conditioning is included only when prescribed by a physician and specified with extensive documentation in the plan as to how it is essential in the treatment of the beneficiary's illness or condition. This supporting documentation must demonstrate the cost-effectiveness of central air compared to the cost of window units in all rooms that the beneficiary must use. Environmental modifications that are required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in a beneficiary's home.

The PIHP must assure there is a signed contract or bid proposal with the builder prior to the start of an environmental modification. It is the responsibility of the PIHP to work with the beneficiary and builder to ensure that the work is completed as outlined in the contract or bid proposal.

Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner, the beneficiary, and the PIHP must specify any requirements for restoration of the property to its original condition if the occupant moves. If a beneficiary or his family purchases or builds a home while receiving waiver services, it is the beneficiary's or family's responsibility to assure that the home will meet basic needs, such as having a ground floor bath/bedroom if the beneficiary has mobility limitations. HSW funds may be authorized to assist with the adaptations noted above (e.g., ramps, grab bars, widening doorways, etc.) for a home recently purchased. If modifications are needed to a home under construction that require special adaptation to the plan (e.g., roll-in shower), the HSW may be used to fund the difference between the standard fixture and the modification required to accommodate the beneficiary's need.

Environmental modifications for **licensed settings** includes only the remaining balance of previous environmental modification costs that accommodate the specific needs of current waiver beneficiaries, and will be limited to the documented portion being amortized in the mortgage, or the lease cost per bed. Environmental modifications exclude the cost of modifications required for basic foster care licensure or to meet local building codes.

The existing structure must have the capability to accept and support the proposed changes. The infrastructure of the home involved in the funded modifications (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must be in compliance with any applicable local codes. Environmental modifications shall exclude costs for improvements exclusively required to meet local building codes.



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	<p>The environmental modification must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values.</p> <p>The beneficiary, with the direct assistance by the PIHP supports coordinator when necessary, must make a reasonable effort to access all available funding sources, such as housing commission grants, Michigan State Housing Development Authority (MSHDA), and community development block grants, for assistance. A record of efforts to apply for alternative funding sources must be documented in the beneficiary's records, as well as acceptances or denials by these funding sources. The HSW is a funding source of last resort.</p> <p>Adaptations to the work environment are limited to those necessary to accommodate the person's individualized needs, and cannot be used to supplant the requirements of Section 504 of the Rehabilitation Act, the Americans with Disabilities Act (ADA), or covered by Michigan Rehabilitation Services (MRS) or the Bureau of Services for Blind Persons (BSBP).</p> <p>All services must be provided in accordance with applicable state or local building codes.</p>
Family Training	<p>Training and counseling services for the families of beneficiaries served on the waiver. For purposes of this service, "family" is defined as the family members who live with or provide care to the beneficiary in the HSW, and may include parent, spouse, children, relatives, foster family, unpaid caregivers, or in-laws.</p> <p>Training includes instructions about treatment regimens and use of equipment specified in the individual plan of services, and includes updates as needed to safely maintain the person at home. Family training goals, and the content, frequency, and duration of the training and/or counseling, should be identified in the beneficiary's individual plan of services.</p> <p>Not included are individuals who are employed to provide waiver services for the beneficiary.</p>



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<p>Goods and Services</p>	<p>The purpose of Goods and Services is to promote individual control over, and flexible use of, the individual budget by the HSW beneficiary using arrangements that support self-determination and facilitate creative use of funds to accomplish the goals identified in the individual plan of services (IPOS) through achieving better value or an improved outcome. Goods and services must increase independence, facilitate productivity, or promote community inclusion and substitute for human assistance (such as personal care in the Medicaid State Plan and community living supports and other one-to-one support as described in the HSW or §1915(b)(3) Additional Service definitions) to the extent that individual budget expenditures would otherwise be made for the human assistance.</p> <p>A Goods and Services item must be identified using a person-centered planning process, meet medical necessity criteria, and be documented in the IPOS. Purchase of a warranty may be included when it is available for the item and is financially reasonable.</p> <p>Goods and Services are available only to individuals participating in arrangements of self-determination whose individual budget is lodged with a fiscal intermediary.</p> <p>This coverage may not be used to acquire goods or services that are prohibited by federal or state laws or regulations, e.g., purchase or lease or routine maintenance of a vehicle.</p>
<p>Out-of-Home Nonvocational Habilitation</p>	<p>Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills; and the supports services, including transportation to and from, incidental to the provision of that assistance that takes place in a non-residential setting, separate from the home or facility in which the beneficiary resides.</p> <p>Examples of incidental support include:</p> <ul style="list-style-type: none"> ▪ Aides helping the beneficiary with his mobility, transferring, and personal hygiene functions at the various sites where habilitation is provided in the community. ▪ When necessary, helping the person to engage in the habilitation activities (e.g., interpreting). <p>Services must be furnished four or more hours per day on a regularly scheduled basis for one or more days per week unless provided as an adjunct to other day activities included in the beneficiary's plan of service.</p> <p>These supports focus on enabling the person to attain or maintain his maximum functioning level, and should be coordinated with any physical, occupational, or speech therapies listed in the plan of services. Services may serve to reinforce skills or lessons taught in school, therapy, or other settings.</p>
<p>Overnight Health and Safety Supports</p>	<p>For information regarding Overnight Health and Safety Support (OHSS) Services, refer to the Covered Waiver Services section of the Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix of this chapter. (text added per bulletin MSA 20-04)</p>



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Personal Emergency Response Systems (PERS)	<p>Electronic devices that enable beneficiaries to secure help in the event of an emergency. The beneficiary may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once the button is activated. The response center is staffed by trained professionals. This service includes a one-time installation and up to twelve monthly monitoring services per year.</p> <p>PERS coverage should be limited to beneficiaries living alone (or living with a roommate who does not provide supports), or who are alone for significant parts of the day; who have no regular support or service provider for those parts of the day; and who would otherwise require extensive routine support and guidance.</p>
Prevocational Services	<p>Prevocational services involve the provision of learning and work experiences where a beneficiary can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated, community settings. Services are expected to occur over a defined period of time and provided in sufficient amount and scope to achieve the outcome, as determined by the beneficiary and his/her care planning team in the ongoing person-centered planning process. Services are expected to specifically involve strategies that enhance a beneficiary's employability in integrated, community settings. Competitive employment and supported employment are considered successful outcomes of prevocational services. However, participation in prevocational services is not a required prerequisite for competitive employment or receiving supported employment services.</p>



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Prevocational services should enable each beneficiary to attain the highest possible wage and work which is in the most integrated setting and matched to the beneficiary's interests, strengths, priorities, abilities, and capabilities. Services are intended to develop and teach general skills that lead to employment including, but not limited to:

- ability to communicate effectively with supervisors, co-workers and customers;
- generally accepted community workplace conduct and dress;
- ability to follow directions;
- ability to attend to tasks;
- workplace problem solving skills and strategies;
- general workplace safety; and
- mobility training.

Support of employment outcomes is a part of the person-centered planning process and emphasizes informed consumer choice. This process specifies the beneficiary's personal outcomes toward a goal of productivity, identifies the services and items, including prevocational services and other employment-related services that advance achievement of the beneficiary's outcomes, and addresses the alternatives that are effective in supporting his or her outcomes. From the alternatives, the beneficiary selects the most cost-effective approach that will help him or her achieve the outcome.

Beneficiaries who receive prevocational services during some days or parts of days may also receive other waiver services, such as supported employment, out-of-home non-vocational habilitation, or community living supports, at other times. Beneficiaries who are still attending school may receive prevocational training and other work-related transition services through the school system and may also participate in prevocational services designed to complement and reinforce the skills being learned in the school program during portions of their day that are not the educational system's responsibility, e.g., after school or on weekends and school vacations. Prevocational services may be provided in a variety of community locations.

Beneficiaries participating in prevocational services may be compensated in accordance with applicable Federal laws and regulations, but the provision of prevocational services is intended to lead to a permanent integrated employment situation.

Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for supported employment services provided by Michigan Rehabilitation Services (MRS) or the Bureau of Services for Blind Persons (BSBP). Information must be updated when MRS or BSBP eligibility conditions change.



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	<p>Prevocational services may be provided to supplement, but may not duplicate, services provided under supported employment or out-of-home non-vocational habilitation services. Coordination with the beneficiary's school is necessary to assure that prevocational services provided in the waiver do not duplicate or supplant transition services that are the responsibility of the educational program. Transportation provided between the beneficiary's place of residence and the site of the prevocational services, or between habilitation sites, is included as part of the prevocational and/or habilitation services.</p> <p>Assistance with personal care or other activities of daily living that are provided to a beneficiary during the receipt of prevocational services may be included as part of prevocational services or may be provided as a separate State Plan Home Help service or community living supports service under the waiver, but the same activity cannot be reported as being provided to more than one service.</p> <p>Only activities that contribute to the beneficiary's work experience, work skills, or work-related knowledge can be included in prevocational services.</p>
Private Duty Nursing (PDN)	<p>Private Duty Nursing (PDN) services are skilled nursing interventions provided to individuals age 21 and older, up to a maximum of 16 hours per day, to meet an individual's health needs that are directly related to his developmental disability. PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurses within the scope of the State's Nurse Practice Act, consistent with physician's orders and in accordance with the written health care plan which is part of the beneficiary's individual plan of services (IPOS). PDN services are for beneficiaries who require more individual and continuous care than periodic or intermittent nursing available through state plan services, e.g., Home Health. The individual receiving PDN must also require at least one of the following habilitative services, whether being provided by natural supports or through the waiver.</p> <ul style="list-style-type: none">▪ Community living supports▪ Out-of-home non-vocational habilitation▪ Prevocational or supported employment <p>To be determined eligible for PDN services, the PIHP must find that the beneficiary meets Medical Criteria I as well as Medical Criteria III, or meets Medical Criteria II as well as Medical Criteria III. Regardless of whether the beneficiary meets Medical Criteria I or II, the beneficiary must also meet Medical Criteria III.</p> <p>Medical Criteria I – The beneficiary is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:</p> <ul style="list-style-type: none">▪ Mechanical rate-dependent ventilation (four or more hours per day), or assisted rate-dependent respiration (e.g., some models of Bi-PAP); or▪ Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period; or▪ Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or



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- Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or
- Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter and a documented need for skilled nursing assessment, judgment, and intervention in the rate of oxygen administration. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO2 level is 55 mm HG or below.

Medical Criteria II – Frequent episodes of medical instability within the past three to six months, requiring skilled nursing assessments, judgments or interventions (as described in III below) due to a substantiated medical condition directly related to the developmental disability.

Definitions:

- "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months. "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder.
- "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention would result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

For beneficiaries described in II above, the requirement for frequent episodes of medical instability is applicable only to the initial determination for private duty nursing. A determination of need for continued private duty nursing services is based on the continuous skilled nursing care.



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- "Directly related to the developmental disability" means an illness, diagnosis, or syndrome occurred during the developmental period prior to age 22, is likely to continue indefinitely, and results in significant functional limitations in 3 or more areas of life activity. Illnesses or disability acquired after the developmental period, such as stroke or heart conditions, would not be considered directly related to the developmental disability.
- "Substantiated" means documented in the clinical/medical record, including the nursing notes.

Medical Criteria III – The beneficiary requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services.

Definitions:

- "Continuous" means at least once every 3 hours throughout a 24-hour period, and/or when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode.
- Equipment needs alone do not create the need for skilled nursing services.
- "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to:
 - performing assessments to determine the basis for acting or a need for action, and documentation to support the frequency and scope of those decisions or actions;
 - managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the beneficiary four or more hours per day;
 - deep oral (past the tonsils) or tracheostomy suctioning;
 - injections when there is a regular or predicted schedule, or prn injections that are required at least once per month (insulin administration is not considered a skilled nursing intervention);
 - nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility;
 - total parenteral nutrition delivered via a central line and care of the central line;
 - continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter, and a documented need for adjustments in the rate of oxygen administration requiring skilled nursing assessments, judgments and interventions. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO₂ level is 55 mm HG or below;



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	<p>➤ monitoring fluid and electrolyte balances where imbalances may occur rapidly due to complex medical problems or medical fragility. Monitoring by a skilled nurse would include maintaining strict intake and output, monitoring skin for edema or dehydration, and watching for cardiac and respiratory signs and symptoms. Taking routine blood pressure and pulse once per shift that does not require any skilled assessment, judgment or intervention at least once every three hours during a 24-hour period, as documented in the nursing notes, would not be considered skilled nursing.</p> <p>Once the Medical Criteria eligibility for PDN has been established, and as part of determining the amount of PDN a beneficiary is eligible for, the Intensity of Care category must be determined. This is a clinical judgment based on the following factors:</p> <ul style="list-style-type: none"> ▪ The beneficiary’s medical condition; ▪ The type and frequency of needed nursing assessments, judgments and interventions; and ▪ The impact of delayed nursing interventions. <p>Equipment needs alone do not determine intensity of care. Other aspects of care (e.g., administering medications) are important when developing a plan for meeting the overall needs of the beneficiary but do not determine the amount of hours of nursing for which the beneficiary is eligible.</p>		
	High Category	Medium Category	Low Category
	Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time each hour throughout a 24-hour period when delayed nursing interventions could result in further deterioration of health status, in loss of function, death, or in acceleration of the chronic condition.	Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours throughout a 24-hour period, or at least one time each hour for at least 12 hours per day, when delayed nursing interventions could result in further deterioration of health status, in loss of function, death, or in acceleration of the chronic condition. This category also includes beneficiaries with a higher need for nursing assessments and judgments due to an inability to communicate and direct their own care.	Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours for at least 12 hours per day, as well as those beneficiaries who can participate in and direct their own care.
	<p>The amount of PDN hours authorized represents a monthly total determined by calculating an average amount of PDN per day multiplied by the number of days in the month. The beneficiary has the flexibility to use the hours as needed during the month, not to exceed the total monthly authorized amount.</p>		



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The amount of PDN (i.e., the number of hours that can be authorized for a beneficiary) is determined through the person-centered planning process to address the individual's unique needs and circumstances. Factors to be considered should include the beneficiary's care needs which establish medical necessity for PDN; the beneficiary's and family's circumstances (e.g., the availability of natural supports); and other resources for daily care (e.g., private health insurance, trusts, bequests). Although the person-centered planning process is used to determine the exact amount of PDN specified in the IPOS, in general, a beneficiary who has Low Category PDN needs would require eight or fewer hours per day, a beneficiary who has Medium Category PDN needs would require 12 or fewer hours per day, and a beneficiary who has High Category PDN needs would require 16 or fewer hours per day.

The nurse may provide personal care only when incidental to the delivery of PDN, e.g., diaper changes, but may not provide routine personal care. The provision of personal care in unlicensed homes is through Home Help, a state plan service. If the beneficiary receiving PDN services demonstrates the need for Home Help services, the IPOS must document coordination of Home Help and PDN to assure no duplication of services.

Licensed nurses provide the nursing treatments, observation, and/or teaching as ordered by a physician, and that are consistent with the written individual plan of services.

These services should be provided to a beneficiary at home or in the community. A physician's prescription is required.

The PIHP must assess and document the availability of all private health care coverage (e.g., private or commercial health insurance, Medicare, health maintenance organization, preferred provider organization, Champs, Worker's Compensation, an indemnity policy, automobile insurance) for private duty nursing and will assist the beneficiary in selecting a private duty nursing provider in accordance with available third-party coverage. This includes private health coverage held by, or on behalf of, a beneficiary.

If a beneficiary is attending school and the Individualized Education Plan (IEP) identifies the need for PDN during transportation to and from school and/or in the classroom, the school is responsible for providing PDN during school hours. For adults up to age 26 who are enrolled in school, PDN services are not intended to supplant services provided in school or other settings or to be provided during the times when the beneficiary would typically be in school but for the parent's choice to home-school.

An exception process to ensure the beneficiary's health, safety and welfare is available if the beneficiary's needs exceed the 16-hours-per-day maximum for a time-limited period not to exceed six months. Factors underlying the need for additional PDN must be identified in the beneficiary's plan, including strategies directed toward resolving the factors necessitating the exception, if applicable. Documentation must substantiate all of the following:

- Current medical necessity for the exception; and
- Additional PDN services are essential to the successful implementation of the beneficiary's written plan of care, and are essential to maintain the beneficiary within the least restrictive, safe, and humane environment suitable to his condition.



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Exceptions must be based on the increased identified medical needs of the beneficiary or the impact on the beneficiary's needs due to the unavailability of the primary unpaid caregiver. Consideration for an exception is limited to situations outside the beneficiary's or family's control that place the beneficiary in jeopardy of serious injury or significant deterioration of health status. Exceptions may be considered for either of the following general situations:

- A temporary alteration in the beneficiary's care needs, resulting in one or both of the following:
 - A temporary increase in the intensity of required assessments, judgments, and interventions.
 - A temporary need for additional training to enable the primary caregiver(s) to identify and meet the beneficiary's care needs.

The total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the beneficiary's increased medical needs for a maximum of six months.

- The temporary inability of the primary unpaid caregiver(s) to provide the required care, as the result of one of the following:
 - In the event the caregiver is hospitalized, a maximum of 24 hours per day can be authorized for each day the caregiver is hospitalized. Upon discharge from the hospital, or in the event of an acute illness or injury of the caregiver, the total number of additional PDN hours per day will be based on the physician's documentation of the extent and duration of the caregiver's limitations and the needs of the beneficiary as it relates to those limitations, not to exceed six months.
 - The death of the primary caregiver. The initial amount of hours allowable under this exception is 24 hours per day for 14 days. Subsequent exceptions can be approved up to an additional 60 days, with monthly reviews thereafter by the PIHP/CMHSP.
 - The death of an immediate family member. "Immediate family member" is defined as the caregiver's spouse, partner, parent, sibling, or child. The maximum number of hours allowable under this exception criterion is 24 hours per day for a maximum of seven days.

"Inability" is defined as the caregiver is either unable to provide care or is prevented from providing care.

"Primary caregiver" is defined as the caregiver who provides the majority of unpaid care.

"Unpaid care" is defined as care provided by a caregiver where no reimbursement is received for those services, e.g., is not being paid as a Home Help provider or Community Living Supports staff.

This exception is not available if the beneficiary resides in a licensed setting or in a home where all care is provided by paid caregivers.



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	<p>In the event that a transition plan has been developed wherein PDN services are to be reduced or eliminated based on a determination of medical necessity, the PIHP may provide PDN for a period of time (not to exceed three months) for the purpose of training the CLS or respite aides or family and assuring a smooth transition. In those cases, the transition plan, including amount, scope, frequency and duration of the training by nurses to aides, must be documented in the IPOS. A transition process is not intended to provide two-to-one (nurse and aide) staffing for any purpose other than for training (with limitations on duration and frequency noted in the IPOS) while the aide or family member becomes familiar with the beneficiary's care needs. This transition period is only permitted when it has been determined that PDN is not medically necessary and the beneficiary's care needs can be met by a trained CLS or respite aide.</p> <div data-bbox="602 730 1310 1039" style="border: 1px solid black; background-color: #ffff00; padding: 10px; text-align: center;"> <p>Private Duty Nursing is a Medicaid coverage for beneficiaries under age 21 who meet the medical criteria for eligibility. Refer to the Private Duty Nursing Chapter of this manual for additional information.</p> </div>
<p>Respite Care</p>	<p>Respite care services are provided to a waiver eligible beneficiary on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.</p> <ul style="list-style-type: none"> ▪ "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations). ▪ "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with periods in between. ▪ "Primary" caregivers are typically the same people who provide at least some unpaid supports daily. ▪ "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school). <p>Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service but may be available at other times throughout the day when the caregiver is not paid.</p>



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	<p>Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work full-time. In those cases, community living supports or other services of paid support or training staff should be used. The beneficiary's record must clearly differentiate respite hours from community living support services. Decisions about the methods and amounts of respite are decided during the person-centered planning process. Respite care may not be provided by a parent of a minor beneficiary receiving the service, the spouse of the beneficiary, the beneficiary's legal guardian, or the primary unpaid caregiver.</p> <p>Respite services may be provided in the following settings:</p> <ul style="list-style-type: none"> ▪ Waiver beneficiary's home or place of residence. ▪ Licensed foster care home. ▪ Facility approved by the State that is not a private residence, such as: <ul style="list-style-type: none"> ➢ Group home; or ➢ Licensed respite care facility. ▪ Home of a friend or relative (not the parent of a minor beneficiary or the spouse of the beneficiary served or the legal guardian) chosen by the beneficiary; licensed camp; in community settings with a respite worker training, if needed, by the beneficiary or family. These sites are approved by the beneficiary and identified in the IPOS. <p>Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence. Respite provided in an institution (i.e., ICF/IID, nursing facility, or hospital) or MDHHS approved day program site is not covered by the HSW. The beneficiary's record must clearly differentiate respite hours from community living support services.</p>
<p>Supports Coordination</p>	<p>Supports coordination works with the waiver beneficiary to assure all necessary supports and services are provided to enable the beneficiary to achieve community inclusion and participation, productivity, and independence in home- and community-based settings. Without the supports and services, the beneficiary would otherwise require the level of care services provided in an ICF/IID. Supports coordination involves the waiver beneficiary and others identified by the beneficiary (i.e., family member(s)) in developing a written individual plan of services (IPOS) through the person-centered planning process. The waiver beneficiary may choose to work with a supports coordinator through the provider agency, an independent supports coordinator, a supports coordinator assistant, or a services and supports broker. Functions performed by a supports coordinator, supports coordinator assistant, or services and supports broker include an assurance of the following:</p> <ul style="list-style-type: none"> ▪ Assistance with access to entitlements and/or legal representation. ▪ Brokering of providers of services/supports. ▪ Developing an IPOS using the person-centered planning process, including revisions to the IPOS at the beneficiary's request or as the beneficiary's changing circumstances may warrant. ▪ Linking to, coordinating with, follow-up of, and advocacy with all supports and services, including the Medicaid Health Plan, Medicaid fee-for-service, or other health care providers.



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- Monitoring of Habilitation Supports Waiver and other mental health services.
- Planning and/or facilitating planning using person-centered principles. This function may be delegated to an independent facilitator chosen by the beneficiary.

The role of the supports coordinator assistant is to perform the functions listed above, as they are needed, when the beneficiary selects an assistant in lieu of a supports coordinator. When a supports coordinator assistant is used, a qualified supports coordinator must supervise the assistant.

The beneficiary may select a services and supports broker to perform supports coordination functions. However, parents of a minor-aged beneficiary, spouse or legal guardian of an adult beneficiary may not provide services and supports broker services to the beneficiary. The primary roles are to assist the beneficiary in making informed decisions about what will work best for him, are consistent with his needs and reflect the beneficiary's circumstances. The services and supports broker helps the beneficiary explore the availability of community services and supports, housing, and employment and then makes the necessary arrangements to link the beneficiary with those supports. Services and supports brokerage services offer practical skills training to enable beneficiaries to remain independent, including the provision of information on recruiting/hiring/managing workers, effective communication and problem solving.

Whenever services and supports brokers perform any of the supports coordination functions, it is expected that the beneficiary will also have a supports coordinator or supports coordinator assistant employed by the PIHP or its provider network that assures the other functions above are in place, and that the functions assigned to the services and supports broker are being performed. The IPOS must clearly identify which functions are the responsibility of the supports coordinator, the supports coordinator assistant and the services and supports broker. The services and supports broker must work under the supervision of a qualified supports coordinator.

Many beneficiaries choose a services and supports broker rather than traditional case management services or supports coordination provided directly by a supports coordinator. If a beneficiary does not want case management or supports coordination services, the PIHP will assist the beneficiary to identify who will assist him in performing each of the functions, including the use of natural supports or other qualified providers, to assure the supports coordination functions are provided. The IPOS must reflect the beneficiary's choices, the responsible person(s) for each of the functions listed in this section, and the frequency at which each will occur.

When the beneficiary chooses a supports coordinator assistant, a services and supports broker, or a natural support to perform any of the functions, the IPOS must clearly identify which functions are the responsibility of the supports coordinator, the supports coordinator assistant, the services and supports broker or the natural support. The PIHP must assure that it is not paying for the supports coordinator or supports coordinator assistant and the services and supports broker to perform the same function. Likewise, when a supports coordinator or supports coordinator assistant facilitates a person-centered planning meeting, it is expected that the PIHP would not "double count" the time of any services and supports broker who also attends. During its on-site visits, MDHHS will review the IPOS to verify that there is no duplication of service provision when both a supports coordinator or supports coordinator assistant and a services and supports broker are assigned supports coordination responsibilities in a beneficiary's plan of service.



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Supports strategies will incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of natural supports. Support coordinators, supports coordinator assistants, or services and supports brokers will work closely with the beneficiary to assure his ongoing satisfaction with the process and outcomes of the supports, services, and available resources.

Supports Coordination is reported only when there is face-to-face contact with the beneficiary. Related activities, such as telephone calls to schedule appointments or arrange supports, are functions that are performed by a supports coordinator but not reported separately. Supports coordination functions must assure:

- Activities are documented.
- Appointments and meetings are scheduled.
- Housing and employment issues are addressed.
- Income/benefits are maximized.
- Information is provided to assure the beneficiary (and his representative(s), if applicable) is informed about self-determination.
- Monitoring of individual budgets (when applicable) for over- or under-utilization of funds is provided.
- Natural and community supports are used.
- Person-centered planning is provided and independent facilitation of person-centered planning is made available.
- Persons chosen by the beneficiary are involved in the planning process.
- Plans of supports/services are reviewed at such intervals as are indicated during planning.
- Social networks are developed.
- The desires and needs of the beneficiary are determined.
- The quality of the supports and services, as well as the health and safety of the beneficiary, is monitored.
- The supports and services desired and needed by the beneficiary are identified and implemented.

Additionally, the supports coordinator, supports coordinator assistant, or services and supports broker coordinates with, and provides information as needed to, the qualified intellectual disability professional (QIDP) on the process of evaluation and reevaluation of beneficiary level of care (e.g., supply status and update information, summarize input from supports providers, planning committee members, etc.).



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	<p>While supports coordination as part of the overall plan implementation and/or facilitation may include initiation of other coverages and/or short-term provision of supports, it shall not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services. Supports coordination does not include any activities defined as Out-of-Home Non-Vocational Habilitation, Prevocational Services, Supported Employment, or CLS. Supports coordinators, supports coordinator assistants, and services and supports brokers are prohibited from exercising the agency's authority to authorize or deny the provision of services. Supports coordination may not duplicate services that are the responsibility of another program.</p> <p>The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the beneficiary's plan. The beneficiary's record must contain sufficient information to document the provision of supports coordination, including the nature of the service, the date, and the location of contacts, including whether the contacts were face-to-face. The frequency and scope of supports coordination contacts must take into consideration health and safety needs of the beneficiary.</p>
Supported Employment	<p>Supported employment is the combination of ongoing support services and paid employment that enables the beneficiary to work in the community. For purposes of this waiver, the definition of "supported employment" is:</p> <ul style="list-style-type: none">▪ Community-based, taking place in integrated work settings where workers with disabilities work alongside people who do not have disabilities.▪ For beneficiaries with severe disabilities who require ongoing intensive supports such as job coach, employment specialist, or personal assistant.▪ For beneficiaries who require intermittent or diminishing amounts of supports from a job coach, employment specialist or personal assistant. <p>Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training, job coach, employment specialist services, personal assistance and consumer-run businesses. Supported employment services cannot be used for capital investment in a consumer-run business. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting or for any services that are the responsibility of another agency, such as Michigan Rehabilitation Services (MRS) or the Bureau of Services for Blind Persons (BSBP).</p> <p>FFP may not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as:</p> <ul style="list-style-type: none">▪ Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;▪ Payments that are passed through to users of supported employment programs; or▪ Payments for vocational training that is not directly related to an individual's supported employment program.



	<p>Transportation provided between the beneficiary’s place of residence and the site of the supported employment service, or between habilitation sites (in cases where the beneficiary receives habilitation services in more than one place), is included as part of the supported employment and/or habilitation service.</p> <p>Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for supported employment services provided by MRS or BSBP. Information must be updated when MRS or BSBP eligibility conditions change.</p>
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15.2 SUPPORTS AND SERVICES PROVIDER QUALIFICATIONS

Providers of Habilitation Supports Waiver supports and services are chosen by the beneficiary and others assisting him during the person-centered planning process, and must meet the staffing qualifications contained in Michigan’s 1915(c) Waiver.

15.2.A. SUPPORTS COORDINATOR QUALIFICATIONS

The Supports Coordinator must be:

- a QIDP;
- Selected by the beneficiary.

15.2.B. TRAINED SUPPORTS COORDINATOR ASSISTANT QUALIFICATIONS

- Minimum of equivalent experience (i.e., provides knowledge, skills and abilities similar to supports coordinator qualifications).
- Functions under the supervision of a supports coordinator.
- Selected by the beneficiary.
- At least 18 years of age.

15.2.C. AIDE QUALIFICATIONS

Minimum qualifications are noted below for aide level work (chore, respite, CLS, and out-of-home habilitation). The planning team should also identify other competencies that will assure the best possible outcomes for the beneficiary. Aide level staff who provide services and supports must be:

- At least 18 years of age.
- Able to prevent transmission of any communicable disease from self to others in the environment in which they are providing supports.
- Able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures, and report on activities performed.
- In good standing with the law (i.e., not a fugitive from justice, not a convicted felon who is either still under jurisdiction or one whose felony relates to the kind of duty he/she would be performing, not an illegal alien).



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- Able to perform basic first aid procedures, as evidenced by completion of a first aid training course, self-test, or other method determined by the PIHP to demonstrate competence in basic first aid procedures.
- Has received training in the beneficiary's IPOS.

15.2.D. SERVICES AND SUPPORTS BROKER QUALIFICATIONS

- Selected by the beneficiary.
- Demonstrates competence in areas of job responsibilities for services and supports broker.
- Functions under the supervision of a supports coordinator.
- At least 18 years of age.



SECTION 16 – MENTAL HEALTH AND SCHOOL BASED SERVICES

This section is applicable to all PIHP programs/provider requirements and pertains to beneficiaries with mental illness and/or developmental disabilities.

The School-Based Services (SBS) policy requires cooperative agreements between the PIHP and the SBS provider. These agreements are not changed by the policies in this chapter. Any required releases of information are part of the existing requirements of the SBS provider.

The quality assurance standards for SBS also requires the coordination of care with other human service agencies where appropriate, including local public health departments, community mental health agencies and the beneficiary's physician or managed care providers. In addition, enrolled SBS providers are required to cooperate with other human service agencies operating within the same service area and are not expected to replace or substitute services already provided by other agencies.

When a beneficiary receives active treatment from a SBS provider, the services must be coordinated with the PIHP. If the PIHP provides mental health services for a special education student with serious emotional disturbance or a developmental disability, PIHP must coordinate such services and information with special education and other human services agencies serving the student.

(Refer to the School Based Services Chapter of this manual for additional information.)



SECTION 17 – ADDITIONAL MENTAL HEALTH SERVICES (B3s)

PIHPs must make certain Medicaid-funded mental health supports and services available, in addition to the Medicaid State Plan Specialty Supports and Services or Habilitation Waiver Services, through the authority of 1915(b)(3) of the Social Security Act (hereafter referred to as B3s). The intent of B3 supports and services is to fund medically necessary supports and services that promote community inclusion and participation, independence, and/or productivity when identified in the individual plan of service as one or more goals developed during person-centered planning. 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.

17.1 DEFINITIONS OF GOALS THAT MEET THE INTENTS AND PURPOSE OF B3 SUPPORTS AND SERVICES

The goals (listed below) and their operational definitions will vary according to the individual’s needs and desires. However, goals that are inconsistent with least restrictive environment (i.e., most integrated home, work, community that meet the individual’s needs and desires) and individual choice and control cannot be supported by B3 supports and services unless there is documentation that health and safety would otherwise be jeopardized; or that such least restrictive arrangements or choice and control opportunities have been demonstrated to be unsuccessful for that individual. Care should be taken to insure that these goals are those of the individual first, not those of a parent, guardian, provider, therapist, or case manager, no matter how well intentioned. The services in the plan, whether B3 supports and services alone, or in combination with state plan or Habilitation Supports Waiver services, must reasonably be expected to achieve the goals and intended outcomes identified. The configuration of supports and services should assist the individual to attain outcomes that are typical in his community; and without such services and supports, would be impossible to attain.

Community Inclusion and Participation	<p>The individual uses community services and participates in community activities in the same manner as the typical community citizen.</p> <p>Examples are recreation (parks, movies, concerts, sporting events, arts classes, etc.), shopping, socialization (visiting friends, attending club meetings, dining out) and civic (volunteering, voting, attending governmental meetings, etc.) activities. A beneficiary’s use of, and participation in, community activities are expected to be integrated with that of the typical citizen’s (e.g., the beneficiary would attend an "integrated" yoga class at the community center rather than a special yoga class for persons with intellectual disability).</p>
Independence	<p>"Freedom from another’s influence, control and determination." (Webster’s New World College Dictionary, 1996). Independence in the B3 context means how the individual defines the extent of such freedom for him/herself during person-centered planning.</p> <p>For example, to some beneficiaries, "freedom" could be living on their own, controlling their own budget, choosing an apartment as well as the persons who will live there with them, or getting around the community on their own. To others, "freedom" could be control over what and when to eat, what and when to watch television, when and how to bathe, or when to go to bed and arise. For children under 18 years old, independence may mean the support given by parents and others to help children achieve the skills they need to be successful in school, enter adulthood and live independently.</p>



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Productivity	<p>Engaged in activities that result in or lead to maintenance of or increased self-sufficiency. Those activities are typically going to school and work. The operational definition of productivity for an individual may be influenced by age-appropriateness.</p> <p>For example, a person who is 76 years old may choose to volunteer or participate in other community or senior center activities rather than have any productivity goals. For children under the age of five years, productivity may be successful participation in home, pre-school, or child care activities. Children under 18 would be expected to attend school, but may choose to work in addition. In order to use B3 supports and services, individuals would be expected to prepare for, or go to, school or work in the same places that the typical citizen uses.</p>
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17.2 CRITERIA FOR AUTHORIZING B3 SUPPORTS AND SERVICES

The authorization and use of Medicaid funds for any of the B3 supports and services, as well as their amount, scope and duration, are dependent upon:

- The Medicaid beneficiary’s eligibility for specialty services and supports as defined in this Chapter;
- The service(s) having been identified during person-centered planning;
- The service(s) being medically necessary as defined in the Medical Necessity Criteria subsection of this chapter;
- The service(s) being expected to achieve one or more of the above-listed goals as identified in the beneficiary’s plan of service; and
- Additional criteria indicated in certain B3 service definitions, as applicable.

Decisions regarding the authorization of a B3 service (including the amount, scope and duration) must take into account the PIHP’s documented capacity to reasonably and equitably serve other Medicaid beneficiaries who also have needs for these services. The B3 supports and services are not intended to meet all the individual’s needs and preferences, as some needs may be better met by community and other natural supports. Natural supports mean unpaid assistance provided to the beneficiary by people in his/her network (family, friends, neighbors, community volunteers) who are willing and able to provide such assistance. It is reasonable to expect that parents of minor children with disabilities will provide the same level of care they would provide to their children without disabilities. MDHHS encourages the use of natural supports to assist in meeting an individual's needs to the extent that the family or friends who provide the natural supports are willing and able to provide this assistance. PIHPs may not require a beneficiary's natural support network to provide such assistance as a condition for receiving specialty mental health supports and services. The use of natural supports must be documented in the beneficiary's individual plan of service.

Provider qualifications and service locations that are not otherwise identified in this section must meet the requirements identified in the General Information and Program Requirement sections of this chapter.

17.3 B3 SUPPORTS AND SERVICES

The B3 supports and services defined below are the supports and services that PIHPs are to provide from their Medicaid capitation.



17.3.A. ASSISTIVE TECHNOLOGY

Assistive technology is an item or set of items that enable the individual to increase his ability to perform activities of daily living with a greater degree of independence than without them; to perceive, control, or communicate with the environment in which he lives. These are items that are not available through other Medicaid coverage or through other insurances. These items must be specified in the individual plan of service. All items must be ordered by a physician on a prescription as defined in the General Information section of this chapter. An order is valid for one year from the date it was signed.

Coverage includes:

- Adaptations to vehicles
- Items necessary for independent living (e.g., Lifeline, sensory integration equipment)
- Communication devices
- Special personal care items that accommodate the person's disability (e.g., reachers, full-spectrum lamp)
- Prostheses necessary to ameliorate negative visual impact of serious facial disfigurements and/or skin conditions
- Ancillary supplies and equipment necessary for proper functioning of assistive technology items
- Repairs to covered assistive technology that are not covered benefits through other insurances

Assessments by an appropriate health care professional, specialized training needed in conjunction with the use of the equipment, and warranted upkeep will be considered as part of the cost of the services.

Coverage excludes:

- Furnishings (e.g., furniture, appliances, bedding) and other non-custom items (e.g., wall and floor coverings, decorative items) that are routinely found in a home.
- Items that are considered family recreational choices.
- The purchase or lease of a vehicle, and any repairs or routine maintenance to the vehicle.
- Educational supplies required to be provided by the school as specified in the child's Individualized Education Plan.

Covered items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained for the item at the time of purchase.

In order to cover repairs of assistive technology items, there must be documentation in the individual plan of services that the assistive technology continues to meet the criteria



for B3 supports and services as well as those in this subsection. All applicable warranty and insurance coverages must be sought and denied before paying for repairs. The PIHP must document that the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the PIHP must provide evidence of training in the use of the equipment to prevent future incidents.

17.3.B. COMMUNITY LIVING SUPPORTS

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

Coverage includes:

- Assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training in the following activities:
 - meal preparation
 - laundry
 - routine, seasonal, and heavy household care and maintenance
 - activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
 - shopping for food and other necessities of daily living

CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, the beneficiary must request Home Help and, if necessary, Expanded Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help or Expanded Home Help. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist him/her in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the MDHHS assessment.

- Staff assistance, support and/or training with activities such as:
 - money management
 - non-medical care (not requiring nurse or physician intervention)



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- socialization and relationship building
 - transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)
 - participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)
 - attendance at medical appointments
 - acquiring or procuring goods, other than those listed under shopping, and non-medical services
- Reminding, observing and/or monitoring of medication administration
 - Staff assistance with preserving the health and safety of the individual in order that he/she may reside or be supported in the most integrated, independent community setting.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, state plan coverage Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through MDHHS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving community living supports.

CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help or Expanded Home Help services when the individual's needs for this assistance have been officially determined to exceed the DHS's allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help or Expanded Home Help.

Community Living Supports (CLS) provides support to children and youth younger than 18, and the family in the care of their child, while facilitating the child's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For children and adults up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when the child or adult would typically be in school but for the parent's choice to home-school.



17.3.C. ENHANCED PHARMACY

Enhanced pharmacy items are physician-ordered, nonprescription "medicine chest" items as specified in the individual's plan of service. There must be documented evidence that the item is not available through Medicaid or other insurances, and is the most cost-effective alternative to meet the beneficiary's need.

The following items are covered only for adult beneficiaries living in independent settings (i.e., own home, apartment where deed or lease is signed by the beneficiary):

- Cough, cold, pain, headache, allergy, and/or gastrointestinal distress remedies
- First aid supplies (e.g., band-aids, iodine, rubbing alcohol, cotton swabs, gauze, antiseptic cleansing pads)

The following items are covered for beneficiaries living in independent settings, with family, or in licensed dependent care settings:

- Special oral care products to treat specific oral conditions beyond routine mouth care (e.g., special toothpaste, toothbrushes, anti-plaque rinses, antiseptic mouthwashes)
- Vitamins and minerals
- Special dietary juices and foods that augment, but do not replace, a regular diet
- Thickening agents for safe swallowing when the beneficiary has a diagnosis of dysphagia and either:
 - A history of aspiration pneumonia, or
 - Documentation that the beneficiary is at risk of insertion of a feeding tube without the thickening agents for safe swallowing.

Coverage excludes:

- Routine cosmetic products (e.g., make-up base, aftershave, mascara, and similar products)

17.3.D. ENVIRONMENTAL MODIFICATIONS

Physical adaptations to the beneficiary's own home or apartment and/or workplace. There must be documented evidence that the modification is the most cost-effective alternative to meet the beneficiary's need/goal based on the results of a review of all options, including a change in the use of rooms within the home or alternative housing, or in the case of vehicle modification, alternative transportation. All modifications must be prescribed by a physician. Prior to the environmental modification being authorized, PIHP may require that the beneficiary apply to all applicable funding sources (e.g., housing commission grants, MSHDA, and community development block grants), for assistance. It is expected that the PIHP case manager/supports coordinator will assist the beneficiary in his pursuit of these resources. Acceptances or denials by these funding sources must be documented in the beneficiary's records. Medicaid is a funding source of last resort.



Coverage includes:

- The installation of ramps and grab-bars.
- Widening of doorways.
- Modification of bathroom facilities.
- Special floor, wall or window covering that will enable the beneficiary more independence or control over his environment, and/or ensure health and safety.
- Installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the beneficiary.
- Assessments by an appropriate health care professional and specialized training needed in conjunction with the use of such environmental modifications.
- Central air conditioning when prescribed by a physician and specified as to how it is essential in the treatment of the beneficiary's illness or condition. This supporting documentation must demonstrate the cost-effectiveness of central air compared to the cost of window units in all rooms that the beneficiary must use.
- Environmental modifications that are required to support proper functioning of medical equipment, such as electrical upgrades, limited to the requirements for safe operation of the specified equipment.
- Adaptations to the work environment limited to those necessary to accommodate the beneficiary's individualized needs.

Coverage excludes:

- Adaptations or improvements to the home that are not of direct medical or remedial benefit to the beneficiary, or do not support the identified goals of community inclusion and participation, independence or productivity.
- Adaptations or improvements to the home that are of general utility or cosmetic value and are considered to be standard housing obligations of the beneficiary. Examples of exclusions include, but are not limited to, carpeting (see exception above), roof repair, sidewalks, driveways, heating, central air conditioning, garages, raised garage doors, storage and organizers, landscaping and general home repairs.
- Cost for construction of a new home or new construction (e.g., additions) in an existing home.
- Environmental modifications costs for improvements exclusively required to meet local building codes.
- Adaptations to the work environment that are the requirements of Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, or are the responsibilities of Michigan Rehabilitation Services (MRS) or the Bureau of Services for Blind Persons (BSBP).

The PIHP must assure there is a signed contract with the builder for an environmental modification and the homeowner. It is the responsibility of the PIHP to work with the



beneficiary and the builder to ensure that the work is completed as outlined in the contract and that issues are resolved among all parties. In the event that the contract is terminated prior to the completion of the work, Medicaid capitation payments may not be used to pay for any additional costs resulting from the termination of the contract.

The existing structure must have the capability to accept and support the proposed changes. The "infrastructure" of the home (e.g., electrical system, plumbing, well/septic, foundation, heating/cooling, smoke detector systems, roof) must be in compliance with all local codes. If the home is not code compliant, other funding sources must be secured to bring the home into compliance.

The environmental modification must incorporate reasonable and necessary construction standards and comply with applicable state or local building codes. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

Adaptations may be made to rental properties when the landowner agrees to the adaptation in writing. A written agreement between the landowner and the beneficiary must specify any requirements for restoration of the property to its original condition if the occupant moves, and must indicate that Medicaid is not obligated for any restoration costs.

If a beneficiary purchases an existing home while receiving Medicaid services, it is the beneficiary's responsibility to assure that the home will meet basic needs, such as having a ground floor bath/bedroom if the beneficiary has mobility limitations. Medicaid funds may be authorized to assist with the adaptations noted above (e.g., ramps, grab bars, widening doorways) for a recently purchased existing home.

17.3.E. FAMILY SUPPORT AND TRAINING [CHANGE MADE 10/1/20]

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

Family-focused services provided to family (natural or adoptive parents, spouse, children, siblings, relatives, foster family, in-laws, and other unpaid caregivers) of persons with serious mental illness, serious emotional disturbance or developmental disability for the purpose of assisting the family in relating to and caring for a relative with one of these disabilities. The services target the family members who are caring for and/or living with an individual receiving mental health services. The service is to be used in cases where the beneficiary is hindered or at risk of being hindered in his ability to achieve goals of:

- performing activities of daily living;
- perceiving, controlling, or communicating with the environment in which he lives; or
- improving his inclusion and participation in the community or productive activity, or opportunities for independent living.

The training and counseling goals, content, frequency and duration of the training must be identified in the beneficiary's individual plan of service, along with the beneficiary's goal(s) that are being facilitated by this service.



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Coverage includes:

- Education and training, including instructions about treatment regimens, and use of assistive technology and/or medical equipment needed to safely maintain the person at home as specified in the individual plan of service.
- Counseling and peer support provided by a trained counselor or peer one-on-one or in group for assistance with identifying coping strategies for successfully caring for or living with a person with disabilities.
- Family Psycho-Education (SAMHSA model -- specific information is found in the GUIDE TO FAMILY PSYCHOEDUCATION, Requirements for Certification, Sustainability, and Fidelity) for individuals with serious mental illness and their families. This evidence-based practice includes family educational groups, skills workshops, and joining.
- Parent-to-Parent Support is designed to support parents/family of children with serious emotional disturbance or intellectual/developmental disabilities, including autism, as part of the treatment process to be empowered, confident and have knowledge and skills that will enable the parent/family to improve their child's and family's functioning. Utilizing their lived experience, the trained parent support partner, who has or had a child with special mental health needs, provides education, coaching, and support and enhances the assessment and mental health treatment process. The parent support partner provides these services to the parents/caregivers. These activities are provided in the home and in the community. The parent support partner is an active member of the treatment team and participates in team consultation with the treating professionals. The parent support partner is to be provided regular supervision. Parent support partners may not have more than one provider role with any one family (i.e., may not be both parent support partner and peer support specialist for the same family). **(text added 10/1/20)**

17.3.F. HOUSING ASSISTANCE

Housing assistance is assistance with short-term, interim, or one-time-only expenses (not including room and board costs) for beneficiaries transitioning from restrictive settings and homelessness into more independent, integrated living arrangements while in the process of securing other benefits (e.g., SSI) or public programs (e.g., governmental rental assistance and/or home ownership programs) that will become available to assume these obligations and provide needed assistance.

Additional criteria for housing assistance:

- The beneficiary must have in his individual plan of services a goal of independent living, and either live in a home/apartment that he/she owns, rents, or leases; or be in the process of transitioning to such a setting; and
- Documentation of the beneficiary's control (i.e., beneficiary-signed lease, rental agreement, deed) of his living arrangement in the individual plan of service; and
- Documentation of efforts (e.g., the person is on a waiting list) under way to secure other benefits, such as SSI or public programs (e.g., governmental rental assistance, community housing initiatives and/or home ownership programs) so when these become available they will assume these obligations and provide the needed assistance.



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Coverage includes:

- Assistance with utilities, insurance, and moving expenses where such expenses would pose a barrier to a successful transition to owning or leasing/renting a dwelling.
- Limited term or temporary assistance with living expenses for beneficiaries transitioning from restrictive settings and homelessness. Limited term or temporary assistance is defined as a total of six (6) occurrences of a funding need.
- Interim assistance with utilities, insurance or living expenses when the beneficiary already living in an independent setting experiences a temporary reduction or termination of his own or other community resources. Interim assistance is defined as a total of three (3) occurrences of a funding need.
- Home maintenance when, without a repair to the home or replacement of a necessary appliance, the individual would be unable to move there, or if already living there, would be forced to leave for health and safety reasons.

Coverage excludes:

- Funding for on-going housing costs. Ongoing is defined as longer than a total of six (6) occurrences of a funding need.
- Funding for any room and board costs (i.e., rental payments, mortgage payments, lease payments, land contract payments, hotel/motel stays, etc.)
- Home maintenance that is of general utility or cosmetic value and is considered to be a standard housing obligation of the beneficiary.

Replacement or repair of appliances should follow the general rules under assistive technology. Repairs to the home must be in compliance with all local codes and be performed by the appropriate contractor (refer to the general rules of the Environmental Modifications subsection of this chapter). Replacement or repair of appliances, and repairs to the home or apartment do not need a prescription or order from a physician.

17.3.G. PEER-DELIVERED OR -OPERATED SUPPORT SERVICES

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

Peer-delivered or peer-operated support services are programs and services that provide individuals with opportunities to learn and share coping skills and strategies, move into more active assistance and away from passive roles, and to build and/or enhance self-esteem and self-confidence.

17.3.G.1. DROP-IN CENTERS

Peer-Run Drop-In Centers provide an informal, supportive environment to assist beneficiaries with mental illness in the recovery process. If a beneficiary chooses to participate in Peer-Run Drop-In Center services, such services may be included in an IPOS if medically necessary for the beneficiary. Peer-Run Drop-In Centers provide opportunities to learn and share coping skills and strategies, to move into more active



assistance and away from passive beneficiary roles and identities, and to build and/or enhance self-esteem and self-confidence. Under no circumstances may Peer-Run Drop-In Centers be used as respite for caregivers (paid or non-paid) or residential providers of individuals.

PIHPs must seek approval from MDHHS prior to establishing new drop-in programs. Proposed drop-in centers will be reviewed against the following criteria:

- Staff and board of directors of the center are 100% primary consumers;
- PIHP actively supports consumers' autonomy and independence in making day-to-day decisions about the program;
- PIHP facilitates consumers' ability to handle the finances of the program;
- The drop-in center is at a non-CMH site;
- The drop-in center has applied for 501(c)(3) non-profit status;
- There is a contract between the drop-in center and the PIHP, or its subcontractor, identifying the roles and responsibilities of each party; and
- There is a liaison appointed by the PIHP to work with the program.

Some beneficiaries use drop-in centers anonymously and do not have a drop-in center listed as a service in their IPOS. For those beneficiaries who do have drop-in specified in their IPOS, it must be documented to be medically necessary and identify:

- Goals and how the program supports those goals; and
- The amount, scope and duration of the services to be delivered.

The individual clinical record provides evidence that the services were delivered consistent with the plan.

17.3.G.2. PEER SPECIALIST SERVICES

Peer specialist services provide individuals with opportunities to support, mentor and assist beneficiaries to achieve community inclusion, participation, independence, recovery, resiliency and/or productivity. Peers are individuals who have a unique background and skill level from their experience in utilizing services and supports to achieve their personal goals of community membership, independence and productivity. Peers have a special ability to gain trust and respect of other beneficiaries based on shared experience and perspectives with disabilities, and with planning and negotiating human services systems.

- Vocational assistance provides support for beneficiaries seeking education and/or training opportunities, finding a job, achieving successful employment activities, and developing self-employment opportunities (reported as skill-building or supported employment).
- Housing assistance provides support locating and acquiring appropriate housing for achieving independent living; finding and choosing roommates; utilizing short-term, interim, or one-time-only financial assistance in order to transition from restrictive settings into independent integrated living arrangements; making applications for



Section 8 Housing vouchers; managing costs or room and board utilizing an individual budget; purchasing a home; etc. (reported as supports coordination).

- Services and supports planning and utilization assistance provides assistance and partnership in:
 - The person-centered planning process (reported as either treatment planning or supports coordination);
 - Developing and applying arrangements that support self-determination;
 - Directly selecting, employing or directing support staff;
 - Sharing stories of recovery and/or advocacy involvement and initiative for the purpose of assisting recovery and self-advocacy;
 - Accessing entitlements;
 - Developing health and wellness plans;
 - Developing advance directives;
 - Learning about and pursuing alternatives to guardianship;
 - Providing supportive services during crises;
 - Developing, implementing and providing ongoing guidance for advocacy and support groups;
 - Integration of physical and mental health care;
 - Developing, implementing and providing health and wellness classes to address preventable risk factors for medical conditions.

Activities provided by peers are completed in partnership with beneficiaries for the specific purpose of achieving increased beneficiary community inclusion and participation, independence and productivity.

Individuals providing Peer Support Services must be able to demonstrate their experience in relationship to the types of guidance, support and mentoring activities they will provide. Individuals providing these services should be those generally recognized and accepted to be peers. Beneficiaries utilizing Peer Support Services must freely choose the individual who is providing Peer Support Services. Individuals who are functioning as Peer Support Specialists serving beneficiaries with mental illness must:

- have a serious mental illness;
- have received public mental health services currently or in the past;
- provide at least 10 hours per week of services described above with supported documentation written in the IPOS; and
- meet the MDHHS application approval process for specialized training and certification requirements.



17.3.G.3. PEER RECOVERY COACH SERVICES

Peer Recovery Coach Services	<p>Peer Recovery Coach services are provided by a person in a journey of recovery from addictions or co-occurring disorders who identifies with a beneficiary based on a shared background and life experience. The Peer Recovery Coach serves as a personal guide and mentor for beneficiaries seeking, or already in, recovery from substance use disorders. Peer Recovery Coaches support a beneficiary’s journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports while role modeling the many pathways to recovery as each individual determines his or her own way. The Peer Recovery Coach helps to remove barriers and obstacles, and links the beneficiary to resources in the recovery community.</p> <p>Services provided by a Peer Recovery Coach support beneficiaries to become and stay engaged in the recovery process and reduce the likelihood of relapse. Activities are targeted to beneficiaries at all places along the path to recovery, including outreach for persons who are still active in their addiction, up to and including individuals who have been in recovery for several years.</p> <p>Peer Recovery Coaches embody a powerful message of hope, helping beneficiaries achieve a full and meaningful life in the community. The Peer Recovery Coach can assist with tasks such as setting recovery goals, developing recovery action plans, and solving problems directly related to recovery.</p> <p>The Peer Recovery Coach supports each beneficiary to fully participate in communities of their choosing in the environment most supportive of their recovery and that promotes housing of their choice to build recovery connections and supports. Utilizing a strength-based perspective and emphasizing assessment of recovery capital, services are designed to include prevention strategies and the integration of physical and behavioral health services to attain and maintain recovery and prevent relapse. Beneficiaries utilizing Peer Recovery Coach services must freely choose the individual who is providing Peer Recovery Coach services.</p> <p>The Peer Recovery Coach shall receive regular supervision by a case manager, treatment practitioner, prevention staff or an experienced Certified Peer Recovery Coach who has over two continuous years in recovery and over two years in the direct provision of recovery coach services and supports.</p>
Requirements	<p>Individuals who work as a Peer Recovery Coach serving beneficiaries with substance use or co-occurring disorders must:</p> <ul style="list-style-type: none">▪ Be at least 18 years of age;▪ Have two continuous years in recovery from addition(s), with experience in navigating treatment services and/or prevention;▪ Share their recovery story as a tool in helping others;▪ Have experience receiving publicly-funded treatment and recovery services for addiction(s);▪ Be employed at least 10 hours per week by a licensed Substance Use Disorder Treatment Organization, a PIHP, a Community Mental Health Services Program, or another organization under contract to one or more of the forgoing organizations that provide substance abuse treatment and/or recovery support services; and▪ Attend and successfully complete the MDHHS Peer Recovery Coach training and certification.



17.3.G.4. YOUTH PEER SUPPORT SERVICES

Youth Peer Support is designed to support youth with a serious emotional disturbance through shared activities and interventions. The goals of Youth Peer Support include supporting youth empowerment, assisting youth in developing skills to improve their overall functioning and quality of life, and working collaboratively with others involved in delivering the youth's care. Youth Peer Support services can be in the form of direct support, information sharing and skill building.

Youth Peer Support Services are provided by trained youth peer support specialists, one-on-one or in a group, for youth with serious emotional disturbance who are resolving conflicts, enhancing skills to improve their overall functioning, integrating with community, school and family and/or transitioning into adulthood. Services provide support and assistance for youth in accordance with the goals in their plan of service to assist the youth with community integration, improving family relationships and resolving conflicts, and making a transition to adulthood, including achieving successful independent living options, obtaining employment, and navigating the public human services system.

Youth Peer Support Specialists must have lived experience navigating behavioral health systems and must participate in and complete the approved MDHHS training curriculum. Youth Peer Support activities are identified as part of the assessment and the person-centered/family-driven, youth-guided planning process. The goals of Youth Peer Support services shall be included in the individualized plan of service where interventions are provided in the home and community. These goals will be mutually identified in active collaboration with the youth receiving services and must be delivered by a Youth Peer Support Specialist with lived experience. Youth Peer Support is intended to be provided to children and youth who are middle school to 21 years of age. It is not intended to substitute for other services such as respite or community living support services. The Youth Peer Support Specialist shall receive regular supervision by a child mental health professional and shall participate as an active member of the treatment team.

Qualifications for the Youth Peer Support Specialist include:

- Young adult, ages 18 through 26, with lived experience who received mental health services as a youth.
- Willing and able to self-identify as a person who has or is receiving behavioral health services and is prepared to use that experience in helping others.
- Experience receiving services as a youth in complex, child serving systems preferred (behavioral health, child welfare, juvenile justice, special education, etc.).
- Employed by PIHP/CMHSP or its contract providers.
- Trained in the MDHHS approved curriculum and ongoing training model.



17.3.G.5. PEER MENTORING SERVICES

Peer Mentoring services provide adults with intellectual and developmental disabilities with opportunities to support, mentor and assist beneficiaries to achieve community inclusion and participation, independence, and productivity. Peer Mentors are individuals with intellectual and developmental disabilities who have a unique skill level from their experience in utilizing services and supports to achieve their goals. Peer Mentors offer the benefit of their personal experiences, passing along encouragement and support to help others construct their own advocacy. Beneficiaries utilizing Peer Mentoring services must freely choose the individual who is providing Peer Mentoring services from available trained Peer Mentors.

Activities provided by Peer Mentors are completed in partnership with beneficiaries for the specific purpose of achieving increased beneficiary community inclusion and participation, independence, and productivity by:

- sharing personal stories of advocacy for the purpose of supporting self-advocacy and independence, person-centered planning goals, and arrangements that support self-direction;
- navigating transportation systems;
- building bridges to people and resources within the community;
- identifying recreation opportunities;
- providing information on entitlements;
- assisting beneficiaries to move towards independence;
- providing housing information by helping to identify affordable and accessible housing for achieving independent living; finding and choosing roommates; making applications for Section 8 Housing vouchers; managing budgets;
- providing vocational information to beneficiaries who are seeking post-secondary education and/or training opportunities, finding a job, and achieving successful employment.

Requirements

Individuals who are functioning as Peer Mentors serving beneficiaries with intellectual and developmental disabilities must:

- be 18 years of age.
- have an intellectual/developmental disability.
- attend the Michigan Developmental Disabilities Council's Peer Mentor 101 training by referral from their local CMHSP.
- complete a supervised 90-120 hour internship at their local CMHSP. (The CMHSP is expected to hire the individual after certification.)
- share their personal experiences to guide and support beneficiaries.



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- participate in annual continuing education trainings to maintain skills and expand knowledge base.

The use of the Peer Mentor code for billing purposes is permissible only after the individual is certified by the Michigan Developmental Disabilities Council.

17.3.H. PREVENTION-DIRECT SERVICE MODELS [CHANGES MADE 7/1/20]

Prevention-direct service models are programs using individual, family and group interventions designed to reduce the incidence of behavioral, social, emotional or cognitive dysfunction and increase the beneficiary's behavioral functionality, resilience and optimal mental health, thus reducing the need for individuals to seek treatment through the public mental health system. Prevention-direct service models are:

- Child Care Expulsion Prevention (NOTE: This program is also known as Infant and Early Childhood Mental Health Consultation.) (text revised 7/1/20)
- School Success Programs
- Children of Adults with Mental Illness/Integrated Services (NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.)
- Infant Mental Health when not enrolled as a Home-Based program
- Parent Education (NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.)

Coverage includes:

<p>Child Care Expulsion Prevention (CCEP) (Infant and Early Childhood Mental Health Consultation) (text added 7/1/20)</p>	<p>CCEP, an infant and early childhood mental health consultation model, provides consultation to child care providers and parents/caregivers who care for children under the age of six who are experiencing behavioral and emotional challenges in their child care settings (non K-12 settings). Sometimes these challenges may put children at risk of suspension and/or expulsion from the child care setting. CCEP aims to reduce expulsion and increase the number of parents/caregivers and child care providers who successfully nurture the social and emotional development of children 0-5 in child care settings. (revised 7/1/20)</p> <p>CCEP programs provide short-term child/family-centered mental health consultation for children with challenging behaviors which includes:</p> <ul style="list-style-type: none"> Observation and functional assessment at home and at child care Individualized plan of service developed by a team comprised of the family, child care provider, other identified support person(s) that the family identifies. Intervention (e.g., coaching, training and support for parents/caregivers and providers to build their reflective capacity, learn new ways to interact with the child to build their social-emotional skills and resilience, by providing educational resources for parents and providers, modifying the physical environment, connecting family to community resources, providing counseling for families in crisis, and referral for ongoing mental health services, if needed). (revised 7/1/20)
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	<p>Provider qualifications:</p> <ul style="list-style-type: none"> Master's prepared early childhood mental health professional plus specific training in the evaluated model as approved by MDHHS. Training requirement must, at a minimum, include Endorsement as Infant Family Specialist by the Michigan Association of Infant Mental Health; Infant Mental Health Specialist is preferred. (revised 7/1/20)
<p>School Success Program</p>	<p>Works with parents of children, 6 years and above, so that they can be more involved in their child's life, monitor and supervise their child's behaviors; works with youth to develop pro-social behaviors, coping mechanisms, and problem solving skills; and consults with K-12 teachers, administrators and support staff (revised 7/1/20) in order to assist them in developing relationships with these students. Mental Health staff also act as a liaison between home and school.</p> <p>Provider qualifications:</p> <ul style="list-style-type: none"> Child Mental Health Professional
<p>Children of Adults with Mental Illness/Integrated Services</p>	<p>Designed to prevent emotional and behavioral disorders among children whose parents are receiving services from the public mental health system and to improve outcomes for adult beneficiaries who are parents. The Integrated Services approach includes assessment and service planning for the adult beneficiaries related to their parenting role and their children's needs. Treatment objectives, services, and supports are incorporated into the service plan through a person-centered planning process for the adult beneficiary who is a parent. Linking the adult beneficiary and child to available community services, respite care and providing for crisis planning are essential components.</p> <p>Provider qualifications:</p> <ul style="list-style-type: none"> Mental Health Professional
<p>Infant Mental Health</p>	<p>Provides home-based parent-infant support and intervention services to families where the parent's condition and life circumstances, or the characteristics of the infant, threaten the parent-infant attachment and the consequent social, emotional, behavioral and cognitive development of the infant. Services reduce the incidence and prevalence of abuse, neglect, developmental delay, behavioral and emotional disorder and promote healthy attachment, resilience and optimal mental health for both the infant and parent/primary caregiver. PIHPs or their provider networks may provide infant mental health services as a specific service when it is not part of a MDHHS-certified home-based program.</p> <p>Provider qualifications:</p> <ul style="list-style-type: none"> Masters-prepared early childhood mental health professional plus specific training. Training requirement must minimally have Endorsement as Infant Family Specialist by the Michigan Association of Infant Mental Health; Infant Mental Health Specialist is preferred. (revised 7/1/20)
<p>Parent Education</p>	<p>Provided to parents using evaluated models that promote nurturing parenting attitudes and skills, teach developmental stages of childhood (including social-emotional developmental stages), teach positive approaches to child behavior/discipline and interventions the parent may utilize to support healthy social and emotional development, and to remediate problem behaviors.</p> <p>Provider qualifications:</p> <ul style="list-style-type: none"> Child Mental Health Professional who is trained in the model



17.3.I. RESPITE CARE SERVICES

Respite care services are intended to assist in maintaining a goal of living in a natural community home and are provided on a short-term, intermittent basis to relieve the beneficiary's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. In those cases, community living supports, or other services of paid support or training staff, should be used. Decisions about the methods and amounts of respite should be decided during person-centered planning. PIHPs may not require active clinical treatment as a prerequisite for receiving respite care. These services do not supplant or substitute for community living support or other services of paid support/training staff.

- "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations).
- "Intermittent" means the respite service does not occur regularly or continuously. The service stops and starts repeatedly or with a time period in between.
- "Primary" caregivers are typically the same people who provide at least some unpaid supports daily.
- "Unpaid" means that respite may only be provided during those portions of the day when no one is being paid to provide the care, i.e., not a time when the beneficiary is receiving a paid State Plan (e.g., home help) or waiver service (e.g., community living supports) or service through other programs (e.g., school).
- Children who are living in a family foster care home may receive respite services. The only exclusion of receiving respite services in a family foster care home is when the child is receiving Therapeutic Foster Care as a Medicaid SED waiver service because that is considered in the bundled rate. (Refer to the Child Therapeutic Foster Care subsection in the Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix for additional information.)

Since adult beneficiaries living at home typically receive home help services and hire their family members, respite is not available when the family member is being paid to provide the home help service but may be available at other times throughout the day when the caregiver is not paid.

Respite care may be provided in the following settings:

- Beneficiary's home or place of residence
- Licensed family foster care home
- Facility approved by the State that is not a private residence (e.g., group home or licensed respite care facility)
- Home of a friend or relative chosen by the beneficiary and members of the planning team
- Licensed camp



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- In community (social/recreational) settings with a respite worker trained, if needed, by the family
- Licensed family child care home

Respite care may not be provided in:

- day program settings
- ICF/IIDs, nursing homes, or hospitals

Respite care may not be provided by:

- parent of a minor beneficiary receiving the service
- spouse of the beneficiary served
- beneficiary's guardian
- unpaid primary care giver

Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence.

17.3.J. SKILL-BUILDING ASSISTANCE

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

Skill-building assistance consists of activities identified in the individual plan of services and designed by a professional within his/her scope of practice that assist a beneficiary to increase his economic self-sufficiency and/or to engage in meaningful activities such as school, work, and/or volunteering. The services provide knowledge and specialized skill development and/or support. Skill-building assistance may be provided in the beneficiary's residence or in community settings.

Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for supported employment services provided by Michigan Rehabilitation Services (MRS) or the Bureau of Services for Blind Persons (BSBP). Information must be updated when the beneficiary's MRS or BSBP eligibility conditions change.

Coverage includes:

- Out-of-home adaptive skills training: Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills; and supports services incidental to the provision of that assistance, including:
 - Aides helping the beneficiary with his mobility, transferring, and personal hygiene functions at the various sites where adaptive skills training is provided in the community.
 - When necessary, helping the person to engage in the adaptive skills training activities (e.g., interpreting).



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Services must be furnished on a regularly scheduled basis (several hours a day, one or more days a week) as determined in the individual plan of services and should be coordinated with any physical, occupational, or speech therapies listed in the plan of supports and services. Services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

- Work preparatory services are aimed at preparing a beneficiary for paid or unpaid employment but are not job task-oriented. They include teaching such concepts as attendance, task completion, problem solving, and safety. Work preparatory services are provided to people not able to join the general workforce or are unable to participate in a transitional sheltered workshop within one year (excluding supported employment programs).

Activities included in these services are directed primarily at reaching habilitative goals (e.g., improving attention span and motor skills), not at teaching specific job skills. These services must be reflected in the beneficiary's person-centered plan and directed to habilitative or rehabilitative objectives rather than employment objectives.

- Transportation from the beneficiary's place of residence to the skill building assistance training, between skills training sites if applicable, and back to the beneficiary's place of residence.

Coverage excludes:

- Services that would otherwise be available to the beneficiary.

17.3.K. SUPPORT AND SERVICE COORDINATION

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

Functions performed by a supports coordinator, supports coordinator assistant, services and supports broker, or otherwise designated representative of the PIHP that include assessing the need for support and service coordination, and assurance of the following:

- Planning and/or facilitating planning using person-centered principles
- Developing an individual plan of service using the person-centered planning process
- Linking to, coordinating with, follow-up of, advocacy with, and/or monitoring of Specialty Services and Supports and other community services/supports.
- Brokering of providers of services/supports
- Assistance with access to entitlements and/or legal representation
- Coordination with the Medicaid Health Plan, Medicaid fee-for-service, or other health care providers

The role of the supports coordinator assistant is to perform the functions listed above, as they are needed, in lieu of a supports coordinator or case manager. A beneficiary would have only one of the three possible options: targeted case manager, supports coordinator, or supports coordinator assistant. When a supports coordinator assistant is



used, a qualified supports coordinator or targeted case manager must supervise the assistant. The role and qualifications of the targeted case manager are described in the Targeted Case Management section of this chapter.

A services and supports broker is used to explore the availability of community services and supports, housing, and employment and then to make the necessary arrangement to link the beneficiary with those supports. The role of the supports coordinator or supports coordinator assistant when a services and supports broker is used is to perform the remainder of the functions listed above as they are needed, and to assure that brokering of providers of services and supports is performed.

Whenever services and supports brokers provide any of the supports coordination functions, it is expected that the beneficiary will also have a supports coordinator or case manager, or their assistant, employed by the PIHP or its provider network who assures that the other functions above are in place.

If a beneficiary has both a supports coordinator or supports coordinator assistant AND a services and supports broker, the individual plan of service must clearly identify the staff who is responsible for each function. The PIHP must assure that it is not paying for the supports coordinator (or supports coordinator assistant) and the services and supports broker to perform service brokering. Likewise, when a supports coordinator (or supports coordinator assistant) facilitates a person-centered planning meeting, it is expected that the PIHP would not "double count" the time of any services and supports broker who also attends. During its annual on-site visits, the MDHHS will review individual plans of service to verify that there is no duplication of service provision when both a supports coordinator assistant and a services and supports broker are assigned supports coordination responsibilities in a beneficiary's plan of service.

Supports strategies will incorporate the principles of empowerment, community inclusion, health and safety assurances, and the use of natural supports. Supports coordinators will work closely with the beneficiary to assure his ongoing satisfaction with the process and outcomes of the supports, services, and available resources.

Supports Coordination is reported only when there is face-to-face contact with the beneficiary. Related activities, such as telephone calls to schedule appointments or arrange supports, are functions that are performed by a supports coordinator but not reported separately. Supports coordination functions must assure:

- The desires and needs of the beneficiary are determined
- The supports and services desired and needed by the beneficiary are identified and implemented
- Housing and employment issues are addressed
- Social networks are developed
- Appointments and meetings are scheduled
- Person-centered planning is provided, and independent facilitation of person-centered planning is made available
- Natural and community supports are used



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- The quality of the supports and services, as well as the health and safety of the beneficiary, are monitored
- Income/benefits are maximized
- Activities are documented
- Plans of supports/services are reviewed at such intervals as are indicated during planning

While supports coordination as part of the overall plan implementation and/or facilitation may include initiation of other coverage and/or short-term provision of supports, it shall not include direct delivery of ongoing day-to-day supports and/or training, or provision of other Medicaid services. Supports coordinators are prohibited from exercising the agency’s authority to authorize or deny the provision of services. Supports coordination may not duplicate services that are the responsibility of another program.

The supports coordination functions to be performed and the frequency of face-to-face and other contacts are specified in the beneficiary’s plan. The beneficiary’s record must contain sufficient information to document the provision of supports coordination, including the nature of the service, the date, and the location of contacts, including whether the contacts were face-to-face. The frequency and scope of supports coordination contacts must take into consideration the health and safety needs of the individual.

Qualifications of Supports Coordinators	A minimum of a Bachelor’s degree in a human services field and one year of experience working with people with developmental disabilities if supporting that population; or a Bachelor’s degree in a human services field and one year of experience with people with mental illness if supporting that population.
Qualifications of Supports Coordinator Assistants and Independent Services and Supports Brokers	Minimum of a high school diploma and equivalent experience (i.e., possesses knowledge, skills and abilities similar to supports coordinator qualifications) and functions under the supervision of a qualified supports coordinator. Independent services and supports brokers must meet these qualifications and function under the guidance and oversight of a qualified supports coordinator or case manager.

17.3.L. SUPPORTED/INTEGRATED EMPLOYMENT SERVICES

NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.

Provide job development, initial and ongoing support services, and activities as identified in the individual plan of services that assist beneficiaries to obtain and maintain paid employment that would otherwise be unachievable without such supports. Support services are provided continuously, intermittently, or on a diminishing basis as needed throughout the period of employment. Capacity to intervene to provide assistance to the individual and/or employer in episodic occurrences of need is included in this service. Supported/ integrated employment must be provided in integrated work settings where the beneficiary works alongside people who do not have disabilities.



Coverage includes:

- Job development, job placement, job coaching, and long-term follow-along services required to maintain employment.
- Consumer-run businesses (e.g., vocational components of Fairweather Lodges, supported self-employment)
- Transportation provided from the beneficiary's place of residence to the site of the supported employment service, among the supported employment sites if applicable, and back to the beneficiary's place of residence.

Coverage excludes:

- Employment preparation.
- Services otherwise available to the beneficiary under the Individuals with Disabilities Education Act (IDEA).

17.3.M. 1915(c) CHILDREN'S SERIOUS EMOTIONAL DISTURBANCE HOME AND COMMUNITY-BASED SERVICES WAIVER (SEDW)

All SEDW Wraparound enrolled providers must meet all the requirements in the enrollment standards as listed in the Qualified Staff subsection. In addition, due to the intense needs and level of risk of children/youth and their families served in the SEDW community-based waiver, all SEDW Wraparound providers must meet the following additional requirements:

- Wraparound facilitators must possess a bachelor's degree and be a CMHP or be supervised by a CMHP.
- Wraparound facilitators and those who provide supervision to facilitators will attend additional training (16 hours) related to provision of support to children/youth and their families served in the waiver annually as required by MDHHS. This training is in addition to requirements identified in the Qualified Staff subsection and is for all supervisors and Wraparound facilitators.
- Caseloads shall be 8-10 per facilitator based on needs and risks of the child/youth and family. Caseloads may increase to a maximum of 12 when two child/youth and family teams are transitioning from Wraparound.
- SEDW site reviews will assess fidelity to the model through case file review, quality assurance of all SEDW-provided services/supports, and interviews with children/youth and family members.
- All SEDW enrolled providers must participate in the statewide evaluation project that consists of gathering data on the Family Status Report at intake, quarterly, and at graduation.
- Completion of the Michigan Wraparound Fidelity Index at six months and upon graduation.
- Participation in any additional model fidelity or quality assurance evaluation tools as requested by MDHHS.



17.3.N. FISCAL INTERMEDIARY SERVICES

Fiscal Intermediary Services is defined as services that assist the adult beneficiary, or a representative identified in the beneficiary's individual plan of services, to meet the beneficiary's goals of community participation and integration, independence or productivity while controlling his individual budget and choosing staff who will provide the services and supports identified in the IPOS and authorized by the PIHP. The fiscal intermediary helps the beneficiary manage and distribute funds contained in the individual budget. Fiscal intermediary services include, but are not limited to:

- Facilitation of the employment of service workers by the beneficiary, including federal, state and local tax withholding/payments, unemployment compensation fees, wage settlements, and fiscal accounting;
- Tracking and monitoring participant-directed budget expenditures and identifying potential over- and under-expenditures;
- Assuring adherence to federal and state laws and regulations; and
- Ensuring compliance with documentation requirements related to management of public funds.

The fiscal intermediary may also perform other supportive functions that enable the beneficiary to self-direct needed services and supports. These functions may include selecting, contracting with or employing and directing providers of services, verification of provider qualifications (including reference and background checks), and assisting the beneficiary to understand billing and documentation requirements.

Fiscal intermediary services may not be authorized for use by a beneficiary's representative where that representative is not conducting tasks in ways that fit the beneficiary's preferences, and/or do not promote achievement of the goals contained in the beneficiary's plan of service so as to promote independence and inclusive community living for the beneficiary, or when they are acting in a manner that is in conflict with the interests of the beneficiary.

Fiscal intermediary services must be performed by entities with demonstrated competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary. Neither providers of other covered services to the beneficiary, family members, or guardians of the beneficiary may provide fiscal intermediary services to the beneficiary.



SECTION 18 – BEHAVIORAL HEALTH TREATMENT SERVICES/APPLIED BEHAVIOR ANALYSIS

The purpose of this policy is to provide for the coverage of Behavioral Health Treatment (BHT) services, including Applied Behavior Analysis (ABA), for children under 21 years of age with Autism Spectrum Disorders (ASD). All children, including children with ASD, must receive EPSDT services that are designed to assure that children receive early detection and preventive care, in addition to medically necessary treatment services to correct or ameliorate any physical or behavioral conditions, so that health problems are averted or diagnosed and treated as early as possible.

According to the U.S. Department of Health & Human Services, autism is characterized by impaired social interactions, problems with verbal and nonverbal communication, repetitive behaviors, and/or severely limited activities and interests. Early detection and treatment can have a significant impact on the child's development. Autism can be viewed as a continuum or spectrum, known as ASD, and includes Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS). The disorders on the spectrum vary in severity and presentation but have certain common core symptoms. The goals of treatment for ASD focus on improving core deficits in communication, social interactions, and restricted behaviors. Changing these fundamental deficits may benefit children by developing greater functional skills and independence.

BHT services prevent the progression of ASD, prolong life, and promote the physical and mental health and efficiency of the child. Medical necessity and recommendation for BHT services is determined by a physician, or other licensed practitioner working within their scope of practice under state law. Direct patient care services that treat or address ASD under the state plan are available to children under 21 years of age as required by the EPSDT benefit.

18.1 SCREENING

The American Academy of Pediatrics (AAP) endorses early identification of developmental disorders as being essential to the well-being of children and their families. Early identification of developmental disorders through screening by health care professionals should lead to further evaluation, diagnosis, and treatment. Early identification of a developmental disorder's underlying etiology may affect the medical treatment of the child and the parent's/guardian's intervention planning. Screening for ASD typically occurs during an EPSDT well child visit with the child's primary care provider (PCP). EPSDT well child visits may include a review of the child's overall medical and physical health, hearing, speech, vision, behavioral and developmental status, and screening for ASD with a validated and standardized screening tool. The EPSDT well child evaluation is also designed to rule out medical or behavioral conditions other than ASD, and include those conditions that may have behavioral implications and/or may co-occur with ASD. A full medical and physical examination must be performed before the child is referred for further evaluation.

18.2 REFERRAL

The PCP who screened the child for ASD and determined a referral for further evaluation was necessary will contact the Pre-paid Inpatient Health Plan (PIHP) directly to arrange for a follow-up evaluation. The PCP must refer the child to the PIHP in the geographic service area for Medicaid beneficiaries. The PIHP will contact the child's parent(s)/guardian(s) to arrange a follow-up appointment for a comprehensive diagnostic evaluation and behavioral assessment. Each PIHP will identify a specific point of access for children who have been screened and are being referred for a diagnostic evaluation and behavioral



assessment of ASD. If the PCP determines the child who screened positive for ASD is in need of occupational, physical, or speech therapy, the PCP will refer the child directly for the service(s) needed.

After a beneficiary is screened and the PCP determines a referral is necessary for a follow-up visit, the PIHP is responsible for the comprehensive diagnostic evaluation, behavioral assessment, BHT services (including ABA) for eligible Medicaid beneficiaries, and for the related EPSDT medically necessary Mental Health Specialty Services. Occupational therapy, physical therapy, and speech therapy for children with ASD who do not meet the eligibility requirements for developmental disabilities by the PIHP are covered by the Medicaid Health Plan or by Medicaid Fee-for-Service.

18.3 COMPREHENSIVE DIAGNOSTIC EVALUATIONS

Accurate and early diagnosis of ASD is critical in ensuring appropriate intervention and positive outcomes. The comprehensive diagnostic evaluation must be performed before the child receives BHT services. The comprehensive diagnostic evaluation is a neurodevelopmental review of cognitive, behavioral, emotional, adaptive, and social functioning, and should include validated evaluation tools. Based on the evaluation, the practitioner determines the child's diagnosis, recommends general ASD treatment interventions, and refers the child for a behavior assessment which is provided or supervised by a BCBA to recommend more specific ASD treatment interventions. The diagnostic evaluations are performed by a qualified licensed practitioner working within their scope of practice and who is qualified and experienced in diagnosing ASD. A qualified licensed practitioner includes:

- a physician with a specialty in psychiatry or neurology;
- a physician with a subspecialty in developmental pediatrics, developmental-behavioral pediatrics or a related discipline;
- a physician with a specialty in pediatrics or other appropriate specialty with training, experience or expertise in ASD and/or behavioral health;
- a psychologist;
- an advanced practice registered nurse with training, experience, or expertise in ASD and/or behavioral health;
- a physician assistant with training, experience, or expertise in ASD and/or behavioral health; or
- a clinical social worker, working within their scope of practice, and is qualified and experienced in diagnosing ASD.

The determination of a diagnosis by a qualified licensed practitioner is accomplished by direct observation and utilizing the Autism Diagnostic Observation Schedule-Second Edition (ADOS-2), and by administering a comprehensive clinical interview including a developmental symptom history (medical, behavioral, and social history) such as the Autism Diagnostic Interview-Revised (ADI-R) or clinical equivalent. In addition, a qualified licensed practitioner will rate symptom severity with the Developmental Disabilities Children's Global Assessment Scale (DD-CGAS). Other tools should be used if the clinician feels it is necessary to determine a diagnosis and medical necessity service recommendations. Other tools may include:

- cognitive/developmental tests, such as the Mullen Scales of Early Learning, Wechsler Preschool and Primary Scale of Intelligence-IV (WPPSI-IV), Wechsler Intelligence Scale for Children-IV (WISC-IV), Wechsler Intelligence Scale for Children-V (WISC-V), or Differential Ability Scales-II (DAS-II);



- adaptive behavior tests, such as Vineland Adaptive Behavior Scale-II (VABS-II), Adaptive Behavior Assessment System-III (ABAS-III), or Diagnostic Adaptive Behavior Scale (DABS); and/or
- symptom monitoring, such as Social Responsiveness Scale-II (SRS-II), Aberrant Behavior Checklist, or Social Communication Questionnaire (SCQ).

18.4 MEDICAL NECESSITY CRITERIA

Medical necessity and recommendation for BHT services is determined by a physician or other licensed practitioner working within their scope of practice under state law. The child must demonstrate substantial functional impairment in social communication, patterns of behavior, and social interaction as evidenced by meeting criteria A and B (listed below); and require BHT services to address the following areas:

- A. The child currently demonstrates substantial functional impairment in social communication and social interaction across multiple contexts, and is manifested by all of the following:
 1. Deficits in social-emotional reciprocity ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation, to reduced sharing of interests, emotions, or affect, to failure to initiate or respond to social interactions.
 2. Deficits in nonverbal communicative behaviors used for social interaction ranging, for example, from poorly integrated verbal and nonverbal communication, to abnormalities in eye contact and body language or deficits in understanding and use of gestures, to a total lack of facial expressions and nonverbal communication.
 3. Deficits in developing, maintaining, and understanding relationships ranging, for example, from difficulties adjusting behavior to suit various social contexts, to difficulties in sharing imaginative play or in making friends, to absence of interest in peers.
- B. The child currently demonstrates substantial restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least two of the following:
 1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypes, lining up toys or flipping objects, echolalia, and/or idiosyncratic phrases).
 2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, and/or need to take same route or eat the same food every day).
 3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects and/or excessively circumscribed or perseverative interest).
 4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, and/or visual fascination with lights or movement).



18.5 DETERMINATION OF ELIGIBILITY FOR BHT

The following is the process for determining eligibility for BHT services for a child with a confirmed diagnosis of ASD. Eligibility determination and recommendation for BHT must be performed by a qualified licensed practitioner through direct observation utilizing the ADOS-2 and symptom rating using the DD-CGAS. BHT services are available for children under 21 years of age with a diagnosis of ASD from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), and who have the developmental capacity to clinically participate in the available interventions covered by BHT services. A well-established DSM-IV diagnosis of Autistic Disorder, Asperger's Disorder or PDD-NOS should be given the diagnosis of ASD. Children who have marked deficits in social communication but whose symptoms do not otherwise meet criteria for ASD should be evaluated for social (pragmatic) communication disorder.

The following requirements must be met:

- Child is under 21 years of age.
- Child received a diagnosis of ASD from a qualified licensed practitioner utilizing valid evaluation tools.
- Child is medically able to benefit from the BHT treatment.
- Treatment outcomes are expected to result in a generalization of adaptive behaviors across different settings to maintain the BHT interventions and that they can be demonstrated beyond the treatment sessions. Measurable variables may include increased social-communication, increased interactive play/age-appropriate leisure skills, increased reciprocal communication, etc.
- Coordination with the school and/or early intervention program is critical. Collaboration between school and community providers is needed to coordinate treatment and to prevent duplication of services. This collaboration may take the form of phone calls, written communication logs, participation in team meetings (i.e., Individualized Education Plan/Individualized Family Service Plan [IEP/IFSP], Individual Plan of Service [IPOS], etc.).
- Services are able to be provided in the child's home and community, including centers and clinics.
- Symptoms are present in the early developmental period (symptoms may not fully manifest until social demands exceed limited capacities or may be masked by learned strategies later in life).
- Symptoms cause clinically significant impairment in social, occupational, and/or other important areas of current functioning that are fundamental to maintain health, social inclusion, and increased independence.
- A qualified licensed practitioner recommends BHT services and the services are medically necessary for the child.
- Services must be based on the individual child and the parent's/guardian's needs and must consider the child's age, school attendance requirements, and other daily activities as documented in the IPOS. Families of minor children are expected to provide a minimum of eight hours of care per day on average throughout the month.

18.6 PRIOR AUTHORIZATION

BHT services are authorized for a time period not to exceed 365 days. The 365-day authorization period for services may be re-authorized annually based on recommendation of medical necessity by a qualified licensed practitioner working within their scope of practice under state law.



18.7 RE-EVALUATION

An annual re-evaluation by a qualified licensed practitioner to assess eligibility criteria must be conducted through direct observation utilizing the ADOS-2 and symptoms rated using the DD-CGAS. Additional tools should be used if the clinician feels it is necessary to determine medical necessity and recommended services. Other tools may include cognitive/developmental tests, adaptive behavior tests, and/or symptom monitoring.

18.8 DISCHARGE CRITERIA

Discharge from BHT services is determined by a qualified BHT professional for children who meet any of the following criteria:

- The child has achieved treatment goals and less intensive modes of services are medically necessary and appropriate.
- The child is either no longer eligible for Medicaid or is no longer a State of Michigan resident.
- The child has not demonstrated measureable improvement and progress toward goals, and the predicted outcomes as evidenced by a lack of generalization of adaptive behaviors across different settings where the benefits of the BHT interventions are not able to be maintained or they are not replicable beyond the BHT treatment sessions through a period of six months.
- Targeted behaviors and symptoms are becoming persistently worse with BHT treatment over time or with successive authorizations.
- The child no longer meets the eligibility criteria as evidenced by use of valid evaluation tools administered by a qualified licensed practitioner.
- The child and/or parent/guardian is not able to meaningfully participate in the BHT services, and does not follow through with treatment recommendations to a degree that compromises the potential effectiveness and outcome of the BHT service.

18.9 BHT SERVICES

18.9.A. BEHAVIORAL ASSESSMENT

Behavioral assessments must use a validated instrument and can include direct observational assessment, observation, record review, data collection, and analysis by a qualified provider. Examples of behavior assessments include function analysis and functional behavior assessments. The behavioral assessment must include the current level of functioning of the child using a validated data collection method. Behavioral assessments and ongoing measurements of improvement must include behavioral outcome tools. Examples of behavioral outcome tools include Verbal Behavior-Milestones Assessment and Placement Program (VB-MAPP), Assessment of Basic Language and Learning Skills -Revised (ABLLS-R), and Assessment of Functional Living Skills (AFLS).

18.9.B. BEHAVIORAL INTERVENTION

BHT services include a variety of behavioral interventions which have been identified as evidence-based by nationally recognized research reviews and/or other nationally



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recognized scientific and clinical evidence. BHT services are designed to be delivered primarily in the home and in other community settings. Behavioral intervention services include, but are not limited to, the following categories of evidence-based interventions:

- Collecting information systematically regarding behaviors, environments, and task demands (e.g., shaping, demand fading, task analysis);
- Adapting environments to promote positive behaviors and learning while discouraging negative behaviors (e.g., naturalistic intervention, antecedent based intervention, visual supports, stimulus fading);
- Applying reinforcement to change behaviors and promote learning (e.g., reinforcement, differential reinforcement of alternative behaviors, extinction);
- Teaching techniques to promote positive behaviors, build motivation, and develop social, communication, and adaptive skills (e.g., discrete trial teaching, modeling, social skills instruction, picture exchange communication systems, pivotal response training, social narratives, self-management, prompting, chaining, imitation);
- Teaching parents/guardians to provide individualized interventions for their child for the benefit of the child (e.g., parent/guardian implemented/mediated intervention);
- Using typically developing peers (e.g., individuals who do not have ASD) to teach and interact with children with ASD (e.g., peer mediated instruction, structured play groups, peer social interaction training); and
- Applying technological tools to change behaviors and teach skills (e.g., video modeling, tablet-based learning software).

In addition to the above listed categories of interventions, covered BHT treatment services may also include any other intervention supported by credible scientific and/or clinical evidence, as appropriate for each individual. Based on the behavioral plan of care which is adjusted over time based on data collected by the qualified provider to maximize the effectiveness of BHT treatment services, the provider selects and adapts one or more of these services, as appropriate for each individual.

18.9.C. BEHAVIORAL OBSERVATION AND DIRECTION

Behavioral observation and direction is the clinical direction and oversight provided by a qualified provider to a lower level provider based on the required provider standards and qualifications regarding the provision of services to a child. The qualified provider delivers face-to-face observation and direction to a lower level provider regarding developmental and behavioral techniques, progress measurement, data collection, function of behaviors, and generalization of acquired skills for each child. This service is for the direct benefit of the child and provides a real time response to the intervention to maximize the benefit for the child. It also informs of any modifications needed to the methods to be implemented to support the accomplishment of outcomes in the behavioral plan of care.

18.9.D. TELEPRACTICE FOR BHT SERVICES

All telepractice services must be prior authorized (i.e., IPOS indicates telepractice as an identified treatment modality for the beneficiary) by the Michigan Department of Health



and Human Services (MDHHS). Telepractice is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of services (e.g., access or travel to needed medical services may be prohibitive). Telepractice must be obtained through real-time interaction between the child's physical location (patient site) and the provider's physical location (provider site). Telepractice services are provided to patients through hardware or internet connection. It is the expectation that providers, facilitators, and staff involved in telepractice are trained in the use of equipment and software prior to servicing patients, and services provided via telepractice are provided as part of an array of comprehensive services that include in-person visits and assessments with the primary supervising BHT provider. Qualified providers of behavioral health services are able to arrange telepractice services for the purposes of teaching the parents/guardians to provide individualized interventions to their child and to engage in behavioral health clinical observation and direction (i.e. increase oversight of the provision of services to the beneficiary to support the outcomes of the behavioral plan of care developed by the primary supervising BHT provider). Qualified providers of behavioral health services include Board Certified Behavior Analysts (BCBA), Board Certified Assistant Behavior Analysts (BCaBA), Licensed Psychologists (LP), Limited Licensed Psychologists (LLP), and Qualified Behavioral Health Professionals (QBHP). The provider of the telepractice service is only able to monitor one child/family at a time. The administration of telepractice services are subject to the same provision of services that are provided to a patient in person. Providers of telepractice services must be currently certified by the Behavior Analyst Certification Board (BACB), be a QBHP, be licensed in the State of Michigan as a fully licensed psychologist, or be a practitioner who holds a limited license and is under the direction of a fully licensed psychologist. Providers must ensure the privacy of the child and secure any information shared via telemedicine.

The technology used must meet the requirements of audio and visual compliance in accordance with current regulations and industry standards. Refer to the General Information for Providers Chapter of this manual for the complete Health Insurance Portability and Accountability Act (HIPAA) compliance requirements.

The patient site may be located within a center, clinic, at the patient's home, or any other established site deemed appropriate by the provider. The room must be free from distractions that would interfere with the telepractice session. A facilitator must be trained in the use of the telepractice technology and be physically present at the patient site during the entire telepractice session to assist the patient at the direction of the qualified provider of behavioral health. Occupational, physical, and speech therapy are not covered under telepractice services. Refer to the Telemedicine Services database on the MDHHS website for appropriate or allowed telemedicine services that may be covered by the Medicaid Health Plan or by Medicaid Fee-for-Service. (Refer to the Directory Appendix for website information.)

18.10 BHT SERVICE LEVEL

BHT services are available for Medicaid beneficiaries diagnosed with ASD and are provided for all levels of severity of ASD. The behavioral intervention should be provided at an appropriate level of intensity in an appropriate setting(s) within their community for an appropriate period of time, depending on the needs of the child and their parents/guardians. Clinical determinations of service intensity, setting(s), and duration are designed to facilitate the child's goal attainment. These supports may serve to reinforce



skills or lessons taught in school, therapy, or other settings, but are not intended to supplant services provided in school or other settings, or to be provided when the child would typically be in school but for the parent's/guardian's choice to home-school their child. Each child's IPOS must document that these services do not include special education and related services defined in the Individuals with Disabilities Education Act (IDEA) that are available to the child through a local education agency. The recommended service level, setting(s), and duration will be included in the child's IPOS, with the planning team and the parent(s)/guardian(s) reviewing the IPOS at regular intervals (minimally every three months) and, if indicated, adjusting the service level and setting(s) to meet the child's changing needs. The service level includes the number of hours of intervention provided to the child. The service level determination will be based on research-based interventions integrated into the behavioral plan of care with input from the planning team. Service intensity will vary with each child and should reflect the goals of treatment, specific needs of the child, and response to treatment. The PIHP's Utilization Management will authorize the level of services prior to the delivery of services.

- **Focused Behavioral Intervention:** Focused behavioral intervention is provided an average of 5-15 hours per week (actual hours needed are determined by the behavioral plan of care and interventions required).
- **Comprehensive Behavioral Intervention:** Comprehensive behavioral intervention is provided an average of 16-25 hours per week (actual hours needed are determined by the behavioral plan of care and interventions required).

18.11 BHT SERVICE EVALUATION

As part of the IPOS, there is a comprehensive, individualized behavioral plan of care that includes specific targeted behaviors, along with measurable, achievable, and realistic goals for improvement. BCBA and other qualified providers develop, monitor, and implement the behavioral plan of care. These providers are responsible for effectively evaluating the child's response to treatment and skill acquisition. Ongoing determination of the level of service (minimally every six months) requires evidence of measurable and ongoing improvement in targeted behaviors that are demonstrated with the use of reliable and valid assessment instruments (i.e., VB-MAPP, ABLLS-R, AFLS) and other appropriate documentation of analysis (i.e., graphs, assessment reports, records of service, progress reports, etc.).

18.12 BHT SERVICE PROVIDER QUALIFICATIONS

BHT services are highly specialized services that require specific qualified providers who are available within PIHP/CMHSP provider networks and have extensive experience providing specialty mental health and behavioral health services. BHT services must be provided under the direction of a BCBA, another appropriately qualified LP or LLP, or a Master's prepared QBHP. These services must be provided directly to, or on behalf of, the child by training their parents/guardians, behavior technicians, and BCaBAs to deliver the behavioral interventions. The BCBA and other qualified providers are also responsible for communicating progress on goals to parents/guardians minimally every three to six months; clinical skill development and supervision of BCaBA, QBHP, and behavior technicians; and collaborating with support coordinators/case managers and the parents/guardians on goals and objectives with participation in development of the IPOS that includes the behavioral plan of care.



18.12.A. BHT SUPERVISORS

<p>Board Certified Behavior Analyst-Doctoral (BCBA-D) or Board Certified Behavior Analyst (BCBA)</p>	<ul style="list-style-type: none"> • Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction. • License/Certification: Current certification as a BCBA through the BACB. The BACB is the national entity accredited by the National Commission for Certifying Agencies (NCCA). • Education and Training: Minimum of a master's degree from an accredited institution conferred in a degree program in which the candidate completed a BACB approved course sequence.
<p>Licensed Psychologist (LP)</p>	<ul style="list-style-type: none"> • Must be certified as a BCBA by September 30, 2025. • Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction. • License/Certification: LP means a doctoral level psychologist licensed by the State of Michigan. Must complete all coursework and experience requirements. • Education and Training: Minimum doctorate degree from an accredited institution. Works within their scope of practice and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented coursework at the graduate level from an accredited university in at least three of the six following areas: <ul style="list-style-type: none"> ➤ Ethical considerations. ➤ Definitions and characteristics; and principles, processes and concepts of behavior. ➤ Behavioral assessment and selecting interventions outcomes and strategies. ➤ Experimental evaluation of interventions. ➤ Measurement of behavior, and developing and interpreting behavioral data. ➤ Behavioral change procedures and systems supports. • A minimum of one year experience in treating children with ASD based on the principles of behavior analysis. Works in consultation with the BCBA to discuss the caseload, progress, and treatment of the child with ASD.



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<p>Limited License Psychologist (LLP)</p>	<ul style="list-style-type: none"> • Must be certified as a BCBA by September 30, 2025. • Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction. • License/Certification: LLP means a doctoral or master level psychologist licensed by the State of Michigan. Master’s Limited Psychologist license is good for one two (2)-year period. Must complete all coursework and experience requirements. • Education and Training: Minimum of a master’s or doctorate degree from an accredited institution. Works within their scope of practice and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented coursework at the graduate level from an accredited university in at least three of the six following areas: <ul style="list-style-type: none"> ➢ Ethical considerations. ➢ Definitions and characteristics and principles, processes and concepts of behavior. ➢ Behavioral assessment and selecting interventions outcomes and strategies. ➢ Experimental evaluation of interventions. ➢ Measurement of behavior, and developing and interpreting behavioral data. ➢ Behavioral change procedures and systems supports. • A minimum of one year experience in treating children with ASD based on the principles of behavior analysis. Works in consultation with the BCBA to discuss the progress and treatment of the child with ASD.
<p>Board Certified Assistant Behavior Analyst (BCaBA)</p>	<ul style="list-style-type: none"> • Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction. • License/Certification: Current certification as a BCaBA through the BACB. The BACB is the national entity accredited by the NCCA. • Education and Training: Minimum of a bachelor’s degree from an accredited institution conferred in a degree program in which the candidate completed a BACB approved course sequence. • Other Standard: Works under the supervision of the BCBA.
<p>Qualified Behavioral Health Professional (QBHP)</p>	<ul style="list-style-type: none"> • Must be certified as a BCBA by September 30, 2025. • Services Provided: Behavioral assessment, behavioral intervention, and behavioral observation and direction. • License/Certification: Must be certified as a BCBA within two years of successfully completing ABA graduate coursework. • Education and Training: QBHP must meet one of the following state requirements: <ul style="list-style-type: none"> ➢ Must be a physician or licensed practitioner with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD.



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	<ul style="list-style-type: none"> ➤ Minimum of a master's degree in a mental health-related field or BACB approved degree category from an accredited institution with specialized training and one year of experience in the examination, evaluation, and treatment of children with ASD. Works within their scope of practice, works under the supervision of the BCBA, and has extensive knowledge and training in behavior analysis. Extensive knowledge is defined as having received documented coursework at the graduate level (i.e. completion of three BACB evaluated graduate courses or BACB verified course sequences meeting specific standards toward certification) from an accredited university in at least three of the six following areas: <ul style="list-style-type: none"> ◆ Ethical considerations. ◆ Definitions and characteristics; and principles, processes and concepts of behavior. ◆ Behavioral assessment, and selecting interventions outcomes and strategies. ◆ Experimental evaluation of interventions. ◆ Measurement of behavior, and developing and interpreting behavioral data. ◆ Behavioral change procedures and systems supports.
<p>Behavior Technician</p>	<ul style="list-style-type: none"> • Services Provided: Behavioral intervention. • License/Certification: A license or certification is not required. • Education and Training: Will receive BACB Registered Behavior Technician (RBT) training conducted by a professional experienced in BHT services (BCBA, BCaBA, LP, LLP, and/or QBHP), but is not required to register with the BACB upon completion in order to furnish services. • Works under the supervision of the BCBA or other professional (BCaBA, LP, LLP or QBHP) overseeing the behavioral plan of care, with minimally one hour of clinical observation and direction for every 10 hours of direct treatment. • Must be at least 18 years of age; able to practice universal precautions to protect against the transmission of communicable disease; able to communicate expressively and receptively in order to follow individual plan requirements and beneficiary-specific emergency procedures and to report on activities performed; and be in good standing with the law (i.e., not a fugitive from justice, a convicted felon who is either under jurisdiction or whose felony relates to the kind of duty to be performed, or an illegal alien). Must be able to perform and be certified in basic first aid procedures and is trained in the IPOS/behavioral plan of care utilizing the person-centered planning process.



SECTION 19 – OPIOID HEALTH HOME

Pursuant to the requirements of Section 2703 of the Patient Protection and Affordable Care Act and the State Plan and Alternative Benefit Plan Amendments, the purpose of this policy is to provide for the coverage and reimbursement of Opioid Health Home (OHH) services. This policy is effective for dates of service on and after October 1, 2018. The policy applies to Fee-for-Service (FFS) and managed care beneficiaries enrolled in Medicaid, the Healthy Michigan Plan, or MICHild who meet OHH eligibility criteria. In addition to this policy, an operations guide for providers called the Opioid Health Home (OHH) Handbook is posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

Note: Continuation of the OHH policy/benefit after eight (8) quarters of the effective date is subject to Michigan Department of Health and Human Services (MDHHS) review and approval.

19.1 GENERAL INFORMATION

Effective October 1, 2018, MDHHS implemented a new care management and care coordination primary care Health Home benefit called the Opioid Health Home (OHH). The goals of the program are to ensure seamless transition of care and to connect eligible beneficiaries with needed clinical and social services. MDHHS expects the benefit will enhance patient outcomes and quality of care, while simultaneously shifting people from emergency departments and hospitals to a primary care setting.

19.2. BENEFICIARY ELIGIBILITY

Eligible beneficiaries meeting geographic area requirements cited in the Provider Eligibility Requirements subsection of this policy include those enrolled in Medicaid, the Healthy Michigan Plan, or MICHild who have a diagnosis of opioid use disorder and have or are at risk of another chronic condition.

19.3 BENEFICIARY ENROLLMENT

19.3.A. ENROLLMENT PROCESSES

The Michigan OHH Program uses a two-pronged enrollment approach where MDHHS, the regional Prepaid Inpatient Health Plan (PIHP), and OHH providers participate. The process is as follows:

- **Autoenrollment**

MDHHS identifies and enrolls eligible beneficiaries using administrative claims data and provides a batch list of these beneficiaries to the regional PIHP for which they are assigned via the electronic Waiver Support Application (WSA) system. The list of eligible beneficiaries is updated at least monthly. From the list, the PIHP will identify beneficiaries who are currently receiving Medication Assisted Treatment (MAT). The PIHP will send current MAT recipients a letter indicating their enrollment in the OHH. The letter will provide the beneficiary with information regarding OHH services and indicate that the beneficiary may opt-out (disenroll) from the OHH at any time with no impact on their currently entitled Medicaid services. Beneficiaries not currently in MAT will be made aware of the OHH through community referrals, including through



peer recovery coach networks, other providers, courts, health departments, law enforcement, and other community-based settings. MDHHS and the PIHP will strategically provide these settings with informational brochures, posters, and other outreach materials to facilitate awareness and engagement of the OHH.

While beneficiary enrollment is automatic, receipt and full payment of OHH services is contingent on beneficiary consent to share information (refer to the Beneficiary Consent subsection) and verification of diagnostic eligibility. The PIHP must document these steps within the WSA. Failure to verify consent or diagnostic eligibility will be considered a de facto opt-out (disenrollment). The PIHP shall have six months from the date of autoenrollment to document the preceding steps in the WSA, after which time the beneficiary will be presumed unresponsive and automatically disenrolled from the benefit. (Note: If a beneficiary in this scenario continues to meet OHH eligibility criteria and wishes to join the OHH at a later date, they are entitled to do so, and a new enrollment must be established via the process in the Recommended Enrollment paragraph below.)

- **Recommended Enrollment**

OHH providers are permitted to recommend potentially eligible beneficiaries for enrollment to MDHHS via the regional PIHP. OHH providers must provide documentation which indicates that a prospective OHH beneficiary meets all eligibility for the benefit, including presence of qualifying conditions, consent, and establishment of an individualized care plan. The regional PIHP must review and process all recommended enrollments. MDHHS reserves the right to review and verify all enrollments.

Once enrolled, the PIHP will work with designated OHH providers and the beneficiary to identify the optimal setting of care. The PIHP will document the setting of care within the WSA. This decision is made only after a beneficiary visits an OHH provider, fills out the behavioral health consent form (refer to the Beneficiary Consent subsection), and establishes an individualized care plan derived from an evidence-based assessment of need. The beneficiary may opt-out (disenroll) at any time with no impact on other entitled Medicaid services.

19.3.B. BENEFICIARY CONSENT

Beneficiaries must provide OHH providers a signed Consent to Share Behavioral Health Information for Care Coordination Purposes form (MDHHS-5515) to receive the OHH benefit. The MDHHS-5515 must be collected and stored in the beneficiary's health record with attestation in the WSA. (The MDHHS-5515 can be found on the MDHHS website. Refer to the Directory Appendix for website information.) The form is also available at the designated OHH provider office. OHH providers are responsible for verifying receipt of the signed consent form and providing proper documentation to MDHHS via the regional PIHP. All documents must be maintained in compliance with MDHHS record-keeping requirements.



19.3.C. OHH BENEFIT PLAN ASSIGNMENT

Once enrolled, the beneficiary is assigned to the Opioid Health Home (HHO) benefit plan associated with their Medicaid member ID in the Community Health Automated Medicaid Processing System (CHAMPS). It is incumbent upon OHH providers to verify a beneficiary's HHO benefit plan assignment prior to rendering services. Beneficiaries without the HHO benefit plan assignment are not eligible for OHH payment.

19.3.D. BENEFICIARY DISENROLLMENT

Beneficiaries may opt-out or disenroll from the OHH benefit at any time. Beneficiaries who opt-out of enrollment initially may elect to enroll later contingent on meeting eligibility requirements. Beneficiaries who decline services or disenroll may do so without jeopardizing their access to other entitled medically necessary Medicaid services.

Other than beneficiary-initiated disenrollment, disengaged beneficiaries are categorized into one of the following two groups which have unique disenrollment processes:

- Beneficiaries who moved out of an eligible geographic area, are deceased, or are otherwise no longer eligible for the Medicaid program. These beneficiaries will have their eligibility files updated per the standard MI Bridges protocol. Providers will receive updated files accordingly.
- Beneficiaries who are unresponsive for reasons other than moving or death. The PIHP must make at least three unsuccessful beneficiary contact attempts within six consecutive months for MDHHS to deem a beneficiary as unresponsive. For auto-enrolled beneficiaries, if no activity occurs after six months from the date of enrollment, the beneficiary is auto-disenrolled. For provider-recommended enrolled beneficiaries, if the beneficiary is unresponsive for six months, the PIHP must mark the beneficiary as disenrolled via the WSA. The PIHP and MDHHS must maintain a list of disenrolled beneficiaries in the WSA. The PIHP must attempt to re-establish contact with these beneficiaries at least every six months after disenrollment, as applicable.

19.3.E. BENEFICIARY CHANGING OHH PROVIDERS

While the beneficiary's stage in recovery and individualized care plan is utilized to determine the appropriate setting and OHH provider of care (i.e., providers within Opioid Treatment Program versus Office-Based Opioid Treatment), beneficiaries have the option to change OHH providers to the extent feasible within the regional PIHP's designated OHH network. To maximize continuity of care and the patient-provider relationship, MDHHS expects beneficiaries to establish a lasting relationship with their chosen OHH provider. However, beneficiaries may change OHH providers, and should notify their current OHH provider immediately if they intend to do so. Current and future OHH providers must discuss the timing of the transfer and communicate transition options to the beneficiary. The change should occur on the first day of the next month with respect to the new OHH provider's appointment availability. Only



one OHH provider may be paid per beneficiary per month for OHH services. The new OHH provider is not eligible for the initial Recovery Action Plan payment if that one-time payment was already made to another OHH provider.

19.4 COVERED SERVICES

OHH services provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of an opioid use disorder and comorbid physical and behavioral health conditions. These services include the following:

- **Comprehensive Care Management**, including but not limited to:
 - Assessment of each beneficiary, including behavioral and physical health care needs;
 - Assessment of beneficiary readiness to change;
 - Development of an individualized care plan;
 - Documentation of assessment and care plan in the Electronic Health Record; and
 - Periodic reassessment of each beneficiary's treatment, outcomes, goals, self-management, health status, and service utilization.
- **Care Coordination and Health Promotion**, including but not limited to:
 - Organization of all aspects of a beneficiary's care;
 - Management of all integrated primary and specialty medical services, behavioral health services, physical health services, and social, educational, vocational, housing, and community services;
 - Information sharing between providers, patient, authorized representative(s), and family;
 - Resource management and advocacy;
 - Maintaining beneficiary contact, with an emphasis on in-person contact (although telephonic contact may be used for lower-risk beneficiaries who require less frequent face-to-face contact);
 - Appointment-making assistance, including coordinating transportation;
 - Development and implementation of care plan;
 - Medication adherence and monitoring;
 - Referral tracking;
 - Use of facility liaisons;
 - Use of patient care team huddles;
 - Use of case conferences;
 - Tracking of test results;
 - Requiring discharge summaries;
 - Providing patient and family activation and education;



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- Providing patient-centered training (e.g., diabetes education, nutrition education, etc.); and
- Connection of beneficiary to resources (e.g., smoking cessation, substance use disorder treatment, nutritional counseling, obesity reduction and prevention, disease-specific education, etc.).
- **Comprehensive Transitional Care**, including but not limited to:
 - Connecting the beneficiary to health services;
 - Coordinating and tracking the beneficiary's use of health services;
 - Providing and receiving notification of admissions and discharges;
 - Receiving and reviewing care records, continuity of care documents, and discharge summaries;
 - Post-discharge outreach to ensure appropriate follow-up services;
 - Medication reconciliation;
 - Pharmacy coordination;
 - Proactive care (versus reactive care);
 - Specialized transitions when necessary (i.e., age, corrections); and
 - Home visits.
- **Patient and Family Support (including authorized representatives)**, including but not limited to:
 - Reducing barriers to the beneficiary's care coordination;
 - Increasing patient and family skills and engagement;
 - Use of community supports (i.e., Community Health Workers, peer supports, peer recovery coaches, support groups, self-care programs, etc.);
 - Facilitating improved adherence to treatment;
 - Advocating for individual and family needs;
 - Assessing and increasing individual and family health literacy;
 - Use of advance directives, including psychiatric advance directives;
 - Providing assistance with maximizing beneficiary's level of functioning; and
 - Providing assistance with development of social networks.
- **Referral to Community and Social Support Services**, including but not limited to:
 - Providing beneficiaries with referrals to support services;
 - Collaborating/coordinating with community-based organizations and key community stakeholders;
 - Emphasizing resources closest to the beneficiary's home;
 - Emphasizing resources which present the fewest barriers;



- Identifying community-based resources;
- Providing resource materials pertinent to patient needs;
- Assisting in obtaining other resources, including benefit acquisition;
- Providing referral to housing resources; and
- Providing referral tracking and follow-up.
- **Use of Health Information Technology to link services**, including but not limited to:
 - Using an Electronic Health Record with meaningful use attainment;
 - Using an Integrated Health Information System to share critical data in real-time;
 - Using CareConnect360 for care coordination, transition and planning; and
 - Using telemedicine as needed.

19.5 PROVIDER ELIGIBILITY REQUIREMENTS

Eligible OHH providers must meet all applicable state and federal licensing requirements, including specifications set forth in this policy. Additionally, eligible providers must complete the MDHHS Opioid Health Home (OHH) Provider Application (MDHHS-5745), which requires attestation to the requirements cited in this policy, the State Plan Amendment, and other applicable MDHHS policies and procedures. Designated OHH providers must also be formally part of the regional PIHP's provider panel. (The MDHHS-5745 and the State Plan are available on the MDHHS website. Refer to the Directory Appendix for website information.)

19.5.A. GEOGRAPHIC AREA

Eligible providers must implement the OHH in Michigan's PIHP Region 2. (Refer to the MDHHS website/OHH page for a map of the applicable area. Refer to the Directory Appendix for website information.)

19.5.B. PROVIDER TYPES

Eligible provider types for the OHH include Opioid Treatment Programs (OTPs) and Office-Based Opioid Treatment (OBOT) providers. All OTPs and OBOT providers must provide MAT. OTPs must meet all state and federal licensing requirements. OBOT providers must attain the proper federal credentials from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Agency (DEA) to provide MAT. OBOT providers may include Community Mental Health Services Programs (CMHSPs), Federally Qualified Health Centers (FQHCs), including Section 330 grantees and FQHC Look-Alikes, Tribal Health Centers (THCs), and individual provider practices.

19.5.C. PROVIDER REQUIREMENTS

PIHPs must adhere to the OHH contractual requirements with MDHHS. Designated OHH providers must meet the requirements indicated in the MDHHS-5745. PIHPs and providers must adhere to the requirements of the State Plan Amendment, all



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Medicaid statutes, policies, procedures, rules, and regulations, and the Opioid Health Home (OHH) Handbook.

19.5.D. PROVIDER INFRASTRUCTURE REQUIREMENTS

OHH providers will ensure beneficiary access to an interdisciplinary care team that addresses the beneficiary’s behavioral and physical health needs. The requirements will span three settings – the regional PIHP, the OTPs, and the OBOT providers. Each setting will have its own unique set of requirements commensurate with the scope of their operations. Contingent upon MDHHS exceptions, specific minimum requirements for each setting are as follows:

Regional PIHP (per 400 patients)	<ul style="list-style-type: none"> Health Home Director (0.25 FTE) Administrative Support Staff (5 FTE)
OTPs (per 400 patients; in addition to current staffing requirements required by licensure)	<ul style="list-style-type: none"> RN Care Manager (3 FTE) Master’s-level Clinical Case Manager (1 FTE) Master’s-level Addiction Counselor (2 FTE) Certified Peer Recovery Coach (3 FTE) Primary Care Provider (.10 FTE) Consulting Psychiatrist (.20 FTE)
OBOT Providers (per 400 patients)	<ul style="list-style-type: none"> RN Care Manager (3 FTE) Master’s-level Clinical Case Manager (3 FTE) Certified Recovery Coach or Community Health Worker (3 FTE) Supervising Primary Care Provider (.15 FTE) Consulting Psychiatrist/Psychologist (.10 FTE)

Contingent upon MDHHS exceptions, all providers referenced above must meet the following criteria:

Primary Care Provider	<ul style="list-style-type: none"> Must be a primary care physician, physician assistant, or certified nurse practitioner with appropriate credentials to practice in Michigan (i.e., full licensure and certification, as applicable).
Clinical Case Manager	<ul style="list-style-type: none"> Must be a licensed master’s level social worker in Michigan.
Nurse Care Manager	<ul style="list-style-type: none"> Must be a licensed registered nurse in Michigan.
Certified Peer Recovery Coach	<ul style="list-style-type: none"> Must obtain requisite peer certification. (Refer to the Peer Recovery Coach Services subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter for additional information.)
Community Health Worker (CHW)	<ul style="list-style-type: none"> Must be at least 18 years of age. Must possess a high school diploma or equivalent. Must be supervised by licensed professional members of the care team. Must complete a CHW Certificate Program or equivalent.
Health Home Coordinator	<ul style="list-style-type: none"> Must be an administrative staff person employed by the PIHP.



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Access to a Psychiatrist/ Psychologist for consultation purposes (can be off-site)	<ul style="list-style-type: none"> • Must be a licensed psychiatrist or doctoral-level psychologist in Michigan.
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In addition to the above Provider Infrastructure Requirements, eligible OHH providers should coordinate care with the following professions:

- Dentist
- Dietician/Nutritionist
- Pharmacist
- Peer support specialist
- Diabetes educator
- School personnel
- Others as appropriate

19.6 PROVIDER ENROLLMENT AND OHH DESIGNATION

The PIHP must contractually adhere to the terms of this policy and the State Plan Amendment. Prospective OHH providers meeting the requirements in the Provider Eligibility Requirements subsection of this policy and the State Plan Amendment will be allowed to enroll as a designated OHH provider contingent upon adherence to this policy, enrolling in the PIHP’s provider panel, and signing the MDHHS-5745 with MDHHS. The fully executed MDHHS-5745 serves as the formal MDHHS recognition of OHH provider designation.

19.6.A. TRAINING AND TECHNICAL ASSISTANCE

MDHHS requires provider participation in state-sponsored training and technical assistance as a standard condition for continued OHH designation. A readiness assessment is completed for each designated OHH site which provides a basis for training and technical assistance needs.

19.6.B. USE OF APPLICABLE HEALTH INFORMATION TECHNOLOGY (HIT)

MDHHS requires OHH providers to utilize appropriate HIT for enrollment, health service documentation, and care coordination purposes. Training on specific HIT resources is provided by MDHHS.

19.7 PROVIDER DISENROLLMENT

To maximize continuity of care and the patient-provider relationship, MDHHS expects OHH providers to establish a lasting relationship with enrolled beneficiaries. However, designated OHH providers wishing to discontinue OHH services must notify the regional PIHP and MDHHS at least six months in advance of ceasing OHH operations. The notification must be provided in writing, with appropriate changes made in the PIHP and OHH provider contract. The PIHP must notify the OHH Team within the MDHHS Behavioral Health and Developmental Disabilities Administration of these events. OHH



services may not be discontinued without MDHHS approval of a provider-created cessation plan and protocols for beneficiary transition.

19.8 OHH PAYMENT

Payment for OHH services is contingent on designated OHH providers meeting the requirements laid out in the State Plan Amendment, this policy, the OHH provider application (MDHHS-5745), the Opioid Health Home (OHH) Handbook, and as determined by MDHHS. Failure to meet these requirements may result in loss of OHH provider designation.

19.8.A. GENERAL PROVISIONS FOR OHH PAYMENT

19.8.A.1. MDHHS TO REGIONAL PIHP

MDHHS distributes monies monthly to the regional PIHP in accordance with the State Plan Amendment. MDHHS periodically reconciles payments made to actual service delivered except for a five percent overage variance, which is reserved for an alternative payment methodology in the form of pay-for-performance (P4P) vis a vis a withhold. (Refer to the Opioid Health Home (OHH) Handbook for additional information.)

Payments depend on enrollment status pursuant to policy in the Provider Enrollment and OHH Designation subsection. MDHHS provides monies to the PIHP based on the following methodology:

- **Baseline Payments (Auto-enrolled but pending consent)**

For auto-enrolled beneficiaries who are not yet assigned to a designated OHH provider and are yet to have consent and diagnostic eligibility verified in the WSA, the PIHP receives a baseline payment (the lower of the two ongoing care management rates) until the PIHP completes the aforementioned steps.

- **Fully Enrolled Payments**

For all beneficiaries for which the PIHP has completed the requisite steps in the WSA, payment is commensurate with the setting of care (i.e., OTP or OBOT provider), encounter type (i.e., "recovery action plan" or "ongoing care management"), and in accordance with the approved rate schedule.

19.8.A.2. REGIONAL PIHP TO OHH PROVIDERS

Designated OHH providers must bill through their regional PIHP to receive OHH payment. Designated OHH providers are paid one of two monthly case rates which are as follows:



- **Recovery Action Plan Rate**

The OHH uses a once-in-a-lifetime-per-beneficiary "recovery action plan" rate to be paid only for the first month that a beneficiary participates in the OHH program. This once-in-a-lifetime-per-beneficiary rate represents reimbursement for certain actions and services including, but not limited to, initial care plan development. This service must be delivered in person. Rates vary by setting (i.e., OTP vs. OBOT provider).

- **Ongoing Care Management Rate**

For all subsequent months following the recovery action plan payment, the "ongoing care management" rate is paid for eligible OHH beneficiaries. Rates vary by setting (i.e., OTP vs. OBOT provider).

Details and guidance regarding applicable service encounter and diagnosis codes can be found in the Opioid Health Home (OHH) Handbook.

Note: Payment for OHH services is in addition to the existing FFS payments, encounters, or daily rate payments for direct clinical services. The MDHHS payment methodology is designed to only reimburse for the cost of the OHH provider staff for the delivery of OHH services that are not covered by any other currently available Medicaid reimbursement mechanism.

19.8.B. RECOUPMENT OF PAYMENT

The monthly payment is contingent upon an OHH beneficiary receiving an OHH service during the month at issue. The payment is subject to recoupment if the beneficiary does not receive an OHH service during the calendar month. The recoupment lookback will occur six months after the monthly payment is made. Thus, six months after the month a payment is made (for example: in January, MDHHS would look back at the payment made in July), CHAMPS will conduct an automatic recoupment process that will look for an approved encounter code (refer to the Opioid Health Home (OHH) Handbook) which documents that the OHH provided at least one of the five core OHH services (refer to the Covered Services subsection) during the calendar month in question. If a core OHH service is not provided during a month, that month's payment will be subject to recoupment by MDHHS. Once a recoupment has occurred, there shall be no further opportunity to submit a valid OHH encounter code and/or claim for the month that has a payment recouped.

Additional details regarding payment recoupment, including the recoupment schedule and other reasons for recoupment, can be found in the Opioid Health Home (OHH) Handbook.



CHILDREN'S WAIVER COMMUNITY LIVING SUPPORT SERVICES APPENDIX

SECTION 1 - CHILDREN WITH CHALLENGING BEHAVIORS

1.1 PURPOSE

This Section is to help the CMHSP determine whether the challenging behavioral needs of the child support hourly care and other support services, and to determine the appropriate range of hourly care that can be authorized under the Community Living Support (CLS) waiver service. The following categories do not, in and of themselves, establish eligibility for publicly funded hourly care.

The amount of CLS services (i.e., the number of hours) that can be authorized for a child is based on several factors, including the child's care needs which establish waiver eligibility, child's and family's circumstances, and other resources for daily care (e.g., private health insurance, trusts bequests, private pay). In addition to identifying the family situation and the specific behaviors as described in the category definitions, the following elements contribute to the overall assessment of need:

- Type of behaviors identified;
- Frequency, intensity, and duration of identified behaviors;
- How recently serious behaviors occurred;
- Actual specific effects of the behavior on persons in family and property;
- Level of family intervention required to prevent behavioral episodes;
- Extent to which family must alter normal routine to address behavioral needs of the child;
- Prognosis for change in the child's behavior;
- Whether or not child functions more effectively in any current setting than in other settings; and
- Age, size, and mobility of child.

1.2 CATEGORIES OF CARE

1.2.A. CATEGORY IV

Qualifications	Demonstrates mild level behaviors that may interfere with the daily routine of the family.
Definitions	Mild Behavior: Infrequent or intermittent behaviors including pinching, hitting, slapping, kicking, head banging, and/or elopement without careful supervision when there is evidence of lack of judgment regarding danger, or an extremely high activity level requiring extensive supervision and redirection.



1.2.B. CATEGORY III

Qualifications	Demonstrates a daily pattern of medium level behaviors including self-injurious, physically aggressive or assaultive behaviors that have not resulted in hospitalization or emergency room treatment for injuries in the past year, or has engaged in occasional, significant property destruction that is not life-threatening.
Definitions	<p>Pattern of Behavior: In addition to a single serious episode in the last year, significant daily behaviors are documented.</p> <p>Medium Behavior: Includes behaviors defined in the Category II definition of "moderate behavior" when emergency room treatment or hospitalization have not been required for treatment of injuries resulting from the behavior. Examples include head banging resulting in bleeding and bruising without concussion or detached retina, hair pulling without removing hair from the scalp, smearing feces without PICA, and biting without drawing blood.</p> <p>Occasional Property Destruction: Property destruction that occurs with a frequency not greater than one time per week.</p>

1.2.C. CATEGORY II

Qualifications	Demonstrates a daily pattern of moderate self-injurious, physically aggressive or assaultive behavior when medical intervention or emergency room treatment has been required for treatment of injuries in the past year without resulting hospitalization, or if the child has engaged in frequent, significant property destruction that is not life-threatening.
Definitions	Moderate Behavior: Includes behaviors that pose a significant risk of injury to self or others in the immediate environment. Examples include physical assault or self-abuse resulting in injuries requiring hospital emergency room treatment without hospital admission in the past year, biting that breaks the skin, hair pulling resulting in removal of clumps of hair from the scalp, multiple daily episodes of smearing feces with associated PICA, and head banging resulting in documented concussion or detached retina.

1.2.D. CATEGORY I

Qualifications	Demonstrates a pattern of severe self-injurious, physically aggressive or assaultive behavior, or life-threatening property destruction that has occurred one or more times in the past year. Documented evidence of additional behavioral problems on a frequent basis each day supports a need for one-to-one intensive behavioral treatment.
Definitions	Severe Behavior: Poses a very significant risk of serious injury or death to self, a family member, or others in the immediate environment. Examples include fire setting, physical assault or self-abuse resulting in injuries to self or others requiring inpatient hospital admission for treatment in the past year.



SECTION 2 – MEDICALLY AND PHYSICALLY COMPLEX CHILDREN

2.1 PURPOSE

The purpose of this Section is to help the CMHSP determine whether CLS services are medically necessary. The following categories do not, in and of themselves, establish eligibility for publicly funded hourly care.

2.1.A. CATEGORY IV

Qualifications	A medical condition and requires significant levels of daily assistance or guidance with activities of daily living (ADLs). In addition, medical condition is stable and observations and interventions are required infrequently. Interventions require minimal training and are associated with minimal or no risk to health status.
Examples	Includes levels of support that would exceed those expected for a person of the child's age in the areas of: <ul style="list-style-type: none"> ▪ Assistance and/or guidance in ADLs including eating, toileting, bathing, grooming, dressing, and mobility (ambulation and transferring); ▪ Assistance and/or guidance with physical transfer (e.g. bed to chair); ▪ Assistance and/or guidance with therapeutic positioning and physical therapy; or ▪ The child weighs 80 pounds or more and is not ambulatory and/or not mobile and unable to assist the primary caregiver.

2.1.B. CATEGORY III

Qualifications	A medical condition that routinely requires daily hourly care or support in order to maintain and/or improve health status. Clinical observations and interventions may be intermittent. Medical interventions are typically associated with minimal risk to health status, and delayed interventions are not associated with imminent risk to health status.
Examples	Includes a combination of interventions such as: <ul style="list-style-type: none"> ▪ G-tube feedings with no oral suctioning needs; ▪ PRN oxygen administration less often than daily over the past 30 days with or without pulse oximeter; ▪ Daily oxygen administration at less than two liters without pulse oximeter and without the need for on-going judgments and observations for oxygen needs (e.g. routine nightly administration without other skilled nursing interventions); ▪ Catheterization fewer than five times per day; ▪ Routine chest physiotherapy four or more times per day; ▪ Ostomy care; ▪ Total feeding or formal feeding program requiring more than 45 minutes per meal with need for special trunk-head positioning;



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|--|---|
| | <ul style="list-style-type: none">▪ Concurrent diagnosis of severe hypertonicity, severe contractures, or severe scoliosis that requires therapeutic positioning every two hours; or▪ Documented evidence that positioning causes apnea and cyanosis, and that positioning is limited to positions with the body in less than a 45 degree angle to horizontal plane. |
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2.1.C. CATEGORY II AND CATEGORY I

Services for Category II and Category I children are covered under the Medicaid State Plan private duty nursing (PDN) benefit. Refer to the Private Duty Nursing Chapter of this manual for PDN coverage criteria.



SECTION 3 – COVERAGE DECISIONS

3.1 DECISION RESPONSIBILITY

The MDHHS Children's Waiver Review Team will continue to review all plans of service and current assessments, and prior authorize waiver services, for those children who:

- Qualify for Category of Care I; or
- Have been approved to receive additional CLS hours under the exception process.

The responsible CMHSP, following the Children's Waiver Decision Guide in the following subsection, will review and prior authorize waiver services for those Children's Waiver beneficiaries who are determined to qualify for Categories II, III, or IV.

3.2 DECISION GUIDE

The determination of the amount of hourly care should result from a person-centered planning/family-centered practice process that considers both the child's and family's needs. The Children's Waiver Decision Guide Table below assists in identifying the range of hours provided for children based on their category of care and the family's resources to provide that care. It is expected that hourly care services will be provided within the range for which the child qualifies. Within the four Categories of Care are five sections that apply to the child's family status. In determining the total number of hours, it is acceptable to use the highest range within the appropriate section of the eligible category. If the child is receiving Home Help services, those hours must be considered as part of the total hours allowable. For example, a child determined to have Category III level of care needs is eligible for a maximum of six hours a day while in school. If that child receives two hours per day of Home Help, CWP could then provide a maximum of four hours of CLS staffing per day. The range of hours identified in the guide is an average daily amount that is provided seven days a week, based on a monthly total authorization.

If the child is attending school an average of 25 hours per week, the Section VI maximum would apply unless the maximum exceeds the range qualified for in Sections I-V. In that case, the maximum range in Sections I-V would apply. The Section VI maximum would not be required during school breaks, such as Christmas, Easter, and summer vacations, or if the child is out of school due to illness for 5 or more consecutive days.



CHILDREN'S WAIVER DECISION GUIDE TABLE				
ADDITIONAL FAMILY RESOURCES	DOCUMENTED CATEGORY OF NEED FOR HOURLY CARE AUTHORIZATION			
	CATEGORY IV	CATEGORY III	CATEGORY II	CATEGORY I
Section I – Number of Caregivers				
1. Two or more caregivers live in home; both work F/T	4 - 8	6 - 10	8 - 12	12 - 16
2. Two adult caregivers; one works F/T	2 - 8	2 - 8	4 - 10	10 - 16
3. Two adult caregivers; neither is employed	2 - 4	2 - 6	4 - 8	8 - 12
4. One adult caregiver lives in home and works F/T	4 - 8	4 - 10	8 - 12	12 - 16
5. One adult caregiver; does not work F/T	2 - 6	2 - 8	8 - 10	10 - 14
Section II – Health Status of Caregivers				
1. Significant health issues	6 - 8	6 - 10	10 - 14	12 - 16
2. Some health issues	4 - 6	4 - 8	8 - 12	10 - 12
Section III – Additional Dependent Children				
1. Applicant has one or more siblings age 5 or older	2 - 4	2 - 6	4 - 8	8 - 12
2. Applicant has one or more siblings under age 5	4 - 6	4 - 8	6 - 8	8 - 12
Section IV – Additional Children with Special Needs				
1. Applicant has one or more siblings with nursing needs	4 - 8	6 - 8	4 - 8	8 - 12
2. Applicant has one or more siblings with non-nursing special needs	2 - 4	2 - 6	N/A	N/A
Section V – Night Interventions				
1. Requires 2 or fewer interventions at night or total time less than one hour	2 - 4	2 - 6	4 - 8	8 - 12
2. Requires 3 or more interventions requiring one hour or more to complete	4 - 8	6 - 8	6 - 10	8 - 12
Section VI – School				
1. Child attends school an average of 25 hours per week	6 max	6 max	8 max	12 max

3.3 DECISION GUIDE TABLE DEFINITIONS

The definitions used in each section of the Decision Guide Table are as follows:

SECTION	DEFINITIONS
I – Number of Caregivers	Caregiver is defined as a legally responsible adult(s) living in the home or adult(s) who is not legally responsible but chooses to participate in providing care for the child. Full-Time (F/T) is defined as a person who works 30 or more hours per week for wages, or a person who attends school 30 or more hours per week.
II – Health Status of Caregivers	Significant health concerns of a caregiver is defined as one or more of the primary caregivers have a significant health or emotional condition which prevents that caregiver from providing care for the child. Example: A parent that recently had back surgery with full body cast or similar condition. Some health concerns of a caregiver is defined as one or more primary caregivers (as defined above) have a health or emotional condition that interferes with, but does not prevent, provision of care. Examples: Alcoholism, depression, lupus, back pain when lifting, lifting restrictions and similar health concerns; or primary caregiver is in therapy three or more times per month.



SECTION	DEFINITIONS
III - Additional Dependent Children	This section applies when the child has one or more siblings or related individuals under age 18 who reside in the home full-time and the caregiver is not paid for providing care.
IV - Additional Children With Special Needs	<p>Additional special needs are identified when the child has one or more siblings or related individuals who reside in the home and do not currently receive hourly care supports.</p> <p>Siblings with nursing needs are children who meet the criteria for Intensity of Care-High or Intensity of Care-Medium (refer to the Additional Mental Health Services (B3s) Section of this chapter), whether or not those children are developmentally disabled.</p> <p>Siblings without skilled nursing needs are children with needs as identified in Category of Care I-IV definitions.</p>
V – Night Interventions	<p>If the child requires one or two interventions at night and the time required to complete the interventions is one hour or less, Section V-1 applies.</p> <p>If the child requires an average of three or more interventions per night, or the time required to complete the interventions is more than one hour, Section V-2 applies.</p>
VI – School	<p>Average hours of school should be used to determine the appropriate range of hours. Include transportation time if provided by the school.</p> <p>The number of hours of school attendance is based on the school year that applies to the child’s educational classification. Variations in hours may be seen for children without a summer program.</p> <p>This factor limits the maximum number of hours that can be authorized for a child of any age in a center-based school program for more than 25 hours per week, or a child who has reached the age of 6 and for whom there is no medical justification for a home-bound school program.</p> <p>The school maximum is also waived for that time period when a child is out of school for at least 5 consecutive days due to illness, surgery, or scheduled school breaks.</p>

3.4 EXCEPTION PROCESS

The exception process ensures the safety and quality of care of children served by the waiver through consideration of the unique needs of each child and family, and special circumstances that may arise. When occasional relief through respite services is not sufficient, an exception of hourly care may be authorized.

Contingent upon the availability of funds and upon receipt of a Prior Review and Approval Request (PRAR), limited authority to exceed the published hourly care amount defined in the Decision Guide subsection may be granted by MDHHS to a CMHSP to better serve identified children with exceptional care needs. The PRAR must be developed pursuant to family request, person-centered planning/family-centered practice team recommendation, and CMHSP administrative concurrence.

The PRAR must document and substantiate both a current clinical (either medical or psychological) necessity for the exception and a current lack of natural supports requisite for the provision of the needed level of care. The hourly care services must be essential to the successful implementation of a plan of active treatment as defined by CMS ICF/IID rules, and any enhancements must be essential to maintain the child within their home. Consideration for an exception will be limited to situations outside



the family's control that place the child in jeopardy of serious injury or significant deterioration of health status such as:

- A temporary deterioration of the child's clinical condition (e.g. need for nursing care following an acute hospitalization or surgical procedure, or an acute cyclic exacerbation of challenging behaviors);
- A temporary inability of the primary caregivers to provide the requisite level of care (e.g., an acute illness or injury);
- Health condition requires continuous implementation of high risk medically prescribed procedures requiring licensed nursing personnel that are not already addressed within the Decision Guide subsection. The procedures must be beyond the demonstrated capacity of the parents to provide;
- Behavior treatment needs significantly exceed the recommended ranges for the assigned category of care **and** this exception is essential to prevent an otherwise inevitable (i.e., previously documented) deterioration in behavior. The enhanced staffing must be continuously active in the implementation of the behavior treatment plan;
- Natural supports are unable to provide the requisite level of care (e.g., only available care providers have a physical, mental, or emotional disability or they cannot demonstrate competence with the procedures essential to the implementation of the treatment plan). The plan of service must also address plans to rectify the condition or circumstance.

Exceptions may be granted for a specified period not to exceed 180 days. Renewal requests must substantiate the continuing clinical necessity and lack of natural supports.

Exceptions approved by MDHHS can occur in one of the following ways:

- Temporary emergency basis only. Verbal approval can be given to the CMHSP, with written justification to be forwarded to MDHHS within 10 days; or
- In a non-emergency situation, the CMHSP provides MDHHS with written documentation of the specific rationale to support the exception (i.e., physician's prescription). This would include a revised Plan of Care, highlighting the care needs to be provided with the additional staffing hours, and all current assessments. A response from MDHHS will occur within 10 working days.

When approval of an exception is not granted through either of the two processes listed above, the family, case manager, or MDHHS may request a meeting in order to clarify and reconsider the basis for the exception.

MDHHS has the option to request a home visit to meet the child when it is necessary for an effective decision.

3.5 APPEAL PROCESS

The child and family have the right, under the Michigan Mental Health Code, to appeal a negative coverage decision to the director of the CMHSP. The child and family may also request a recipient's rights investigation through their CMHSP.



The CMS approval of the Children's Waiver requires the availability of a fair hearing for any Medicaid-eligible child enrolled in the Children's Waiver Program when that child is subject to a negative action. A negative action results when a Medicaid-covered service or benefit is taken away, reduced, or denied to a Medicaid beneficiary. The Medicaid beneficiary must be notified of the negative action in writing. The negative action notice must indicate:

- The beneficiary's right to appeal through the MDHHS administrative hearing process;
- The beneficiary has 90 days to submit an appeal; and
- Where to send the appeal.

The MDHHS appeal process may occur simultaneously with a recipient's rights or CMHSP administrative appeal process. Individuals and their families are encouraged to resolve disputes regarding waiver services at the local CMHSP level.

The CMHSP is financially responsible for any services that may be approved as a result of the judgment from the administration appeal process.



CHILDREN'S SERIOUS EMOTIONAL DISTURBANCE HOME AND COMMUNITY-BASED SERVICES WAIVER APPENDIX

SECTION 1 – GENERAL INFORMATION

The Children's Serious Emotional Disturbance Home and Community-Based Services Waiver (SEDW) Program provides services that are enhancements or additions to Medicaid state plan coverage for children up to age 21 with serious emotional disturbance (SED) who are enrolled in the SEDW. MDHHS operates the SEDW through contracts with the CMHSPs. The SEDW is a fee-for-service program administered by the CMHSP in partnership with other community agencies. The CMHSP will be held financially responsible for any costs authorized by the CMHSP and incurred on behalf of a SEDW beneficiary.

1.1 KEY PROVISIONS [CHANGE MADE 7/1/20]

The SEDW enables Medicaid to fund necessary home and community-based services for children up to age 21 with SED who meet the criteria for admission to a state inpatient psychiatric hospital **and/or (revised 7/1/20)** who are at risk of hospitalization without waiver services. The CMHSP is responsible for assessment of potential waiver candidates.

Application for the SEDW is made through the CMHSP. The CMHSP is responsible for the coordination of the SEDW services. The Wraparound Facilitator, the child and his family and friends, and other professional members of the planning team work cooperatively to identify the child's needs and to secure the necessary services. All services and supports must be included in an IPOS.

A SEDW beneficiary must receive at least one SED waiver service per month in order to retain eligibility.

1.2 ELIGIBILITY

To be eligible for this waiver, the child must meet all of the following criteria.

- Live in a participating county (refer to the Coverage Area subsection in this chapter); OR
- Live in foster care in a non-participating county pursuant to placement by MDHHS or the court of a participating county, with SEDW oversight by a participating county's CMHSP; AND
- Reside with the birth or adoptive family or have a plan to return to the birth or adoptive home; OR
- Reside with a legal guardian; OR
- Reside in a foster home with a permanency plan; OR
- Be age 18 or age 19 and live independently with supports; AND
- Meet current MDHHS criteria for the state psychiatric hospital for children; AND
- Medicaid eligibility criteria and become a Medicaid beneficiary; AND



- Demonstrate serious functional limitations that impair the ability to function in the community. As appropriate for age, functional limitation will be identified using the Child and Adolescent Functional Assessment Scale (CAFAS®) or the Preschool and Early Childhood Functional Assessment Scale (PECFAS®):
 - CAFAS® score of 90 or greater for children age 7 to 12; OR
 - CAFAS® score of 120 or greater for children age 13 to 18; OR
 - For children age 3 to 7, elevated PECFAS® subscale scores in at least one of these areas: self-harmful behaviors, mood/emotions, thinking/communicating or behavior towards others; AND
- Be under the age of 18 when approved for the waiver. If a child on the SEDW turns 18, continues to meet all non-age-related eligibility criteria, and continues to need waiver services, the child can remain on the waiver up to their 21st birthday.

1.3 COVERAGE AREA

Waiver services are limited to eligible children (up to the federally-approved maximums) living in the counties whose CMHSPs have:

- An approved SED Waiver plan with MDHHS;
- Demonstrated strong collaboration with essential community partners;
- The capacity to provide intensive community-based services; and
- The fiscal capacity to manage interagency funding appropriately or have been approved to participate in the MDHHS SED Waiver Pilot program.



SECTION 2 – COVERED WAIVER SERVICES

Each child must have a comprehensive IPOS that specifies the services and supports that the child and his family will receive. The IPOS is to be developed through the Wraparound Planning Process. Each child must have a Wraparound Facilitator who is responsible to assist the child/family in identifying, planning and organizing the Child and Family Team, developing the IPOS, and coordinating services and supports. The Wraparound Facilitator is responsible for monitoring supports and service delivery, as well as the health and safety of the child, as part of their regular contact with the child and family, with oversight by the Community Team.

In addition to Medicaid state plan services, children enrolled in the SEDW may receive any of the following SED waiver services as identified in the IPOS.

2.1 COMMUNITY LIVING SUPPORTS

Community Living Supports (CLS) are used to increase or maintain personal self-sufficiency, thus facilitating a beneficiary's achievement of his goals of community inclusion and remaining in their home. The supports may be provided in the beneficiary's home or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

CLS provides assistance to the family in the care of their child while facilitating the child's independence and integration into the community. The supports, as identified in the IPOS, are provided in the child's home and may be provided in community settings when integration into the community is an identified goal. Skills related to activities of daily living (such as personal hygiene, household chores, and socialization) may be included. CLS may also promote communication, relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the child enabling the child to attain or maintain their maximum potential. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings.

Community Living Supports includes:

- Assistance with skill development related to:
 - Activities of daily living (such as personal hygiene)
 - Household chores
 - Socialization
 - Improving communication and relationship-building skills
 - Participation in leisure and community activities
- Staff assistance, support and/or training with such activities as:
 - Improving the child's social interactions and internal controls by instilling positive behaviors and increasing resiliency factors that should reduce risk factors
 - Non-medical care (i.e., not requiring nurse or physician intervention)



- Transportation (excluding to and from medical appointments) from the beneficiary's home to community activities, among community activities, and from the community activities back to the beneficiary's residence
 - Participation in regular community activities and recreation opportunities (attending classes, movies, concerts and events in a park; volunteering; etc.)
 - Assisting the family in relating to and caring for their child
 - Attendance at medical appointments
 - Acquiring or procuring goods other than those listed as shopping and non-medical services
- Reminding, observing, rewarding and monitoring of pro-social behaviors.
 - Medication administration.
 - Staff assistance with preserving the health and safety of the beneficiary in order that he may reside or be supported in the most integrated, independent community setting.

2.2 FAMILY HOME CARE TRAINING

Family Home Care Training provides training and counseling services for the families of beneficiaries served by this waiver. For purposes of these services, "family" is defined as the person(s) who lives with or provides care to a beneficiary served by the waiver and may include a parent and/or siblings or the foster parent(s) for a child in Therapeutic Child Foster Care. This service is provided by a Master's level social worker, psychologist, or QMHP, and includes instruction about treatment interventions and support intervention plans specified in the IPOS, and includes updates as necessary to safely maintain the child at home.

Family Home Care Training is also a counseling service directed to the family and designed to improve and develop the family's skills in dealing with the life circumstances of parenting a child with special needs and to help the child remain at home. All family training must be included in the child's IPOS and must be provided on a face-to-face basis (i.e., in person and with the family present).

2.3 FAMILY SUPPORT AND TRAINING [CHANGE MADE 7/1/20]

This service is provided by a peer-parent who has completed MDHHS endorsed training. It is a family-focused service provided to families (birth or adoptive parents, siblings, relatives, foster family, and other unpaid caregivers) of children with serious emotional disturbance (SED) for the purpose of assisting the family in relating to and caring for a child with SED. The services target the family members who are caring for and/or living with a child receiving waiver services. The service is to be used in cases where the child is hindered or at risk of being hindered in their ability to achieve goals of: performing activities of daily living; improving functioning across life domain areas; perceiving, controlling or communicating with the environment in which they live; or improving their inclusion and participation in the community or productive activity, or opportunities for independent living.



Coverage includes education and training, including instructions about treatment regimens, to safely maintain the child at home (as specified in the individual plan of service (POS)) and peer support provided by a trained peer-parent (one-on-one or in a group) for assistance with identifying coping strategies for successfully caring for or living with a person with SED. Parent-to-parent support is designed to support parents/families of children with SED as part of the treatment process to be empowered, confident, and have skills that will enable them to assist their child to improve in functioning. The trained parent support partner has had or currently has a child with special mental health needs; provides education, training, and support; and augments the assessment and mental health treatment process. The peer-parent support partner provides these services to the enrolled child's parents and their family. These activities are provided in the home and in the community. NOTE: The unit of service when billing S5111 HM for children/youth on the SEDW is per session, 45 minutes or more.

The parent support partner must complete the MDHHS endorsed statewide training curriculum and be provided regular supervision and team consultation by the treating professionals. Completion of the initial three-day training curriculum is documented by a Certificate of Completion which must be maintained in the parent support partner's personnel file. Parent Support Partners may not have more than one provider role with any one family (i.e., may not be both Parent Support Partner and Peer Support Specialist for the same family). (text added 7/1/20)

2.4 THERAPEUTIC ACTIVITIES

A therapeutic activity is an alternative service that can be used in lieu of, or in combination with, traditional professional services. The focus of therapeutic activities is to interact with the child to accomplish the goals identified in the POS. The POS ensures the child's health, safety and skill development and maintains the child in the community. Services must be directly related to an identified goal in the POS. Providers are identified through the wraparound planning process and participate in the development of a POS based on strengths, needs, and preferences of the child and family. Therapeutic activities may include the following: child and family training, coaching and supervision, monitoring of progress related to goals and objectives, and recommending changes to the POS. Services provided under Therapeutic Activities include music therapy, recreation therapy, and art therapy. NOTE: The unit of service when billing G0176 for children/youth on the SEDW is per session, 45 minutes or more.

The training, coaching, supervision and monitoring activities provided under this service are specific to music, art, and recreation therapy and must be provided by providers with the qualifications listed below.

Recreation Therapy	Must be provided by a Certified Therapeutic Recreation Specialist credentialed by the National Council for Therapeutic Recreation Certification (NCTRC).
Music Therapy	Must be provided by a Music Therapist - Board Certified (MT-BC) or by a music therapist listed on the National Music Therapy Registry (NMTR).
Art Therapy	Must be provided by a Registered Art Therapist - Board Certified (ATR-BC).



2.5 RESPITE CARE

Respite care is services provided to beneficiaries unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care.

Federal Financial Participation (FFP) may not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite care can be provided in the following locations:

- Beneficiary's home or place of residence
- Family friend's home in the community
- Licensed Therapeutic Foster Home
- Licensed Group Home

2.6 CHILD THERAPEUTIC FOSTER CARE

Child Therapeutic Foster Care (CTFC) is an evidence-based practice. It provides an intensive therapeutic living environment for a child with challenging behaviors. Important components of CTFC include:

- intensive parental supervision,
- positive adult-youth relationships,
- reduced contact with children with challenging behaviors, and
- family behavior treatment skills.

CTFC seeks to change the negative trajectory of a child's behavior by improving his social adjustment, family adjustment and peer group. CTFC attempts to decrease negative behavior, increase appropriate behavior, and build pro-social skills. Foster parents, teachers, therapists and other adults act as change agents for the child. The change agents contribute to the treatment of the child and the preparation of his family for the child's return to the home and community. Foster parents are specially recruited, trained and supervised. The total number of individuals (including beneficiaries served in the waiver) living in the home who are unrelated to the primary caregiver may not exceed one.

In addition to being licensed, all CTFC programs under this waiver are to be pre-enrolled by MDHHS to ensure they meet the requirements set forth in this policy. Separate payment will not be made for homemaker or chore services, for community living services provided by the foster parents, or for respite care furnished for the foster care parents to a child receiving CTFC services since these services are integral to, and inherent in, the provision of CTFC.



2.7 THERAPEUTIC OVERNIGHT CAMP

A group recreational and skill building service in a camp setting aimed at meeting the goal(s) detailed in the beneficiary's IPOS. A session can be one or more days and nights of camp. Room and Board costs are excluded from the SEDW payment for this service.

Additional criteria:

- Camps are licensed by MDHHS;
- The child's IPOS includes Therapeutic Overnight Camp; and
- Camp staff is trained in working with children with SED.

Coverage includes:

- Camp fees, including enrollment and other fees;
- Transportation to and from the camp; and
- Additional costs for staff with specialized training with this population.

Coverage excludes:

- Room and board for the camp.

2.8 TRANSITIONAL SERVICES

Transitional services is a one-time-only expense to assist beneficiaries returning to their family home and community while the family is in the process of securing other benefits (e.g., SSI) or resources (e.g., governmental rental assistance and/or home ownership programs) that may be available to assume these obligations and provide needed assistance.

Additional criteria for using Transitional Services:

- The beneficiary must have in his/her IPOS a goal to return to his/her home and community; and
- Documentation of the family's control (i.e., signed lease, rental agreement, deed) of their living arrangement in the family-centered plan of service; and
- Documentation of efforts (e.g., the family is on a waiting list) under way to secure other benefits (such as SSI) or public programs (e.g., governmental rental assistance, community housing initiatives and/or home ownership programs) so when these benefits become available, they will assume the obligation and provide the needed assistance.

Coverage includes:

- Assistance with utilities, insurance, and moving expenses where such expenses would pose a barrier to a successful transition to the beneficiary's family home;



- Interim assistance with utilities, insurance, or living expenses when the beneficiary's family, already living in an independent setting, experiences a temporary reduction or termination of their own or other community resources; and
- Home maintenance when, without a repair to the home or replacement of a necessary appliance, the beneficiary would be unable to move there or, if already living there, would be forced to leave for health and safety reasons.

All services provided must be in accordance with applicable state or local building codes. Standards of value purchasing must be followed. The home maintenance must be the most reasonable alternative, based on the results of a review of all options. The existing structure must have the capability to accept and support the proposed changes. The infrastructure of the home involved must be in compliance with any applicable local codes. The home maintenance involved shall exclude costs for improvements required exclusively to meet local building codes. The home maintenance must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The home maintenance or repair cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

Coverage excludes those home maintenance or repairs to the home that are:

- Of general utility or are cosmetic;
- Considered to be standard housing obligations of the beneficiary's family;
- Not of direct medical or remedial benefit to the child;
- On-going housing costs; and
- Costs for room and board that are not directly associated with transition arrangements while securing other benefits.

Requests for transitional services must be prior authorized by the CMHSP following denial by all other applicable resources (e.g., private insurance, Medicaid). All services shall be provided in accordance with applicable state or local building codes.

2.9 WRAPAROUND SERVICES

Wraparound services for children and adolescents is a highly individualized planning process facilitated by specialized supports coordinators.

Wraparound utilizes a Child and Family Team, with team members determined by the family often representing multiple agencies and informal supports. The Child and Family Team creates a highly individualized Wraparound plan with the child/youth and family that consists of mental health specialty treatment, services and supports covered by the Medicaid mental health state plan, waiver, B3 services, and other community services and supports.

The Wraparound plan may also consist of other non-mental health services that are secured from, and funded by, other agencies in the community. The Wraparound plan is the result of a collaborative team planning process that focuses on the unique strengths, values and preferences of the child/youth and family, and is developed in partnership with other community agencies. This planning process tends to



work most effectively with children/youth and their families who, due to safety and other risk factors, require services from multiple systems and informal supports. The Community Team, which consists of parents/guardians/legal representatives, agency representatives, and other relevant community members, oversees Wraparound.

Coverage includes:

- Planning and/or facilitating planning using the Wraparound process, including at least one monthly face-to-face contact;
- Developing an IPOS utilizing the Wraparound process;
- Linking to, coordinating with, follow-up of, advocacy for, and/or monitoring of services with the Wraparound Community Team and other community services and supports;
- Brokering with providers of services with the assistance of the Wraparound Community Team;
- Assistance with access to other entitlements; and
- Coordination with the Medicaid Health Plan or other health care providers.

Coverage excludes:

- Case management that is the responsibility of the child welfare, juvenile justice, or foster care systems;
- Case management for legal or court-ordered non-medically necessary services;
- Direct service provision; and
- Services and supports that are the responsibility of other agencies on the Community Team.

All SEDW Wraparound enrolled providers must meet all of the requirements in the enrollment standards as listed in the Wraparound Services for Children and Adolescents subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter. In addition, due to the intense needs and level of risk of children/youth and their families served in the SEDW community-based waiver, all SEDW Wraparound providers must meet the following additional requirements:

- Wraparound facilitators must possess a bachelor's degree and be a CMHP or be supervised by a CMHP.
- Wraparound facilitators and those who provide supervision to facilitators will attend additional training (16 hours) related to provision of support to children/youth and their families served in the waiver annually as required by MDHHS. This training is in addition to identified requirements for all supervisors and Wraparound facilitators.
- Caseloads shall be 8-10 per facilitator based on needs and risks of the child/youth and family. Caseloads may increase to a maximum of 12 when two child/youth and family teams are transitioning from Wraparound.



- SEDW site reviews will assess fidelity to the model through case file review, quality assurance of all SEDW-provided services/supports, and interviews with children/youth and family members.
- All SEDW Wraparound enrolled providers must participate in the statewide evaluation project that consists of gathering data on the Family Status Report at intake, quarterly and at graduation.
- Completion of the Michigan Wraparound Fidelity Index at six months and upon graduation.
- Participation in any additional model fidelity or quality assurance evaluation tools as requested by MDHHS.

2.10 HOME CARE TRAINING, NON-FAMILY

HCPCS Code S5116 – Non-Family Home Care Training/Session should be used to bill for this service. This service is reimbursable for up to four sessions per day but no more than 12 sessions per 90 days (i.e., three calendar months). A session can be of varying lengths of time but should meet the needs of the plan of service (POS); a billable session must be at least 45 minutes.

This service provides coaching, training, supervision and monitoring of Community Living Supports (CLS) staff by clinicians (i.e., licensed psychologist, Master’s level social worker, occupational therapist, physical therapist, speech therapist, or Child Mental Health Professional). Professional staff work with CLS staff to implement the consumer’s POS, with focus on services designed to improve the child’s/youth’s social interactions and self-control by instilling positive behaviors instead of behaviors that are socially disruptive, injurious to the consumer or others, or that cause property damage. The activities of the professional staff ensure the appropriateness of services delivered by CLS staff and continuity of care. This service can be provided by more than one clinician in any given month, as the service provider is selected on the basis of his/her competency in the aspect of the POS on which training is conducted.

Services must be provided by qualified providers who meet the requirements of, and in accordance with, 42 CFR §440.50 through §440.60(a) and other applicable state and federal laws or regulations.

2.11 OVERNIGHT HEALTH AND SAFETY SUPPORT (OHSS) SERVICES [SUBSECTION ADDED 7/1/20]

NOTE: OHSS is not available for individuals residing in licensed non-community facilities or settings. Payment of OHSS may not be made directly or indirectly to responsible relatives (i.e., spouses or parents of minor children) or a legal guardian. (text added per bulletin MSA 20-04)

2.11.A. ELIGIBILITY [SUBSECTION ADDED 7/1/20]

To be eligible for OHSS, an individual must:

- Be Medicaid eligible;
- Be enrolled in one of the following waiver programs: CWP, HSW, or SEDW;
- Be living in a community-based setting (not in a hospital, Intermediate Care Facility for Individuals with Intellectual Disabilities [ICF/IID], nursing facility, licensed Adult Foster Care home, correctional facility, or child caring institution); and



- Require supervision overnight to ensure and maintain the health and safety of an individual living independently.

The need for OHSS must be reviewed and established through the person-centered planning process with the beneficiary's specific needs identified that outline health and safety concerns and a history of behavior or action that has placed the beneficiary at risk of obtaining or maintaining their independent living arrangement. Each provider of OHSS services will ensure the provision of, or provide as its minimum responsibility, overnight supervision activities appropriate to the beneficiary's needs to achieve or maintain independent living, health, welfare, and safety. **(text added per bulletin MSA 20-04)**

2.11.B. COVERAGE [SUBSECTION ADDED 7/1/20]

For purposes of this service, "overnight" includes the hours a beneficiary is typically asleep for no more than 12 hours in a 24-hour period

The purpose of OHSS is to enhance individual safety and independence with an awake provider supervising the health and welfare of a beneficiary overnight. OHSS is defined as the need for an awake provider to be present (i.e., physically on-site) to oversee and be ready to respond to a beneficiary's unscheduled needs if they occur during the overnight hours when they are typically asleep.

OHSS services are generally furnished on a regularly scheduled basis, for multiple days per week, or as specified in the Individual Plan of Service (IPOS), encompassing both health and safety support services needed for the individual to reside successfully in their own home and community-based settings.

OHSS may be appropriate when:

- Service is necessary to safeguard against injury, hazard, or accident.
- A beneficiary has an evaluation that includes medical necessity that determines the need for OHSS and will allow an individual to remain at home safely after all other available preventive interventions/appropriate assistive technology, environmental modifications and specialty supplies and equipment (i.e., Lifeline, Personal Emergency Response System [PERS], electronic devices, etc.) have been undertaken to ensure the least intrusive and cost-effective intervention is implemented.
- A beneficiary requires supervision to prevent or mitigate mental health or disability related behaviors that may impact the beneficiary's overall health and welfare during the night.
- A beneficiary is non-self-directing (i.e., struggles to initiate and problem solve issues that may intermittently come up during the night or when they are typically asleep), confused or whose physical functioning overnight is such that they are unable to respond appropriately in a non-medical emergency (i.e., fire, weather-related events, utility failure, etc.).



- A beneficiary has a documented history of a behavior or action that supports the need to have an awake provider on-site for supported assistance with incidental care activities that may be needed during the night that cannot be pre-planned or scheduled.
- A beneficiary requires overnight supervision in order to maintain living arrangements in the most integrated community setting appropriate for their needs.

The following exceptions apply for OHSS:

- OHSS does not include friendly visiting or other social activities.
- OHSS is not available when the need is caused by a medical condition and the form of supervision required is medical in nature (i.e., nursing facility level of care, wound care, sleep apnea, overnight suctioning, end-stage hospice care, etc.) or in anticipation of a medical emergency (i.e., uncontrolled seizures, serious impairment to bodily functions, etc.) that could be more appropriately covered under PERS or medical specialty supplies.
- OHSS is not intended to supplant other medical or crisis emergency services to address acute injury or illness that poses an immediate risk to a person's life.
- OHSS is not available to prevent, address, treat, or control significantly challenging anti-social or severely aggressive individualized behavior.
- OHSS is not available for an individual who is anxious about being alone at night without a history of a mental health or disability related behavior(s) that indicates a medical need for overnight supports.
- OHSS is not intended to compensate or supplant services for the relief of the primary caregiver or legal guardian living in the same home or to replace a parent's obligations and parental rights of minor children living in a family home
- OHSS is not an alternative to inpatient psychiatric treatment or other appropriate levels of care to meet the beneficiary's needs and is not available to prevent potential suicide or other self-harm behaviors. **(text added per bulletin MSA 20-04)**

2.11.C. COORDINATION OF SERVICES AND CARE [SUBSECTION ADDED 7/1/20]

The service normally involves the co-provision of several services through an awake provider in order to achieve the purpose of the service. OHSS services typically fall into this category of "round-the-clock" by the nature and institutional level of care required for HCBS Waiver participants. OHSS is intended to supplement other HCBS (i.e., Community Living Supports [CLS], respite, etc.) that are provided to the beneficiary as part of a comprehensive array of specialized waiver or developmental disabilities services (i.e., supports coordination, peer-delivered, etc.).

If a beneficiary is receiving CLS or respite supports and demonstrates the need for OHSS, the IPOS must document coordination of services to ensure the scope, nature of supervision and/or provider differ from the other community support services to prevent issues of duplicative services. OHSS is complementary of the other habilitative services, but typically does not comprise the entirety of the supports a beneficiary may need to obtain or maintain their independence in their community. OHSS services are enhanced



services that are in addition to or concurrent with other waiver services, as outlined in the IPOS, and allow for the provision of supervision to ensure the health and safety of an individual overnight. **(text added per bulletin MSA 20-04)**

2.11.D. PROVIDER SERVICES [SUBSECTION ADDED 7/1/20]

Providers have the responsibility for the health, welfare, and safety of the beneficiary overnight and must be awake to have the ability to intervene on behalf of the beneficiary. This assistance may take the form of observation and minor redirection of the beneficiary to perform tasks that will enable the beneficiary to maintain their overnight health and sleep safety.

Providers may perform minor redirection and/or prompting that are incidental to the care and supervision of the beneficiary over the course of the night such as:

- The ability to intervene on behalf of the beneficiary supervision of overnight activities, such as reinforcing independent living skills and minor redirection of their independent daily living tasks.
- Provide the level of supervision needed to ensure a beneficiary’s safety, along with the actions required if a beneficiary’s health or welfare are at risk.
- Safeguard the individualized supports needed overnight appropriate to the beneficiary's needs. Common issues, which include fire and evacuation ability, ability to respond independently to health needs during the night, and safety awareness. **(text added per bulletin MSA 20-04)**

2.11.E. PROVIDER QUALIFICATIONS [SUBSECTION ADDED 7/1/20]

Provider Type	Direct Support Professional/Aide
License	None
Certification	None
Other Standards	<ul style="list-style-type: none"> ▪ individual with specialized training; ▪ is able to perform basic first-aid procedures; ▪ is trained in the beneficiary's IPOS, as applicable; ▪ is at least 18 years of age; ▪ is able to prevent transmission of communicable disease; ▪ is able to communicate expressively and receptively in order to follow IPOS requirements and beneficiary-specific emergency procedures, and to report on activities performed; and ▪ is in good standing with the law. (text added per bulletin MSA 20-04)



SECTION 3 – MEDICAID STATE PLAN SERVICES

In addition to SEDW services, children served by the SEDW have access to Medicaid Mental Health State Plan services (e.g., psychotherapy, medication management, OT and PT evaluations, home based services) provided by their CMHSP on a fee-for-service basis. Services that can be billed to Medicaid are listed on the MDHHS CMHSP Serious Emotional Disturbance (SED) Waiver Database which is available on the MDHHS website. The database lists the CPT/HCPCS code, modifiers (when applicable), short description, Medicaid fee screen, and applicable quantity/timeframe parameters for each service. (Refer to the Directory Appendix for website information.)

Transportation is a Mental Health State Plan service covered under a number of HCPCS codes, only one of which can be billed fee-for-service for children on the SEDW. Parameters related to this service for SEDW enrollees are identified.

Prepaid Inpatient Health Plans (PIHPs) are responsible for transportation to and from the beneficiary's place of residence when provided so that a beneficiary may participate in a state plan, HSW, or additional/B3 service at an approved day program site or in a clubhouse psychosocial rehabilitation program. Medicaid Health Plans (MHPs) are responsible for assuring enrollee transportation to the primary health care services provided by the MHPs, and to non-mental health specialists and out-of-state medical providers. MDHHS is responsible for assuring transportation to medical appointments for Medicaid beneficiaries not enrolled in MHPs; and to dental, substance abuse, and mental health services (except those noted above and in the HSW program – described in the Habilitation Supports Waiver for Persons with Developmental Disabilities Section of this chapter) for all Medicaid beneficiaries.

For children enrolled in the SEDW, transportation may be reimbursed when separately specified in the individual plan of care and provided in order to enable a child served by the SEDW to gain access to waiver and other community services, activities, and resources. The transportation benefit is limited to mileage reimbursement, and can be paid to hourly staff (e.g., respite and CLS) and clinical/professional staff providers. Family, neighbors, friends, or community agencies that can provide this service without charge must be utilized before seeking funding through the SEDW. The SEDW-enrolled child, legally responsible caregivers, and foster care providers cannot be reimbursed for mileage.



SECTION 4 – PROVIDER QUALIFICATIONS

4.1 RESPITE AND CLS

Individuals who provide respite and CLS must, in addition to the specific training, supervision and standards for each support/service, be:

- A responsible adult at least 18 years of age;
- Free from communicable disease;
- Able to read and follow written plans of service/supports as well as beneficiary-specific emergency procedures;
- Able to write legible progress and/or status notes;
- In "good standing" with the law (i.e., not a fugitive from justice, a convicted felon or illegal alien); and
- Able to perform basic first aid and emergency procedures.

The individual must also have successfully completed Recipient Rights Training.

4.2 WRAPAROUND FACILITATOR

Wraparound facilitators must:

- Complete MDHHS wraparound training;
- Possess a bachelor's degree in human services or a related field, or other approved work/personal experience in providing direct services or linking of services for children with SED;
- Have a criminal history screen, including state and local child protection agency registries; and
- Be supervised by an individual who meets criteria as a qualified mental health professional who has completed MDHHS required training.

4.3 CHILD THERAPEUTIC FOSTER CARE

Child Therapeutic Foster Care providers must be:

- Licensed as a Foster Care Provider (MCL 722.122);
- Certified by MDHHS;
- Enrolled by MDHHS as a CTFC provider; and
- Trained in the child's IPOS.

4.4 THERAPEUTIC OVERNIGHT CAMP

Therapeutic Overnight Camps must be licensed and certified by MDHHS. Staff must be trained in the child's IPOS.



NON-PHYSICIAN BEHAVIORAL HEALTH APPENDIX

SECTION 1 - GENERAL INFORMATION

This appendix applies to non-physician behavioral health providers, psychologists, social workers, counselors, and marriage and family therapists. Information is included to assist the practitioner in determining how the Michigan Department of Health and Human Services (MDHHS) covers specific services. This information should be used in conjunction with the Billing & Reimbursement Chapters of this manual, as well as the Medicaid Code and Rate Reference tool, MDHHS Practitioner and Medical Clinic Fee Schedule, and other related procedure databases/fee schedules located on the MDHHS website. (Refer to the Directory Appendix for website information.) For beneficiaries not enrolled in Medicaid Health Plans and services not included in the capitation payments to the PIHP/CMHSP, behavioral health services are covered through Medicaid FFS.



SECTION 2 – PROVIDER QUALIFICATIONS [CHANGE MADE 7/1/20]

Medicaid covers non-physician behavioral health services when performed by any of the following provider types:

- Licensed Psychologist (Doctoral Level)
- Licensed Social Worker (Master’s level)
- Licensed Marriage and Family Therapist (Master’s or Doctoral level)
- Licensed Professional Counselor (Master’s or Doctoral level),
- Limited Licensed Psychologist (Master’s or Doctoral Educational level) (LLPs) under the supervision of an enrolled, fully licensed psychologist (except as noted in Section 333.18223 of the Public Health Code).

These practitioners are required to be currently licensed by the Department of Licensing and Regulatory Affairs (LARA), enroll as Medicaid providers, and be uniquely identified on all claims. (Refer to the Billing & Reimbursement for Professionals Chapter for billing information.)

LLPs must enroll as Rendering/Service Only providers and associate themselves to at least one Billing Provider within CHAMPS. Associated Billing Providers may be either employers or organizations the LLP is contracted with to perform services (i.e., Community Mental Health Services Programs [CMHSPs], Prepaid Inpatient Health Plans [PIHPs]).

Non-physician behavioral health services may also be performed by any of the following provider types under the supervision of an enrolled, fully licensed provider of the same profession:

- Temporary Limited License Psychologist (Master’s or Doctoral Level)
- Educational or Temporary Limited License Social Worker, Marriage and Family Therapist, or Professional Counselor
- Student Intern. A student intern is an individual who is currently enrolled in a health profession training program for psychology, social work, counseling, or marriage and family therapy that has been approved by the appropriate board, is performing the duties assigned in the course of training, and is appropriately supervised according to the standards set by the appropriate board and the training program. Social work student interns must be pursuing a Master’s degree in social work and be supervised by a Licensed Master’s Social Worker in a manner that meets the requirements of a Council on Social Work Education (CSWE) accredited education program curriculum that prepares an individual for licensure.

These temporary or educational limited licensed providers or student interns are not eligible to enroll or be directly reimbursed by Medicaid. Services should be billed to Medicaid under the National Provider Identifier (NPI) of the supervising provider.

Supervision is defined by Section 333.16109 of the Public Health Code (Act 368 of 1978) when required. **(text revised per bulletin MSA 20-02)**



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To comply with 42 CFR 431.110, licensed health professionals employed by a Tribal Health Program must be licensed in good standing in at least one state, but do not need to be licensed in the state where they are practicing. This Federal regulation supersedes any licensing requirements of individual states.



SECTION 3 – COVERED SERVICES [CHANGE MADE 7/1/20]

Medicaid beneficiaries who are not enrolled in a Medicaid Health Plan, and whose needs do not render them eligible for specialty services and supports through the PIHPs/CMHSPs, may receive outpatient mental health services through the Medicaid Fee-for-Service (FFS) program. Providers should refer to the Beneficiary Eligibility subsection in the General Information section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter for information on which services are covered by Medicaid FFS. FFS non-physician behavioral health services are covered when performed in a non-facility setting or outpatient hospital clinic and provided within their specific profession's scope of practice guidelines as defined by State law. **(revised per bulletin MSA 20-02)**

Services covered by the PIHPs/CMHSPs are available and reimbursed through the PIHP/CMHSP.

Providers should refer to the Medicaid Code and Rate Reference tool and the Non-Physician Behavioral Health Provider fee schedule on the MDHHS website for the current list of covered procedure codes. The list of allowable services is reviewed annually and updated as applicable.



SECTION 4 – TELEMEDICINE

Behavioral health services may be delivered via telemedicine in accordance with current Medicaid policy. In compliance with the Michigan Insurance Code of 1956 (Act 218 of 1956), telemedicine services must be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in his or her health care profession in the state where the patient is located. Refer to the Practitioner Chapter for additional information regarding telemedicine services.



SECTION 5 – CLAIMS PROCESSING AND REIMBURSEMENT AMOUNTS [CHANGES MADE 4/1/20 & 7/1/20]

Information regarding claims processing is available in the Billing & Reimbursement for Professionals chapter of this manual.

Licensed Psychologist (Doctoral level), Licensed Social Worker (Master’s level), Licensed Marriage and Family Therapist (Master’s or Doctoral level), or Licensed Professional Counselor (Master’s or Doctoral level) behavioral health professionals may receive direct reimbursement for Medicaid covered services.

Limited License Psychologists (LLPs) (Master’s and Doctoral Educational level) are not eligible to be directly reimbursed by Medicaid and must associate themselves to at least one billing provider within CHAMPS. LLP services requiring supervision and billed on a professional claim form must include the NPI of the LLP in the Rendering Provider field and the NPI of the Medicaid enrolled supervising Licensed Psychologist in the Supervising Provider field.

All temporary limited licensees, educational limited licensees other than Doctoral Educational Limited License Psychologists, and student interns are not eligible to be directly reimbursed by Medicaid. Services should be billed to Medicaid under the NPI of the supervising provider. The supervising provider must be listed as the Rendering Provider on the claim. **(text added per bulletin MSA 20-02)**

Non-physician behavioral health payment rates are established by MDHHS as a fee screen for each procedure. **(text deleted 4/1/20)** Services performed by non-physician behavioral health providers are reimbursed at a percentage of the Medicaid practitioner fee schedule rate. **(revised 4/1/20)** Refer to the Medicaid Non-Physician Behavioral Health fee schedule or the Community Health Automated Medicaid Processing System (CHAMPS) Medicaid Rate and Reference tool for additional information. The fee schedule is reviewed and updated at least annually.



CHILDREN’S SPECIAL HEALTH CARE SERVICES

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SECTION 1 – GENERAL INFORMATION [CHANGE MADE 10/1/20]

CSHCS is mandated by the Michigan Public Health Code, Public Act 368 of 1978, Part 58, children and youth with special health care needs (MCL 333.5801 – 333.5879), in cooperation with the federal government under Title V of the Social Security Act, Sec. 501. [42 U.S.C. 701] (a) 1 (D) and the annual Michigan Department of Health and Human Services (MDHHS) Appropriations Act. **CSHCS is (revised 10/1/20)** a separate program from Medicaid.

However, CSHCS partners closely with the Medicaid program regarding the use of the Medicaid system. This allows for greater efficiency in administering the two programs and allows both programs to collaborate on the care of a beneficiary to avert duplication of services. CSHCS does not pay for Medicaid-covered services that have been denied by Medicaid.

CSHCS is charged by the Social Security Act, Title V, Maternal and Child Health Office with promoting the development of systems of care that are family-centered, community-based, coordinated, and culturally-competent with a focus on health equity. CSHCS strives for having the most appropriate pediatric subspecialists and services that are identified by combining the family's expertise regarding their child and the condition, the medical services provider, MDHHS medical expertise, and CSHCS policy and program intent.

CSHCS increases access to resources and supports for the families and beneficiaries. Services occur in partnership, recognizing the family as the constant in the child's life. The goal is to reduce or eliminate barriers that are inherent to the condition. This, in turn, is intended to increase the quality of life for the beneficiary and the family. This family-centered approach impacts the level of independence most beneficiaries are able to achieve.

CSHCS identifies children with special health care needs when the child appears to have a condition that CSHCS may cover. CSHCS does not cover behavioral, developmental or mental health conditions. The child's pediatric subspecialist submits medical reports to CSHCS for determination of medical eligibility. When the child does not have a pediatric subspecialist and there is no other option to obtain a medical report (i.e., private insurance, Medicaid, etc.), CSHCS pays for a diagnostic evaluation of medical conditions that are likely to be covered by CSHCS. The beneficiary may be diagnosed with a CSHCS covered condition, which is the first step toward CSHCS eligibility but is not the only criterion. The condition must also meet chronicity, medical severity criteria, and the need for treatment by a pediatric subspecialist before the beneficiary can be determined medically eligible for CSHCS. Unlike other programs, there are no financial criteria that would limit eligibility for CSHCS. Eligibility is determined based upon medical circumstances and not on financial circumstances. Medical eligibility (and allowable citizenship/permanent residency status) must be established by MDHHS before the beneficiary can enroll in CSHCS.

Once enrolled, CSHCS covers pediatric specialty medical treatment (adult specialty for the few enrolled adults) related to the qualifying condition. Care is limited to the qualifying diagnosis and related conditions. The limitation occurs by authorizing particular specialty providers for each child and having the authorized provider(s) order additional services, such as therapies, lab tests, etc., as needed as related to their specialty. Providers who are not CSHCS-authorized are not eligible for reimbursement. CSHCS does not cover primary care or condition-related care delivered by a primary care provider.



NOTE: CSHCS and Medicaid interface – CSHCS follows Medicaid policy except where specified in this chapter. Many of the CSHCS processes (e.g., prior authorizations, medical determinations, claims, etc.) are integrated into the Medicaid system and processes for CSHCS beneficiaries.

CSHCS strives to enroll CSHCS beneficiaries into Medicaid when they are eligible in order to access the broader range of medical services that are covered by Medicaid.

CSHCS also partners with Medicaid when beneficiaries have both CSHCS and Medicaid. Most beneficiaries who also have Medicaid are required to enroll with a Medicaid Health Plan. Under this situation, medical coverage is subject to the Medicaid rules. CSHCS can, at times, provide additional services beyond what is available through the Medicaid benefit package. These services include care coordination, the development of a plan of care in which the family participates, referral to appropriate medical providers, and assistance with locating, accessing, and navigating community support services, etc.



SECTION 2 – CSHCS PROVIDERS: APPROVED/AUTHORIZED

In addition to enrollment with the Michigan Medicaid Program, physicians and hospitals serving beneficiaries must meet criteria to serve as a CSHCS specialty care provider. The criteria are detailed in the CSHCS Approved Providers subsection below.

All providers must comply with Medicaid policies and requirements, including prior authorization requirements described elsewhere in this manual.

For beneficiaries without Medicaid/MiChild/Healthy Michigan Plan coverage, approved physicians and/or hospitals (including hospital-owned ambulance and hospice agencies) must also be authorized by CSHCS to provide medical services related to the beneficiary's CSHCS qualifying condition. (Refer to the CSHCS Authorized Providers subsection for authorization requirements.)

2.1 CSHCS APPROVED PROVIDERS

2.1.A. PHYSICIANS

Physicians desiring to be CSHCS approved specialty care providers must:

- Be licensed to practice as a doctor of medicine (MD) or osteopathy (DO) by the state where the service is performed.
- Have successfully completed medical residency.
- Possess Specialty Board Certification. (Board eligible physicians in the process of completing certification requirements may be provisionally approved.)
- Be enrolled in the Michigan Medicaid program. (Refer to the General Information for Providers Chapter of this manual for additional information.)
- Have clinical privileges in a CSHCS approved hospital/facility.
- Have documented clinical training or experience with children who have diagnoses eligible for CSHCS services. A physician not having experience treating infants and young children may be conditionally approved to supervise the care of children over 12 years of age.

2.1.B. HOSPITALS

Hospitals desiring to be CSHCS approved must:

- Be enrolled in the Michigan Medicaid program (refer to the General Information for Providers Chapter of this manual for additional information);
- Have an organized Pediatrics Unit with an average daily census of six (6) or greater; and
- Have a Pediatrics Department identified in the medical staff structure.



Exceptions:

- Local laboratory and/or local imaging services ordered by the CSHCS subspecialist during the hospital visit and emergency care are not required to meet the organized Pediatrics Unit requirement, as stated above.
- Emergency services do not require an order by the CSHCS subspecialist.

2.2 CSHCS AUTHORIZED PROVIDERS

The following requirements apply only to providers serving CSHCS beneficiaries who do not also have Medicaid/MICHild/Healthy Michigan Plan coverage:

- An authorized provider is an approved physician and/or hospital that is specifically identified on the CSHCS system as a provider for a specific beneficiary. (Refer to the CSHCS Approved Providers subsection for participation requirements.)
- CSHCS authorization of a provider is the step that allows for reimbursement for medical services rendered that are related to the CSHCS qualified condition(s).
- To become CSHCS authorized for a specific beneficiary, the family or the provider contacts the county health department in which the beneficiary lives.

Providers serving beneficiaries with CSHCS who also have Medicaid/MICHild/Healthy Michigan Plan coverages do not need to be authorized.

2.3 PROVIDERS WHO DO NOT NEED TO BE CSHCS AUTHORIZED

Non-physician providers typically do not need CSHCS authorization to render services to a beneficiary (except for hospital-owned ambulances and hospice agencies).

These providers may render services (and be reimbursed) when ordered or prescribed by a CSHCS authorized provider and the services are related to the beneficiary's CSHCS qualifying diagnosis.

The National Provider Identifier (NPI) number of the CSHCS authorized ordering or prescribing provider must be entered in the appropriate field on the claim.

2.4 VERIFYING PROVIDER AUTHORIZATION

Authorized provider and diagnosis information can be obtained from the beneficiary's Client Eligibility Notice. The CHAMPS Eligibility Inquiry and/or HIPAA 270/271 transaction will also indicate if the inquiring provider NPI number is authorized to render CSHCS services for the beneficiary on that date of service. Providers will receive the Benefit Plan ID of CSHCS along with one of the following messages in the eligibility response:

- This NPI is listed. See CSHCS guidelines.
- This NPI is not listed. See CSHCS guidelines.

(Refer to the Verifying Beneficiary Eligibility section of the Beneficiary Eligibility chapter for additional information.)



2.5 CHILDREN'S MULTI-DISCIPLINARY SPECIALTY (CMDS) CLINIC REQUIREMENTS

CMDS clinics are required to operate under the authority of hospitals or medical universities. Hospitals and medical universities requesting CMDS clinic designation must adhere to the requirements as stated in this policy and acquire approval and oversight from the CSHCS program. Hospitals and medical universities that administer CMDS clinics require a separate National Provider Identifier (NPI) number with which to enroll and submit claims specifically for the CMDS clinic fee.

CSHCS-approved organizations with responsibility for CMDS clinics must enroll through the online MDHHS CHAMPS Provider Enrollment (PE) subsystem to be reimbursed for clinic fees for services rendered to eligible beneficiaries. Each CMDS clinic must operate under the unique CMDS National Provider Identifier (NPI) held by the organization responsible for those CMDS clinics and must identify the providers who render the services in the CMDS clinic as affiliated providers. All affiliated providers whose services are directly reimbursable per MDHHS policy must be separately enrolled in CHAMPS and must also receive a beneficiary-specific authorization from CSHCS prior to the clinic billing for the clinic fees.

Refer to the General Information for Providers chapter for additional provider enrollment information.



SECTION 3 – MEDICAL ELIGIBILITY

CSHCS covers over 2,700 medical diagnoses that are handicapping in nature and require care by a medical or surgical subspecialist. A current list of covered diagnoses is maintained on the MDHHS website. (Refer to the Directory Appendix for website information.) Diagnosis alone does not guarantee medical eligibility for CSHCS. To be medically eligible, the individual must:

- Have at least one of the CSHCS qualifying diagnoses.
- Be within the age limits of the program:
 - Under the age of 21; or
 - Age 21 and above with cystic fibrosis or hereditary coagulation defects commonly known as hemophilia.
- Meet the medical evaluation criteria during the required medical review period as determined by a MDHHS medical consultant regarding the level of severity, chronicity and need for treatment. (Refer to the Medical Renewal Period subsection of the Coverage Period Section of this chapter.)

A MDHHS medical consultant conducts the medical determination by reviewing the written report of a physician subspecialist. The medical information may be provided to CSHCS in the form of a comprehensive letter, hospital consultation or summary, or the Medical Eligibility Report Form (MERF) (MSA-4114). (A copy of the form is available in the Forms Appendix.) Medical information is reviewed in the context of current standards of care, as interpreted by a MDHHS medical consultant. All of the criteria described below must be met for the individual to be considered medically eligible:

Diagnosis	The individual must have a CSHCS qualifying diagnosis where his activity is or may become so restricted by disease or other medical condition as to reduce his normal capacity for education and self-support. Psychiatric, emotional and behavioral disorders, attention deficit disorder, developmental delay, intellectual disability, autism, or other mental health diagnoses are not conditions covered by the CSHCS Program.
Severity of Condition	The severity criteria is met when it is determined by the MDHHS medical consultant that specialty medical care is needed to prevent, delay, or significantly reduce the risk of activity becoming so restricted by disease or other medical condition as to reduce the individual’s normal capacity for education and self-support.
Chronicity of Condition	A condition is considered to be chronic when it is determined to require specialty medical care for not less than 12 months.
Need for Treatment by a Physician Subspecialist	The condition must require treatment by a medical and/or surgical subspecialist at least annually, as opposed to being managed exclusively by a primary care physician.



CSHCS covers diagnostic evaluations for individuals when symptoms and history indicate the possibility of a CSHCS qualifying condition but the appropriate medical information cannot be obtained from their current provider(s). Diagnostic evaluations are to determine whether an individual meets the medical eligibility criteria for CSHCS, not for providing treatment. The local health department (LHD) assists in obtaining these diagnostic evaluations. Treatment is not a CSHCS benefit until a qualifying diagnosis is established and the individual has enrolled in the CSHCS Program. Individuals currently enrolled in a commercial Health Maintenance Organization (HMO), Medicaid Health Plan (MHP), or with other commercial insurance coverage must seek an evaluation by an appropriate physician subspecialist through the network of the respective health plan or health insurance carrier to provide medical documentation of a CSHCS qualifying diagnosis.

Medical information submitted for the purpose of renewing CSHCS eligibility is generally considered current when it is no more than 12 months old. Initial determination of medical eligibility may require reports that are more current to document the individual's current medical status.

Covered medical diagnostic categories include, but are not limited to:

- Cardiovascular Disorders
- Certain chronic conditions peculiar to newborn infants
- Congenital anomalies
- Digestive Disorders
- Endocrine Disorders
- Genito-Urinary Disorders
- Immune Disorders
- Late effects of injuries and poisonings
- Musculoskeletal Disorders
- Neoplastic Diseases
- Neurologic Disorders
- Oncologic and Hematologic Disorders
- Respiratory Disorders
- Special Senses (e.g., vision, hearing)

CSHCS does not cover acute/specialty care that is not related to the CSHCS qualifying diagnosis. CSHCS also does not cover mental health care, primary care, well child visits, or immunizations. Examples of diagnoses, conditions or procedures not covered include, but are not limited to:

- Acne
- Allergies, without anaphylaxis
- Anorexia Nervosa
- Appendicitis
- Attention Deficit Disorder
- Autism
- Behavioral Problems
- Bronchitis (acute), croup
- Childhood Illnesses (measles, mumps, chicken pox, scarlet fever, etc.)
- Cosmetic Surgery
- Depression
- Developmental Delay
- Headache, migraines
- Hernia (inguinal or umbilical)
- In utero treatment
- Pneumonia
- Refractive Errors and Astigmatism
- Sinusitis
- Tonsillitis, strep throat



SECTION 4 – APPLICATION PROCESS

When the MDHHS medical consultant determines the individual is medically eligible for CSHCS, MDHHS sends the individual a Children’s Special Health Care Services Application (MSA-0737). The individual must complete the application and return it to MDHHS to be considered for enrollment in the program. (Refer to the Directory Appendix for contact information.) Applications submitted by the family cannot be processed until medical eligibility has been determined by MDHHS.

Applications must be signed by the medically eligible individual (when legally responsible for self) or the person(s) who is legally responsible for the individual. Verification of court-appointed guardianship may be required.

Stepparents are not considered the legally responsible persons to sign the application unless the stepparent is in the legal process of adopting the child or is the child’s court-appointed guardian.

The application must be completed and submitted to MDHHS as directed on the application form. MDHHS will notify the individual by mail if the application is incomplete and cannot be processed. The individual has 30 calendar days from the date of the MDHHS letter to submit the required information in order to preserve the initial coverage date. Failure to submit the required information within the required time frame may result in the coverage date being delayed.

When a medical report is submitted to CSHCS on behalf of a beneficiary with full Medicaid, MICHild or Healthy Michigan Plan coverage, and the CSHCS medical consultant determines that the beneficiary is medically eligible for CSHCS, the beneficiary is automatically enrolled in CSHCS without completing the CSHCS application.



SECTION 5 – FINANCIAL DETERMINATION

MDHHS reviews the CSHCS Income Review/Payment Agreement (MSA-0738) submitted by all* individuals to evaluate the family/individual financial resources. The review serves to:

- Determine whether the family/individual income is sufficient to establish a payment agreement to pay toward the costs of the medical care received through CSHCS.
- Aid in identifying additional services or benefits for which the family/individual may be eligible.

5.1 FINANCIAL DETERMINATION PROCESS

Families/individuals are exempt from a payment agreement if at least one of the following applies:

- The beneficiary to be covered has full Medicaid coverage or is enrolled in MICHild or the Healthy Michigan Plan;
- The beneficiary is a ward of the county or state;
- The beneficiary lives in a foster home or a private placement agency;
- The beneficiary has a court-appointed guardian; or
- The beneficiary is deceased (retroactive coverage).

When more than one individual in the family is applying for CSHCS coverage, or already has CSHCS coverage, each individual must be determined exempt as indicated above for the family to be exempt. When any individual in the family fails to meet the exemption criteria, the family will have a payment agreement.

The MSA-0738 must be completed and submitted, when applicable, either indicating the family/individual status is exempt from a payment agreement, or with the responsible party's income and family size as reported on the federal income tax return (Form 1040, 1040A, or 1040EZ) from the previous year. If no federal income tax return is available, families may contact the local health department (LHD) or the CSHCS Family Phone Line for further assistance. (Refer to the Directory Appendix for contact information.)

5.2 VERIFICATION OF INCOME

Families/individuals self declare income at the time of CSHCS application and renewal. Periodic reviews of randomly selected family/individual financial documentation are conducted. When the information submitted is problematic to completing the payment participation determination, or when a family/individual is randomly selected for verification of income, their federal income tax return may be requested. When the federal income tax return is not available, the family/individual may contact the LHD or CSHCS Family Phone Line for further assistance. (Refer to the Directory Appendix for contact information.)

* Individuals determined medically eligible based on documentation submitted by their Medicaid Health Plan (MHP) are not required to submit the MSA-0738 as MHP enrollment is pre-verification of Medicaid coverage resulting in exemption from a payment agreement.



5.3 PAYMENT AGREEMENT

CSHCS is required to determine a family's/individual's ability to pay toward the cost of the individual's care through the financial determination process. Those determined to be exempt from payment participation, as described in the Financial Determination Process subsection, are not required to pay toward the cost of care covered by CSHCS. The family/individual payment amount is established based on the income and family size reported by the responsible party on their most recent federal income tax return as indicated on the CSHCS Payment Agreement Guide (MSA-0738-B). The income is applied to a tiered scale to determine the amount of the payment agreement. The MSA-0738-B is updated at least annually.

Financial reviews occur and new payment agreements are redetermined annually and implemented (if still applicable) according to the beneficiary's CSHCS coverage period.

The MSA-0738 must be signed by the responsible party for CSHCS coverage to be implemented. The amount of the payment agreement is the total family/beneficiary financial obligation for one year, regardless of the number of family members with CSHCS coverage. The total amount of the financial obligation is due upon receipt of the payment agreement notification. The family/beneficiary is responsible for the total amount even if CSHCS coverage ends. Payments are non-refundable.

Beneficiaries who acquire full Medicaid, MICHild, or Healthy Michigan Plan coverage after enrollment into CSHCS will be reimbursed in full for any money paid toward the payment agreement that is in place for the current CSHCS coverage period. Unpaid balances may be forgiven and CSHCS coverage continued when the beneficiary has acquired full Medicaid, MICHild, or Healthy Michigan Plan coverage. Beneficiaries can call the local health department or the CSHCS Family Phone Line to request assistance with the CSHCS payment agreement. (Refer to the Directory Appendix for contact information.)

When death of a beneficiary occurs during the beneficiary's CSHCS coverage period, a notice is sent to the family that the unpaid balance is forgiven. When the family notifies MDHHS that the payment agreement has been paid ahead, in part or in full, MDHHS pro-rates the monthly amount related to the coverage period for which the beneficiary is no longer covered due to death. The family is reimbursed the pro-rated amount. When death of a beneficiary occurs and one or more of the surviving family members have CSHCS coverage, the payment agreement remains intact for the remaining family members.

A family/beneficiary may have no more than two outstanding years of incomplete or unpaid payment agreements. The family/beneficiary will not receive CSHCS coverage under a third year of a payment agreement until the oldest payment agreement obligation has been met.

When the beneficiary reaches the age of majority, or otherwise becomes emancipated, outstanding payment agreements remain with the family who entered into the original agreement. When a beneficiary acquires Medicaid, MICHild, or Healthy Michigan Plan coverage after the beneficiary reaches the age of majority, the current payment agreement entered into by the family while the beneficiary was a minor does not qualify for forgiveness of balance or return of money. The income of the legally independent beneficiary is not assessed for a payment agreement until the beneficiary's next CSHCS renewal period.



SECTION 6 – OTHER ELIGIBILITY CONSIDERATIONS

6.1 CITIZENSHIP STATUS

The individual, parent of a minor, or court-appointed guardian of the individual must be a citizen of the U.S., a noncitizen lawfully admitted for permanent residence, or a lawfully admitted migrant farm worker (i.e., temporary agricultural worker). Any individual born in the United States who meets all other program eligibility criteria is deemed eligible regardless of the citizenship status of the parents/court-appointed guardian.

- Noncitizens who have been granted admission to the U.S. for a temporary or specific period of time are not eligible for CSHCS coverage other than as specified below.
- MDHHS requires a statement of citizenship status from the family if the information is unclear from the application.
- MDHHS may request verification of citizenship or permanent resident status.

There are some exceptions by the U.S. Citizenship and Immigration Services (USCIS) that allow legal status for individuals with specific reasons for nonpermanent entry in the U.S who are recognized as potentially eligible for full Medicaid coverage (as opposed to Emergency Services Only coverage). CSHCS recognizes the same individuals for coverage when all other CSHCS qualifying criteria are met.

6.2 RESIDENCY

The individual, parent, court-appointed guardian, or foster parent of the individual must be:

- A Michigan resident(s); or
- Working or looking for a job in Michigan, and living in Michigan (including migrant status); or
- In Michigan with the clear intent to make Michigan their home.

A Michigan resident who is temporarily absent from the state (e.g., out-of-state college attendance, member of a family stationed out-of-state for military service, or other extenuating circumstances allowed by MDHHS) and agrees to return to Michigan at least annually for subspecialty medical treatment of the qualifying diagnosis(es) meets the criteria for residency.

CSHCS does not issue or maintain coverage when the individual is known to be out-of-state (except for the circumstances listed above) even if the parent, court-appointed guardian or foster parent meets the criteria for residency.

CSHCS does not issue or maintain coverage when the individual is known to reside in a long term care facility whose rate of payment includes medical care and treatment (e.g., nursing facility, ICF/IID, inpatient psychiatric hospitals, etc.). The individual can re-apply for CSHCS coverage or have CSHCS coverage reinstated when the living arrangement changes and all other eligibility criteria are met.



SECTION 7 – EFFECTIVE DATE

The effective date of CSHCS coverage is dependent upon the date of the event that medically qualifies the individual for CSHCS. The CSHCS begin date is the first day of the month of this qualifying event, and may be retroactive up to six (6) months from the date MDHHS receives all necessary documentation that results in a final determination of CSHCS eligibility.

When application information is missing, the individual has 30 days from the date of the letter sent from MDHHS requesting the missing information to submit* the information in order to preserve the initial effective date of coverage. If the information is not submitted within 30 days, the effective date of coverage may be retroactive up to six (6) months from the date the required information has been submitted. Retroactive coverage does not guarantee that providers of services already rendered will accept CSHCS payment.

CSHCS does not reimburse families directly for payments made to providers.

Families/individuals are required to provide complete and accurate information at the time of application and as circumstances change. At a minimum, changes in address and insurance must be reported as they occur.

* Submission date is considered the date the document is received by CSHCS.



SECTION 8 – COVERAGE PERIOD

Upon completion of the application or renewal process requirement (as specified below), CSHCS coverage is typically issued in 12-month increments.

Families/beneficiaries are required to provide updated financial information during the annual renewal of the coverage period to determine financial participation with the CSHCS Program. Those with Medicaid, MICHild, or Healthy Michigan Plan coverage are determined complete in the annual financial review each year those circumstances remain true. Beneficiaries are requested to provide updated information during the annual renewal of the coverage period regarding current providers, address, other insurance, etc.

Beneficiaries are required to apply for MICHild/Healthy Kids/Healthy Michigan Plan coverage when the Income Review/Payment Agreement (MSA-0738) indicates the beneficiary may be eligible for one of these programs based on age and family income. The Income Review/Payment Agreement is submitted at the time of the initial CSHCS application or renewal (refer to the Payment Agreement subsection). A CSHCS temporary eligibility period (TEP) of 90 days is activated to allow the family time to complete the MICHild/Healthy Kids/Healthy Michigan Plan application process.

Upon notification that the family has completed the MICHild/Healthy Kids/Healthy Michigan Plan application process, CSHCS coverage is extended to complete the full 12-month enrollment period from the initial coverage date (begin date of the TEP), regardless of the MICHild/Healthy Kids/ Healthy Michigan Plan eligibility decision. CSHCS coverage terminates at the end of the 90-day TEP if the family fails to submit the application for one of these programs.

All coverage periods end on the last day of a month, or the beneficiary's 21st birthday if the beneficiary does not have a qualifying diagnosis that is covered beyond age 21.

8.1 MEDICAL RENEWAL PERIOD

The CSHCS medical renewal period is established at one year, two years, three years, or five years, depending upon the CSHCS primary diagnosis. Medical reports for renewal of coverage (refer to the Renewal of Coverage subsection within this section) are required consistent with the timeframes indicated by the CSHCS medical renewal period.

When the beneficiary has more than one CSHCS qualifying diagnosis, the diagnosis determined by MDHHS to be primary is used to determine the time interval for required medical information to be submitted for all covered diagnoses. This results in a single periodic medical review process per beneficiary. When the medical review process results in the elimination of one of the qualifying diagnoses while maintaining another diagnosis, the new coverage period is based on the timeframe associated with the new primary diagnosis.

Example: Beneficiary has three diagnoses, each related to a different medical review period. All new medical information is required according to the medical renewal time period of the primary diagnosis.

A change of primary diagnosis during the medical renewal period does not change the time period unless and until the current medical renewal period has been completed and a new one is established.



8.2 PARTIAL MONTH COVERAGE

If a beneficiary enters or leaves a facility that is not a covered facility (e.g., nursing facility, or intermediate care facility) during a month of eligibility, the beneficiary remains a beneficiary for the remainder of that month. However, services provided to the beneficiary while in the facility are not covered (i.e., reimbursable) by CSHCS as these facilities are responsible for providing the medical care. (Refer to the General Information for Providers Chapter in this manual for additional information for beneficiaries who also have Medicaid coverage.)

8.3 RENEWAL OF COVERAGE

The beneficiary's coverage may be renewed as needed if all eligibility criteria continue to be met and the family completes the renewal process. Medical review reports are required according to the timeframes established based on the primary diagnosis for the beneficiary. An annual financial review is also required. If all of the criteria continue to be met for CSHCS coverage, a new coverage period is typically issued in 12-month increments.



SECTION 9 – BENEFITS

CSHCS covers services that are medically necessary, related to the beneficiary’s qualifying diagnosis(es), and ordered by the beneficiary’s CSHCS authorized specialist(s) or subspecialist(s). Services are covered and reimbursed according to Medicaid policy unless otherwise stated in this chapter.

The primary CSHCS benefits may include:

- Ambulance
- Care Coordination*
- Case Management*
- Dental (Specialty and General)
- Dietary Formulas (limited)
- Durable Medical Equipment (DME)
- Emergency Department (ED)
- Hearing and Hearing Aids
- Home Health (intermittent visits)
- Hospice*
- Hospital at approved sites (Inpatient/Outpatient)
- Laboratory Tests
- Medical Supplies
- Monitoring Devices (Nonroutine)
- Office Visits to CSHCS Authorized Physicians
- Orthopedic Shoes
- Orthotics and Prosthetics
- Parenteral Nutrition
- Pharmacy
- Physical/Occupational/Speech Therapy
- Radiological Procedures
- Respite*
- Telemedicine
- Transplants and Implants
- Vision

(* Refer to the information and authorization requirements stated in this Section.)

Private Duty Nursing (PDN) may be available for beneficiaries who also have Medicaid coverage.

9.1 SPECIALTY DENTAL BENEFITS

Specialty dentistry refers to services that are not covered under the Medicaid dental benefit but are covered for CSHCS enrollees who have a qualifying diagnosis that may include specialty dental services. Services include, but are not limited to, dental implants, orthodontia and specialty crown and bridge. All CSHCS beneficiaries do not qualify for specialty dental services. Qualification for specialty dental services is based on the specific diagnoses and treatment plan. Examples of CSHCS diagnoses that may qualify for specialty dental services include:

- Amelogenesis imperfecta, Dentinogenesis imperfecta



- Anodontia which has significant effect on function
- Cleft palate
- Ectodermal dysplasia, epidermolysis bullosa with significant tooth involvement
- Juvenile periodontosis
- Juvenile rheumatoid arthritis and related connective tissue disorders with jaw dysfunction secondary to temporomandibular joint arthritic involvement
- Post-operative care related to neoplastic jaw disease
- Severe malocclusion requiring orthognathic surgery
- Severe maxillofacial or craniofacial anomalies that require surgical intervention
- Traumatic injuries to the dental arches

To request approval as a CSHCS Specialty provider, dentists must contact MDHHS. (Refer to the Directory Appendix for contact information.)

9.2 GENERAL DENTAL BENEFITS

General dentistry refers to services covered under the Medicaid dental benefit that may be covered for CSHCS enrollees who have a qualifying diagnosis that includes general dental services. Examples include, but are not limited to, diagnostic, preventive, restorative, endodontia, prosthodontia, and oral surgery. MDHHS may determine a beneficiary eligible for certain general dentistry services when the CSHCS qualifying diagnosis is related to conditions eligible for this coverage as identified below:

- Chemotherapy or radiation which results in significant dental side effects
- Cleft lip/palate/facial anomaly
- Convulsive disorders with gum hypertrophy
- Cystic Fibrosis
- Hemophilia and/or other coagulation disorders
- Pre- and post-transplant

To request approval as a CSHCS General Dentistry provider, dentists must contact MDHHS. (Refer to the Directory Appendix for contact information.)

NOTE: Hospital charges (e.g., general anesthesia, facility charges, etc.) may be covered for dental services provided through the inpatient or outpatient hospital facility for beneficiaries with certain CSHCS diagnoses even though CSHCS does not cover the dental care itself.

9.3 CARE COORDINATION BENEFIT

Beneficiaries enrolled in CSHCS with identified needs may be eligible to receive Care Coordination services.

Care Coordination services may be provided by the local health department. LHD staff includes registered nurses (RNs), social workers, or paraprofessionals under the direction and supervision of RNs.



Staff must be trained in the service needs of the CSHCS population and demonstrate skill and sensitivity in communicating with children with special needs and their families.

Care Coordination is not reimbursable for beneficiaries also receiving Case Management services during the same LHD billing period, which is usually a calendar quarter. In the event Care Coordination services are no longer appropriate and Case Management services are needed, the change in services may only be made at the beginning of the next billing period.

Families/beneficiaries can contact the LHD for assistance in obtaining Care Coordination services.

9.4 CASE MANAGEMENT BENEFIT

Beneficiaries with either CSHCS, CSHCS and Medicaid, or Medicaid only (no CSHCS) may be eligible to receive Case Management services if they have a CSHCS medically eligible diagnosis, complex medical care needs and/or complex psychosocial situations which require that intervention and direction be provided by an outside, independent professional. LHDs or approved contractors may provide Case Management services. When there is additional training criteria required to perform a specific Case Management role based upon the service being provided (e.g., Elevated Blood Lead services), the provider of the service must be trained and certified, and services must be performed according to the training and requirements specific to that role. Case Management requires the development of a comprehensive plan of care (POC) which meets the minimum elements, as determined by MDHHS, and is monitored/revised as necessary. All services must relate to objectives/goals documented in the POC.

Case Management services address complex needs and services and include an initial face-to-face encounter with the beneficiary/family. Case Management requires that services be provided in the home setting or other non-office setting based on family preference. Beneficiaries are eligible for a maximum of six billing units per eligibility year. Services above the maximum of six require prior approval by MDHHS. To request approval, the Case Management provider must submit an exception request, including the rationale for additional services, to MDHHS. Limitations on the need for and number of Case Management service units are set by MDHHS and must be provided by a specific Case Management role, in accordance with training and certification requirements and as specified by the rules within that service type.

Each case manager must be licensed to practice as a registered professional nurse in the State of Michigan and be employed by or contracted with a LHD as a Public Health nurse at the entry level or above, or be able to demonstrate to MDHHS that comparable qualifications are met.

Case Management and Care Coordination services within a specific Case Management role cannot be billed during the same LHD billing period, which is usually a fiscal quarter.

Families/beneficiaries can contact the LHD for assistance in obtaining Case Management services.

9.5 HOSPICE BENEFIT

The CSHCS hospice benefit provides assistance to a family/beneficiary when end of life care related to the beneficiary's CSHCS qualifying diagnosis is appropriate. Hospice is intended to address the medical needs of the beneficiary with a terminal illness whose life expectancy is limited to six months or less.

Hospice services must be prior authorized. Prior authorization requests require medical documentation from the beneficiary's enrolled CSHCS subspecialist who is authorized (i.e., listed on the beneficiary's



CSHCS authorized provider file) to treat the terminal illness. The medical documentation must include all of the following:

- A statement of the terminal diagnosis.
- A statement that the beneficiary has reached the terminal phase of illness where the CSHCS subspecialist deems end of life care necessary and appropriate.
- Documentation of the need to pursue end of life care.
- A statement of limited life expectancy of six months or less.
- A proposed plan of care to address the service needs of the beneficiary that is:
 - less than 30 days old;
 - consistent with the philosophy/intent of the CSHCS hospice benefit as described above;
 - clinically and developmentally appropriate to the beneficiary's needs and abilities;
 - representative of the pattern of care for a beneficiary who has reached the terminal phase of illness; and
 - signed by the CSHCS subspecialist authorized to treat the terminal illness.

The prior authorization time period does not exceed six months. To continue hospice services beyond six months, a new prior authorization request with medical documentation must be submitted as described above.

Hospice may not be authorized and/or continued for a beneficiary when **one or more** of the following is true:

- The medical documentation no longer supports the above criteria (e.g., change in condition, change in the plan of care, etc.).
- The family chooses to discontinue hospice.
- The medical services being rendered by the hospice provider are available through another benefit.

Requests for hospice must be made in writing to CSHCS. (Refer to the Directory Appendix for contact information.) CSHCS responds to all prior authorization requests for hospice services in writing.

9.6 RESPITE BENEFIT

Respite services provide limited and temporary relief for families caring for beneficiaries with complex health care needs when the care needs require nursing services in lieu of the trained caregivers. Services are provided in the family home by hourly skilled and licensed nursing services as appropriate. To be eligible and authorized for respite, MDHHS must determine the beneficiary to have:

- Health care needs that meet the following criteria:
 - That skilled nursing judgments and interventions be provided by licensed nurses in the absence of trained and/or experienced parents/caregivers responsible for the beneficiary's care;



- That the family situation requires respite; and
- That no other community resources are available for this service.
- No other publicly or privately funded hourly skilled nursing services in the home that would be duplicated by the CSHCS respite benefit.
- Service needs which can reasonably be met only by the CSHCS Respite benefit, not by another service benefit.

Respite is reimbursed when provided by a Medicaid enrolled home health agency, a Medicaid enrolled registered nurse (RN) who is licensed to practice in the state of Michigan, or a Medicaid enrolled licensed practical nurse (LPN) who is licensed to practice in the state of Michigan and working under supervision according to the Michigan Public Health Code. It is the responsibility of the LPN to secure the appropriate supervision and maintain documentation that identifies the supervising professional.

A maximum of 180 hours of CSHCS Respite services may be authorized per family during the 12-month eligibility period. When there is more than one respite-eligible beneficiary in a single home, the respite service is provided by one nurse at an enhanced reimbursement rate for the services provided to multiple beneficiaries. Allotted respite hours may be used at the discretion of the family within the eligibility period. Unused hours from a particular eligibility period are forfeited at the end of that period and cannot be carried forward into the next eligibility period.

Beneficiaries receiving services through any of the following publicly funded programs and benefits are not eligible for the CSHCS Respite benefit:

- Private Duty Nursing Benefit
- Children's Waiver
- Habilitation Supports Waiver
- MI Choice Waiver

Requests for respite must be made in writing to MDHHS (refer to the Directory Appendix for contact information) and include the following information:

- The health care needs of the beneficiary;
- The family situation that influences the need for respite; and
- Other community resources or support systems that are available to the family (e.g., CMH services, MDHHS services, adoption subsidy, SSI, trust funds, etc.).

MDHHS responds to all requests for respite in writing.

9.7 INSURANCE PREMIUM PAYMENT BENEFIT

CSHCS may be able to assist in paying the beneficiary's portion of an insurance premium cost (as related to the CSHCS qualifying diagnosis) for private insurance, Medicare Part B, or Medicare Part D. Premium payment assistance may also be available when the beneficiary has lost or is about to lose insurance coverage. Depending on the timing of the event, CSHCS may be able to assist the family in reactivating or maintaining that coverage. The cost-effectiveness requirements described below always apply.



Premium payment assistance may be available when:

- The current cost of the premium payment is determined to be cost-effective for CSHCS. Cost-effectiveness is defined as when the cost of the insurance premium is less than the projected cost to CSHCS for covering the CSHCS-related care; and
- The family/beneficiary lacks sufficient financial resources to pay for the beneficiary's part of the premium. The lack of ability to pay the insurance premium is defined as follows:
 - When the family has an Income Review/Payment Agreement (MSA-0738) that is within the two lowest payment agreement categories, the financial need is automatically established.
 - When the family has an Income Review/Payment Agreement (MSA-0738) that is above the two lowest categories, the family must describe the reason for the lack of resources that is impacting the ability to pay for insurance. Examples include:
 - The additional out-of-pocket expenses to address only the special needs of the beneficiary(ies) is 10% or more of the gross family income. Documentation is required; or
 - The family income has dropped and a revised MSA-0738 still results in a payment agreement that is above the two lowest payment agreement categories but extenuating financial circumstances interfere with the family's ability to pay insurance premiums, etc. Documentation is required.

To apply for CSHCS insurance premium payment assistance, the following documents are required from all applicants:

- A completed Application for Payment of Health Insurance Premiums (MSA-0725);
- A copy of a billing statement from the insurance carrier or a statement from the employer or Notice of Medicare Premium Payment Due (CMS-500) that verifies the cost of the premium;
- Copies of previous Explanation of Benefits (EOB) statements or expenditure summaries over the past 12 months from the private health insurance carrier or Medicare; and
- A pharmacy report(s) documenting the cost of the prescriptions and the amount paid by the private health insurance carrier or Medicare, or written evidence that the coverage does not include a prescription benefit.

The following additional documentation is required under two specific circumstances:

- When the family obtained private insurance through the Federally Facilitated Marketplace (FFM) and has a subsidy, proof is required that the subsidy arrangement is the Advanced Premium Tax Credit. Any other subsidy through the FFM enrollment is not eligible for the insurance premium payment assistance; or
- A Consolidated Omnibus Budget Reconciliation Act (COBRA) Election Form is required if the beneficiary lost insurance coverage within three (3) months before application due to termination of employment, death of the policy holder, divorce, etc., and may be eligible for the insurance to remain in place due to COBRA.



The family/beneficiary may contact the Local Health Department CSHCS office to obtain and receive assistance in completing the MSA-0725.

9.7.A. EFFECTIVE DATE OF INSURANCE PREMIUM PAYMENT ASSISTANCE

When premium payment assistance has been approved, the effective date for the coverage is the first day of the month in which the MSA-0725 was received by CSHCS. Insurance premium payments are not covered retroactively for periods before the application was received.

NOTE: Retroactive assistance for premium payment is limited to a one-time-only event when:

- Existing insurance coverage is still active; and
- The private insurance will be terminated due to non-payment; and
- Termination will occur within 30 days of receipt of the MSA-0725 by CSHCS.

The assistance when approved for past coverage is applicable:

- For the beneficiary's portion of the unpaid premium; and
- If those payments will make it possible for the family to pay the remainder of back-payments; and
- When the family can maintain the insurance policy.

9.7.B. ANNUAL REVIEW FOR RENEWAL OF ELIGIBILITY

The MSA-0725 must be submitted each year. The annual eligibility review for continuing premium payment assistance occurs after CSHCS renewal has been completed based on program requirements at that time.

9.7.C. REQUIREMENT TO REPAY CSHCS FOR FUNDS EXPENDED ON TERMINATED POLICIES

In the event that an inappropriate premium payment has been sent to the family (either directly from MDHHS/CSHCS or as a refund to the family by the insurance company), the family is required to return those funds to CSHCS. CSHCS sends the family a letter requesting these funds be submitted to the state. If the funds are not submitted within 60 days from the date on the letter, the Michigan Department of Treasury may collect the funds from the family.

9.8 CHILDREN'S MULTI-DISCIPLINARY SPECIALTY (CMDS) CLINICS

Children's Multi-Disciplinary Specialty (CMDS) clinics provide a coordinated, interdisciplinary approach to the management of specified complex medical diagnoses. Services are provided as a comprehensive package by a team of pediatric specialty physicians and other appropriate health care professionals. When a beneficiary has more than one condition that could be served by more than one CMDS clinic, it is required that only one CMDS clinic assumes the care and coordination responsibility for the beneficiary. This will ordinarily be the responsibility of the CMDS clinic that serves the most complex diagnosis. The



CMDS clinic fees may only be reimbursed to one of the CMDS clinics if the beneficiary is utilizing the services of more than one CMDS clinic.

CMDS clinic services are reserved for those beneficiaries who have CSHCS and have at least one of the conditions for which CMDS clinics are available. Additional clinic information is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

9.8.A. EXPLANATION OF SERVICES

In addition to medical services, CMDS clinics provide:

- A single place and extended appointment for the family to be seen by their team of pediatric specialty providers as well as other appropriate health care professionals during each appointment;
- An environment where providers come to the family for the single appointment at the clinic as opposed to the family needing to set separate dates and times to go to each provider as in the usual service methodology;
- Same day, face-to-face care coordination by all of the providers who saw the beneficiary at each appointment allows for immediate discussion, negotiation, coordination and duty assignment. The family does not need to interpret information from one provider to the next which risks misunderstanding as in the usual service methodology;
- Development and upkeep of a coordinated and comprehensive plan of care (POC) and treatment for beneficiaries, including clear statements of current comprehensive assessment and ongoing treatment plans available to the entire team;
- Facilities that are tailored to the needs of children and their families; and
- Opportunities for the parent/beneficiary to participate in treatment planning, allowing for timely feedback and discussion of concerns with specialists and other health care professionals simultaneously when needed.

Services are provided as a comprehensive package by a team of pediatric specialty physicians and other appropriate health care professionals. CMDS clinic fees are not intended for sporadic users of the services available through CMDS clinics such as support services only. CMDS clinic fees are intended for the comprehensive, coordinated and integrated services that CMDS clinics provide to beneficiaries who return for and continue to use this full package of services.



9.8.B. CMDS CLINIC STAFF REQUIREMENTS

Each CMDS clinic must have the following basic staff available to provide the unique service delivery available through a CMDS clinic model:

Medical Director	A Medicaid-enrolled and CSHCS-approved physician currently licensed to practice under Michigan state law, with special training and demonstrated clinical experience related to the diagnoses followed by the specific CMDS clinic type. Physicians are expected to remain familiar with current developments and standards of treatment in their respective fields. If the medical director is not a pediatrician, a board certified pediatrician must be available and function within the scope of current medical practice.
Physician	A Medicaid-enrolled and CSHCS-authorized pediatric subspecialist, or adult subspecialist physician when serving adults, currently licensed to practice under Michigan state law with special training and demonstrated clinical experience related to the diagnoses treated by the specific CMDS clinic type. Physicians are expected to remain familiar with current developments and standards of treatment in their respective fields. Refer to the CMDS Clinic Guide, tables I and II, for subspecialty designations. The CMDS Clinic Guide is available on the MDHHS website. (Refer to the Directory Appendix for website information.)
Registered Nurse	A Registered Nurse (RN) currently licensed to practice under Michigan state law and having a minimum of two years of pediatric nursing experience or adult nursing experience when serving adults. Certain CMDS clinics are exempt from this requirement (e.g., the Metabolic Diseases CMDS clinics) as long as they have the appropriate additional staff as required in the CMDS Clinic Guide.
Registered Dietitian	A Registered Dietitian (RD) in possession of a master’s degree in human nutrition, public health, or a health-related field with an emphasis on nutrition, and two years of pediatric nutrition experience or adult nutrition experience when serving adults in providing nutrition assessment, education and counseling.
Social Worker	A Licensed Master Social Worker (LMSW) or professional staff member in possession of a master’s degree in social work and two years of experience in counseling and providing service to children/youth, adults and their families.
Parent/Guardian and/or Beneficiary	The parent/guardian and/or the beneficiary must be an actively participating team member in the development of the beneficiary’s comprehensive POC.
Additional Required Staff	Additional staffing requirements are based on clinic diagnosis type. Refer to the CMDS Clinic Guides on the MDHHS website for staffing requirements. (Refer to the Directory Appendix for website information.)

9.8.C. CMDS CLINIC VISIT TYPES

Beneficiaries with multiple, complex diagnoses may receive CMDS coordinated services from more than one CMDS clinic. However, the limits and numbers of CMDS clinic visit types indicate what the beneficiary is eligible to receive regardless of the number of CMDS clinics the beneficiary is accessing. Any CMDS clinic serving the beneficiary under the CMDS clinic process may submit claims for the appropriate clinic fee(s) up to the limit allowed per beneficiary. For example, there are 10 Support Visits allowed per beneficiary in a year. Any organization/clinic serving the beneficiary may bill for those support visits until the beneficiary limit has been reached. That might involve one CMDS clinic receiving reimbursement for all 10 of the Support Visits or a combination of CMDS clinics



receiving reimbursement for some visits until the limit has been reached. The CMDS clinics must document clinic visit levels to include the following:

- Support services must be indicated in the CMDS Plan of Care (POC) developed at a CMDS clinic Comprehensive Initial or Basic Evaluation visit or Management/Follow-up visit.
- The CMDS clinic must collaborate with other CMDS clinics the family/beneficiary may be using regarding which CMDS clinic is the lead CMDS clinic (usually treating the most severe condition) and how the fee billing will occur in coordination between the CMDS clinics that are both serving the same beneficiary.

9.8.C.1. INITIAL COMPREHENSIVE EVALUATION

The Initial Comprehensive Evaluation is performed during the CSHCS beneficiary's first visit to the CMDS clinic. The medical team integrates assessments and recommendations and works with the family/beneficiary in the development of a coordinated and comprehensive POC and treatment for the beneficiary. The CMDS POC is required to be recorded. The CMDS clinic will communicate the written CMDS POC to the appropriate health care providers and the family/beneficiary. Written CMDS POCs may be provided to other appropriate health care providers for whom the parent/guardian/beneficiary has signed a medical release form. A copy of the CMDS POC is to be submitted to CSHCS medical consultants for review.

An Initial Comprehensive Evaluation visit must include the following:

- Physician specialist(s) and non-physician professionals examination or assessment of the beneficiary and submission of an established/confirmed diagnosis(es), identification of strengths and needs and, with family/beneficiary input, development of a course of action or plan for treatment;
- Integration of findings and recommendations at team conferences;
- Discussion of the medical findings and treatment recommendations with family/beneficiary in language the family/beneficiary can comprehend;
- Designation of identified staff to teach the family/beneficiary how to assist in the management of the beneficiary's health problems if appropriate; and
- Compilation of an integrated CMDS POC from the findings of the various health care providers that includes:
 - relevant history;
 - medical findings by specialty;
 - problem areas that may develop and for which the beneficiary should receive care;
 - recommendations and prescriptions for braces, shoes, special equipment, medications, etc.;
 - referral to physical therapy, speech-language therapy, occupational therapy, public health nurse, CMDS support services; and
 - a description of how the CMDS POC will be implemented.



Authorization and processes may differ per health plans and Fee-for-Service (FFS).

Reimbursement for the Initial Comprehensive Evaluation fee occurs only once per beneficiary per lifetime regardless of the number of diagnoses and/or CMDS clinics from which the beneficiary may be receiving services. Medical services continue to be billed as usual.

9.8.C.2. BASIC AND ONGOING COMPREHENSIVE EVALUATION

Basic and ongoing comprehensive evaluation is conducted with established CMDS patients. The evaluation(s) may include the entire CMDS clinic staff composition or as deemed appropriate by each CMDS clinic Medical Director per visit and is documented in the CMDS POC.

A basic and ongoing comprehensive evaluation may include the following activities:

- Comprehensive beneficiary assessment;
- Evaluation and identification of the beneficiary's needs;
- Coordination of the beneficiary's multi-disciplinary needs;
- Review and modification of the comprehensive CMDS POC;
- Assured implementation and follow-up; and
- Referrals to other professionals, resources, and services as applicable.

Reimbursement for the Basic and Ongoing Comprehensive Evaluation fee is provided for a maximum of three (3) visits per beneficiary, per 12-month CSHCS eligibility year regardless of the number of diagnoses or CMDS clinics the beneficiary may have. Medical services continue to be billed as usual.

9.8.C.3. MANAGEMENT/ FOLLOW-UP VISITS

Management/follow-up visits to a CMDS clinic may be provided if they are recommended in the CMDS POC. In addition, a referral may be recommended based on a tertiary hospital inpatient discharge plan that was written within the previous 12 months of the referral. Every effort should be made to include all staff identified as participants in the CMDS POC or as recommended by the CMDS clinic Medical Director.

The management/follow-up visit may include:

- A physical exam by a pediatrician and/or physician subspecialist(s);
- Assessment by at least two of the clinic staff (in addition to the clinic physicians) designated for the clinic type;
- Follow-up on all components identified in the CMDS POC by appropriate staff;
- Update of condition and treatment, and revision of the CMDS POC; and
- Communication with the family/beneficiary, other providers, and other designated health care providers, including provision of copies of the CMDS POC to the family/beneficiary.



Reimbursement for the management/follow-up visit clinic fee is provided for a maximum of three (3) visits per beneficiary, per 12-month CSHCS eligibility year, regardless of the number of diagnoses or CMDS clinics the beneficiary may have. Medical services continue to be billed as usual.

9.8.C.4. SUPPORT SERVICE VISITS

CMDS clinics may provide support services. Services consists of counseling, specialized training, transition assistance and/or treatment. Support services must be ordered as part of the CMDS POC developed at a CMDS clinic Initial Comprehensive Evaluation, Basic and Ongoing Comprehensive Evaluation, and/or Management/Follow-up Visit.

CMDS clinic support services may be provided by any combination of one or more of the non-physician basic CMDS clinic staff to the family/beneficiary as outlined in the CMDS POC. Support services may be conducted by professional members of the team (i.e., nurses, dietitians, certified diabetes counselors, social workers or other clinical professional staff as appropriate). The presence of a physician is not required.

- The clinical encounter must be substantive with clinical information gathered, treatment recommendations provided, transition needs addressed and an update to the CMDS POC.
- The clinical content of the encounter is documented in the CMDS POC.

CMDS support service visits include and provide two different methods of delivery:

- Face-to-Face meetings between the appropriate clinic professional and the family/beneficiary; or
- Telephone meetings between the appropriate clinic professional and the family/beneficiary.

Reimbursement for support services clinic fees can be provided up to a maximum of ten (10) visits per beneficiary as a single method or as a combination of methods, per 12-month CSHCS eligibility year, regardless of the number of diagnoses or CMDS clinics the beneficiary may have. Medical services continue to be billed as usual.

9.8.D. ADDITIONAL RESPONSIBILITIES

CMDS clinics must establish and maintain an agreement with each Medicaid and MICHild Health Plan for health plan enrolled beneficiaries to ensure coordinated care planning and data sharing.

- CMDS clinics must establish a process for clinical staff to communicate with health plan staff on a regular basis to identify health plan enrollees using the CMDS clinic(s), review testing/assessment/screening results, treatment plans, CMDS POCs, and status of mutually served beneficiaries.
- CMDS clinics must collaborate with health plans on the development of referral procedures and effective means of communicating the need for beneficiary-specific referrals. For beneficiaries enrolled in a health plan, CMDS clinics must bill the Medicaid



Health Plan (MHP) for medical services rendered according to the health plan billing rules.

The CMDS clinic fee is billed as a FFS claim through CHAMPS regardless of health plan status. CMDS clinic fees are not intended for sporadic users of the services available through the CMDS clinics such as support services only. CMDS clinic fees are intended for the comprehensive, coordinated and integrated services that CMDS clinics provide to beneficiaries that return for and continue to use the full package of services.

CMDS clinic fees must be billed according to instructions contained in the Billing & Reimbursement for Professionals Chapter of this Manual. CMDS clinics must bill clinic fees following Uniform Billing (UB) guidelines on the professional CMS-1500 claim format or the electronic Health Care Claim Professional (837) ASC X12N version 5010 information. CHAMPS NPI claim editing will be applied to the billing, rendering, supervising, attending, servicing and referring providers as applicable for payment.



SECTION 10 – OUT-OF-STATE MEDICAL CARE

CSHCS covers out-of-state **emergency** medical care when services are related to the qualifying diagnosis. Emergency medical care is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the beneficiary;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Non-emergency medical care related to the qualifying diagnosis is defined as not meeting the definition of emergency medical care stated above. Out-of-state non-emergency medical care is covered only when the service has been prior authorized by MDHHS. Prior authorization requests for out-of-state services may be approved when all of the following criteria are met:

- The requested service is related to the CSHCS qualifying diagnosis;
- The request for out-of-state referral is submitted by the appropriate, CSHCS-authorized in-state subspecialist with whom the beneficiary will maintain a relationship following the out-of-state services, explaining the reason the requested service must be provided out-of-state;
- The in-state subspecialist and the out-of-state specialist maintain a collaborative relationship with regard to determining, coordinating, and providing the beneficiary's medical care, including a plan to transition the beneficiary back to in-state services as appropriate;
- Comparable care (the term "comparable care" does not require that services be identical) for the CSHCS qualifying diagnosis cannot be provided within the State of Michigan;
- The requested service is accepted within the context of current medical standards of care as determined by MDHHS;
- The service has been determined medically necessary by MDHHS because the beneficiary's health would be endangered if he were required to travel back to Michigan for services, if applicable.

All out-of-state providers must complete the Community Health Automated Medicaid Processing System (CHAMPS) enrollment process described in the Provider Enrollment Section of the General Information for Providers Chapter to submit claims to MDHHS.

Medical care provided in borderland areas is allowed without application of the Out-of-State Medical Care criteria if the provider is enrolled in the Michigan Medicaid Program. Borderland is defined as counties outside of Michigan that are contiguous to the Michigan border and the major population centers (cities) beyond the contiguous line as recognized by MDHHS. (Refer to the General Information for Providers Chapter of this manual for additional information.)

The LHD CSHCS offices authorize and assist families with travel for care received in borderland areas in the same manner as for travel in state. Refer to the Non-Emergency Medical Transportation (NEMT) Assistance section of this chapter for specific information.



SECTION 11 – NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) ASSISTANCE

CSHCS may reimburse for travel to assist beneficiaries in accessing and obtaining authorized specialty medical care and treatment (in-state and out-of-state, as appropriate) when the family's resources for the necessary travel pose a barrier to receiving care. NEMT assistance is allowed for the beneficiary and one adult to accompany the beneficiary when the beneficiary:

- Is a minor, or
- Has a court-appointed guardian, and/or
- Has a medical condition that supports the need for a caregiver

The treatment must be related to the qualifying medical condition and provided by a CSHCS approved provider. The NEMT benefit is not intended to assume the entire cost for the expenses incurred.

11.1 IN-AND OUT-OF-STATE TRAVEL

Requests for NEMT assistance must be made as follows:

- Beneficiaries who are not covered by Medicaid must request NEMT assistance through the LHD.
- Beneficiaries who have Fee-For-Service Medicaid and live in Wayne, Oakland or Macomb County must request NEMT assistance from the contracted transportation broker.
- Beneficiaries who have Fee-For-Service Medicaid and live outside of Wayne, Oakland or Macomb County must request NEMT assistance from their local MDHHS office. When NEMT assistance from the local MDHHS office is unavailable, beneficiaries can request NEMT assistance through the LHD.
- Beneficiaries who are Medicaid Health Plan (MHP) members must request NEMT from their health plan. MHPs may have different prior authorization and documentation requirements from those described in this chapter.

To be eligible and authorized for CSHCS NEMT travel assistance, the beneficiary must be determined by MDHHS to meet the following criteria:

- The beneficiary has CSHCS coverage at the time of the travel;
 - NEMT assistance may be authorized for individuals who do not have CSHCS but need NEMT assistance to participate in a diagnostic evaluation that is performed for the purpose of determining CSHCS eligibility.
 - There must be verification that no other resources are available and the individual is otherwise unable to access the site of the diagnostic evaluation.
- The NEMT assistance is for obtaining CSHCS specialty medical care and treatment from a CSHCS approved provider for the CSHCS medically-eligible condition;
- The family/beneficiary lacks the financial resources to pay for all or part of the travel expenses;
- Other travel/financial resources are unavailable or insufficient;
- The mode of travel to be used is the least expensive and most appropriate mode available; and



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- Prior approval for NEMT assistance has been obtained.

The following are additional criteria for out-of-state NEMT assistance:

- Comparable medical care is not available to the beneficiary within the state of Michigan or borderland areas.
- Prior approval for the out-of-state medical care and treatment was obtained from MDHHS before NEMT assistance was requested.

Travel to borderland providers is considered the same as travel to in-state providers and follows the same requirements and rules.

11.2 NEMT REIMBURSEMENT PROCESS

In-state NEMT assistance is prior authorized by the LHD using the process designated by CSHCS. Out-of-state NEMT assistance requests may be initiated by the LHD and must be authorized by the CSHCS state office. Prior authorization may be issued up to one calendar month for recurring visits.

Reimbursement is made according to the allowable amount established by MDHHS. Rates are reviewed at least annually and published on the MDHHS website. (Refer to the Directory Appendix for website information.)

Reimbursement for beneficiaries with Medicaid coverage who request NEMT assistance from their local MDHHS office is provided in accordance with the Medicaid/MDHHS Non-Emergency Medical Transportation policy.

Beneficiaries who are authorized for CSHCS NEMT assistance must request reimbursement by submitting the completed Client Transportation Authorization and Invoice form (MSA-0636) and Addendum according to the General Instructions. Receipts are required for all reimbursable expenditures except mileage. Meal expenditures are not reimbursable. Requests for NEMT reimbursement must be received by MDHHS within 90 days following the authorized month of travel to be considered for payment. New enrollees may be reimbursed retroactive to the date of CSHCS enrollment when applicable.

Ground Transportation	<ul style="list-style-type: none"> ▪ Mileage by private car to and from the health care service. Mileage is reimbursed according to the rate established by MDHHS. ▪ Car rentals, parking costs, and highway, bridge, and tunnel tolls require receipts. ▪ Bus, taxi, ferry or train fare, when it is the least expensive, most appropriate mode of transportation available and supported by receipts.
Air Travel	<ul style="list-style-type: none"> ▪ The family cannot be reimbursed for airline tickets unless prior approval to purchase the tickets was obtained from MDHHS/CSHCS. Receipts are required for reimbursement. ▪ Baggage charges, etc. require receipts.



Lodging	<ul style="list-style-type: none"> ▪ The beneficiary must be required to stay overnight to obtain in-patient or out-patient treatment related to the CSHCS covered condition, performed by a CSHCS approved provider and at a CSHCS approved medical facility, in order for the family to be reimbursed for lodging. ▪ Inpatient Requirements: Reimbursement is for the accompanying adult as needed. ▪ Outpatient Requirements: Reimbursement is for the beneficiary and the accompanying adult as needed. ▪ MDHHS reimburses lodging up to the allowable amount established by MDHHS, regardless of cost. Receipts are required.
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11.3 COMMERCIAL OR NON-PROFIT TRANSPORTATION PROVIDER (NON-AMBULANCE)

Beneficiaries may be eligible for NEMT through a commercial or non-profit provider (e.g., Ambu-Cab, Medi-Van, vans operated by medical facilities or public entities, etc.) when at least one of the following conditions is met. Beneficiary is:

- Wheelchair dependent; or
- Bed bound; or
- Medically dependent on life sustaining equipment which cannot be accommodated by standard transportation; or
- Unable to access public or private transportation for the purpose of obtaining medical care.

CSHCS NEMT provided by a commercial or non-profit transportation provider must be prior approved by the LHD on the Non-Emergent Medical Transportation Authorization and Verification form (MSA-0709). Payment is made directly to the commercial or non-profit transportation provider by MDHHS. The family/beneficiary should not pay the provider directly since the family/beneficiary cannot be reimbursed.

11.4 EMERGENCY AND SPECIAL TRANSPORTATION COVERAGE

CSHCS follows the same policies and procedures regarding emergency and special medical transportation coverage as the Medicaid Program. Coverage must be related to the CSHCS qualifying condition. (Refer to the Ambulance Chapter of this manual for additional information.)

An additional person, such as a donor related to the medical care of the beneficiary, may be considered for NEMT assistance when approved by a MDHHS medical consultant. The treating specialist must provide CSHCS with documentation of the relationship between the beneficiary and the additional person.



SECTION 12 – CSHCS COORDINATION WITH OTHER HEALTH CARE COVERAGE

Beneficiaries may have coverage through CSHCS and another program simultaneously.

12.1 MEDICAID

Beneficiaries may have both Medicaid and CSHCS coverage. The beneficiary must comply with Medicaid requirements.

12.2 MICHILD

Beneficiaries may have both MICHild and CSHCS coverage. The beneficiary must comply with MICHild requirements. CSHCS is not considered health insurance for purposes of MICHild eligibility.

12.3 TRANSITIONAL MEDICAL ASSISTANCE (TMA)

Beneficiaries may have both TMA and CSHCS coverage. For services not covered by CSHCS and covered by TMA, the beneficiary must comply with TMA requirements.

12.4 MATERNITY OUTPATIENT MEDICAL SERVICES

Beneficiaries may have both MOMS and CSHCS coverage. The beneficiary must comply with MOMS requirements.

12.5 COURT-ORDERED MEDICAL INSURANCE

CSHCS cannot be used as court-ordered medical insurance.

12.6 MEDICARE

Beneficiaries may have both Medicare and CSHCS. The beneficiary must comply with Medicare requirements.

CSHCS may cover the out-of-pocket pharmacy costs related to the CSHCS covered diagnoses for CSHCS beneficiaries enrolled with a Medicare Part D Pharmacy Drug Plan. These out-of-pocket costs include copays, co-insurance and deductibles specific to the Medicare Part D pharmacy benefit. Providers and beneficiaries should contact CSHCS for additional information regarding the reimbursement of out-of-pocket pharmacy costs. (Refer to the Directory Appendix for contact information.)

12.7 HEALTHY MICHIGAN PLAN

Beneficiaries may have both the Healthy Michigan Plan and CSHCS. The beneficiary must comply with the Healthy Michigan Plan requirements.



SECTION 13 – APPEALS

13.1 DEPARTMENT REVIEWS

Beneficiaries without Medicaid coverage are entitled to appeal MDHHS negative actions, and to a Department Review when they have been denied CSHCS eligibility or services, or when established CSHCS services have been reduced, changed, or terminated. The beneficiary will be notified in writing of the negative action and the right to appeal. CSHCS follows the same appeal and request for hearing policies and procedures as established by MDHHS for all MDHHS programs.

13.2 ADMINISTRATIVE HEARINGS

Beneficiaries who also have Medicaid coverage have a right to an administrative hearing when services have been denied, reduced, changed or terminated. The beneficiary will be notified in writing of the negative action and the right to appeal. The beneficiary may receive an administrative hearing if the circumstances suggest that Medicaid reimbursement is involved in the coverage or service in question. The beneficiary may receive a department review if the circumstances indicate that Medicaid reimbursement is in no way involved in the coverage or service in question. The Michigan Office of Administrative Hearings and Rules (MOAHR) determines which hearing is appropriate once a beneficiary has requested a hearing.



CHIROPRACTOR

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SECTION 1 – GENERAL INFORMATION

This chapter applies to Chiropractors.

1.1 MEDICAL NECESSITY

Determination of medical necessity and appropriateness of service is the responsibility of chiropractors within the scope of accepted medical practice and Medicaid limitations. Chiropractors are held responsible if excessive or unnecessary services are ordered, regardless of who actually renders these services (e.g., x-rays), or if reimbursement is received for the service. Chiropractors are subject to any corrective action related to these services, including recovery of funds.

1.2 BENEFICIARY COPAYMENT

A copayment for each Medicaid reimbursable chiropractic visit may be required for beneficiaries age 21 years and older. (Refer to the General Information for Providers Chapter for information about copayments.) Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)

When more than one reimbursable service is provided during one visit (e.g., spinal manipulation and x-ray on the same date of service [DOS]), only a single copayment may be charged to the beneficiary.

When billing Medicaid for the service, chiropractors should bill their usual and customary (U&C) charge (i.e., without any adjustment for the copayment). Upon approval of the service, Michigan Department of Health and Human Services (MDHHS) automatically deducts the copayment. If the chiropractor deducts the copayment from the charge billed, an underpayment may result.

Refer to the Billing Beneficiaries Section of the General Information for Providers Chapter of this manual for additional information regarding copayment requirements. Beneficiaries may not be denied care or services based on inability to pay a copayment, except as outlined in that section.

1.3 OTHER INSURANCE AND MEDICARE SERVICES

It is the chiropractor's responsibility to question the beneficiary regarding Medicare and other insurance coverage prior to providing the service. Medicaid is the payer of last resort. Payment must be sought from other third party payers before submitting claims to MDHHS. (Refer to the Coordination of Benefits Chapter of this manual for additional information.)

1.4 NURSING FACILITY

Chiropractors may render manual spinal manipulations to beneficiaries in a NF as an ancillary service. The attending physician (MD or DO) must order all ancillary services, including chiropractic services. The chiropractor must keep and make available complete records of the services provided.



SECTION 2 – COVERED SERVICES

2.1 MANUAL SPINAL MANIPULATION

Medicaid covers medically necessary chiropractic services rendered by a chiropractor for the treatment of a diagnosed condition of subluxation of the spine. The subluxation must be demonstrable on x-rays.

Spinal manipulation is the only covered chiropractic procedure. (Refer to the Codes Section of this chapter for additional information.) Only one of the spinal manipulation procedure codes is billable per day, per beneficiary. Clinical signs and symptoms must be consistent with the level of subluxation.

If documentation other than x-rays supports the medical necessity of spinal manipulation for children, the x-ray requirement may be waived. Medicaid reserves the right to request x-ray documentation if deemed necessary.

Medicaid reimburses up to 18 chiropractic visits per calendar year.

2.2 PRIOR AUTHORIZATION INSTRUCTIONS

If additional visits during the calendar year are medically necessary, providers must submit a prior authorization (PA) request before performing manipulations that exceed the 18-visit limit. Submit a written request to the MDHHS Program Review Division. (Refer to the Directory Appendix for contact information.)

The letter requesting PA must:

- Provide beneficiary name and Medicaid identification (ID) number;
- Specify height;
- Specify weight;
- Provide the date of onset of current complaint and the frequency of visits to date, including a brief history of complaint, initial symptoms and significant symptom characteristics;
- Indicate level of subluxation and associated diagnosis, including complications or predisposing conditions, if present;
- Specify physical and objective findings;
- Specify radiographic findings, including significant findings in support of diagnosis;
- Indicate the patient's response to current treatment (improvement to date, if any);
- Provide an estimate of continued treatment necessary for current complaint;
- Provide expected and anticipated benefit of continued treatment; and
- Include any additional details, comments, etc. that may be of assistance in the evaluation.



The PA request is reviewed and a notice is returned to the provider stating the approval or denial of the request. If approved, the provider is notified of the number of additional visits granted. Providers are also given a PA number that must be placed in the PA field on the claim form when billing for the additional services. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for claim completion instructions.)

2.3 X-RAY SERVICES

A chiropractor may order, and be reimbursed for, no more than one set of spinal x-rays per beneficiary, per year. If more than two procedures are provided for the beneficiary on the same date of service, the services must be combined and billed as one inclusive procedure code, such as the entire radiologic examination of the spine with survey study, anteroposterior and lateral.



SECTION 3 – CODES

3.1 DIAGNOSIS CODES

Chiropractors must use at least one diagnosis code in conjunction with the procedure codes when billing chiropractic services. MDHHS follows the Medicare diagnosis coding requirements for chiropractic services.

3.2 PROCEDURE CODES

Chiropractors must use at least one appropriate procedure code from the Current Procedural Terminology (CPT) and the Healthcare Common Procedure Coding System (HCPCS) coding manuals. A list of procedure codes covered by MDHHS is maintained on the MDHHS website. (Refer to the Directory Appendix for website information.)



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SECTION 4 – NONCOVERED SERVICES

Chiropractic services excluded from Medicaid coverage are all services other than manual manipulation of the spine and spinal x-rays. Medicaid does not cover the following services when rendered by a chiropractor:

- Consultations
- Fracture care
- Home visits
- Injections
- Laboratory tests
- Maintenance therapy
- Medical supplies
- Evaluation and management services
- Plaster casts
- Inpatient hospital visits



DENTAL

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SECTION 1 – GENERAL INFORMATION

This chapter applies to Dentists/Dental Clinics.

The primary objective of Medicaid is to ensure that essential medical/dental services are made available to Medicaid beneficiaries. Medicaid goals are aimed at making the best use of Medicaid resources and assuring the quality of medically necessary health care services provided to Medicaid beneficiaries.

Determination of medical necessity and appropriateness of services is the responsibility of the dentist, within the scope of current accepted dental practice and the limitations of Medicaid (e.g., the prior authorization [PA] process).

In cases where the Michigan Department of Health and Human Services (MDHHS) determines that the dentist did not provide a service within the scope of current accepted dental practice or the service was not provided within the limitations of Medicaid, MDHHS may:

- Require the service to be immediately provided;
- Require the dentist to repeat the service at no additional charge;
- Refuse payment to the dentist for the service; or
- Recover from the dentist reimbursement made for the service.

Dental services that may be provided to all Medicaid beneficiaries include emergency, diagnostic, preventive, and therapeutic services for dental disease which, if left untreated, would become acute dental problems or cause irreversible damage to teeth or supportive structures.

1.1 DENTAL PROGRAM COVERAGE

1.1.A. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is available to all Medicaid beneficiaries under 21 years of age. This program was established to detect and correct or ameliorate defects and physical and mental illnesses and conditions discovered in children. Under EPSDT, dental services are to be provided at intervals which meet reasonable standards of dental practice. Primary care providers (PCPs) should provide an oral health screening and caries risk assessment for beneficiaries at each well child visit as recommended by the AAP periodicity schedule. Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter for additional information.

1.1.B. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT DENTAL PERIODICITY SCHEDULE

The Dental Periodicity Schedule follows the American Academy of Pediatric Dentistry (AAPD) Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling schedule. (Refer to the Directory Appendix for AAPD website information.)



The AAPD guidelines are designed for the care of children developing normally and without contributing medical conditions. The guidelines include recommendations to modify as needed for children with special health care needs, disease or trauma. The AAPD guidelines emphasize the importance of early professional intervention and continuity of care based on the individualized needs of the child.

The guidelines recommend that a child have a first dental visit when the first tooth erupts or no later than 12 months of age. The examination includes assessment of pathology and injuries, growth and development, and caries-risk assessment. Based on clinical findings and susceptibility to disease, the timing and frequency of radiographic imaging, oral prophylaxis, and topical fluoride should be provided as determined necessary. Systemic fluoride supplementation should be considered when fluoride exposure is suboptimal. The examination is to be repeated every six months or as indicated by the child's risk status and susceptibility to disease.

Anticipatory guidance/counseling should be an integral part of each dental visit. Counseling on oral hygiene, nutrition/dietary practices, injury prevention, and nonnutritive oral habits should be included. A referral for speech/language development should be made as needed.

Determined by growth and developmental assessment, the prevention and treatment of developing malocclusion should be evaluated beginning at 2 years of age. Following current policy, caries-susceptible pits and fissures of teeth should have sealants placed as soon as possible after eruption. Children 6 years of age and older should receive counseling on substance abuse and intraoral and perioral piercing. Children 12 years of age and older need third molar assessment and potential removal as deemed medically necessary.

1.1.C. ADULT DENTAL PROGRAM

Beneficiaries age 21 and older receive dental benefits that are more limited in coverage. Dental benefits are provided for adult Medicaid and Medicaid Health Plan (MHP) beneficiaries through the Medicaid Fee-For-Service (FFS) Program. Healthy Michigan Plan beneficiaries will receive their dental benefits through the Medicaid FFS program until they are enrolled in a health plan. The health plan becomes responsible for the beneficiary's dental services on the enrollment effective date. Upon enrollment in a health plan, beneficiaries must obtain dental services through the health plan's dental provider network. The Program of All-Inclusive Care for the Elderly (PACE) is responsible for the coverage of dental benefits for PACE enrollees.

1.1.D. HEALTHY MICHIGAN PLAN DENTAL

Beneficiaries enrolled in a health plan will receive their dental coverage through their health plan. Each health plan contracts with a dental provider group or vendor to provide dental services administered according to the contract. The contract is between the health plan and the dental provider group or vendor, and beneficiaries must receive services from a participating provider to be covered. Questions regarding eligibility, prior authorization or the provider network should be directed to the beneficiary's health plan.



It is important to verify eligibility at every appointment before providing dental services. Dental services provided to an ineligible beneficiary will not be reimbursed.

For those beneficiaries who are not enrolled in a health plan, dental services will be provided by enrolled dental providers on a FFS basis.

1.1.E. CSHCS PROGRAM

Dentists providing specialty dental services to Children's Special Health Care Services (CSHCS) Program beneficiaries should refer to the Children's Special Health Care Services Dental Services Section of this chapter. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.



SECTION 2 – PRIOR AUTHORIZATION

Prior authorization (PA) is only required for those services identified in the Dental Chapter and the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)

2.1 PRIOR AUTHORIZATION REQUIREMENTS IN CASES OF OVER-UTILIZATION

MDHHS may require a dentist found to be misutilizing services to obtain PA for all or selected dental services separate from those generally requiring authorization. MDHHS is required to explain to the dentist, in writing, the reasons for applying this requirement.

2.2 COMPLETION INSTRUCTIONS

The Dental Prior Approval Authorization Request form (MSA-1680-B) is used to obtain authorization. (Refer to the Forms Appendix for instructions for completing the form.) When requesting authorization for certain procedures, dentists may be required to send specific additional information and materials. Based on the MSA-1680-B and the documentation attached, staff reviews and makes an authorization determination. Approved requests are assigned a PA number and notification is sent to the provider. For billing purposes, the PA number must be entered in the appropriate field on the claim form. An electronic copy of the MSA-1680-B is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.3 CHAMPS WEBSITE

Information on specific coverage and reimbursement policies can be accessed using the Medicaid Code and Rate Reference tool in the Community Health Automated Medicaid Processing System (CHAMPS). Dentists should refer to the CHAMPS website for information on previous PA requests, status of current requests, and to update PA requests. To assist in the efficient use of this service, providers should have the beneficiary's file, including all necessary data and information, available when making an inquiry.

All other inquiries, such as billing problems, should be directed to Provider Inquiry. (Refer to the Directory Appendix for contact information.)

2.4 APPROVED PRIOR AUTHORIZATION REQUESTS

An approved PA request confirms that the beneficiary meets Medicaid's established medical criteria for the services and that the services are Medicaid-covered benefits. This approval does not guarantee eligibility nor verify a beneficiary's age. It is also not to be considered an authorization for payment.

The dentist is responsible for verifying the beneficiary's Medicaid eligibility and age by checking the eligibility response. Eligibility should be verified prior to each appointment. (Refer to the Enrollment Information subsection of this chapter and the Verifying Beneficiary Eligibility section of the Beneficiary Eligibility chapter for additional information.)

PA is granted under the NPI submitted on the PA form. Provided it is the group NPI, it may be transferred or used by any dentist within the same organization without contacting the MDHHS Dental Prior Authorization Unit.



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 must be submitted for existing PA plans over one year old.

Providers may update the PA request by contacting the Dental Prior Authorization Unit by fax or mail if there are no treatment plan changes. (Refer to the Directory Appendix for contact information.)

If a change in the treatment plan is necessary, dentists should submit a new MSA-1680-B with appropriate radiographs and information to the Dental Prior Authorization Unit. Radiographs submitted are returned only upon provider request. Providers must complete the checkbox in field 17 to request the return of submitted radiographs.

If a PA request is denied, the dentist receives a denial notice. The beneficiary also receives a notice of denial for the requested service along with their notice of appeal rights.

2.5 LOSS OR CHANGE IN ELIGIBILITY

No service is covered after loss of eligibility except for the following services:

- Endodontic Therapy
- Complete and Partial Dentures
- Laboratory-Processed Crowns

Reimbursement for these services is only allowed under the following circumstances:

- Services were started prior to the loss of eligibility.
- For complete or partial dentures and laboratory-processed crowns, impressions were taken prior to the loss of eligibility.
- Services are completed within 30 days of change and/or loss of eligibility.

Conditions not eligible for reimbursement include:

- If a beneficiary's Medicaid eligibility is terminated after extractions were performed, but prior to the initial impressions. The extractions alone do not qualify the beneficiary for dentures.
- Immediate dentures.

The date of service on the claim is the date the endodontic therapy was started or the date of the initial impressions for complete or partial dentures and laboratory-processed crowns.



SECTION 3 – COPAYMENT

A copayment for each separately reimbursable Medicaid visit may be required for beneficiaries age 21 years and older with the following limitations:

- When more than one reimbursable service is provided during a visit, only one copayment may be charged.
- Where several visits are required to complete a service (such as dentures), only one copayment may be charged.
- Beneficiaries cannot be charged a copayment for procedures that are considered part of normal office operations.

A provider cannot refuse to render service if the beneficiary is unable to pay the required copayment on the date of service.

Some beneficiaries, programs, and places of service are exempt from co-payment requirements. (Refer to the General Information for Providers Chapter for information on Medicaid copayment requirements.) Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)



SECTION 4 – PLACE OF SERVICE

All dental services must be performed in the dental office, public health department dental clinic, dental school, dental hygiene program, or Federally Qualified Health Centers (FQHCs). Special situations may necessitate the provision of services at an alternate site such as a hospital/surgical setting or nursing facility.

4.1 ALTERNATIVE SETTINGS

4.1.A. INPATIENT OR OUTPATIENT HOSPITAL SETTING

Admission to an inpatient or outpatient hospital setting for any non-emergency dental service is covered for beneficiaries for the following reasons:

- The patient has a high-risk medical condition;
- The type of procedure requires it to be performed in a hospital setting; or
- Other contributing factors could compromise the safety of the patient, such as age, behavioral problems due to mental impairment, etc.

The dentist/physician must document in the beneficiary's medical record the condition that required the dental service to be done in the hospital setting.

Hospitalization is not a benefit for the convenience of the dentist or beneficiary or because of apprehension on the part of the beneficiary.

4.1.B. SURGICAL SETTING

For services performed in a surgical setting, the dentist should use the usual and customary (U & C) fee for the service as performed in an office setting. In addition, the CDT procedure code for hospital or ambulatory surgical center call may also be billed if services are provided in a hospital or surgical center. This code may be billed in addition to the appropriate dental procedure code for the actual service performed. This procedure code is not for administrative purposes, such as arranging appointment times, gathering signatures for release forms, etc.

4.1.C. NURSING FACILITIES

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.

4.1.D. MOBILE DENTAL FACILITIES

A mobile dental facility is defined as a self-contained, intact facility in which dentistry or dental hygiene is practiced that may be transported from one location to another, or a site used on a temporary basis to provide dental services using portable equipment.

A mobile dental permit must be obtained by an operator before providing dental services. Requirements include:

- Completion of the permit application;
- Submission of the required documents;
- Submission of the administrative fee; and
- Memorandum of agreement for follow-up services.

Mobile dental operators can access the Mobile Dental Facility Application and additional information and requirements on the MDHHS website. (Refer to the Directory Appendix for website information.)

To provide dental services and bill Medicaid, a provider must be enrolled in the Community Health Automated Medicaid Processing System (CHAMPS). Instructions for provider enrollment, as well as updating enrollment, can be found on the MDHHS website. (Refer to the Directory Appendix for website information.)

Enrollment as a mobile dental provider is required within 30 days of approval of the Mobile Dental Facility Permit. Groups may select more than one specialty. Dental Hygienists operating in mobile facilities will need to enroll as a mobile provider.

4.1.E. OTHER SITES

All other sites must be prior approved. In order to receive prior authorization (PA), the dental provider must complete the Dental Prior Approval Authorization Request form (MSA-1680-B) for each individual and submit it to the Prior Authorization Section. (Refer to the Forms Appendix for a copy of the form.) Providers should follow the same instructions for submission of the PA request for site of service as they do requests for procedures.



SECTION 5 – ANCILLARY SERVICES

5.1 PHARMACY SERVICES

Medicaid has a list of covered drugs that include selected legend and over-the-counter drugs. The intent is to maintain coverage of economical products for most drugs. Medicaid does not reimburse dentists for drugs dispensed in the office setting. For those beneficiaries enrolled in a Medicaid Health Plan (MHP), dentists should refer to the MHP's formulary for the list of approved drugs.

Prescribed quantities should be limited to an amount necessary to keep the beneficiary supplied during the therapeutic regimen. In certain cases and conditions, more than a month's supply is appropriate while, for other conditions, more frequent monitoring is essential. However, in no instance may the dentist prescribe a drug for more than a 100-day supply.

Dentists must report their individual National Provider Identifier (NPI) with a prescription order for Medicaid beneficiaries. All prescription orders must comply with state and federal laws.

Refer to the Pharmacy chapter of this manual for additional information.

5.2 MEDICAL LABORATORY SERVICES

Medically necessary laboratory services ordered by dentists are a Medicaid benefit. Only the provider who performs the service may bill for the service.

Dentists should use their provider NPI number on medical laboratory service orders written for Medicaid beneficiaries. (The laboratory is required to provide this information when billing.)



SECTION 6 – COVERED SERVICES

This section provides information on Medicaid covered services and is divided into the following subsections that correspond to the categories of services in Current Dental Terminology (CDT) as published by the American Dental Association.

- Diagnostic Services
- Preventive Services
- Restorative Treatment
- Endodontics
- Periodontics
- Prosthodontics (Removable)
- Oral Surgery
- Adjunctive General Services

Providers must use the current CDT procedure codes published by the American Dental Association (ADA) when completing both the claim and PA form. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

6.1 DIAGNOSTIC SERVICES

6.1.A. CLINICAL ORAL EVALUATION (EXAMINATIONS)

A periodic, comprehensive or problem-focused evaluation is considered a benefit for all beneficiaries only if detailed written documentation of medical and dental findings (both negative and positive) and tests are included in the beneficiary's dental record. (Refer to the General Information for Providers Chapter of this manual for additional information.) Typically, it should include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, periodontal conditions, occlusal relationships, hard and soft tissue anomalies, oral cancer screening, and prosthesis condition and usage. All clinical oral evaluations must include a diagnosis and treatment plan. Examinations without this documentation are not a covered benefit.

6.1.B. COMPREHENSIVE ORAL EVALUATION

A comprehensive oral evaluation is performed on a new patient or an established patient with significant health changes or absence from treatment for three or more years. The evaluation must include a documented medical and dental history, a thorough evaluation and recording of the condition of extraoral and intraoral hard and soft tissues, including a complete charting of the condition of each tooth and supporting tissues, occlusal relationships, periodontal conditions, including periodontal charting, oral cancer screening and appropriate radiographic studies (radiographs are separately reimbursable). The comprehensive oral evaluation is a covered benefit for all beneficiaries. In addition, a complete treatment plan must be included that addresses the beneficiary's needs.



6.1.C. PERIODIC ORAL EVALUATION

A periodic oral evaluation is an examination of a patient of record to determine any changes in a beneficiary's dental and medical health status since a previous comprehensive or periodic examination. The periodic oral evaluation must include a written update of the beneficiary's dental and medical history, clinically appropriate charting necessary to update and supplement the comprehensive oral examination data, including periodontal screening and appropriate radiographs as necessary to update previous radiograph surveys (radiographs are separately reimbursable). A periodic oral evaluation is a covered benefit once every six months for all beneficiaries, but may not be billed within six months of a Comprehensive Oral Evaluation. In addition, a complete treatment plan must be included that addresses the beneficiary's needs.

6.1.D. LIMITED ORAL EVALUATION - PROBLEM FOCUSED EXAM

A limited oral evaluation-problem focused exam consists of an examination for diagnosis and observation of a specific oral health problem or complaint, such as injuries to teeth and supporting structures. A limited oral evaluation must include appropriate recording of the beneficiary's dental and medical history, and charting that is clinically appropriate for the particular problem. In addition, the findings, diagnosis, and treatment plan for the diagnosis must be included in the beneficiary's chart.

A limited oral evaluation can be billed in conjunction with radiographs and/or extractions (simple or surgical) and considered as a covered benefit. Routine restorative procedures, root canal therapy, elective surgery, and denture services are not considered emergency procedures and cannot be billed in conjunction with a limited oral evaluation. Limited oral evaluation-problem focused exam is a covered benefit for all ages.

6.1.E. PRE-DIAGNOSTIC SERVICES

6.1.E.1. ORAL EVALUATION, PATIENT <3 YEARS

An oral evaluation of a patient <3 years of age is performed by a dentist preferably within the first six months of the eruption of the first primary tooth. An oral evaluation includes a clinical examination to identify disease, malformation, injury and caries risk. Counseling with the primary caregiver and the development of an appropriate preventive oral health plan are required. The oral evaluation of a patient <3 years may be billed in conjunction with other dental services, but may not be billed on the same date of service as other oral evaluation services.

6.1.E.2. ORAL HEALTH SCREENING OF A PATIENT

An oral health screening of a patient is an inspection of the oral cavity by a primary care provider (PCP) as part of the well child exam to determine the need for referral to a dentist for evaluation and diagnosis. This includes state or federally mandated screenings. Counseling with the primary caregiver and referral (as needed) is required. The oral health screening of a patient may be billed in conjunction with topical fluoride varnish applications, but may not be billed on the same date of service as other oral evaluation services. PCPs should provide an oral health screening and caries risk assessment for beneficiaries at each well child visit as recommended by the AAP



periodicity schedule. Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter for additional information.

6.1.E.3. ASSESSMENT OF A PATIENT

An assessment of a patient is a clinical evaluation performed by a dental hygienist operating in a public health setting or an approved Public Act 161 of 2005 (PA 161) program. Assessment services performed within the scope of dental hygiene practice can be provided to identify signs of disease, malformation or injury and the need for referral for examination, diagnosis and treatment. An assessment of a patient is a benefit for all ages. The assessment must include written documentation of the beneficiary's dental and medical history. Written documentation of significant clinical findings and the appropriate referral is required. The assessment code cannot be used when a dentist is on site to perform the examination. An oral examination by the dentist always supersedes the assessment of a patient in place of service settings where the dentist is present. It can be billed in conjunction with other dental hygiene services, but may not be billed on the same date of service as other oral evaluation services.

6.1.F. CONSULTATION

A consultation provided by another dentist or a physician (MD, DO) is a benefit for all beneficiaries. Medicaid defines a consultation as a service rendered by a physician/dental specialist whose opinion or advice is formally requested by another appropriate practitioner (e.g., physician, certified nurse-midwife [CNM], dentist) for the further evaluation and/or management of the beneficiary. The consultant does not render patient care or treatment. If a consultant assumes responsibility for any patient management or treatment, then all services subsequent to the consultation must be billed under the appropriate procedure code (e.g., exams, procedures). If a dentist provides a consultation, the only separately reimbursable services that may be provided in addition to the consultation are radiographs.

A consultation service includes examination and evaluation of the beneficiary, documentation of history and physical examination findings, recommendations, and submission of a written formal consultation report to the requesting practitioner. The dentist requesting the consultation cannot bill the consultation procedure code.

A consultation related to routine dental treatment (e.g., caries) is not a covered benefit.

6.1.G. RADIOGRAPHS

The policy applies to all radiographs and radiographic procedures, both digital and traditional film, unless otherwise stated. (Refer to the Directory Appendix for website information.)

Radiographs are benefits for all beneficiaries and are limited to the number medically necessary to make a diagnosis (other limitations apply to radiographs - see below). The provider must maintain documentation in the beneficiary's file stating the reason the radiographs were necessary, the diagnosis/radiographic findings, treatment plan, and referral if appropriate.



6.1.G.1. BITEWINGS

Bitewing radiographs are a covered benefit only once in a 12-month period for all beneficiaries.

6.1.G.2. OCCLUSAL RADIOGRAPHS

An occlusal radiograph is a covered benefit for beneficiaries under age 21 once every three years per arch. All occlusal radiographs, regardless of film size or method of exposure, will be reimbursed at the established fee for a periapical, first film.

6.1.G.3. PANORAMIC RADIOGRAPHS

A panoramic radiograph is a covered benefit once every five years for all beneficiaries ages five years and older.

6.1.G.4. FULL MOUTH OR COMPLETE SERIES

A full mouth or complete series is a covered benefit once every five years for all beneficiaries ages five years and older.

A full mouth or complete series consists of:

- A minimum of 10 periapical radiographs in conjunction with a minimum of two bitewing radiographs; or
- An intraoral/extraoral combination of a panoramic radiograph in conjunction with a minimum of two bitewing radiographs.

The maximum reimbursement for any combination of radiographs will not exceed the established fee for a full mouth or complete series. Any combination of 10 or more intraoral radiographs will be considered a full mouth series.

6.1.G.5. COPIES OF FULL MOUTH SERIES

Dental providers are expected to provide a copy of full mouth x-rays taken within the previous 12 months to a subsequent provider as requested.

6.1.G.6. RADIOGRAPH SUBMISSION REQUIREMENTS FOR PRIOR AUTHORIZATION

When requesting prior authorization (PA) for procedures, the dentist may be required to submit radiographs along with the request. Radiographs submitted are returned only upon provider request. Providers must complete the checkbox in field 17 to request the return of submitted radiographs. (Refer to the Billing & Reimbursement for Dental Providers Chapter of this manual for additional information.)



In some cases, pre-op radiographs are necessary to document the presence and/or absence of teeth, related tooth structure, or related chronic pathology within the alveolar process(es).

A full mouth radiograph series must be submitted with PA requests for complete dentures in cases where beneficiaries are receiving their first denture. A full mouth radiograph series is optional for PA requests for replacement of existing complete dentures (i.e., the beneficiary is edentulous, has worn dentures for years, and needs replacement dentures). In this case, the dentist may submit radiographs if they deem them necessary in the evaluation of the beneficiary’s oral condition.

A full mouth radiograph series must be submitted with all PA requests for partial dentures.

A periapical radiograph is required when submitting PA requests for crown coverage.

6.1.G.7. TECHNICAL CONSIDERATIONS AND ADDITIONAL REQUIREMENTS

All radiographs submitted must be diagnostically acceptable and meet the following technical considerations and additional requirements.

<p>Technical Considerations</p>	<ul style="list-style-type: none"> ▪ All teeth or areas of concern must be visible on the radiographs. ▪ Density and clarity of the radiograph must be such that radiographic interpretation can be made without difficulty. ▪ On a periapical view, the apex of the tooth must be demonstrated clearly, as well as a minimum of one-eighth of an inch of surrounding bone. ▪ Where pathologic change is in question, healthy bone must be seen surrounding the questionable area. ▪ Interproximal bone must be visible without the overlapping of interproximal surfaces of teeth under consideration. ▪ Posterior teeth areas (e.g., demonstrated impactions, developing third molars) must be completely visible.
<p>Additional Requirements</p>	<ul style="list-style-type: none"> ▪ All film radiographs submitted must be mounted in an x-ray mount, with the exception of a single film which may be submitted in an envelope. Only actual films or diagnostically acceptable duplicates will be accepted. ▪ Digital radiographs submitted must be regulation film size and diagnostically acceptable. ▪ All radiographs must be identified with the beneficiary's name and Medicaid ID number. ▪ All radiographs must have the date the radiograph was taken. ▪ All full-mouth radiographs and panoramic radiographs must have "right" and "left" identification. ▪ All radiographs must include the provider's name and address.



Technically unacceptable radiographs are returned to the dentist for replacement with no additional reimbursement provided.

Radiographs are returned to the dentist with a letter of status of the PA.

6.1.G.8. PHOTOGRAPHS

Photographs are not reimbursed under Medicaid, but they may be submitted with the PA form as documentation to make the beneficiary's condition clearly visible.

For CSHCS beneficiaries, photographs are not separately reimbursable. They are part of the pretreatment records for orthodontic services.

6.2 PREVENTIVE SERVICES

6.2.A. PROPHYLAXIS

Oral prophylaxis is a covered benefit once every six months for all beneficiaries. It includes routine scaling and debridement, as well as stain removal and polishing of the tooth surface.

If more than one visit is necessary to complete the prophylaxis, it must be billed only once and the date of service used on the claim must be the date of the final visit.

6.2.B. TOPICAL APPLICATION OF FLUORIDE

Non-Varnish	Topical application of fluoride is a benefit for beneficiaries under age 16. It is covered only once every six months and cannot be combined with topical application of fluoride varnish within the six month time period. The fluoride must be approved by the ADA Council on Dental Therapeutics and administered using tray application only if age appropriate.
Varnish	Topical application of fluoride varnish is a benefit for beneficiaries under age 16. Frequency and parameters vary based on the age of the beneficiary as noted below: <ul style="list-style-type: none"> ▪ Ages 0 through 2: Four times per 12 months as a therapeutic application for all children. ▪ Ages 3 through 15: One time per six months and cannot be combined with topical application of non-varnish fluoride within the six month period.

The following types of fluoride treatment are not covered as a dental benefit:

- Treatment that incorporates fluoride with the polishing compound (this is considered to be part of the prophylaxis procedure and is not separately reimbursable);
- Topical application of fluoride to the prepared portion of a tooth prior to restoration;
- Fluoride rinses;
- The use of self or home fluoride application procedures; or
- Prescription fluoride supplements prescribed by the dentist (may be covered as a pharmacy benefit for beneficiaries under the age of 10).



6.2.B.1. INTERIM CARIES ARRESTING MEDICAMENT

CDT D1354 - Interim Caries Arresting Medicament Application is a Medicaid covered dental benefit for all ages. Advantage Arrest™ by Elevate Oral Care -Silver Diamine Fluoride (SDF) at 38% is the only Food and Drug Administration (FDA) approved SDF for use in the United States. It is also the only caries arresting medicament allowed by Medicaid policy.

SDF is billable once per date of service regardless of the number of teeth treated up to a maximum of 5 teeth per visit. Direct application to the tooth is required to arrest active carious lesions; however, application to sound teeth is not necessary for the additional anti-caries benefit. Application of SDF has an antimicrobial effect on the entire oral cavity in addition to the teeth being treated for caries arrest. (Refer to the Billing and Reimbursement for Dental Providers chapter for additional billing information.)

D1354 is considered a temporary measure to arrest and slow the progression of caries. It should be used only when traditional methods of restoration are not available or are contraindicated. A minimum of two applications per year has been shown to increase the caries arresting effectiveness. Treated lesions must be monitored over time to assess caries arrest. Additional applications may not be necessary or recommended if caries arrest is still in effect.

SDF is not meant to be used as a full-mouth fluoride varnish therapy. SDF application does not eliminate the need for tooth restoration, nor does it preclude the ability to restore the tooth. It is not used as a base prior to restoration and it has the disadvantage of darkening the carious area of the tooth. SDF will not stain non-carious tooth structure. The darkened tooth structure can be removed with restoration of the tooth.

<p>Indications for use include:</p>	<ul style="list-style-type: none"> ▪ high-caries risk ▪ behavioral or medical management issues ▪ dentinal hypersensitivity ▪ caries stabilization ▪ xerostomia from cancer treatment or multiple hyposalivatory medications ▪ treating vulnerable surfaces, such as roots exposed from periodontal attachment loss, overdenture and partial denture abutments, or partially exposed third molars ▪ difficult-to-treat caries lesions (e.g., furcations, margins of fixed bridges) ▪ patients without access to restorative dental services ▪ cognitive disabilities (e.g., patients with autism or dementia) ▪ physical disabilities ▪ dental phobias
<p>Contraindications for SDF use</p>	<ul style="list-style-type: none"> ▪ allergy to silver or other heavy-metal ions ▪ oral ulcerations, stomatitis, or ulcerative gingivitis present at the time of application ▪ more than five teeth treated on the same date of service.



<p>Education and Informed Consent</p>	<ul style="list-style-type: none"> ▪ SDF application requires education of providers and staff on the application process, benefits, risks and projected outcomes. Also required is education of the beneficiary and informed consent signed by the beneficiary or guardian. ▪ Treatment with SDF requires more than one application to effectively arrest decay ▪ Treatment with SDF does not eliminate the need for restorations to repair function or esthetics. ▪ Affected areas will stain black permanently until replaced with a restoration. ▪ Tooth-colored restorations may discolor from SDF but can generally be removed with polishing. ▪ SDF accidentally applied to the skin or gum tissue may stain white or brown if not immediately washed off but will disappear within a couple of weeks. ▪ Although SDF has been proven to be highly successful, application does not guarantee caries arrest.
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6.2.C. SEALANTS

Coverage is limited to fully erupted permanent first and second molars (2, 3, 14, 15, 18, 19, 30, 31) for children ages 5 through 15 for the prevention of pit and fissure caries.

Conditions required for coverage include:

- Surfaces must be free from caries.
- Surfaces to be sealed must be free of any restorations.

Medicaid does not cover sealants applied on beneficiaries with:

- Rampant decay.
- Previous restoration on identified tooth.

Coverage for sealants is limited to once every three years and the fee includes repair and replacement for three years. Application of sealants may be by a dentist or dental hygienist.

6.2.D. SPACE MAINTAINERS

Coverage is limited to beneficiaries under age 13. They are limited to the necessary maintenance of a posterior space for a permanent successor to a prematurely lost primary tooth.

Only one space maintainer is covered for a quadrant. Frequency limitations are once every two years.

6.3 RESTORATIVE TREATMENT

Restorative treatment using Amalgam or Direct Resin-Based Composite materials to restore carious lesions or fractured teeth is a covered benefit for all beneficiaries. Limited indirect restorations (crowns) are covered for beneficiaries under age 21. Restorative treatment is limited to those services necessary



to restore and maintain adequate dental health. 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.

Replacement or repair of a restoration is the provider’s responsibility for the first two years following placement of all restorations. 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. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

Restorations are not covered for deciduous teeth where exfoliation is expected to occur within 180 days. Restorations of deciduous molars and cuspids are not covered for ages 12 or older, and restorations of deciduous incisors are not covered for ages five or older.

Dentists must report procedures using the appropriate dental procedure codes defined in the CDT (Current Dental Terminology) resources. The current definitions of surfaces and the multiple surface codes are to be used as written.

6.3.A. AMALGAM RESTORATIONS

Tooth preparation, all adhesives (including amalgam bonding agents), liners and bases are not separate benefits and must be included in the total fee for the restorations. If pins are used, they should be reported under the appropriate code.

6.3.B. RESIN-BASED COMPOSITE RESTORATIONS – DIRECT

Resin-based composite refers to a broad category of materials including, but not limited to, composite, light-cured composite and glass ionomers. Tooth preparation, acid etching, adhesives, bonding agents, liners, bases and curing are included as part of the restoration. If pins are used, they should be reported under the appropriate code.

6.3.C. INDIRECT RESTORATIONS

Limited crown coverage is a covered benefit for beneficiaries under age 21. Limited crown coverage includes:

Provisional Crowns	<ul style="list-style-type: none"> Stainless steel crown – for primary teeth and permanent molars Stainless steel crown with resin window – for anterior primary teeth Crowns are covered only once per two years by any provider.
Crowns	<ul style="list-style-type: none"> Laboratory-processed resin crown and ¾ resin crowns (indirect) – for anterior permanent teeth only; prior authorization (PA) is required. Crowns are covered only once per five years by any provider.

The following are allowed for permanent teeth only when a restorative crown will be placed:

- Direct core build-up, including any pins
- Post and core substructures (indirectly fabricated or prefabricated)



6.4 ENDODONTICS

Endodontics is a benefit only for beneficiaries under age 21.

6.4.A. ROOT CANAL THERAPY

Program coverage for root canal therapy is solely for the professionally accepted, conventional root canal treatment modalities. These involve complete removal of pulpal tissue to the tooth apex, canal enlargement and debridement, and the obliteration of the entire root canal by the permanent insertion of an inert, nonresorbable filling material. The Sargenti technique is not a covered benefit.

Root canal therapy is a benefit only where otherwise sound teeth can be reasonably restored under program coverages, and the condition of the rest of the mouth supports this method of treatment.

The root canal therapy is not covered if the following conditions exist:

- Furcation pathology is present.
- A posterior tooth has no opposing tooth.
- Tooth is not restorable under Medicaid guidelines.

6.4.B. PULPOTOMY

A therapeutic pulpotomy is a benefit for beneficiaries under age 13 if it is performed on primary teeth or permanent teeth with open apices. It is not considered the first stage of root canal therapy. If exfoliation appears imminent, a pulpotomy is not a covered benefit.

6.4.C. PULPECTOMY

Pulpal therapy is a benefit for beneficiaries under age 8 on anterior primary teeth and under age 13 on posterior primary teeth when the tooth is non-vital or hemostasis cannot be established by conventional pulpotomy.

6.4.D. PULPAL DEBRIDEMENT

Pulpal debridement is a benefit for beneficiaries under age 13 if it is performed on primary teeth or permanent teeth prior to conventional root therapy. It is not covered when root canal therapy is completed on the same day.

6.4.E. APEXIFICATION

Apexification is a benefit for beneficiaries under age 13 and is limited to permanent teeth when the apex has not completely closed.



6.4.F. APEXOGENESIS

Apexogenesis is a benefit for beneficiaries under age 21 and is limited to permanent teeth. This service is not considered the first stage of root canal therapy.

6.4.G. RETREATMENT OF PREVIOUS ROOT CANAL THERAPY

Retreatment of previous root canal therapy is a covered benefit for beneficiaries under age 21 once per tooth per lifetime. Prior authorization is required. Retreatment requires the removal of all previous root canal materials and the necessary preparation of the canals for new root canal filling materials. It includes all procedures necessary for complete root canal therapy and should be considered prior to performing an apicoectomy. Prior authorization requests must include a periapical image and documentation of the reason for retreatment.

6.4.H. APICOECTOMY

Apicoectomy is a surgical procedure to repair a root pathology, defect, fracture or removal of extruding instruments, materials or root fragments. It also includes the sealing of accessory canals. An apicoectomy should be done only after a tooth has had at least one root canal procedure and retreatment has not been successful or is not possible.

6.5 PERIODONTICS

Full mouth debridement is performed as a therapeutic, not preventive, treatment for beneficiaries to aid in the evaluation and diagnosis of their oral condition. It is the removal of subgingival and/or supragingival plaque and calculus.

Full mouth debridement is a benefit for beneficiaries age 14 and over once every 365 days. It is not covered when a prophylaxis is completed on the same day.

No other periodontal procedures are considered to be covered benefits.

6.6 PROSTHODONTICS (REMOVABLE)

6.6.A. GENERAL INSTRUCTIONS

Complete and partial dentures are benefits for all beneficiaries. All dentures require PA. Remaining maxillary teeth must be structurally and periodontally sound, with good distribution to support a maxillary partial denture for five years. Providers must assess the beneficiary's general oral health and provide a five-year prognosis for the prosthesis requested. The provider is responsible for discussing the treatment plan with the beneficiary, including any applicable frequency limits and other pertinent information related to the proposed services. Documentation of the beneficiary's agreement with the proposed treatment plan must be retained in the beneficiary's dental record.



Complete or partial dentures are authorized when one or more of the following conditions exist:

- One or more anterior teeth are missing.
- There are less than eight posterior teeth in occlusion (fixed bridges and dentures are to be considered occluding teeth).

If an existing complete or partial denture can be made serviceable, the dentist should provide the needed restorations to maintain use of the existing removable prosthesis. This includes extracting teeth, adding teeth to the existing prosthesis, and removing hyperplastic tissue as necessary to restore the functionality of the complete or partial denture.

Before the final impressions are taken for the fabrication of a complete or partial denture, adequate healing necessary to support the prosthesis must take place following the completion of extractions and/or surgical procedures. This includes the posterior ridges of any immediate denture. When an immediate denture is authorized involving the six anterior teeth (cuspid to cuspid), this requirement is waived.

Reimbursement for a complete or partial denture includes all necessary adjustments, relines, repairs, and duplications within six months of insertion. This also includes such services necessary for an immediate complete denture when authorized. If any necessary adjustments or repairs are identified within the six month time period but are not provided until after the six month time period, no additional reimbursement is allowed for these services.

Complete or partial dentures are not authorized when:

- A previous prosthesis has been provided within five years, whether or not the existing denture was obtained through Medicaid.
- An adjustment, reline, repair, or rebasing will make a prosthesis serviceable.
- A complete or partial denture has been lost or broken beyond repair within five years, whether or not the existing denture was obtained through Medicaid.

When denture services have commenced but irreversible circumstances have prevented delivery, the dentist should bill using the Not Otherwise Classified (NOC) procedure code. A copy of the lab bill and an explanation in the Remarks section of the claim must be included. Providers are paid a reduced rate to offset a portion of the costs incurred. It is the expectation that the probability of removable appliances being delivered and follow-up treatment completed is assessed prior to the initiation of treatment to evaluate whether the treatment is appropriate for the specific patient. Contact the Program Review Division (PRD) regarding the requirements for incomplete dentures. (Refer to the Directory Appendix for contact information.)

6.6.B. COMPLETE DENTURES

Only complete dentures with noncharacterized teeth (i.e., without cosmetic enhancements, such as gold denture teeth) and acrylic resin bases are a benefit of



Medicaid. To be covered by Medicaid, all of the following procedures must be used to fabricate the dentures:

- Individual positioning of the teeth;
- Waxup of the entire denture body; and
- Conventional laboratory processing.

A preformed denture with teeth already mounted (i.e., teeth already set in acrylic prior to initial impressions) forming a denture module is not a covered benefit. Overdentures or Cusil dentures are not a covered benefit.

6.6.C. IMMEDIATE COMPLETE DENTURE

An immediate complete denture is a benefit only when the immediate extractions involve only the anterior teeth, whether maxillary or mandibular. When requesting PA, the dentist must state on the request that the denture will be an immediate denture, which teeth will be extracted at the denture insertion visit, and the reason the immediate denture is needed.

For reasons of denture stability and retention, an immediate denture is not a benefit:

- For the posterior segments of the maxillary or mandibular arch.
- Where cast metal base saddle areas are to be provided.

6.6.D. PARTIAL DENTURE

Partial dentures are a covered benefit for all beneficiaries over age 16 with the following limitations:

- A one-piece cast metal partial denture is not a benefit.
- Elaborate appliance items, such as semi-precision or precision attachments, stress breakers, hinge saddle areas, or Kennedy (lingual) blankets are not benefits.

All clasps are included in the fee for the partial denture.

To ensure that eruption of the teeth is completed before a permanent appliance is placed, partial dentures are not a covered benefit for beneficiaries under age 16. To replace a lost anterior tooth on a patient under age 16, PA must be submitted for an interim partial denture.

6.6.E. INTERIM COMPLETE & PARTIAL DENTURES

Interim complete dentures are authorized only in very unusual situations. For beneficiaries under the age of 16, interim partial dentures (sometimes called a "stay-plate") to replace anterior teeth are authorized. The provider must submit justification and explanation of proposed future treatment with the PA request.



6.6.F. RELINES

After the initial six-month interval, relines or duplications are covered benefits only once within a two-year period. Relines may be laboratory-processed or chair side. Relines and adjustments are not payable on the same date of service.

6.6.G. REPAIRS

After the initial six-month interval, repairs and adjustments to complete or partial dentures are covered benefits only twice in a 12-month period. If more repairs are needed, they are the responsibility of the treating dentist. Repairs for interim partial dentures are not covered.

The allowance for a complete or partial denture repair, including a reline or rebase, does not exceed half the fee for a new denture if repairs are within six months of the replacement date for the dentures.

6.7 ORAL SURGERY

Oral surgical procedures are benefits for all beneficiaries.

The extraction of teeth for orthodontic purposes is not a benefit. Reimbursement for operative or surgical procedures includes local anesthesia, analgesia, and routine postoperative care.

Surgical procedures such as surgeries of the jaw or facial bones are considered a medical benefit, not a dental benefit.

6.7.A. EXTRACTIONS

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.

6.7.B. TOOTH REPLANTATION AND FIXATION

Tooth replantation and fixation is a benefit for beneficiaries under age 21 when permanent anterior teeth are avulsed or displaced due to traumatic injury.



6.7.C. ALVEOLOPLASTY

Alveoloplasty is a covered benefit for all beneficiaries.

Alveoloplasty performed in conjunction with extractions is a separate procedure performed at the time of the extractions in the surgical preparation of the ridge for complete or partial dentures.

Alveoloplasty in an edentulous area not performed in conjunction with extractions (secondary alveoloplasty) is not covered if recent extractions have been performed in that quadrant.

6.8 ADJUNCTIVE GENERAL SERVICES

6.8.A. ANESTHESIA

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.

6.8.B. PROFESSIONAL VISITS

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.



SECTION 7 – NONCOVERED SERVICES

The following dental services are excluded from Medicaid coverage:

- Orthodontics
- Gold Crowns, Gold Foil Restorations, Inlay/Onlay restorations
- Fixed Bridges
- Bite Splints, Mouthguards, sports appliances
- TMJ Services
- Services or Surgeries that are experimental in nature
- Dental Devices not approved by the FDA
- Analgesia, Inhalation of Nitrous Oxide



SECTION 8 – CHILDREN'S SPECIAL HEALTH CARE SERVICES DENTAL SERVICES

8.1 COVERED SERVICES

Covered CSHCS dental services are primarily for the specialty care of children with complicated congenital defects affecting the oral cavity. Refer to the Children's Special Health Care Services Chapter of this manual for the qualifying dental diagnosis that covers specialty dental services. Once it is determined that the qualifying diagnosis renders the child eligible for dental care, all of the dental services necessary to address the qualifying condition are covered by the CSHCS program. The range of specialty services may include treatment by an oral-maxillofacial surgeon, orthodontist, pedodontist, and/or prosthodontist. The services of a general dentist may be authorized as supportive service to the specialty care. Service coverage determination for the multiply-handicapped child or for conditions of spasticity requiring dental services in a hospital setting are made on an individual basis.

General dental services are also available for CSHCS beneficiaries with a qualifying diagnosis. Refer to the Children's Special Health Care Services Chapter of this manual for the qualifying diagnosis for general dental services. The general dental services are those benefits that are provided through the Medicaid Fee-For-Service (FFS) program. These services are diagnostic, preventive, restorative, and oral surgery procedures.

Beneficiaries under age 21 who are dually-enrolled in Medicaid and Children's Special Health Care Services (CSHCS) will receive their general dental benefits through *Healthy Kids Dental* up to age 21. If the beneficiary's CSHCS diagnosis qualifies for CSHCS specialty dental services (e.g., orthodontics), the specialty dental services are administered through MDHHS and are not part of the *Healthy Kids Dental* benefit plan. The specialty provider must be a CSHCS approved provider listed on the beneficiary's file, and must follow the coverage requirements and claims procedures for specialty dentistry described in this chapter and in the Billing & Reimbursement for Dental Providers Chapter.

The CSHCS representative at the local health department should be contacted if there are questions regarding a beneficiary's eligibility for the CSHCS program.

No treatment is authorized for beneficiaries beyond age 21.

8.2 COVERED SERVICES AND GENERAL PRIOR AUTHORIZATION INFORMATION

Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters, including CSHCS covered services and prior authorization requirements.

The majority of dental services covered for the CSHCS program require PA. Providers must follow the PA completion instructions explained in the Prior Authorization Section of this chapter. PA requests are effective for a six-month period.

8.2.A. ORTHODONTIC SERVICES

Orthodontic treatment is covered for CSHCS beneficiaries who have a qualifying dental diagnosis that includes orthodontia. Only CSHCS approved orthodontists may provide accepted standards of orthodontic treatment. Services that are non-traditional or



experimental are not covered. It is the responsibility of the provider to verify CSHCS eligibility prior to rendering services.

NOTE: CSHCS coverage ends at age 21. Services completed after the client's 21st birthday will not be reimbursed.

Information regarding CSHCS medical eligibility criteria and qualifying diagnoses for specialty dental services can be found in the Children's Special Health Care Services chapter. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

Prior authorization (PA) is required for each phase of orthodontic treatment, including interceptive, comprehensive, and continued care. PA requests for orthodontic services must be submitted on the Dental Prior Approval Authorization Request form (MSA-1680-B). PA requests must be approved prior to the initiation of any treatment. Requests submitted after the initiation of services will result in the denial of the PA request and non-payment of services.

The following documentation must be included with each completed MSA-1680-B as applicable to each phase of treatment:

- Tooth chart documenting teeth present/absent
- A complete orthodontic treatment plan
- Proposed surgery
- Expected timeframe for completion of treatment
- Radiographs (cephalometric, panoramic, full series)
- Optional: Intraoral and facial photographs (not reimbursed by Medicaid)

8.2.A.1. PRE-ORTHODONTIC TREATMENT VISIT

The pre-orthodontic treatment visit includes the examination and diagnostic casts. Radiographs (full mouth series, cephalometric, panoramic) are reimbursed separately from the evaluation. The pre-orthodontic treatment visit does not require prior authorization (PA).

8.2.A.2. INTERCEPTIVE ORTHODONTIC TREATMENT

Interceptive orthodontic treatment is considered intervention in the early stages of a developing problem. It must be completed during the appropriate developmental stage for success. The treatment must be deemed necessary to lessen the severity or prevent future effects of a malformation and may involve non-surgical appliances used for palatal expansion. Interceptive orthodontic treatment is a one-time PA request for the entire time period of treatment. Early phases of comprehensive treatment are not considered interceptive treatment.



A single claim is submitted for the entire interceptive treatment phase. The banding/start date is the Date of Service (DOS), and the PA number must be included on the claim. Reimbursement is made for the entire treatment time period and is considered payment in full.

8.2.A.3. COMPREHENSIVE ORTHODONTIC TREATMENT

Comprehensive orthodontic treatment codes are used when multiple phases of treatment are provided at different stages of orofacial development. Comprehensive orthodontic treatment services are covered for a lifetime maximum of six years, with each phase of treatment covered for up to two years. There is an initial reimbursement for each stage, with a maximum allowable amount within the two year period. The submission of the first PA request for comprehensive orthodontic treatment should list the appropriate procedure code and the banding/start date of treatment.

Comprehensive orthodontic procedure codes are used in the first stage of each comprehensive treatment phase. The DOS is the banding insertion date, and the PA number must be included on the claim. An initial payment is made with a claim submission using the comprehensive orthodontic procedure code and the banding insertion date as the DOS. Subsequent payments are made bi-annually using the periodic orthodontic treatment procedure code.

8.2.A.4. PERIODIC ORTHODONTIC TREATMENT

Periodic orthodontic treatment requires prior authorization (PA). For each six-month time period, a new PA request must be approved prior to the continuation of treatment.

For each additional six-month time period, a separate PA request for a periodic orthodontic treatment visit must be submitted, including the periodic treatment code and description of service. In addition, the start date of the entire stage of orthodontic treatment should be included. The periodic orthodontic treatment procedure code may be used up to a maximum of four times per comprehensive orthodontic treatment. This information is necessary for reviewing case histories and verifying the payment status of the client. No additional PA will be approved if the provider has received the maximum allowable reimbursement for treatment.

When billing the periodic orthodontic treatment visit, the DOS is the first day of the six-month treatment period. The DOS cannot be the same as the banding insertion date. The beginning and end dates for the entire time period should be entered in the Remarks Section of the claim form. The PA number must be included on the claim.

Periodic orthodontic treatment is reimbursed based on a six-month time period. If treatment ends prior to the completion of the six-month time period, the provider pro-rates the charges according to the treatment time frame (e.g., if only three months are needed to complete treatment, the charges should reflect half of the current periodic orthodontic treatment fee).



When paid reimbursement to the provider has met the maximum allowable for the specific phase of treatment, no additional reimbursement will be made and the case is considered paid in full.

8.2.A.5. DEBANDING/RETENTION

Debanding and retention are considered part of the interceptive and comprehensive orthodontic treatment phases and are included in the reimbursement rate.

Replacement of lost or broken retainers is allowed twice per lifetime per client.

8.2.B. SPECIALTY CROWN AND BRIDGE SERVICES

Qualification for specialty crown and bridge services is based on the specific diagnoses and treatment plan. Not all CSHCS beneficiaries will qualify for specialty crown and bridge services.

Crowns and bridges:

- Require prior authorization.
- Will not be replaced within five years of the insertion date.

Refer to the Children's Special Health Care Services chapter for additional information on specialty dental benefits.

8.2.C. IMPLANT SERVICES

Dental implants, surgical guides and occlusal guards are covered for CSHCS beneficiaries who have a qualifying diagnosis of anodontia or traumatic injury to the dental arches, and standard restorative treatment is contraindicated.

Dental implants require prior authorization and must be approved before the initiation of treatment. Submission of the following information is required:

- Complete medical history
- Complete dental history
- Diagnoses
- Treatment plan
- Panoramic x-ray
- Medical justification for the implant services, including the reason alternative forms of prosthetics would not restore function effectively

Providers performing dental implant and adjunctive services must have specialized training in implant procedures (e.g., licensed oral-maxillofacial surgeons or periodontists). Providers must be approved by CSHCS and authorized on the individual CSHCS beneficiary's authorized provider file to receive reimbursement. (Refer to the



Children's Special Health Care Services chapter for CSHCS provider approval/authorization information.)

Adjunctive services, including surgical stents, surgical splints and occlusal guards, are covered only when necessary for the success of implant services. Adjunctive services require prior authorization and must include a reason why the services are necessary.

Procedure codes and descriptions for surgical implants, custom or prefabricated abutments, implant supported crowns, occlusal guards and specialized prosthetics are found within the American Dental Association's Current Dental Terminology (CDT) Manual. For additional information regarding coverage parameters, refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter.

When billing for implant procedures, the date of service is the date of completion.

NOTE: CSHCS coverage ends at age 21. The client cannot be billed for services completed after CSHCS eligibility ends.

8.2.D. ADDITIONAL SERVICES

For those services for which there is no procedure code, the Not Otherwise Classified (NOC) code is used. These services also require prior authorization.



SECTION 9 – HEALTHY KIDS DENTAL

9.1 COVERAGE AND SERVICE AREA INFORMATION

MDHHS contracts with dental health plans (DHPs) for the administration of dental services for *Healthy Kids Dental* (HKD) beneficiaries. The DHPs are paid a monthly capitation rate to provide covered services to enrolled Medicaid beneficiaries. The DHP is responsible for providing, arranging, and reimbursing covered dental services.

The HKD benefit plan covers, at a minimum, all Codes on Dental Procedures and Nomenclature listed on the MDHHS Dental Fee Schedule, including:

- Emergency dental services
- Diagnostic services
- Preventive services
- Restorative services
- Limited adjunctive services
- Endodontic services
- Limited crown coverage
- Prosthodontics
- Removable prosthodontics
- Oral surgery services
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services
- All medically necessary services

DHPs may cover additional dental services not included on the MDHHS Dental Fee Schedule. Providers must contact the DHP for specific information about covered HKD benefits.

HKD beneficiaries must access dental services through a DHP network dentist. DHP networks provide services throughout the entire state.

9.2 ENROLLMENT INFORMATION

All newly eligible HKD beneficiaries are automatically enrolled in a DHP using the following methodology:

The effective date of enrollment in the DHP will be the first day of the month that CHAMPS receives information that the beneficiary has been determined eligible for Medicaid. For example, if CHAMPS is notified that a beneficiary was determined eligible on October 24, the beneficiary will have a DHP enrollment effective date of October 1.

MDHHS mails confirmation letters to all beneficiaries who have been automatically enrolled in a DHP. The letter includes the beneficiary's assigned DHP and information on their right to choose a different DHP.



Before providing services, dentists and dental staff should verify enrollment and covered dental benefits with the beneficiary's DHP.

9.2.A. CHANGE IN ENROLLMENT

A beneficiary may change DHPs within 90 days of the DHP enrollment effective date. Beneficiaries may contact the MDHHS contracted enrollment broker, MI Enrolls, for help with their DHP selection. MI Enrolls is independent from the DHPs and provides beneficiaries with choice counseling information, including dental provider participation in each DHP's network. Beneficiaries may call or send a form to MI Enrolls to change their DHP.

Any change of DHP made by a beneficiary is made on a prospective basis. If the beneficiary contacts MI Enrolls prior to the last business day of the month, the new DHP enrollment is effective on the first day of the following month. For example, a beneficiary who calls MI Enrolls on October 5 and selects a different DHP is changed to the new DHP effective November 1.

MDHHS gives beneficiaries the opportunity to change DHPs without cause during each beneficiary's annual open enrollment period.

(Refer to the Directory Appendix for MI Enrolls contact information.)

9.2.B. VOLUNTARY ENROLLMENT

American Indian/Alaska Native HKD beneficiaries are a voluntary enrollment population. American Indian/Alaska Native beneficiaries are automatically assigned to a DHP but are given the option to opt-out of dental managed care and be placed in the Medicaid FFS program. MDHHS mails all new automatically assigned American Indian/Alaska Native beneficiaries confirmation letters disclosing their assignment and the option to choose a different DHP or opt-out of dental managed care. American Indian/Alaska Native beneficiaries can opt-out of managed care at any time during the beneficiary's enrollment in the HKD program.

9.2.C. SPECIAL DISENROLLMENT

Beneficiaries are required to remain in their DHP if they do not make a change during their allotted open enrollment period or within 90 days of their assigned DHP's effective enrollment date. Any request to change DHP outside these time frames requires a good cause justification. Beneficiaries who believe they can show good cause may complete and submit the special disenrollment form for a MDHHS Special Disenrollment review. Beneficiaries are required to explain their reason for the requested change and may need to include a statement of support from their dental provider. Providers should refer beneficiaries to MI Enrolls for additional information and for instructions on how to obtain the special disenrollment form.



9.2.D. LOSS OF ENROLLMENT

Beneficiaries who lose Medicaid or Children's Health Insurance Program (CHIP) eligibility while enrolled in a DHP during active treatment that requires appointments beyond the last day of eligibility are covered for services that are completed within 60 days from the date of eligibility loss.

9.3 TRANSITION TO HKD

If a beneficiary enrolled in HKD starts dental treatment prior to being enrolled in a DHP and requires multiple visits, and the dentist has incurred costs related to that care, the dentist must bill Medicaid FFS for the procedure using the begin date as the date of service. For example, a beneficiary is enrolled in a DHP on October 1. If the provider started a root canal treatment on September 26, but does not complete the treatment until October 3, the provider has already incurred the costs of the beneficiary's care and must bill Medicaid FFS for the entire root canal treatment using September 26 as the date of service on the dental claim.

Providers who submit a Dental Prior Approval Authorization Request (MSA-1680-B) to the MDHHS Program Review Division for beneficiaries receiving the FFS dental benefit but have not begun treatment or incurred treatment costs for a procedure must follow the policies and procedures of the beneficiary's assigned DHP to deliver dental treatment.

Covered services rendered during the beneficiary's DHP effective enrollment period must be billed to the beneficiary's DHP. Beneficiaries who are automatically enrolled in a DHP and receive services prior to CHAMPS notification but after the DHP effective enrollment date are eligible to receive services through their assigned DHP for the entire first month of enrollment. Providers must accept payment from the DHP as payment in full. Beneficiaries must not be billed for HKD covered services during their DHP enrollment period.

9.4 BENEFICIARY IDENTIFICATION

Beneficiaries receive a *Healthy Kids Dental* DHP identification card upon enrollment in a DHP. Providers must use the DHP identification card when verifying beneficiary enrollment with the DHP.

9.5 BENEFIT ADMINISTRATION

Dental providers must be enrolled in the Michigan Medicaid program via CHAMPS and be a network provider of the DHP to provide dental services to HKD beneficiaries. Providers may choose to participate in either one or both DHP networks.

DHPs administer covered dental services according to Medicaid policy, contract requirements, and the DHP's standard policies, procedures, prior authorization, and claim submission process. It is the responsibility of the provider to be familiar with and follow the DHP's policies and procedures when providing services to HKD beneficiaries.

There is no beneficiary copayment for HKD services. Reimbursement for covered services rendered to HKD beneficiaries is based on the individual DHP's fee schedule. The DHP provides its fee schedule directly to its network providers. Providers must accept the DHP's reimbursement as payment in full and cannot balance bill the beneficiary for services rendered. For specific information on a DHP's HKD



network participation requirements, reimbursement schedule, or other DHP-specific policies and procedures, providers may contact the DHPs.

(Refer to the Directory Appendix for DHP contact information.)

9.6 DENTAL HEALTH PLAN PROVIDER ENROLLMENT

DHPs are prohibited from making payments to all typical network and out-of-network Michigan providers who appear on a claim and are not enrolled in CHAMPS. Typical providers are professional health care providers that provide health care services to beneficiaries. Typical providers must meet education and state licensure requirements and have assigned National Provider Identifiers (NPIs). Examples of typical provider types include, but are not limited to, dentists, pediatric dentists, and oral surgeons.

A list of currently allowed typical provider enrollment information is available on the MDHHS Provider Enrollment website. Providers not included on the allowed list are not required to enroll. The Provider Enrollment website is updated periodically. Any updates to the MDHHS Provider Allowed Enrollment lists will be subject to provider enrollment requirements. (Refer to the Directory Appendix for website information.)

MDHHS does not prohibit payment to out-of-state, out-of-network pharmacies and providers who provide Medicaid beneficiaries with emergency medical services. Payment for out-of-state, out-of-network dental services is subject to Medicaid policy and applicable health policies and procedures.

Refer to the General Information for Providers Chapter, Provider Enrollment section of this manual for additional provider enrollment information.



EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT

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SECTION 1 – GENERAL INFORMATION

Federal regulations require state Medicaid programs to offer early and periodic screening, diagnosis, and treatment (EPSDT) services to Medicaid eligible beneficiaries younger than 21 years of age; however, beneficiary participation is voluntary. The intent of EPSDT is to provide necessary health care, diagnostic services, treatment, and other measures according to section 1905(a) and 1905(r) [42 U.S.C. 1396d] of the Social Security Act (1967) to correct or ameliorate defects and physical and mental illnesses and conditions discovered whether or not such services are covered under the state plan. State Medicaid programs are required to provide for any services that are included within the mandatory and optional services that are determined to be medically necessary for children under 21 years of age. Accordingly, EPSDT well child visits and any needed follow-up services are covered by Medicaid.

EPSDT visits cover any medically necessary screening and preventive support services for children, including nutritional and at-risk assessments as well as resulting health education and mental health services. These services are available to all children for the purpose of screening and identifying children who may be at risk for, but not limited to, drug or alcohol abuse, child abuse or neglect, trauma, failure to thrive, low birth weight, low functioning/impaired parent, or homeless or dangerous living situations.

EPSDT visits are to be performed in accordance with the American Academy of Pediatrics (AAP) periodicity schedule, its components, and medical guidelines. Michigan recognizes the AAP definition of "medical necessity" as:

Health care interventions that are evidence based, evidence informed, or based on consensus advisory opinion and that are recommended by recognized health care professionals to promote optimal growth and development in a child and to prevent, detect, diagnose, treat, ameliorate, or palliate the effects of physical, genetic, congenital, developmental, behavioral, or mental conditions, injuries, or disabilities.

EPSDT requires the coverage of medically necessary inter-periodic screenings outside of the AAP periodicity schedule. Coverage for such screenings is required based on an indication of a medical need to diagnose an illness or condition that was not present at the regularly scheduled screening or to determine if there has been a change in a previously diagnosed illness or condition that requires additional services.

Medically necessary services include habilitative or rehabilitative services that are expected to attain, maintain, or regain functional capacity and to achieve maximum health and function. A service need not cure a condition in order to be covered under EPSDT, and maintenance services or services that improve the child's current health condition are also covered in EPSDT because they ameliorate a condition. The common definition of ameliorate is "to make more tolerable." Thus, services such as physical and occupational therapy are covered when they have an ameliorative, maintenance purpose. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. It is important to identify illnesses and conditions early and to treat any health problems discovered in children before they become worse and more costly. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. Refer to the Special Coverage Provisions section of the Healthy Michigan Plan chapter for the definition of "habilitative services".



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EPSDT includes a broad range of services that can be covered and includes:

- licensed practitioners services;
- speech, occupational, and physical therapies;
- physician services;
- private duty nursing;
- personal care services;
- home health;
- medical equipment and supplies;
- habilitative and rehabilitative services;
- vision services;
- hearing services; and
- dental services.

In addition, the coverage of other diagnostic, screening, preventive and rehabilitative services is required, and includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level. The coverage of EPSDT services is particularly important for children with disabilities, because such services can prevent conditions from worsening, reduce pain, and avert the development of more costly illnesses and conditions. Other less common examples include items of durable medical equipment, such as decubitus cushions, bed rails and augmentative communication devices. Such services are a crucial component of a good, comprehensive child-focused health benefit.

The determination of whether a service is medically necessary must be made on a case-by-case basis, taking into account the particular physical, behavioral, mental, or dental health needs of the child. While the treating provider is responsible for determining or recommending that a particular service is needed to correct the child's condition, both the Michigan Department of Health and Human Services (MDHHS) and a child's treating provider play a role in determining whether a service is medically necessary. If there is a disagreement between the treating provider, health plan, and/or Medicaid as to whether a service is medically necessary for a particular child, Medicaid is responsible for making a decision for the individual child based on information presented to departmental staff. The MDHHS Office of Medical Affairs consists of a panel of physicians, including pediatricians, who will review the medical necessity of a particular service when there is a disagreement between the treating provider, health plan or Medicaid. These physicians review, on a case-by-case basis, the particular needs of the child based on the medical standards and literature, and in consultation with subspecialists when appropriate in accordance with Michigan Medicaid policy.

A medically necessary treatment service should not be denied to a child based on cost alone, but the relative cost effectiveness of alternative services may be considered as part of the prior authorization process. Services may be covered in the most cost effective mode as long as the less expensive service is equally effective and actually available. Prior authorization must be conducted on a case-by-case basis, evaluating each child's needs individually. Prior authorization is not required for medically necessary screenings.



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The main parts of the EPSDT program that providers are responsible for are:

- Well child visits, including immunizations and developmental screening, using a validated and standardized screening tool at specified intervals as defined in the periodicity schedule by the AAP (hereafter referred to as the "AAP periodicity schedule"). A copy of the AAP periodicity schedule is available on the AAP website. (Refer to the Directory Appendix for website information.)

NOTE: The AAP periodicity schedule requires a risk assessment to be performed for vision, hearing, and blood lead screening at the specified intervals. MDHHS requires vision, hearing, and blood lead testing to be performed at the specific ages indicated on the AAP periodicity schedule. A parent/guardian (or person in loco parentis) applying to register a child for the first time in kindergarten or first grade in a school in this state shall present to school officials, at the time of registration or no later than the first day of school, a certificate of hearing and vision testing or screening or a statement of exemption. Refer to the appropriate section within this chapter for MDHHS requirements regarding vision, hearing, and blood lead screening.

- Referrals for:
 - Other preventive health care;
 - Medically necessary follow-up services to treat detected conditions; and
 - Transportation for health care services.



SECTION 2 – AAP PERIODICITY SCHEDULE AND COMPONENTS

The AAP periodicity schedule and its components are available on the AAP website, and they are to be followed for well child visits. (Refer to the Directory Appendix for AAP website information.)

Head Start agencies are directed by federal regulation to meet state EPSDT standards for health screening. MDHHS urges providers to cooperate with these agencies. Providers are strongly encouraged to share the results with the Head Start agency if that agency was the referral source, and if the provider receives authorization.

Providers must complete all testing components at the ages indicated on the AAP periodicity schedule. Well child visits may be performed more frequently than the AAP periodicity schedule indicates if required by court order, foster care standards, or if considered medically necessary. The child's medical record must reflect documentation of the circumstances.

The following sections follow the AAP periodicity schedule and are meant to provide further guidance to providers. The sections include additional policies and procedures to be performed that are beyond the AAP periodicity schedule guidelines.



SECTION 3 – HISTORY AND WELL CHILD VISITS

An initial history must be obtained for each new patient at the first well child visit, with an update (interval history) at each subsequent well child visit. MDHHS supports the concept of a medical home for each Medicaid beneficiary. A medical home is a primary care provider (PCP) who assumes responsibility for assuring the overall care of a beneficiary, and for the maintenance and updating of a beneficiary's medical record. When a PCP accepts a child in a primary care relationship, the provider takes responsibility for arranging or providing EPSDT well child visits.

Well child visits are the health check-ups, newborn, well baby, and well child exams represented by appropriate Current Procedural Terminology (CPT) preventive medicine services procedure codes and are used in conjunction with the following International Classification of Diseases (ICD) diagnosis codes:

- ICD-9: V20.0 - V20.2, V20.31, V20.32, and/or V70.0, and/or V70.3 - V70.9
- ICD-10: Z76.2, Z00.110, Z00.111, Z00.121, Z00.129, and/or Z00.00-01, and/or Z02.0-Z02.6, Z02.81-Z02.83, Z02.89, Z00.5, Z00.6, Z00.70, Z00.71, Z00.8

The AAP periodicity schedule indicates all components and age-specific indicators for performing the various components. Developmental screening, using an objective validated and standardized screening tool as recommended by the AAP, should be performed at the specified intervals.



SECTION 4 – MEASUREMENTS

4.1 LENGTH/HEIGHT AND WEIGHT

Length, height, and weight must be measured using standardized techniques each time the PCP conducts a well child visit, with good practice requiring graphing of the measurements. A suitable graphing document may be found on the Centers for Disease Control and Prevention (CDC) website. (Refer to the Directory Appendix for website information.)

4.2 HEAD CIRCUMFERENCE

A head circumference measurement is required at each well child visit through 24 months of age.

4.3 WEIGHT FOR LENGTH

Weight for length must be measured each time the PCP conducts a well child visit through 18 months of age, with good practice requiring graphing of the measurements. A suitable graphing document may be found on the CDC website. (Refer to the Directory Appendix for website information.)

4.4 BODY MASS INDEX (BMI)

Body mass index (BMI) must be measured each time the PCP conducts a well child visit for children 24 months of age and older, with good practice requiring graphing of the measurements. A suitable graphing document may be found on the CDC website. (Refer to the Directory Appendix for website information.)

4.5 BLOOD PRESSURE

PCPs must obtain a blood pressure reading at each well child visit beginning at 3 years of age. Blood pressure measurement in infants and children with specific risk conditions should be performed at well child visits before 3 years of age.



SECTION 5 – SENSORY SCREENING

5.1 VISION SCREENING

PCPs are to perform a subjective vision screening (i.e., by history) or risk assessment at each well child visit as recommended by the AAP periodicity schedule. For asymptomatic children 3 years of age and older, an objective screening must occur as indicated on the AAP periodicity schedule. An objective vision screening is accomplished using a standardized screening tool. A visual acuity screen is recommended at 4 and 5 years of age, as well as in cooperative children 3 years of age. Instrument-based screening may be used to assess risk at 12 and 24 months of age, in addition to the well child visits at 3 through 5 years of age. MDHHS requires vision testing at specific well child visits for children 3 years of age and older.

5.1.A. PRESCHOOL

An objective vision screening may be performed on Medicaid eligible preschool-age children each year beginning at 3 years of age through 6 years of age by qualified Local Health Department (LHD) staff. If the child is uncooperative, the screening should be re-administered within six months. LHDs may provide objective vision screening services and accept referrals for screening from the PCP and from Head Start agencies. In an effort to promote communication with the child's medical home, the objective vision screening results must be reported to the child's PCP. In the event the LHD is unable to report the objective vision screening results to the child's PCP, the LHD must clearly document why this could not be accomplished. Providers are strongly encouraged to share the results with the Head Start agency if that agency was the referral source, and if the provider receives authorization.

5.1.B. REFERRAL

For children of any age, referral to an optometrist or ophthalmologist should be made if there are symptoms or other medical justification (e.g., parent/guardian has suspicions about poor vision in the child). A routine eye examination by an optometrist or ophthalmologist once every two years is a Medicaid benefit and does not require prior authorization.

5.2 HEARING SCREENING

Providers are to perform a subjective hearing screening (i.e., by history) or risk assessment at each well child visit as recommended by the AAP periodicity schedule. For asymptomatic children, an objective screening must occur as indicated on the AAP periodicity schedule. Screen the child with audiometry, including 6,000 and 8,000 Hz high frequencies, once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. Confirm the initial screen was completed, verify the results as soon as possible, and follow-up as appropriate.



5.2.A. NEWBORNS/INFANTS [CHANGE MADE 10/1/20]

All newborns must be screened using evoked otoacoustic emissions (EOAE) and/or auditory brainstem response (ABR) methods. The hospital must provide newborn hearing screenings for Medicaid-covered newborns as indicated by the AAP. If the newborn fails the first screening, another screening must be conducted prior to the newborn's discharge. Coverage for the EOAE and ABR newborn hearing screenings is included within the applicable diagnosis related group (DRG) payment for the newborn's inpatient stay. If the hospital is not equipped for EOAE and/or ABR, the newborn's PCP must be made aware of this fact by the hospital so the newborn can be referred for a hearing screening prior to 1 month of age.

For infants who do not pass ABR testing in the neonatal intensive care unit (NICU), a referral should be made directly to an audiologist for rescreening and, when indicated, a comprehensive evaluation including ABR. For rescreening, a complete screening on both ears is recommended, even if only one ear failed the initial screening. For readmissions in the first month of life for all infants, when there are conditions associated with potential hearing loss, a repeat hearing screening is recommended before discharge. All infants who do not pass the initial hearing screening and the subsequent rescreening should have appropriate audiological and medical evaluations to confirm the presence of hearing loss at no later than 3 months of age. All infants with confirmed permanent hearing loss should receive early intervention as soon as possible after diagnosis but at no later than 6 months of age.

The results of all hearing tests and screenings conducted on infants who are younger than 12 months of age must be reported to the MDHHS Early Hearing Detection and Intervention (EHDI) program. The Audiological/Medical Follow-up Services Report form (DCH-0120) is to be completed and shall include the type, degree, and symmetry of the diagnosis, along with where and when the diagnosis was made. The form is to be submitted to the EHDI program. (Refer to the Directory Appendix for contact and form information.)

Refer to the Newborn Hearing Services subsection of the Hearing Services **and Devices (revised 10/1/20)** Chapter for additional information.

5.2.B. PRESCHOOL

An objective hearing screening may be performed on Medicaid eligible preschool-age children by qualified LHD staff. LHDs may provide objective hearing screening services and accept referrals for screening from the PCP and from Head Start agencies. In an effort to promote communication with the child's medical home, the objective hearing screening results must be reported to the child's PCP. In the event the LHD is unable to report the objective hearing screening results to the child's PCP, the LHD must clearly document why this could not be accomplished. The results of all hearing tests and screens conducted on children who have been diagnosed with hearing loss who are younger than 3 years of age must be reported to the EHDI program. Providers are strongly encouraged to share the results with the Head Start agency if that agency was the referral source, and if the provider receives authorization.



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5.2.C. REFERRAL

A referral to a hearing center, audiologist, otologist, or Children’s Special Health Care Services (CSHCS)-sponsored otology clinic at a LHD should be made if there are symptoms (e.g., parent/guardian has suspicions about poor hearing in the child), risk factors (e.g., exposure to ototoxic medications, family history of hearing deficits), or other medical justification for further objective testing or diagnosis.



SECTION 6 – DEVELOPMENTAL/BEHAVIORAL ASSESSMENT

A developmental/behavioral assessment is required at each scheduled EPSDT well child visit from birth through adolescence as recommended by the AAP periodicity schedule. The PCP should screen all children for developmental and behavioral concerns, including engaging in risky behavior, using a validated and standardized screening tool as indicated by the AAP periodicity schedule.

A maximum of three objective standardized screenings may be performed in one day for the same beneficiary by a single provider. (Refer to the Billing & Reimbursement for Professionals Chapter for billing instructions.) If the screening is positive or suspected problems are observed, further evaluation must be completed by the PCP, or the child should be referred for a prompt follow-up assessment to identify any further health needs. The provider may administer additional screenings, surveillance, or assessments as described in the following subsections.

6.1 DEVELOPMENTAL SCREENING

A developmental screening using an objective validated and standardized screening tool must be performed following the AAP periodicity schedule at 9, 18 and 30 (or 24) months of age, and during any other preventive health care well child visits when there are parent/guardian and/or provider concerns. Developmental screening may be accomplished by using a validated and standardized developmental screening tool such as the Ages and Stages Questionnaire (ASQ) or Parents' Evaluation of Developmental Status (PEDS). If the screening is positive, PCPs should further evaluate the child, provide counseling, and refer the child as appropriate.

6.2 AUTISM SPECTRUM DISORDER SCREENING

A validated and standardized screening tool must be administered as part of the well child visit by a physician. Proper assessment of autism spectrum disorder is accomplished by administering a validated and standardized screening tool, such as the Modified Checklist for Autism in Toddlers (M-CHAT), at 18 and 24 months of age as indicated by the AAP periodicity schedule. Surveillance for Autism Spectrum Disorder (ASD) must be completed during other well child visits beginning at 12 months of age by listening for parent/guardian concerns and by watching for red flag abnormalities, such as no babbling by 12 months of age. Children 24 months of age and older who have not been screened may be screened during preventive health care well child visits using a validated and standardized screening tool such as the M-CHAT or the Social Communication Questionnaire (SCQ).

The screening tool may be completed by the parent/guardian and reviewed/verified by the PCP. The M-CHAT is validated for children 16 through 30 months of age. For children 4 years of age and older (mental age greater than 2 years of age), the SCQ may be utilized. For children 30 months through 4 years of age, the more applicable of the two screening tools should be administered (M-CHAT if mental age is younger than 2 years of age; SCQ if mental age is greater than 2 years of age). If the screening is positive, the PCP should contact the Pre-paid Inpatient Health Plan (PIHP) directly to arrange for a follow-up evaluation. (Refer to the Directory Appendix for the National Autism Center contact information and for additional resources regarding ASD.)



6.3 DEVELOPMENTAL SURVEILLANCE

Developmental surveillance should occur at every well child visit throughout childhood and must be performed as indicated by the AAP periodicity schedule. Developmental surveillance includes eliciting and attending to parent/guardian concerns, maintaining a developmental history, making accurate and informed observations of the child, identifying the presence of risk and protective factors, and documenting the process and findings. Further investigation, an appropriate referral, and/or an early return visit should be scheduled for children whose surveillance raises concerns that are not confirmed by a developmental screening tool.

6.4 PSYCHOSOCIAL/BEHAVIORAL ASSESSMENT

Children should be observed to detect psychosocial and behavior issues. A psychosocial/behavioral assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. A psychosocial/behavioral assessment should occur during every well child visit and may be accomplished by surveillance or by using a validated and standardized screening tool such as the Ages and Stages Questionnaire – Social-Emotional (ASQ-SE) or Pediatric Symptom Checklist (PSC), with appropriate action to follow if the assessment is positive. The use of validated and standardized screening tools improves the detection rate of social-emotional problems in children compared to the reliance on subjective clinical judgment. Social-emotional screening for children from birth to 5 years of age should be performed whenever there are general development delays; at any time the clinician observes poor growth, poor attachment, or symptoms such as excessive crying, clinginess, or fearfulness for developmental stage, or regression to earlier behavior; and/or at any time the parent/guardian identifies psychosocial/behavioral concerns. If the assessment is positive, the PCP should further evaluate the child, provide counseling, and refer the child as appropriate. Refer to the Children in Foster Care Section of this chapter for more information regarding the administration of a psychosocial/behavioral assessment for children in foster care.

6.5 TOBACCO, ALCOHOL OR DRUG USE ASSESSMENT

A tobacco, alcohol or drug use assessment must be performed annually at each preventive health care well child visit beginning at 11 years of age or when there are circumstances suggesting the possibility of substance abuse beginning at an earlier age. A risk assessment should be administered and, if necessary, the child should be screened for tobacco, alcohol, and other drug use with a validated and standardized screening tool, such as the CRAFFT (Car, Relax, Alone, Forget, Friends, Trouble) screen. If the assessment and screening are positive, the PCP should further evaluate the child, provide counseling, and refer the child as appropriate.

6.6 DEPRESSION SCREENING

A depression screening is to be performed annually for all children and adolescents who are 12 years of age and older as indicated by the AAP periodicity schedule. A depression screening may be accomplished using a standardized screening tool such as the Patient Health Questionnaire-2 (PHQ-2), Patient Health Questionnaire (PHQ-9), or other screening tools available in the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) toolkit and the Mental Health Screening and Assessment Tools for Primary Care. (Refer to the Directory Appendix for website information.)



6.7 MATERNAL DEPRESSION SCREENING

Screening for maternal depression with a screening tool, such as the Edinburgh scale, is to be performed by the infant's PCP as recommended by the AAP periodicity schedule. It is intended that the service should be reported and billed under the infant's Medicaid ID number using the appropriate Current Procedural Terminology (CPT) code as it is a service rendered for the benefit of the infant. If the screening is positive, the PCP should address the mother-child dyad relationship (attachment and bonding), follow-up, and refer as appropriate.



SECTION 7 – TRAUMA SERVICES

Children under 21 years of age are covered for trauma-related services under the EPSDT benefit. Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and has lasting adverse effects on the child's functioning and physical, social, or emotional well-being. According to adverse childhood experiences (ACEs), adverse early trauma experiences are related to increased rates of health problems in adulthood including obesity, cardiovascular disease, substance use, mental health problems, social risk factors, and poor health-related quality of life. "Toxic stress" is described as a type of unremitting stress that ultimately compromises a child's ability to regulate their stress response system effectively and can lead to adverse long-term structural and functional changes in the brain and elsewhere in the body. Trauma-specific interventions should be identified to reduce the prevalence and consequences of ACEs and trauma. Trauma-specific interventions generally recognizes the following:

- The child's need to be respected, informed, connected, and hopeful regarding their own recovery;
- The interrelation between trauma and symptoms of trauma such as substance use, eating disorders, depression, and anxiety; and
- The need to work in a collaborative way with the child, family and friends of the child, and other human services agencies.

The primary care provider (PCP) should:

- Strengthen their provision of anticipatory guidance to support children's social-emotional-linguistic skills and to encourage the adoption of positive parenting techniques;
- Actively screen for precipitants of toxic stress that are common in their particular practices;
- Assess the child's exposure to trauma and risk of exposure to trauma using a questionnaire or screening tool. Screening tools are available through the American Academy of Pediatrics (AAP); and
- Identify (or advocate for the development of) local resources that address risks for toxic stress that are prevalent in their communities.

Providers may use current best practices to screen for precipitants of toxic stress. Examples of current trauma screening tools, as indicated by the AAP, include:

- Adverse Childhood Experiences Questionnaire (ACE-Q)
- Resilience Questionnaire
- Pediatric Intake Form

History of trauma may or may not be disclosed by the family or child. The PCP may need to ask about possible current or past exposure to traumatic events and assess for the child's safety. Questions may be targeted when there are unexplained somatic complaints or other indicators that may be associated with exposures to trauma or adversity. The PCP may consider asking the caregiver and/or child explicitly about the exposure to trauma. Providers may refer to the AAP policy statement for questions to ask parent/caregivers. Examples of those questions include:



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- “Has your home life changed in any significant way (e.g., moving, new people in the home, people leaving the home)?”
- “Do you have any concerns about your child’s behavior at home, child care or school, or in the neighborhood? Has your child’s teacher mentioned any concerns?”
- “Many children are exposed to violence at home, in the neighborhood, at school or with friends. Do you think your child may have been exposed to violence?”
- “All children are exposed to stress. Sometimes stress can make a child sad or scared. Do you have any concerns about your child’s stress?”

Examples of questions to ask the school-aged child include:

- “Are you having any problems at home, at school, or in the neighborhood?”
- “Do you feel safe at home and/or at school?”
- “How do you deal with stress?”

7.1 REFERRALS FOR BEHAVIORAL HEALTH SERVICES/THERAPY

If the screening is positive, the PCP should refer the child to a mental health professional trained to provide trauma assessment, treatment using a trauma-specific model, and/or support. Behavioral health services are a Medicaid covered service.

Behavioral health services are covered by the local Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) for the services included under the capitation payments to the PIHPs/CMHSPs. A limited outpatient benefit is covered for children enrolled in a Medicaid Health Plan (MHP) or through Fee-for-Service (FFS) Medicaid.

In general, MHPs are responsible for outpatient mental health treatment when the child is experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior. For children not enrolled in a MHP, behavioral health services are covered through FFS Medicaid. Under FFS, behavioral health services may be provided by a physician (MD or DO), physician assistant, nurse practitioner, psychologist, social worker, professional counselor, or marriage and family therapist working within their scope of practice under State law.

In general, PIHPs/CMHSPs are responsible for outpatient mental health treatment for a child with a serious emotional disturbance as indicated by the diagnosis, intensity of current signs and symptoms, and substantial impairment in ability to perform daily living activities. The child may experience substantial interference in achievement or maintenance of developmentally appropriate social, behavioral, cognitive, communicative or adaptive skills. For children not enrolled in an MHP and for services not included in the capitation payments to the PIHP/CMHSP, behavioral health services are covered through FFS Medicaid. (Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter for additional information. Additional information is also available on the MDHHS website; refer to the Directory Appendix for website information.)



SECTION 8 – PHYSICAL EXAMINATION

A complete physical examination must be performed at each well child visit. Infants are to be totally unclothed and older children must be undressed and suitably draped. If the patient is an adolescent or young adult and the examination requires inspection or palpation of anorectal or genital areas and/or the female breast, a chaperone is recommended. The use of a chaperone should be a shared decision between the patient and the PCP. If the patient declines the use of a chaperone, the provider should document this fact in the medical record. The purpose of the well child examination is to promote health, detect medical problems, and to counsel in order to prevent injury and future health problems. The physical examination also provides opportunities to educate children, adolescents, and their parents/guardians about the body and the growth and development process. The physical examination must be comprehensive and appropriate for the infant's, child's, or adolescent's age, gender, and developmental status, and should build on the history gathered during previous medical and well child visits. The provider should review the scope and findings of the examination with the patient and parents/guardians at the completion of the examination. This review should be documented in the medical record.



SECTION 9 – PROCEDURES

9.1 NEWBORN BLOOD SCREENING

A provider in charge of the care of a newborn child shall administer or cause to be administered to the newborn child a newborn blood screening test. Hospitals must test newborns for over 50 disorders as indicated by the AAP periodicity schedule and as required by Michigan law. The complete list of disorders is determined by MDHHS. If the results of a test administered are positive, the results shall be reported to the newborn child's parents/guardians. Blood samples are to be sent to the MDHHS Bureau of Laboratories Newborn Screening Section. If further sickle cell testing is appropriate, a capillary blood sample may be mailed to the Sickle Cell Disease Association of America, Michigan Chapter (SCDAA-MI). Tubes, forms, and envelopes may be obtained from SCDAA-MI. (Refer to the Directory Appendix for contact information.)

9.2 NEWBORN BILIRUBIN

A universal predischarge newborn bilirubin screening (measurement and assessment of clinical risk factors) is to be performed using total serum bilirubin (TSB) or transcutaneous bilirubin (TcB) measurements to evaluate the risk of subsequent severe hyperbilirubinemia as recommended by the AAP periodicity schedule. The PCP should confirm initial screening was accomplished, verify the results, and follow-up as appropriate.

9.3 CRITICAL CONGENITAL HEART DEFECT SCREENING

A critical congenital heart defect (CCHD) screening is to be administered to the newborn child as indicated by the AAP periodicity schedule. The screening should not be performed until 24 hours after the birth of the child and should be performed as late as possible if an early discharge is planned in order to reduce the number of false positive results. The screening should be performed with motion-tolerant pulse oximeters using either disposable or reusable pulse oximetry probes.

Oxygen saturations should be obtained from the right hand and one foot. Screening that has a pulse oximetry reading of $\geq 95\%$ in either extremity with a $\leq 3\%$ absolute difference between the upper and lower extremity is considered a passing result. It is recommended that repeated measurements be performed in those cases in which the initial screening result was positive in an effort to reduce false-positive results. Infants with saturations $< 90\%$ should receive an immediate evaluation. It is important to note that the oxygen saturation thresholds for a positive screening result may vary at high altitude. If the screening is positive, CCHD needs to be excluded with a diagnostic echocardiogram. Infectious and pulmonary causes of hypoxemia should also be excluded. Every hospital is required to report each newborn's pulse oximetry screening results to the Newborn Screening Program. (Refer to the Directory Appendix for contact information.)

9.4 IMMUNIZATIONS

A review of immunization status shall be performed at each well child visit, with immunizations administered according to recommendations and standards of practice recognized by the AAP and the Advisory Committee on Immunization Practices (ACIP). Providers are reminded that all immunizations must be reported to the Michigan Care Improvement Registry (MCIR). (Refer to the Directory Appendix for contact information.)



Immunizations are covered when administered according to ACIP recommendations. MDHHS encourages providers to immunize all Medicaid beneficiaries.

- For Medicaid eligible children 18 years of age and younger, the Vaccines for Children (VFC) Program provides covered immunizations at no cost to the provider.
- Medicaid covers immunizations for beneficiaries 19 years of age and older.
- Any LHD in the state can be contacted for specifics about the VFC program.

For immunizations available free of charge under the VFC program, the amount a provider may charge for vaccine administration may be limited. Providers cannot charge more for services provided to Medicaid beneficiaries than for services provided to their general patient population. For example, if the charge for administering a vaccine to a private-pay patient is \$5.00, then the charge for immunization administration to the Medicaid beneficiary cannot exceed \$5.00.

Medicaid Health Plan (MHP) providers enrolled in the VFC program are encouraged to immunize and are discouraged from referring beneficiaries to a LHD for these services. (Refer to the Practitioner Chapter for additional information.)

9.5 ANEMIA

The PCP must screen the child for anemia according to the AAP periodicity schedule.

9.6 BLOOD LEAD SCREENING

All children covered by Medicaid are considered at high risk for blood lead poisoning. The AAP periodicity schedule requires children to be tested for blood lead poisoning at 12 and 24 months of age. In addition, the Centers for Medicare & Medicaid Services (CMS) mandates that if a child is covered by Medicaid, is between 36 and 72 months of age, and has not been tested for blood lead, the child must be tested. The AAP also requires a blood lead risk assessment to be performed during specific visits as indicated by the AAP periodicity schedule. If the parent/guardian is unsure if the child was previously tested, the child must be tested.

For children who have been tested, the following questions are intended to assist the PCP in determining if further testing is necessary in addition to that completed at the mandated ages:

- Does the child live in (or often visit) a house built before 1950 with peeling or chipping paint? This could include day care, preschool, or home of a relative.
- Does the child live in (or often visit) a house built before 1978 that has been remodeled within the last year?
- Does the child have a brother or sister (or playmate) with blood lead poisoning?
- Does the child live with an adult whose job or hobby involves lead? (The chart following these questions presents examples.)
- Does the child's family use any home remedies that may contain lead? (The chart following these questions presents examples.)



Possible means of exposure to lead hazards:

Occupational	Hobbies	Environmental	Other
<ul style="list-style-type: none"> ▪ Battery manufacturing or repair ▪ Bridge reconstruction worker ▪ Chemical manufacturing ▪ Construction worker ▪ Glass manufacturing ▪ Industrial machine operator ▪ Migrant farm worker ▪ Painting ▪ Plastics manufacturing ▪ Plumber, pipe fitter ▪ Police officer ▪ Printing ▪ Radiator repair ▪ Rubber products manufacturing ▪ Steel welding and cutting ▪ Vehicle repair 	<ul style="list-style-type: none"> ▪ Brass/copper/aluminum processing ▪ Casting lead figures (e.g., toy soldiers) ▪ Furniture refinishing ▪ Jewelry and pottery making ▪ Lead soldering (e.g., electronics) ▪ Making lead shot, fishing sinkers, bullets ▪ Painting ▪ Stained glass making ▪ Target shooting at firing ranges ▪ Vehicle repair 	<ul style="list-style-type: none"> ▪ Burning lead-painted wood ▪ Ceramic ware/pottery ▪ Lead crystal ▪ Lead-soldered cans (imported) ▪ Lead paint ▪ Lead-painted homes ▪ Living near lead-related industries ▪ Renovating/remodeling older homes ▪ Soil/dust near industries and roadways ▪ Use of water from lead pipes 	<ul style="list-style-type: none"> ▪ Cosmetics (e.g., Kohl, sindoor) ▪ Food/spices and/or food additives (e.g., Greta, Azarcon, pay-loo-ah, ghasard, Hai ge fen, Bali Goli, Kandru, Xyoo- Fa, Mai ge fen, poying tan, lozeena, turmeric, hot sauce, some Mexican candy)

Publications and other materials concerning blood lead may be obtained from the MDHHS Childhood Lead Poisoning Prevention Program. The MDHHS Bureau of Laboratories – Trace Metals Section can also be contacted. (Refer to the Directory Appendix for contact information.)

There are providers in all areas of the state who have expertise in the treatment of blood lead and are available to discuss blood lead issues with other providers. Providers with questions concerning blood lead testing or treatment should contact the Childhood Lead Poisoning Prevention Program to obtain contact information for these providers. (Refer to the Directory Appendix for contact information.)

For blood lead analysis, the blood sample may be obtained via the capillary method (i.e., heel prick or finger stick) or venipuncture. The sample may be sent to the MDHHS Bureau of Laboratories – Trace Metals Section or to any Michigan Medicaid-enrolled laboratory qualified to perform blood lead testing. If the MDHHS Bureau of Laboratories – Trace Metals Section is used, blood lead testing supplies may be obtained from the laboratory. (Refer to the Directory Appendix for contact information.)



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Michigan has an established statewide blood lead registry. This requires that certain information accompany each blood lead specimen (or request, if the specimen is drawn elsewhere).

- If blood lead samples are sent to the MDHHS Bureau of Laboratories – Trace Metals Section:
 - Providers must obtain a Submitter Clinic Code prior to sending blood lead samples. Providers may obtain a Submitter Clinic Code by contacting the MDHHS Bureau of Laboratories – Data and Specimen Handling (DASH) Unit. (Refer to the Directory Appendix for contact information.)
 - The “Blood Lead Test Requisition” form (DHHS-0696) must be used. (The form is available on the MDHHS website. Refer to the Directory Appendix for website information.)
- If blood lead samples are sent to a private laboratory or if the private laboratory draws and tests the sample, the provider must include the following:
 - information with respect to the individual tested (name, sex, ethnicity, race, birthdate, address (and, to the extent available, whether the residence or property is owned or rented), telephone number, Medicaid number, parent/guardian (if individual is a minor), employer (if individual is an adult), secondary contact (name and phone number) for individual tested or parent/guardian;
 - date of the sample collection;
 - the type of sample (capillary or venous); and
 - provider’s name, name of practice (if applicable), telephone number, fax number, e-mail address, and mailing address.

When testing is completed, the laboratory completes the required information and submits it to the blood lead registry.

PCPs are encouraged to draw blood in their offices for all children needing blood lead testing, but may refer children to a lab if necessary. There may be instances when a blood draw is not accomplished. If this occurs and the child resides in a jurisdiction where the LHD agrees to obtain a blood sample for blood lead testing, the PCP may refer a child to the LHD for the service. (Refer to the Local Health Department Chapter for additional information.)

The MDHHS Bureau of Laboratories – Trace Metals Section will report all results to the child’s ordering provider. All clinical laboratories in Michigan that analyze blood samples for lead shall report all blood lead results to the MDHHS Childhood Lead Poisoning Prevention Program/Community Public Health Agency (CLPPP/CPHA). Reports shall be made within five working days after test completion. If a blood lead test has been completed but is not displayed in the MCIR, the LHD or PCP should contact the MDHHS CLPPP to report the blood lead results. (Refer to the Directory Appendix for contact information.)

There is no established safe level of lead for children. While the below recommendations indicate that certain actions should begin at a blood lead level of 5 µg/dL, providers may use their own clinical judgement in determining the appropriate actions in the medical management of children potentially exposed to lead whose blood lead levels are below this level. These activities may include, but are not limited to, repeat testing, follow-up evaluations, treatment services, referral for nurse case management services through the local health department, and referral for environmental investigation.



Recommendations on Medical Management of Childhood Lead Exposure and Poisoning*

Blood Lead Level	Action
< 5 mcg/dL	<ul style="list-style-type: none"> ▪ Review lab results with family. ▪ Repeat the blood lead level in 6-12 months if the child is at high risk or risk changes during the time frame. ▪ For children screened at <12 months of age, consider retesting in 3-6 months. ▪ Perform routine health maintenance, including assessment of nutrition, physical and mental development, as well as iron deficiency risk factors. ▪ Provide anticipatory guidance on common sources of environmental lead exposure: paint in homes built prior to 1978, soil near roadways or other sources of lead, take-home exposures related to adult occupations, imported spices, cosmetics, folk remedies, and cookware.
5-14 mcg/dL	<ul style="list-style-type: none"> ▪ Perform steps as described above for blood lead levels < 5 mcg/dL. ▪ Obtain venous blood lead level within 1-3 months of the initial blood lead test to ensure the lead level is not rising. If it is stable or decreasing, retest the blood lead level in 3 months. ▪ Refer the patient to the LHD to determine if blood lead poisoning follow-up services are available. ▪ Perform an environmental history to identify potential sources of exposure and provide preliminary advice about reducing/eliminating exposure. Consider other children who may be exposed. ▪ Provide nutritional counseling related to calcium and iron. Encourage the consumption of iron-enriched foods (e.g., cereals, meats). Some children may be eligible for the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) or other nutritional counseling. All children younger than 5 years of age and enrolled in Medicaid are eligible for the WIC Program. ▪ Ensure iron sufficiency with adequate laboratory testing (e.g., CBC, Ferritin, CRP) and treatment per AAP guidelines. Consider recommending a multivitamin with iron. ▪ Perform structured developmental screening evaluations at well child visits.
15-44 mcg/dL	<ul style="list-style-type: none"> ▪ Perform steps as described above for blood lead levels 5-14 mcg/dL. ▪ Refer to the LHD for blood lead poisoning follow-up services. ▪ Confirm the blood lead level with repeat venous sample within 1 to 4 weeks. ▪ A specific evaluation of the child, such as an abdominal x-ray, should be considered based on the environmental investigation and history (e.g., pica for paint chips, mouthing behaviors). Gut decontamination may be considered if leaded foreign bodies are visualized on x-ray. ▪ Any treatment for blood lead levels in this range should be performed in consultation with an expert.



Recommendations on Medical Management of Childhood Lead Exposure and Poisoning*

Blood Lead Level	Action
>44 mcg/dL	<ul style="list-style-type: none"> ▪ Follow guidance for blood lead levels 15-44 mcg/dL as listed above. ▪ Confirm the blood lead level with repeat venous lead level within 48 hours. ▪ Consider hospitalization and/or chelation therapy (managed with the assistance of an experienced provider). Safety of the home with respect to lead hazards, isolation of the lead source, family social situation, and chronicity of the exposure are factors that may influence management.
<p>* Notes:</p> <ul style="list-style-type: none"> ▪ Table and recommendations adopted from the AAP. ▪ No level of lead in the blood is safe. 	

9.7 TUBERCULOSIS TESTING

Medicaid covers tuberculosis (TB) testing according to the AAP periodicity schedule, and upon the recognition of high risk factors. Coverage for the TB test includes any return visit to read the results of the TB test. A risk assessment must be completed at each well child visit. Mantoux testing is the preferred testing method. For assistance in determining high risk and testing, providers may refer to the AAP Red Book: Report of the Committee on Infectious Diseases, or contact the MDHHS Division of Communicable Diseases and/or the Division of Immunization. (Refer to the Directory Appendix for contact information.)

9.8 DYSLIPIDEMIA SCREENING

All children and adolescents should undergo a dyslipidemia (cholesterol) screening once between 9 and 11 years of age and once between 17 and 21 years of age. For children with a significant family history or other risk factors, a lipid assessment should be considered as early as 2 years of age. If a family history cannot be ascertained and other risk factors exist, testing is at the provider’s discretion. The lipid assessment should include a fasting or non-fasting lipid profile. Children and adolescents identified as being high risk should be counseled on lifestyle changes in an effort to reduce the risk of Cardiovascular Disease (CVD). Children younger than 10 years of age should not be treated with medication unless they have a severe hyperlipidemia or a high-risk condition that is associated with serious medical morbidity. Decisions regarding the need for medication therapy should be based on the average of results from two fasting lipid profiles obtained at least two weeks but no more than three months apart.

9.9 SEXUALLY TRANSMITTED INFECTIONS (STI)

A risk assessment for sexually transmitted infections (STIs) is to be performed annually for all sexually active individuals beginning at 11 years of age as recommended by the AAP periodicity schedule. Adolescents and children should be fully immunized, screened for risk, and appropriately tested and treated for STIs. It is recommended to screen males who have sex with males (MSM) at least annually for STIs, and screen every three to six months if the male adolescent is considered high risk because of multiple or anonymous partners, having sex in conjunction with illicit drug use, or having sex partners who participate in these activities.



9.10 HUMAN IMMUNODEFICIENCY VIRUS (HIV) SCREENING

A risk assessment for the human immunodeficiency virus (HIV) is to be performed annually for children beginning at 11 years of age and as recommended by the AAP periodicity schedule. A routine HIV screening should be offered to all individuals at least one time between 15 and 18 years of age, making every effort to preserve confidentiality of the adolescent. Youth at increased risk of HIV infection (including those who are sexually active, participate in injection drug use, or are being tested for other STIs) should be tested for HIV and reassessed annually. The PCP should verify the results, follow-up, and refer as appropriate.

9.11 CERVICAL DYSPLASIA SCREENING, BREAST EXAMS, COUNSELING AND RISK FACTOR INTERVENTIONS

Screening for cervical cancer in females younger than 21 years of age is not recommended unless a patient has an immune suppression or infection with HIV, in which case an annual Pap test should be administered with the onset of sexual activity. Females previously screened who had a documented cervical intraepithelial neoplasia (CIN) 2 or 3 or carcinoma will require continued screening. Clinical breast exams and the teaching of breast self-examinations for women younger than 21 years of age is not recommended as part of the routine physical examination; breasts should be examined in the female adolescent as part of the assessment of sexual maturity and in the male adolescent to observe for gynecomastia. Whenever a screening for cervical dysplasia as part of a pelvic examination and Pap smear is provided, a breast exam, counseling, and risk factor interventions must be provided.

9.12 DIABETES (TYPE 2)

High-risk children must be tested according to the AAP periodicity schedule. Beginning at 10 years of age (or at the onset of puberty if it occurs at a younger age), a risk assessment must be performed at each well child visit. Children at risk should be tested in accordance with the AAP periodicity schedule guidelines.

A child is considered high risk if he is overweight (i.e., BMI >85th percentile for age and sex, weight for height >85th percentile, or weight >120 percent of ideal for height) and has any two of the following factors:

- A family history of Type 2 diabetes in first- and second-degree relatives;
- Belongs to a certain race/ethnic group (e.g., Native American, African-American, Hispanic, Asian/Pacific Islander); or
- Signs of insulin resistance or conditions associated with insulin resistance (e.g., acanthosis nigricans, hypertension, dyslipidemia, polycystic ovarian syndrome).



SECTION 10 – ORAL HEALTH

The dental health of the beneficiary begins with an oral health screening and caries risk assessment by the child's PCP for beneficiaries at each well child visit as recommended by the AAP periodicity schedule. The oral cavity must be inspected at each well child visit regardless of whether teeth have erupted or not. MDHHS requires providers to stress the importance of preventive and restorative dental care. Encourage parents/caregivers to brush their child's teeth as soon as teeth erupt with fluoride toothpaste in the proper dosage appropriate for the child's age. Children should be referred to establish a dental home when the first tooth erupts and as recommended by the AAP periodicity schedule. Communication between the dental and medical homes should be ongoing to appropriately coordinate care for the child. If a dental home is not available, the PCP should continue to perform an oral health risk assessment during each well-child visit. The PCP should follow-up, educate, and refer as appropriate. Refer to the Directory Appendix for website information on the American Academy of Pediatric Dentistry (AAPD) Caries Risk Assessment Tool. A separate periodicity schedule for dentists is established. The Dental Periodicity Schedule follows the AAPD Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling schedule. Refer to the Dental chapter of the Medicaid Provider Manual for additional information.

10.1 FLUORIDE VARNISH

Providers should apply fluoride varnish as recommended by the AAP periodicity schedule. Fluoride varnish should be applied to the teeth of all infants and children under the delegation and supervision of the PCP when the first tooth erupts until establishment of a dental home as recommended by the AAP periodicity schedule. The AAP recommends that providers receive additional training on oral screenings, fluoride varnish indications and application, and office implementation. Providers and staff are encouraged to complete the online Children's Oral Health Smiles for Life Course 6: Caries Risk Assessment, Fluoride Varnish and Counseling training module and obtain certification prior to providing oral health screenings and fluoride varnish applications. (Refer to the Directory Appendix for website information.)

10.2 FLUORIDE SUPPLEMENTATION

The PCP should consider oral fluoride supplementation as recommended by the AAP periodicity schedule if the primary water source is deficient in fluoride. It is important to consider a child's overall systemic exposure to fluoride from multiple sources (e.g., water fluoridation, toothpaste, supplements, and/or varnish) prior to prescribing fluoride supplements to minimize the risk of mild fluorosis.



SECTION 11 – ANTICIPATORY GUIDANCE

Anticipatory guidance provided by the AAP explains any and all changes that will most likely occur before the next recommended well child visit, and offers strategies for dealing with the anticipated changes. This applies to all aspects of the child's/adolescent's life. Anticipatory guidance gives the PCP, parent(s)/guardian(s), and the child/adolescent an opportunity to ask questions and to discuss issues of concern. Anticipatory guidance focuses on five priority areas including physical growth and development, social and academic competence, emotional well-being, risk reduction, and violence and injury prevention. The PCP is encouraged to inquire about these priority areas, and to adapt questions and discussion points to meet the specific needs of the families and communities to whom they provide care.

An interpretive conference should also be included to explain the results of the well child visit. Depending on the age and/or family status of the child/adolescent, the conference may be held directly with the child/adolescent, the child/adolescent and parent/guardian, or only with the parent/guardian. If a child/adolescent has a potential or apparent abnormality, the PCP is responsible for providing, or referring for, follow-up diagnostic services and treatment.

11.1 SLEEP POSITION COUNSELING

Positioning of infants on their backs on a firm sleep surface and discussing recommendations for creating a safe sleeping environment with the parent(s)/guardian(s) must occur at each well child visit through 12 months of age. Infants should be placed on their back unless a medical condition warrants that a provider recommends otherwise after weighing the relative risks and benefits. (Refer to the Maternal-Child Educational Resources portion of the Directory Appendix for additional sources regarding infant sleep positioning and to the AAP for recommendations for a safe infant sleeping environment.)

11.2 NUTRITIONAL ASSESSMENTS

Age-appropriate nutrition counseling must be provided at each well child visit. Nutritional assessments must be based on:

- Height, weight, and their relatedness;
- The most recent hematocrit/hemoglobin value;
- Physical examination; and
- Health history.

11.3 VIOLENCE AND INJURY PREVENTION

Violence and injury prevention must be discussed at each well child visit. Providers should become familiar with Connected Kids: Safe, Strong, Secure, the AAP's primary care violence prevention protocol. This resource gives providers recommendations and resources to incorporate preventive education, screening for risk, and linkages to community-based counseling and treatment resources. Treatment and/or a referral for violence and injury related problems identified should be appropriate and timely. (Refer to the Provider Resources portion of the Directory Appendix for additional sources regarding youth violence and injury.)



SECTION 12 – CHILDREN IN FOSTER CARE

Medical interventions, screenings, and various preventive health care services are to be up-to-date for all children in foster care. For purposes of this section, any reference to “child” or “children” in foster care includes any individual in foster care who is younger than 21 years of age. The care of children should be comprehensive, well-coordinated, and fully documented throughout their stay in foster care. All children in foster care younger than 21 years of age must receive a full medical examination and screening for potential mental health issues by a PCP within the first 30 days of entering foster care. All children in foster care are eligible for Medicaid from the first day of the month of entry into foster care. The PCP must verify the child in foster care’s eligibility and enrollment status. In case of difficulty confirming Medicaid status, or of verifying Medicaid Health Plan enrollment, the PCP should contact the foster care worker or the local MDHHS office designee. The PCP must complete the health maintenance visit regardless of whether or not the child in foster care recently received a health maintenance visit prior to entry into the foster care system.

The PCP’s office staff should obtain the completed MDHHS "Consent to Routine, Non-surgical Medical Care and Emergency Medical or Surgical Treatment" form (DHS-3762) from the foster care parent, or consent from the child in foster care if the child is at least 18 years of age, before the child is seen by the PCP. This form provides the PCP with informed consent to routine, non-surgical medical care and emergency medical or surgical treatment and provides the child’s foster care worker’s or local MDHHS office designee’s contact information. This form does not grant informed consent for the physician to provide psychotropic medication treatment. The MDHHS "Psychotropic Medication Informed Consent" form (DHS-1643) must be completed to receive informed consent to provide psychotropic medication treatment. (Refer to the MDHHS website for copies of forms and form information. Refer to the Directory Appendix for website information.)

A child may be assigned to a new PCP upon entry into the foster care system, and it will be necessary for the child’s previous PCP to share the child’s health information with the new PCP. In an order placing a child in foster care, the court shall include an order that each of the child’s medical providers release the child’s medical records. The court order requires the parent(s) to provide names and contact information for all previous medical and mental health providers, and to sign a consent to release health information on the day of the court proceedings.

The supervising agency shall develop a medical passport for each child who comes under its care. The medical passport shall contain all medical information required by policy or law to be provided to the PCP and to the foster care parent. The medical passport includes a basic medical history, a record of all immunizations from the Michigan Care Improvement Registry (MCIR), a complete and regularly updated statement of medical appointments, prescribed medications, and any other information available to the foster care worker concerning the child’s medical, physical, and mental health status. The medical passport should be shared with the child’s foster care parents and all medical providers even if the document is not complete or up to date. Updates to the medical passport should be shared with the foster care parents and medical providers when new information becomes available. If health information, including the medical passport, is not made available to the medical provider at or before the time of the medical examination, the medical provider should contact the foster care worker and/or the local MDHHS office designee (noted on the DHS-3762 form) to assist with obtaining the missing health information.

The medical evaluation must follow the AAP periodicity schedule and Medicaid EPSDT policy. The examination should be completed according to the recommendations for the nearest or most appropriate periodic examination age. The PCP will assess the child for medical, dental, developmental, and mental



health needs. The full medical evaluation will include an immunization review, health history, and physical examination. The medical examination and screenings should be documented for the initial and for all subsequent well child visits and will become a part of the child's medical record. PCPs may reference the age appropriate MDHHS Well Child Exam form and use their own Well Child Exam form or electronic medical record (EMR) if the form or EMR contains all of the elements of the AAP periodicity schedule. (Refer to the Directory Appendix for AAP and MDHHS website information.)

The Implementation, Sustainability and Exit Plan (ISEP) requires that all children who are 3 years of age or older at the time of entry into foster care will receive a dental examination within 90 days of entry into foster care unless the child had a dental exam in the six months prior to foster care placement. It is the responsibility of the foster care parent to take the child to the dentist.

A developmental/behavioral assessment must be completed according to the recommendations of the AAP. A developmental/behavioral assessment includes developmental screening; autism spectrum disorder screening; developmental surveillance; psychosocial/behavioral assessment; tobacco, alcohol or drug use assessment; and depression screening. Screening for these potential developmental/behavioral issues is accomplished by using an objective validated and standardized screening tool and should be completed with the assistance of a person who knows the child best. This may be the child's biological parent, foster care parent, caregiver, or other adult who knows the child. The foster care worker is available to assist the provider in identifying the person who knows the child best. The psychosocial/behavioral assessment is required at each scheduled well child visit and may be accomplished by surveillance or by using a validated and standardized screening tool such as the ASQ-SE or PSC with appropriate action to follow if the assessment is positive. PCPs should use a validated and standardized screening tool for all children in foster care and for children with mental health conditions. The use of validated and standardized screening tools improves the detection rate of social-emotional problems of children in foster care compared to the reliance on subjective clinical judgment (i.e., surveillance).

The foster care worker is trained in the use of the ASQ-SE and PSC. If the physician chooses to use either of these tools, the foster care worker is available to assist in completing the screening tool and ensure that it is made available to the medical provider for scoring and for incorporation into the treatment plan. The individual accompanying the child to the medical examination should present the completed screening tool to the PCP at the initial appointment or for any other periodic examinations. The PCP is responsible for scoring and interpreting the results of the screening tool and proposing recommendations regarding follow-up. (Refer to the Directory Appendix for foster care resources.)

The PCP will recommend to the foster care worker, the birth parents, and the foster care parents (when applicable) when the child in foster care may benefit by visiting with a mental health professional. The child will be referred for a prompt follow-up assessment by an appropriate medical, dental, developmental, or mental health professional for any further identified health needs. For more information, refer to the Developmental/Behavioral Assessment Section of this chapter.

12.1 PSYCHOTROPIC MEDICATION TREATMENT

A psychiatric diagnosis using the Diagnostic and Statistical Manual (DSM) of Mental Disorders (published by the American Psychiatric Association) must be made before prescribing psychotropic medications to any child in foster care. When the physician determines that the child requires psychotropic medication treatment, the prescribing physician must obtain a written and signed informed consent from the child's legal parent (when the child is a temporary court ward), the child (if the child is at least 18 years of age), the foster care worker (when the child is a ward of the state and is committed to the Michigan Children's



Institute), or the court (when the child is a permanent court ward of the county) before treatment with any psychotropic medication begins. If a signed informed consent cannot be obtained (e.g., the parent is unable or unwilling to sign, and the physician documents a medical necessity), a court order is required prior to prescribing psychotropic medications to any child in foster care. Foster care parents cannot consent to administration of psychotropic medication. For questions regarding who may provide consent for treatment with psychotropic medications, the physician may contact the child's foster care worker.

Informed consent must be documented by completion of the MDHHS "Psychotropic Medication Informed Consent" form (DHS-1643). (MDHHS forms are available on the MDHHS website. Refer to the Directory Appendix for website information.) Informed consent includes an explanation from the prescribing physician regarding the child's diagnosis, proposed treatment, expected outcomes, any side effects, risks involved, discussion of laboratory findings and ongoing monitoring, uncommon but potentially severe adverse events, a discussion of alternative treatments, the risks associated with no treatment, and the overall potential benefit-to-risk ratio of treatment. If consent is denied by the child's birth parent or legal guardian, or the consent cannot be obtained, a court order shall be obtained by the foster care worker to authorize the administration of the psychotropic medication to the child held in legal custody based on the physician's attestation that treatment with psychotropic medication is medically necessary. If a child is prescribed psychotropic medication prior to enrollment in the foster care system, the DHS-1643 must be completed within 45 days of a child's entry into the foster care system to assure uninterrupted psychotropic medication treatment. The child in foster care who is at least 18 years of age is able to consent to and/or refuse medical treatment. A new DHS-1643 will be required if there is a new psychotropic medication prescribed, a discontinuation of the psychotropic medication, a change in dosage that exceeds the limits of the provided consent, or if the child is at least 18 years of age. The DHS-1643 must be renewed annually.

12.2 ENROLLMENT AND BILLING

MDHHS has designated a Health Liaison Officer (HLO) or an HLO point person to every county in Michigan to assist children in foster care with health plan enrollment/disenrollment, facilitate the timely completion of an initial medical examination, and generally provide technical support to foster care workers. Until HLO positions are allocated for complete statewide coverage, each local MDHHS office has an assigned supervisor to serve as the point person for obtaining any health-related information or for resolving health-related issues.

PCPs may complete and bill for an EPSDT/preventive health care well child visit for any child who must be seen within 30 days of entering the foster care system, and for any additional follow-up visits the PCP believes are necessary. The PCP may bill for the visit even if the child in foster care received a recent preventive health care service prior to entry into the foster care system. The PCP may bill for up to three screenings administered during a well child visit using the appropriate developmental screening codes for scoring and interpreting developmental, autism, and behavioral health screens for beneficiaries younger than 21 years of age.

Children in foster care not enrolled with a health plan by the time a full medical examination is provided within the 30 day requirement will be considered Fee for Service (FFS). Children in foster care residing in detention facilities, child care institutions, or out-of-state placements will be considered FFS and will not be transitioned to a health plan. PCPs must verify eligibility and enrollment status prior to providing services to children in foster care. If the child in foster care is enrolled in an MHP, prior authorization requirements may apply.



SECTION 13 – REFERRALS

If a medical issue is determined or suspected during a well child visit, the (suspected) issue must be diagnosed and treated as appropriate. This determination may result in a referral to another provider or a self-referral for further diagnosis and treatment. Referrals must be made based on standards of good practice and the AAP Recommendations for Preventive Pediatric Health Care or presenting need, if outside the normal schedule.

When a FFS provider performs medically necessary treatment involving diagnostic or therapeutic procedures for a medical condition found during a well child visit (e.g., wart removal), these procedures are covered in addition to the well child visit. For information regarding billing a well child evaluation and management (E/M) visit and other E/M visits occurring on the same date of service, refer to the Evaluation and Management Services Section of the Practitioner Chapter. If the provider cannot perform the needed treatment, a referral must be made to an appropriate provider. If providers are not familiar with other providers in the area, the LHD can be of assistance with referrals. MHP providers must follow the referral procedures for the specific health plan in which the beneficiary is enrolled.

13.1 PSYCHIATRIC SERVICES

Psychiatric services are available for Medicaid FFS beneficiaries younger than 21 years of age with mild/moderate mental health conditions or suspected behavioral disorders. (Refer to the Behavioral Health and Substance Use Disorder Services subsection of the Practitioner Chapter for specific coverages.) MHP contracts include mental health benefit coverage for beneficiaries with mild/moderate mental health conditions.

PIHPs/Community Mental Health Services Programs (CMHSPs) are responsible for the provision of covered specialty mental health services necessary for the treatment of Medicaid beneficiaries who have more significant and/or complex psychiatric conditions.

13.2 AUTISM SPECTRUM DISORDERS

The PCP who screened the child for ASD and determined a referral for further evaluation was necessary will contact the PIHP directly to arrange for a follow-up evaluation. The PCP must refer the child to the PIHP in the geographic service area. (Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter for information/policy regarding the treatment of children with autism.)

13.3 SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS AND CHILDREN (WIC)

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) program is located in each county in Michigan at LHDs, Tribal Health Centers, and federally funded clinics. WIC is a special health and nutrition program that has demonstrated a positive effect on pregnancy outcomes and child growth and development. WIC provides supplemental healthy foods, nutrition counseling and education, breast feeding support, immunization screening, and referrals to other helpful services to pregnant women, breastfeeding and post-partum women, infants, and children younger than 5 years of age. The PCP is expected to make referrals to a WIC site for eligibility determination if appropriate. (Refer to the Directory Appendix for website and contact information.)



13.4 PEDIATRIC OUTPATIENT INTENSIVE FEEDING PROGRAM SERVICES

Pediatric outpatient intensive feeding program services are for beneficiaries with significant feeding and swallowing difficulties. Pediatric Outpatient Intensive Feeding Program services may be considered medically necessary for individuals with anatomical, physiological, congenital, or cognitive conditions and/or complications of severe illness who experience significant feeding difficulties. The child should be referred to a CSHCS-approved, Medicaid-enrolled program site that is certified by MDHHS. (Refer to the Pediatric Outpatient Intensive Feeding Program Services Section of the Special Programs Chapter for additional information.)

13.5 BLOOD LEAD POISONING FOLLOW-UP SERVICES

Many LHDs provide blood lead poisoning follow-up services which consist of environmental investigations and blood lead nursing assessment visits. The PCP must contact the LHD to determine if blood lead services are available in the area and the blood lead levels at which referrals are accepted. In locations where LHDs do not provide this service, the MDHHS Healthy Homes Section can be contacted to perform the environmental investigation. (Refer to the Additional Information on Blood Lead Testing Section of the Local Health Departments Chapter for additional information and to the Directory Appendix for contact information.)

The PCP may refer pregnant women and children who were served by the Flint water system to the Genesee Health System, the local community mental health (CMH) serving Genesee County that serves as the Designated Provider Organization (DPO), for any needed Family Supports Coordination services. (Refer to the Special Programs Chapter, Flint Family Supports Coordination Services Section, for additional information.)

13.5.A. ENVIRONMENTAL INVESTIGATIONS

An environmental investigation of a beneficiary's home or primary residence is covered for the LHD. If more than one child in the home has blood lead poisoning, the LHD must select one child's Medicaid ID number and report a single environmental investigation visit. (Refer to the Local Health Departments Chapter for additional information on blood lead testing and follow-up services.)

13.5.B. BLOOD LEAD NURSING ASSESSMENT VISITS

Blood lead nursing assessment visits for children with blood lead levels of 5 mcg/dL or greater are covered under the CSHCS case management benefit. Beneficiaries are eligible for a maximum of six billing units per year. (Refer to the Children's Special Health Care Services Chapter, Case Management Benefit for more information.)

13.5.C. BLOOD LEAD RESOURCE DOCUMENTS

Providers are encouraged to obtain and review materials and resources concerning blood lead poisoning from the MDHHS Childhood Lead Poisoning Prevention Program. (Refer to the Directory Appendix for contact information.)



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13.6 OTHER PROGRAMS

There are other programs that could benefit Medicaid beneficiaries such as Head Start, intermediate school district/regional education service agency services, genetics counseling, nutrition programs, and public health nursing. Providers are encouraged to become familiar with available programs and make full use of the programs whenever referrals are appropriate.



SECTION 14 – OUTREACH

MDHHS provides outreach to beneficiaries through various means, including informational publications and other beneficiary contacts.

When the beneficiary's **mihealth** card is issued, it is mailed with the MDHHS publication "Michigan Free Health Check-Ups." The publication explains the benefits of a well child visit, describes procedures included in the free health check-up, and presents information about medical transportation options available to beneficiaries for travel to and from well child visits.

Soon after the **mihealth** card is issued, the beneficiary will receive a monthly outreach list, a letter that stresses the importance of well child visits, and medical transportation information.

14.1 FEE-FOR-SERVICE (FFS)

For beneficiaries younger than 2 years of age, a letter stressing the importance of well child visits is sent to the parent/guardian every six months as a reminder to schedule a well child visit with the PCP. The parent/guardian of the beneficiary is encouraged to schedule the well child visits recommended during those six months with the beneficiary's PCP. For beneficiaries 2 years of age and older, if a claim for a well child visit has not been processed by Medicaid by the time the child is halfway to their next well child visit due date (according to the AAP periodicity schedule), the parent/guardian will receive a second letter. A list of FFS beneficiaries who did not have a claim for a well child visit processed will be generated and issued to each LHD. LHDs may assist Medicaid in informing parents/guardians of the EPSDT program, scheduling appointments, and arranging medical transportation options.

14.2 MEDICAID HEALTH PLANS (MHP)

Each MHP is able to download an electronic monthly outreach list of enrollees due or overdue for a well child visit. The MHP must either, directly or through the LHD, notify the parent/guardian of the required action or assist in scheduling appointments or arranging medical transportation options. The "Michigan Free Health Check-ups" publication is mailed to the Medicaid beneficiary once each year.



SECTION 15 – MEDICAL TRANSPORTATION

Medical transportation is available free of charge to the beneficiary and parent/guardian for travel to and from well child visits if requested by the family.

- For beneficiaries enrolled in an MHP, the parent/guardian of the beneficiary should make arrangements directly through the MHP.
- The parent/guardian of the beneficiary not enrolled in an MHP should contact their local MDHHS office directly, or with the assistance of the LHD, to make transportation arrangements for the EPSDT well child visit. MDHHS should be contacted as soon as the date and time of the appointment are known.

MDHHS contracts with a transportation brokerage company to arrange and provide Non-Emergency Medical Transportation (NEMT) for beneficiaries residing in Wayne, Oakland and Macomb counties. Transportation may be provided when the beneficiary qualifies for the service and has no other means of transportation. (Refer to the Directory Appendix for contractor contact information.)



EMERGENCY SERVICES ONLY MEDICAID

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SECTION 1 – GENERAL INFORMATION

This chapter applies to all providers.

Aliens who are not otherwise eligible for full Medicaid because of immigration status may be eligible for Emergency Services Only (ESO) Medicaid.

For the purpose of ESO coverage, federal Medicaid regulations define an emergency medical condition (including emergency labor and delivery) as a sudden onset of a physical or mental condition which causes acute symptoms, including severe pain, where the absence of immediate medical attention could reasonably be expected to:

- Place the person's health in serious jeopardy, or
- Cause serious impairment to bodily functions, or
- Cause serious dysfunction of any bodily organ or part.



SECTION 2 – ELIGIBILITY

Michigan Department of Health and Human Services (MDHHS) determines eligibility for ESO coverage. To qualify for ESO Medicaid, non-citizens must meet all Medicaid eligibility requirements not related to immigration status. The Beneficiary Eligibility Chapter of this manual contains information on how to identify ESO beneficiaries.

Pregnant ESO beneficiaries may also qualify for pregnancy-related services under the MDHHS Maternity Outpatient Medical Services (MOMS) program. Refer to the Maternity Outpatient Medical Services Chapter of this manual for additional information on MOMS covered services.



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SECTION 3 – COVERAGE

ESO Medicaid coverage is limited to labor and delivery services, and those services necessary to treat emergency conditions. The following services are **not** covered under this benefit:

- preventative services
- follow-up services related to emergency treatment (e.g., removal of cast, follow-up laboratory studies, etc.)
- treatment of chronic conditions (e.g., ongoing dialysis, chemotherapy, etc.)
- sterilizations performed in conjunction with delivery
- organ transplants
- pre-scheduled surgeries

The following table provides additional information regarding specific coverage under the ESO program. Prior authorization and/or copayment requirements may apply to some services listed. Those requirements are described in other chapters of this manual.

Service	Coverage
Ambulance	Limited to emergency transport to a hospital Emergency Department (ED).
Case Management	Not covered
Chiropractor	Not covered
Dental	Not covered
Eyeglasses	Not covered
Family Planning	Not covered
Hearing Aids	Not covered
Home Health	Not covered
Home Help (personal care)	Not covered
Hospice	Not covered



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Service	Coverage
Inpatient Hospital	Limited to labor and delivery, and emergency-related services only.
Lab & X-Ray	Limited to services related to labor and delivery, or necessary to diagnose/treat an emergency condition. Follow-up services to emergency treatment are not covered.
Medical Supplies/ Durable Medical Equipment (DME)	Medical supplies are limited to those items necessary to treat an emergency condition within an inpatient or outpatient hospital setting. Durable medical equipment is not covered.
Mental Health Services	Limited to emergency stabilization of a psychiatric episode within the emergency department of a medical hospital.
Nursing Facility	Not covered
Optometrist	Not covered
Outpatient Hospital/ Emergency Department	Limited to the treatment of emergency conditions. Follow-up care to emergency treatment and chronic care (e.g., dialysis, chemotherapy, etc.) is not covered.
Pharmacy	Limited to those drugs directly related to the emergency condition. Refills are not covered. Medicaid copays apply. (Refer to the Pharmacy Chapter of this manual for additional information.)
Physician and Non- Physician Practitioner (NPP) Services	Limited to labor and delivery services, and treatment of an emergency condition. Preventative care, follow-up care to emergency treatment, and chronic care are not covered. Medically necessary services provided by physician and non-physician practitioners (NPPs) provided in compliance with state law will be considered for reimbursement.
Podiatrist	Not covered
Prosthetics/ Orthotics	Not covered
Private Duty Nursing	Not covered



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Service	Coverage
Substance Abuse	Limited to medically necessary inpatient detoxification services in a life-threatening situation. Inpatient detoxification of a beneficiary who is simply incapacitated is not covered. (Refer to the Acute Inpatient Medical Detoxification subsection of the Hospital Chapter of this manual for additional information.)
Therapies	Not covered
Transportation (nonambulance)	Not covered



FAMILY PLANNING CLINICS

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SECTION 1 – GENERAL INFORMATION

This chapter applies to Title X clinics.

The Michigan Medicaid Program includes Family Planning services for qualified beneficiaries when the services are determined to be necessary for the health and well-being of the beneficiary. The services provided, as well as the type of provider and setting, must be appropriate to the specific medical needs of the beneficiary. Determination of medical necessity is the responsibility of the attending physician (MD or DO) and must be within the scope of current medical practice and Medicaid limitations. Submission of the claim for payment serves as the provider's certification of the medical necessity for these services. This determination of medical necessity is subject to review, in the context of accepted standards of medical practice.

1.1 EXPLANATION OF SERVICES

A family planning clinic or a primary care provider (i.e., MD, DO) or other Medicaid-approved provider (i.e., certified nurse midwife [CNM], certified nurse practitioner [NP], certified clinical nurse specialist [CNS] or physician assistant [PA]) can provide family planning services. Family planning clinics are limited to providing only family planning services.

Family planning services are defined as any Medicaid covered contraceptive service, including diagnostic evaluation, drugs, and supplies, for voluntarily preventing or delaying pregnancy.

Services must be furnished under the supervision of a physician or dispensed by a pharmacy for beneficiaries of childbearing age, including minors considered to be sexually active. Family planning services enable beneficiaries to voluntarily choose to prevent initial pregnancy or to limit the number of and spacing of their children.

Covered services include an office visit for a complete exam, pharmaceuticals (including some over the counter [OTC] products), supplies and devices when such services are provided by or under the supervision of a medical doctor, osteopath, or eligible family planning provider. Family planning supplies not furnished by the provider as part of the medical services must be prescribed by a physician and purchased at a pharmacy. Exceptions are condoms and similar supplies which do not require a prescription.

Medicaid does not cover services for treatment of infertility.

1.2 REIMBURSEMENT

If the beneficiary is enrolled in a Medicaid Health Plan (MHP), the MHP is responsible for payment for family planning services provided to their enrollees. Family planning clinics are encouraged to establish a contract with the MHP to define services they will provide and reimbursement methodology. MHP enrollees have freedom of choice to obtain family planning services from any family planning clinic provider; therefore, a referral from the MHP is not required.

Michigan Department of Health and Human Services (MDHHS) reimburses for services provided to beneficiaries who are not enrolled in a MHP.



In order to receive reimbursement, family planning clinics must meet established guidelines and be certified by MDHHS. For additional information regarding family planning clinic procedure codes, refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter. Drugs purchased at 340B prices (actual acquisition costs) will be reimbursed at 340B prices. Medicaid does not reimburse for physician services, lab tests, prescription drugs, or supplies beyond those specified in the Medicaid Code and Rate Reference tool or on the MDHHS Family Planning Clinics Fee Schedule when billed by a family planning clinic. Additional services, when appropriate, are available through the primary care provider and other providers (such as pharmacy, labs, etc.) in accordance with Medicaid policy and procedures. Family planning clinics wishing to provide services in addition to contraceptive management may specifically enroll in the Medicaid program to provide the broader range of services (i.e., Physicians/NPs or Medical Clinics).

Where applicable, special billing instructions for family planning clinics are noted with the service definitions. General billing instructions are located in the Billing & Reimbursement for Professionals Chapter of this manual.

1.3 DIAGNOSIS CODES

The appropriate ICD diagnosis code(s) must be indicated on the claim form when billing for family planning services. For dates of service (DOS) before 10/1/15, family planning services are limited to the V25 (ICD-9) diagnosis code range. For DOS on and after 10/1/15, family planning services are limited to the Z30 (ICD-10) code range. Providers must enter the appropriate code on the claim form.



SECTION 2 – OFFICE VISITS

2.1 PREVENTIVE MEDICINE SERVICES - EVALUATION AND MANAGEMENT/OFFICE VISITS

Family Planning Clinic providers are limited to providing preventive services for purposes of delaying or preventing pregnancy (i.e., family planning services). Services provided must be in accordance with the standards of care established for contraceptive management for initial and follow-up services as needed. The appropriate lab services required to manage contraceptive services must be made available, either by the clinic or through a referral process.

Providers must bill using the appropriate Preventive Medicine Evaluation and Management (E/M) codes from the Current Procedural Terminology (CPT) manual and/or the Healthcare Common Procedure Coding System (HCPCS) codes for the services and products listed in the Medicaid Code and Rate Reference tool or on the MDHHS Family Planning Clinics Fee Schedule. If additional medical problems are identified which need follow-up services, beneficiaries must be referred to their primary care provider.

Counseling services are considered a part of E/M services. As such, no separate reimbursement is available for counseling-only services. The appropriate E/M code that most closely describes the service provided must be billed.

2.2 INFORMATION AND EDUCATION REGARDING CONTRACEPTIVE METHODS

Beneficiaries must be given information and education for all methods of contraception available, including reversible methods (e.g., oral, injectable, implant, IUD, diaphragm, cervical cap, contraceptive patch, vaginal ring, foam, condom, and rhythm) and irreversible methods (e.g., tubal ligation, vasectomy). Education regarding all contraceptive methods must include relative effectiveness, common side effects, and difficulty in usage. Basic information concerning sexually transmitted disease (STD) must also be discussed.

Prescriptions for a contraceptive method must reflect the beneficiary's choice, except where such choice is in conflict with sound medical practice.

2.3 PROBLEM VISITS

Beneficiaries should be encouraged to return whenever they have specific problems related to the contraceptive method or wish to have additional guidance or service, including additional supplies. For follow-up care unrelated to contraception, referrals must be made to the primary care provider.

All beneficiaries, regardless of the contraceptive method chosen, must be encouraged to return for a physical examination, laboratory services, and health history at least once per year.



SECTION 3 – LABORATORY

Laboratory testing related to contraceptive management or STDs is a covered service. The family planning clinic or a licensed laboratory may provide services. For additional information regarding family planning clinic procedure codes, refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter.

Clinics can bill only for services actually performed by the family planning clinic and in the clinic setting. If an outside lab provides the service, that lab must bill Medicaid directly. For example, Pap smear specimens sent for testing to a lab outside the clinic must be billed by the lab performing the lab test.

Clinics seeking reimbursement for lab services are required to obtain Clinical Laboratory Improvement Amendments (CLIA) certification. The type of certification determines the complexity of the lab tests the clinic can perform. If a clinic does not have CLIA certification for specific lab service(s) needed by a beneficiary, the beneficiary should be referred to a provider that has CLIA certification to provide the required laboratory service. The clinic's CLIA certification number must be reported when completing the CHAMPS PE on-line enrollment application process. (Refer to the Provider Enrollment Section of the General Information for Providers Chapter for additional information about the CHAMPS PE enrollment application process.) MDHHS may conduct post-payment reviews to verify the certification level and services performed.

Laboratory tests other than those listed in the Medicaid Code and Rate Reference tool or on the MDHHS Family Planning Clinics Fee Schedule are available to beneficiaries when medically necessary, ordered by a physician, and provided by an independent laboratory or outpatient hospital laboratory. For additional information, refer to the Laboratory Subsection in the Practitioner Chapter of this manual.



SECTION 4 – STERILIZATION

For Medicaid purposes, a sterilization procedure is defined as any medical procedure, treatment, or operation for the purpose of rendering a beneficiary (male or female) permanently incapable of reproducing. Surgical procedures performed solely to treat an injury or pathology are not considered sterilizations under Medicaid's definition of sterilization, even though the procedure may result in sterilization (e.g., oophorectomy). Physicians are responsible for obtaining the signed Consent for Sterilization (MSA-1959/HHS-687) 30 days prior to surgery. A copy of the form can be found in the Forms Appendix of this manual.

Sterilizations are covered only if:

- The beneficiary is at least 21 years of age at time of informed consent;
- The beneficiary is not legally declared to be mentally incompetent;
- The beneficiary is not institutionalized in a corrective, penal, or mental rehabilitation facility;
- Informed consent is obtained; and
- Informed consent is not obtained while the beneficiary is in labor or childbirth; seeking to obtain or obtaining an abortion; or under the influence of alcohol or other substances that affect the beneficiary's state of awareness.

4.1 INFORMED CONSENT

Sterilization requires the beneficiary's voluntary informed consent. Persons obtaining the informed consent must adhere to the following requirements:

- The beneficiary must be advised that the sterilization will not be performed for at least 30 days, but within 180 days, after signing the MSA-1959/HHS-687 except in cases of emergency abdominal surgery or premature delivery.
- The person who obtains the informed consent must answer any questions the beneficiary may have concerning the procedure.
- Information must be effectively communicated to the deaf, blind, or otherwise physically challenged.
- An interpreter must be provided if the beneficiary to be sterilized does not understand the language on the consent form or used by the person obtaining the informed consent.
- Beneficiaries may have a witness of their choice present when informed consent is obtained.
- A copy of the consent form must be given to the beneficiary.
- Informed consent may not be obtained while the beneficiary to be sterilized is:
 - In labor or childbirth;
 - Seeking to obtain or obtaining an abortion; or
 - Under the influence of alcohol or other substances that affect the beneficiary's state of awareness.



The following information must be presented orally to the beneficiary both at the time the beneficiary signs the consent form and again by the physician performing the sterilization shortly before the procedure, normally during the pre-operative examination.

- The beneficiary is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the beneficiary might be otherwise entitled.
- A description of available alternative methods of family planning and birth control.
- The sterilization procedure is considered to be irreversible.
- A thorough explanation of the specific sterilization procedure to be performed.
- A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used.
- A full description of the benefits or advantages that may be expected as a result of the sterilization.
- The beneficiary, the person who obtained the consent, and the interpreter or translator (if required) must sign the consent form at least 30 days but no more than 180 days prior to the sterilization. The physician performing the sterilization must sign and date the consent form after the sterilization has been performed.

4.2 EXCEPTIONS FOR STERILIZATION

All of the above requirements may not be met in some instances, e.g., in cases of premature delivery and emergency abdominal surgery. Exceptions apply when the beneficiary to be sterilized has signed a consent form and, during the required 30-day waiting period, a premature delivery or an emergency abdominal surgery is necessary. To avoid an additional surgery at the conclusion of the required 30-day waiting period, federal regulations permit the sterilization to be performed at the same time as the premature delivery or emergency abdominal surgery if 72 hours have elapsed since the beneficiary signed the consent form. In cases of premature delivery, an additional requirement is that the consent form was signed at least 30 days before the expected delivery date.

4.3 REIMBURSEMENT POLICY FOR STERILIZATION

Pre- and post-operative examinations for the sterilization procedure are included in the reimbursement for the surgical procedure. No additional reimbursement is allowed for the pre-operative examination or the sterilization explanation.

Reimbursement for a vasectomy includes pre- and post-operative visits for counseling, clamp removal, the post-operative semen analysis, etc. No additional charges are allowed for these services and Medicaid does not make separate payment.

Reimbursement for female sterilization and other related medical procedures are available to Medicaid enrolled physicians performing the sterilization. Physicians must bill using their provider NPI number in these cases.



4.4 SPECIAL BILLING INSTRUCTIONS

All items of the MSA-1959/HHS-687 must be completed except in the following circumstances:

- The ethnic information is optional.
- The interpreter statements must be completed only when applicable.

All invoices submitted to MDHHS by the clinic for the sterilization must include a copy of the fully completed MSA-1959/HHS-687. (Refer to the Forms Appendix for additional information.) This requirement applies to all practitioners, technical surgical assistants, anesthesiologists, etc., as well as the hospital and clinics. All sterilization claims suspend and documentation is reviewed by MDHHS. Invoices submitted without the appropriate documentation are rejected. If any field on the form is improperly completed, the claim will be rejected.

When billing for charges related to a sterilization procedure, a copy of the completed MSA-1959/HHS-687 must be included. This form may be submitted by fax or accompany the claim. (Refer to the Directory Appendix for contact information.)

4.5 CONSENT FORM FOR STERILIZATION

MDHHS allows submission of MSA-1959/HHS-687 forms via fax. Federal regulations require that this form be submitted to Medicaid before reimbursement can be made for any sterilization procedure. Submitting the form via fax eliminates attachments to claims and confirms that the form is acceptable, thus reducing costly claim rejections.

The provider who obtains the consent and completes the MSA-1959/HHS-687 may fax or mail the completed consent form, along with a cover sheet, to the Medicaid Payments Division. (Refer to the Directory Appendix for contact information.) The form is reviewed within five working days. Either an explanation of errors or notice that the form has been accepted and is on file is returned to the submitting provider via the same method it was submitted. When the provider receives notice that the form is accepted and on file, all invoices related to the service may be submitted to MDHHS without paper attachments.

4.6 PROCEDURE FOR SUBMITTING THE CONSENT FOR STERILIZATION FORM

Providers must complete the following steps when submitting a MSA-1959/HHS-687:

- Complete a cover sheet according to Document Management Portal instructions.
- Fax the cover sheet and completed consent form to Medicaid Payments Division, Sterilization Consent Form Approval. Do not fax invoices.
- Wait for a response. When notified that the consent form has been accepted and is on file, inform other providers via a copy of the response.
- Providers may then submit claims (either electronic or hard copy) to MDHHS. The Remarks section or Comment Record must include the statement "Consent on File."
- When sterilization claims are received with this information in the Remarks section, the claim is forced for payment if the submitted invoice matches the consent form on file.



- If there is no response from MDHHS within five working days, review the request submitted to insure that MDHHS received the fax (i.e., confirm that the fax is working, make sure the cover sheet included the necessary provider contact information, etc.). Resend the information if necessary.

Providers have the option to attach a copy of the MSA-1959/HHS-687 to the claim without going through the pre-approval process outlined above.



SECTION 5 – PHARMACEUTICALS

Clinics may dispense and receive reimbursement for contraceptives and limited pharmaceutical supplies. For additional information regarding family planning clinic procedure codes, refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter.

Oral contraceptives dispensed may not exceed a six-month supply, and the Nuvaring and contraceptive patches should not exceed a three month supply. All other contraceptive supplies should be dispensed for one month, with the exception of implants and hormonal contraceptives such as Depo Provera.

If the only service provided is supplies, no visit code may be billed. A billing unit must equal a billing quantity of one on the claim.

Medicaid covers a broader range of pharmaceuticals than those listed in the Medicaid Code and Rate Reference tool or on the MDHHS Family Planning Clinics Fee Schedule. These products must be prescribed by a physician and dispensed by a Medicaid-enrolled pharmacy. The Pharmacy Chapter of this manual or the local pharmacy may be referenced/contacted for details.

5.1 SPECIAL BILLING INSTRUCTIONS

If a pharmaceutical, contraceptive supply, or medical device is purchased at the 340B price, the actual acquisition cost must be billed to Medicaid. In addition, drugs purchased through the 340B program must be indicated as such on the claim. Professional/institutional claims for drugs purchased through the 340B program must be indicated on the claim using the modifier U6. Pharmacy claims for outpatient drugs purchased through the 340B program must be indicated on the claim using a Submission Clarification Code of 20. (Refer to the Billing & Reimbursement for Professionals Chapter for additional information.)



SECTION 6 – OTHER SERVICES

6.1 REFERRALS

Each clinic is responsible for making appropriate referrals in the following circumstances:

- Medical problems identified by the history or physical examination
- All positive Gonorrhea and other STD cultures and/or serology
- Vaginal infections
- Beneficiaries with abnormal cervical cytology
- Beneficiaries with positive urine cultures
- Prenatal services
- Beneficiaries suffering from anemia
- Female sterilizations

6.2 INPATIENT SERVICES

Each clinic must make arrangements for inpatient care for fee-for-service (FFS) beneficiaries requiring inpatient care as a result of complications arising from contraceptive services provided by that clinic. Arrangements for MHP enrollees must be made through the MHP.

6.3 EMERGENCY SERVICES

Each clinic must have a mechanism in place for handling emergency services related to contraceptive services after regular clinic hours.



FEDERALLY QUALIFIED HEALTH CENTERS

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SECTION 1 – GENERAL INFORMATION

This chapter applies to Federally Qualified Health Centers (FQHCs), designated FQHC look-alikes, and Tribal Health Centers (THCs) electing to be reimbursed as an FQHC. Subsequent references to FQHCs in this chapter are applicable to all three entities. This chapter provides policy and reimbursement information specific to FQHCs and is to be used in combination with other chapters in this manual.

Section 330 of the Public Health Service Act establishes guidelines for health centers applying for grant funding under the Health Centers Consolidation Act of 1996 (Public Law 104-299). This act combined four federal health center grant programs under one authority (community, migrant, homeless and public housing). Health centers applying for, and meeting the criteria for, grant funding under Section 330 are eligible to be recognized as FQHCs by Centers for Medicare & Medicaid Services (CMS) for reimbursement purposes. Once FQHC status is designated by CMS and notification of that status is provided to the Michigan Department of Health and Human Services (MDHHS), an FQHC is eligible to enroll with Medicaid as an FQHC provider in the State of Michigan.

Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 makes provision for the reimbursement of FQHCs under a prospective payment system (PPS). Section 702 of BIPA created a new section 1902(bb) in the Social Security Act. This PPS applies to the ambulatory/outpatient medical services that FQHCs are required, under federal regulation, to provide to Medicaid beneficiaries.

States may elect to reimburse FQHCs under the PPS methodology outlined in the Act or they may choose to implement an alternative payment methodology, referred to as the Memorandum of Understanding (MOU). The MOU must be agreed to by both the state and the FQHC. If an alternative payment methodology is implemented, it must result in payment at least equal to that which an FQHC would receive under the PPS. Refer to the Alternative Payment Methodology subsection of this chapter for additional information.

1.1 ENROLLMENT [CHANGE MADE 7/1/20]

Each FQHC that is certified by CMS to provide services as a Medicare-enrolled FQHC is eligible to apply to MDHHS to be a Medicaid provider. To apply, the FQHC must complete the on-line CHAMPS Provider Enrollment application process. (Refer to the Provider Enrollment Section of the General Information for Providers Chapter for enrollment information.)

MDHHS requires all FQHCs to have a Group (Type 2 - Organization) National Provider Identification (NPI) number in order to receive the enhanced FQHC reimbursement. For FQHCs with multiple locations and multiple rates, an NPI number for each location may be necessary so that the proper reimbursement rate of all encounters can be determined. If the FQHC fails to obtain and/or use the correct NPI number, the FQHC reimbursement will be determined under fee for service rules. The NPI number must be reported to MDHHS before billing Medicaid services.

Individual providers (doctors, dentists, optometrists, etc.) are required to obtain a Provider (Type 1 - Individual) NPI number and report the number to MDHHS.

FQHC services that are furnished under contract with physicians, clinical social workers, clinical psychologists, physician assistants, certified family and pediatric NPs, visiting nurses, and other approved



professionals are billed as FQHC services. However, preventive primary services must be provided by an employee of the FQHC or by a physician under contract with the FQHC. Preventive primary services do not qualify as FQHC services if non-employee providers (except physicians) contracting with the FQHC provide the services.

In accordance with 42 CFR 455.104 and the Provider Ownership and Control Disclosures subsection of the General Information for Providers chapter of this Manual, clinics are required to disclose ownership information to MDHHS within 35 days of a change of ownership. Failure to notify MDHHS of any change in identification information may result in the loss of Medicaid enrollment, lapse of provider eligibility, or nonpayment of services. **(text added 7/1/20)**

1.1.A. NON-PHYSICIAN BEHAVIORAL HEALTH SERVICES

Licensed psychologists (Master's Limited or Doctoral level), social workers (Master's level), professional counselors (Master's or Doctoral levels), and marriage and family therapists who serve Medicaid beneficiaries are required to enroll as Medicaid providers to provide behavioral health services. The NPI of the psychologist, social worker, professional counselor, or marriage and family therapist is reimbursed under the FQHC PPS or MOU. These services must be billed using the appropriate evaluation and management (E/M) codes listed in the American Medical Association's Current Procedural Terminology (CPT) Book or Healthcare Common Procedure Coding System (HCPCS) codes. Providers should refer to the Non-Physician Behavioral Health provider database on the MDHHS website for covered procedure codes. The list of allowable services is reviewed annually and updated as applicable. Refer to the Additional Code/Coverage Resource Materials Section of the General Information for Providers Chapter for additional information regarding coverage parameters.

For information relating to service coverage and authorization requirements, refer to the Practitioner and the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapters of this manual.

1.2 SITE SPECIFIC CERTIFICATION

FQHCs are required to report CMS and Health Resources and Services Administration (HRSA) site-specific certification numbers for each site operated by the FQHC as part of the CHAMPS PE online enrollment process. Satellite(s) and/or mobile center(s) locations not approved by HRSA as a Section 330 eligible site will not be eligible for PPS or MOU reimbursement.

FQHCs are required to notify the MDHHS Hospital and Clinic Reimbursement Division (HCRD) in writing within seven (7) business days of any of the following changes:

- HRSA notification of lost FQHC status; or
- Opening(s) and/or closing(s) of any HRSA approved satellite(s) and/or mobile center(s) sites.

1.3 ALLOWABLE PLACES OF SERVICE

Services provided to beneficiaries within the four walls of the FQHC and approved FQHC satellite(s) and/or mobile center(s) are allowable for reimbursement under the PPS or the MOU. Off-site services provided by employed practitioners of the FQHC to beneficiaries temporarily homebound or in any



assisted living or skilled nursing facility because of a medical condition that prevents the beneficiary from traveling to the FQHC are also allowable for reimbursement under the PPS or the MOU.

If a practitioner employed by an FQHC provides services at an inpatient hospital, the service must be billed under the individual practitioner's NPI and will be reimbursed the appropriate fee screen rate. Services performed in an inpatient hospital setting are not included under the PPS or MOU. The costs that are associated with these services must be excluded from the FQHC's Medicaid Reconciliation Report.

1.4 NONENROLLED PROVIDER SERVICES

Professional services performed by limited licensed psychologists (except as noted in Section 333.18223 of the Public Health Code), social workers, professional counselors, marriage and family therapists, or student interns must be performed under the supervision of an enrolled, fully-licensed provider of the same profession. These services are reimbursed under the FQHC PPS or MOU. Since MDHHS does not directly enroll these providers, claims for their services must be billed using the NPI of the supervising provider responsible for ensuring the medical necessity and appropriateness of the services. Claims submitted with the non-enrolled provider's NPI in the rendering provider field will reject. The clinical psychologist and clinical social worker services must be billed with the appropriate procedure codes that reflect the services provided.

Services provided by clinical psychologists and clinical social workers are included in the outpatient visits for MHP members. FQHCs must participate as part of a MHP provider panel in order to bill for services provided to members, and all services must be prior authorized by the respective MHP.



SECTION 2 – BENEFITS

FQHC services subject to PPS reimbursement are FQHC services defined at Section 1861 (aa)(3)(A)-(B) of the Social Security Act.

2.1 PRIMARY CARE SERVICES

Primary care services are defined as:

- Those required under Section 330 of the Public Health Service Act.
- Medicaid-covered services provided in a place of service that is the FQHC's office or clinic, patient's home, Domiciliary Facility Nursing Home, Nursing Facility (NF), or Skilled Nursing Facility (SNF) by a provider type physician, medical clinic, podiatrist, dentist, CNP or CNM.
- Visits by a clinical psychologist or clinical social worker at the FQHC's office or clinic, patient's home, Domiciliary Facility Nursing Home, Nursing Facility, or Skilled Nursing Facility.
- Other ambulatory services, i.e., Medicaid transportation, Medicaid outreach, and Maternal Infant Health Program (MIHP) services.

2.2 TRANSPORTATION/OUTREACH

The cost of outreach and non-emergency transportation is part of an FQHC's encounter rate. These services are not cost settled.

The FQHC provides non-emergency transportation to and from the FQHC for Medicaid covered services provided to Medicaid Fee-for-Service beneficiaries. For Medicaid managed care enrollees, the FQHC may provide transportation in certain circumstances. Refer to the Managed Care Programs section of the Non-Emergency Medical Transportation chapter for additional information.

2.3 TELEMEDICINE

An FQHC can be either an originating or distant site for telemedicine services. Refer to the Billing & Reimbursement for Professionals Chapter for specific billing instructions. Refer to the Telemedicine Section of the Practitioner Chapter for additional information regarding telemedicine services.

Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

2.4 CHILDREN'S HEALTH INSURANCE PROGRAM SERVICES

Section 503 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 authorizes states to incorporate a PPS rate for reimbursement of services provided to children receiving health care services through FQHCs when covered by the Children's Health Insurance Program (CHIP). Reimbursement for eligible services must comply with the requirements of section 1902 (bb) of the Social Security Act.

For beneficiaries enrolled in state CHIP-funded programs (MIChild, Healthy Kids–Expansion, and Maternity Outpatient Medical Services [MOMS]), providers must bill the program according to their existing processes. For beneficiaries enrolled in a health plan, the MDHHS HCRD will perform an annual



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reconciliation of these encounters provided by FQHCs. (Refer to the Medicaid Health Plans subsection of this chapter for additional information.)

For Healthy Kids–Expansion, MICHild and MOMS beneficiaries, the HCRD will perform an annual reconciliation of these encounters provided by FQHCs. The FQHC PPS rates established for eligible CHIP services are equivalent to those applicable to Medicaid for each respective year they are in effect.



SECTION 3 – ENCOUNTERS

3.1 DEFINITION

An allowable FQHC encounter means a face-to-face medical visit between a patient and the provider of health care services who exercises independent judgment in the provision of health care services. Encounters may be classified as medical, dental, or behavioral health.

An encounter occurs between a medical provider and a patient when medical services are provided for the prevention, diagnosis, treatment, or rehabilitation of an illness or injury. Included in this category are physician visits and mid-level practitioner visits. Family planning medical visits are a subset of medical visits.

An encounter occurs between a dentist or dental hygienist and a patient when services are for the purpose of prevention, assessment, or treatment of a dental problem, including restoration. A dental hygienist is credited with an encounter only when the professional provides a service independently, not jointly with a dentist. However, two encounters may not be billed for the dental clinic in one day.

An encounter occurs between a speech or physical therapist, audiologist, occupational therapist, clinical psychologist, or clinical social worker and a patient when allied health or mental health services are provided. Allied health services are those provided by specially trained health workers, other than medical and dental personnel. Mental health services are those of a psychological or crisis intervention nature or related to alcohol or drug abuse treatment. For the purpose of these reports, visits with a psychiatrist are included under medical visits.

The following examples help to define an encounter:

- To meet the encounter criteria for independent judgment, the provider must be acting independently and not assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history or drawing a blood sample is not credited with a separate encounter.
- Such services as drawing blood, collecting urine specimens, performing laboratory tests, taking X-rays, filling/dispensing prescriptions, or optician services, in and of themselves, do not constitute encounters. However, these procedures may accompany services performed by medical, dental, or other health providers that do constitute encounters.
- Encounters must be documented in the medical record. When a provider renders services to several patients simultaneously, the provider can be credited with a visit for each person if the provision of services is noted in each person's health record. This also applies to family therapy or counseling sessions in which several members of the family receive services relating to mutual family problems and the services are noted in each family member's health record.
- The same timely filing billing limitations identified in the General Information for Providers Chapter of this manual apply to claims submitted for FQHC encounters.

The encounter criteria are not met in the following circumstances:

- When a provider participates in a community meeting or group session that is not designed to provide health services.



- When the only service provided is part of a larger scale effort, such as a mass immunization program, screening program, or community-wide service program.
- When the following services are provided as stand-alone services: taking vital signs, taking a history, drawing a blood sample, collecting urine specimens, performing laboratory tests, taking x-rays, and/or filling/dispensing prescriptions. Refilling prescriptions, filling out insurance forms, etc. are not visits. Allergy injections are not visits.

3.2 MEDICAID HEALTH PLANS

Medicaid-covered services provided by an FQHC to Medicaid-eligible beneficiaries enrolled with an MHP are subject to the PPS when the following conditions are met:

- The FQHC and the MHP must be signatories to a contract that addresses the FQHC providing Medicaid covered services to an MHP enrollee.
- The contract must provide for the MHP to reimburse the FQHC at a fair market rate for similarly situated beneficiaries served by a non-PPS provider. The contractor must implement a payment method equal to, or above that of, other affiliated inter-plan and intra-plan subcontracting arrangements when entering into a subcontract with an FQHC.
- The FQHC must submit documentation of the encounters and payments when requesting MDHHS pay the PPS rate for health plan enrollees.

MHP beneficiaries are identified in the eligibility response with the Benefit Plan ID of CSHCS-MC, MA-HMP-MC, MA-MC or MME-MC. Providers must verify eligibility before providing services. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.)

3.3 HEALTHY KIDS DENTAL

Dental services provided to Medicaid beneficiaries enrolled in the *Healthy Kids Dental* program are subject to the PPS or MOU rate.

3.4 SUBSTANCE USE DISORDER SERVICES

Selected services provided by an FQHC will be included in the FQHC annual reconciliation when a contract exists between the FQHC and the behavioral health contracting entity. FQHCs that have a contract in place with a behavioral health agency must follow the service and billing arrangements set forth by the contract. Refer to the Medical Clinics and/or Federally Qualified Health Centers databases on the MDHHS website or the Medicaid Code and Rate Reference tool for additional information. (Refer to the Directory Appendix for website information.)

3.5 ALLOWABLE ENCOUNTERS PER DAY

An FQHC may be credited with one encounter for each different type of visit provided to a beneficiary during a single day, regardless of the number of services provided at the visit. A maximum of three encounters are allowed per beneficiary per day (one medical, one dental, and one behavioral health). In cases where the beneficiary, after the first visit, suffers illness or injury requiring additional diagnosis or treatment, these visits may be classified as two encounters.



- Example 1: A beneficiary sees a dentist for an exam and three restorations and sees the dental hygienist for a prophylaxis on the same day. These visits count as one encounter (dental).
- Example 2: A beneficiary sees a physician at the FQHC, and then later sees a dentist and a social worker on the same day. These visits may be classified as three encounters (one medical, one dental, and one behavioral health).
- Example 3: A beneficiary sees a physician for flu symptoms early in the day, and then later the same day sees the same physician for a broken leg. These visits may be counted as two encounters (both medical – subsequent injury).

3.6 SERVICES AND SUPPLIES INCIDENTAL TO AN FQHC ENCOUNTER

Services and supplies incidental to a FQHC encounter are included in the PPS reimbursement if the service or supply is:

- Of a type commonly furnished in a physician's office.
- Of a type commonly rendered either without charge or included in the professional bill.
- Furnished as an incidental, although integral, part of professional services furnished by a physician, CNP, CNM, or physician's assistant.
- Furnished under the direct personal supervision of a physician, CNP, CNM, or physician's assistant.
- In the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic.

The direct personal supervision requirement is met in the case of a CNP, CNM, or physician's assistant only if such a person is permitted to supervise such services under the written policies governing the FQHC.



SECTION 4 – BILLING

FQHC providers are expected to practice in accordance with the accepted standards of care and professional guidelines applicable to medical, dental, and behavioral health services, and comply with all applicable policies published in the Michigan Medicaid Provider Manual. FQHC services must be billed according to instructions published in the Billing & Reimbursement for Institutional Providers Chapter of this manual. FQHCs must refer to this chapter for information needed to submit claims for Medicaid services, as well as information about how MDHHS processes claims and notifies the FQHC of its action. Policies for specific services are found in the provider-specific chapters of this manual.

It is the responsibility of the FQHC to properly bill all Medicaid FFS claims. Since the annual reconciliation and final reimbursement is based on approved Medicaid claims, incorrect or improper billing may adversely affect reimbursement.

The Group (Type 2 - Organization) NPI number must be used as the billing provider on all electronic and paper claims submitted to Medicaid. Do not use Provider (Type 1 - Individual) as the billing provider. The billing provider loop or field is mandatory to complete.

The NPI (Type 1 – Individual) number of the physician (MD or DO) overseeing the beneficiary's care must be entered as the attending provider. The attending provider field is mandatory to complete. Additionally, the NPI (Type 1 – Individual) number of the practitioner who performed the service should be entered as the rendering provider. Do not enter a Group (Type 2) NPI number as the attending or rendering provider.

MDHHS will use the billing provider NPI field (Type 2 - Organization) to determine the number of encounters and calculate the settlement for the year-end reconciliation.

The FQHC's MDHHS-approved claims must be available for review by authorized personnel or agents of MDHHS, the Health Care Fraud Division of the Michigan Department of Attorney General, and U.S. Department of Health & Human Services (HHS) in conformity with the provisions of the Social Security Act. Inappropriate payments identified in post-payment review are subject to recoupment. The FQHC has the full responsibility to maintain proper and complete documentation to verify the services provided.

4.1 PLACE OF SERVICE

Place of service codes are not applicable to institutional billing. However, if the FQHC performs a service that must be billed on the professional claim form within the FQHC, the appropriate place of service code is 50. For services not provided in the FQHC, bill the appropriate place of service (POS) code listed in the Billing & Reimbursement for Professionals Chapter of this manual.

FQHCs providing Medicaid-covered services in locations other than the FQHC office, home, nursing facility or domiciliary facility are reimbursed at Medicaid fee screens.

4.2 BILLING FOR MATERNITY CARE

Global codes for maternity care are used to reimburse a package of services (prenatal visits and delivery) at different places of services (FQHC and hospital). In order for the FQHC to be reimbursed for prenatal visits under the PPS methodology, the FQHC should not bill for global maternity care. The claims for



delivery and prenatal care should be billed separately. The claim for delivery should show a hospital place of service and will be paid under the FFS methodology. The claim for prenatal care will be reimbursed under the PPS methodology.

If the FQHC elects to bill for global maternity care, all services will be reimbursed under the FFS rules.

4.3 OTHER INSURANCE

Billing instructions related to coordination of benefits are contained in the Coordination of Benefits Chapter of this manual. Other insurance and all other payments received for services rendered to a Medicaid beneficiary must be reported. Even if the other insurance payment for a specific service exceeds the amount Medicaid would have paid, the FQHC must still bill the procedure code to receive credit for the encounter.

4.4 MEDICARE AND MEDICAID CROSSOVER CLAIMS

Refer to the Billing & Reimbursement Chapters of this manual for specific instructions regarding Medicare and Medicaid claims. If the Medicare payment exceeds the Medicaid fee screen, the appropriate FFS procedure code should still be billed to Medicaid for encounter and reconciliation purposes.

4.5 COPAYMENTS

Medicaid copayments for chiropractic, dental, physician, podiatry, and vision services are waived under the FQHC benefit as part of the reconciliation.

4.6 DENTAL CLAIMS

FQHCs providing dental services must refer to the Dental and to the Billing & Reimbursement for Dental Providers chapters of this manual for information regarding program coverages, prior authorization requirements, claim completion, and billing instructions.



SECTION 5 – MEDICAID RECONCILIATION REPORT

5.1 RECONCILIATION OF FEE-FOR-SERVICE

Each FQHC is required to submit an annual Medicaid Reconciliation Report. MDHHS will include, as part of the annual Medicaid Reconciliation Report, fee-for-service (FFS) primary care services claims that are approved through the claims system. In order for this to occur, all FFS primary care services must be submitted and processed through CHAMPS. (Refer to the Primary Care Services subsection in this chapter.) Every individual provider or electronic biller (the billing agent) receives a remittance advice (RA) for services that are billed. The RA informs the provider of the action taken on claims. It is the responsibility of FQHC providers to monitor claim activity and take appropriate steps to resolve suspended and rejected claims prior to the final reconciliation. (Refer to the Billing & Reimbursement Chapters of this manual for additional billing information.)

For non-primary care services, the FQHC will receive the Medicaid FFS amounts or the amount agreed to with the MHP as payment in full. The FQHC may enter into a risk contract with the MHP for services not included in the primary care definition. Non-primary care services and risk contracts will not be reconciled and are not included in the Medicaid Reconciliation Report.

5.2 DOCUMENTING ENCOUNTERS

Encounter data for FQHCs services provided to beneficiaries through Medicaid Health Plans, *Healthy Kids Dental*, and/or regional Prepaid Inpatient Health Plans (PIHP) is accessible through the Community Health Automated Medicaid Processing System (CHAMPS).

No individual payment information is needed if health plan payments are made on a capitated basis; however, a separate summary of the monthly payments must be provided.

Upon review and audit, MDHHS will reimburse the difference between the FQHC PPS rate and the amount received from the Medicaid Health Plans, *Healthy Kids Dental*, and/or the regional PIHP.

5.3 RECONCILIATION OF QUARTERLY ADVANCES

Quarterly advances are included as Medicaid revenue on the Medicaid Reconciliation Report and are reconciled with the FQHC PPS. The quarterly payment will be made on the RA at the beginning of each quarter.

Quarterly advances are an estimate of the difference between the payments that an MHP, PIHP, or Dental Health Plan (DHP) make to the FQHC, and the payments the FQHC would have received under the PPS. This quarterly amount may be adjusted periodically by MDHHS to account for changes in the payment limits, cost, utilization, and other factors that affect Medicaid reimbursement to FQHCs. The FQHC may request a change in the quarterly payment through the MDHHS HCRD.



5.4 RECONCILIATION OF TRANSPORTATION/OUTREACH

Medicaid outreach and non-emergency transportation are combined into the all-inclusive encounter rate. Transportation requirements are defined in the Benefits Section of this chapter.

5.5 PROSPECTIVE PAYMENT RATE

An FQHC is reconciled to the prospective payment rate (PPR) determined under the PPS or the MOU. In accordance with section 1902(bb) of the Social Security Act, the PPS per visit payment is equal to 100 percent of the average of the FQHC reasonable costs of providing Medicaid services during Fiscal Years 1999 and 2000. The PPR amount is an all-inclusive rate that covers all defined primary care services. (Refer to the Medicaid Reconciliation Report subsection of this section for a definition of reasonable costs.) The per visit amount is adjusted annually using the Medicare Economic Index (MEI) based on changes in the MEI for the prior calendar year.

5.6 PROSPECTIVE PAYMENT RATE FOR NEW FQHC SITES

An entity that initially qualifies as an FQHC after fiscal year 2000 will be paid as follows:

- Upon enrollment, an interim prospective payment rate (PPR) will be established for new FQHCs equal to the facility type average rate for the county in which they are located or the statewide average (if no previous average exists for the county subject to any limit applied to the specific facility type). The FQHC will be cost settled at the end of its first fiscal year of operation.
- After the facility has been in operation for two full cost reporting periods, the average rate per visit for those two periods will be considered the revised PPR for the facility, subject to the following criteria:
 - The first year will be inflated to the second fiscal year end using the appropriate MEI factors.
 - The PPR shall not exceed the Medicare limit (rural or urban depending upon classification) plus the Medicaid add-on amounts adjusted for MEI.

Newly established FQHCs shall be paid using the PPS methodology or may agree to payment in accordance with the MOU. A newly established FQHC is eligible for quarterly payments. The amount of the quarterly payment will be estimated until the first reconciliation period.

5.7 ADJUSTMENTS TO THE PROSPECTIVE PAYMENT RATE

The prospective payment rate may also be adjusted to reflect changes in the scope of services provided to Medicaid beneficiaries by an FQHC. All scope of service changes are made on a prospective basis. The adjustment may result in either an increase or decrease in the per visit amount paid to the FQHC. (Refer to the Scope of Service subsection of this section for additional information.)

5.8 ALTERNATIVE PAYMENT METHODOLOGY

In accordance with State Plan authority, MDHHS may enter into an alternative payment methodology with an FQHC, referred to as a Memorandum of Understanding (MOU). Reimbursement for Medicaid primary care services provided by an FQHC to Medicaid beneficiaries is subject to the terms of the signed



MOU. For an FQHC paid under the MOU, the PPS base methodology described within this chapter will be maintained to ensure compliance with Section 1902(bb)(6)(B) of the Social Security Act.

The MOU is effective when both MDHHS and an FQHC are signatories to the document. CMS, rather than the State, is the final arbiter of the permissibility of this agreement. The MOU does not supersede any corresponding policy in the Michigan Medicaid Provider Manual, but documents the clinic's acceptance of the terms outlined in the Michigan Medicaid State Plan. If an FQHC does not sign the MOU, reimbursement and corresponding policy defaults to that which is described under the PPS methodology and outlined in this manual.

5.9 SCOPE OF SERVICE

5.9.A. INCREASE/DECREASE IN SCOPE OF SERVICE

The prospective payment rate may be adjusted for an increase or decrease in scope of service. Any facility approved for rebasing due to a change in scope of services shall be treated as a new facility. In order to qualify for a scope of service change, the cost related to the specific change must account for an increase or decrease to the existing PPR of five percent or greater. A facility that changes classification to a system utilizing a different rate limit or methodology shall be considered a change of scope (by default).

- An increase in scope of service results from the addition of a new professional staff member (i.e., contracted or employed) who is licensed to perform medical services that are approved FQHC benefits that no current professional staff is licensed to perform.
- A decrease in scope of service results when no current professional staff member is licensed to perform the medical services currently performed by a departing professional staff member.

An increase or decrease in scope of service does not result from any of the following (although some of these changes may occur in conjunction with a change in scope of service):

- An increase, decrease or change in number of staff working at the clinic.
- An increase, decrease or change in office hours.
- An increase, decrease or change in office space or location.
- The addition of a new site that provides the same set of services.
- An increase, decrease or change in equipment or supplies.
- An increase, decrease or change in the number or type of patients served.

5.9.B. NOTICE OF INTENT TO CHANGE SCOPE OF SERVICE

If an FQHC intends to change its scope of service, the MDHHS HCRD must be notified 90 days before any financial commitments (i.e., money paid or committed to be paid, contracts signed, etc.) have been made. It is the responsibility of the FQHC to notify MDHHS for an increase or decrease in scope of service. Notification should include the following documentation:



- A complete description of the service to be changed (addition or deletion).
- A listing of procedure codes to be billed as a result of this new service.
- A budget for the fiscal year showing an estimate of the total increase or decrease in cost resulting from change.
- An estimate of the change in number of visits.
- Estimates of the cost change on the current Medicaid per visit rate.
- The proposed customary charges for this service by the clinic.
- The customary charges for this service by other providers in the area served by this clinic.
- The amount to be paid by a MHP for this service for various programs (Medicare/Medicaid).
- Medicare fee screen for this service for non-PPS providers.
- The current Medicare visit rate.
- Total encounters for last two years by program (Medicaid, Medicare, uninsured, etc.) and type (MHP, fee screen, contracted amount).
- Estimated increase in encounters by program for two fiscal periods following the change in scope of service.
- Copies of notices, certifications, applications, approvals and other documentation from state licensing agency, CMS, Medicare intermediary, or other organizations documenting the change in scope of service.
- Other information showing cost, visits or approvals/denials of the change.
- Other information as requested by the MDHHS HCRD.

After a review of the information submitted, the MDHHS HCRD determines if a per visit rate change will be made and notifies the FQHC, specifying the effective date of any change. All scope of service changes are made on a prospective basis.

5.10 MEDICAID RECONCILIATION REPORT

Each FQHC must complete a Medicaid Reconciliation Report for its fiscal year. The MDHHS HCRD must receive the report by the due date for the Medicare Cost Report in order for the FQHC to receive PPS reimbursement.

The FQHC's authorized individual who certifies the report and accompanying worksheets for the period noted must sign its Medicaid Reconciliation Report. If the required report and supplemental documents are not submitted within the required time limit, the FQHC waives its rights to PPS reimbursement for that year.

The Medicaid Reconciliation Report must be for the same fiscal period and cover the same sites as the Medicare Cost Report.



5.10.A. REASONABLE COSTS

Reasonable costs are defined as the per visit amount approved and paid by Medicare as of October 1, 2001, and then adjusted to reflect the cost of providing services to Medicaid beneficiaries who are not covered by Medicare.

5.10.B. MAINTENANCE OF MEDICAL AND FINANCIAL RECORDS

The FQHC must maintain, for a period of not less than seven years, financial and clinical records for the period covered by the reconciliation report that are accurate and in sufficient detail to substantiate the cost data reported. The records must be maintained until all issues are resolved. Expenses reported as reasonable costs must be adequately documented in the financial records of the FQHC or the expenses will be disallowed.

The MDHHS HCRD will maintain each required FQHC Medicaid Reconciliation Report submitted by the provider for seven years following the date of submission of the report. In the event that there are unresolved issues at the end of this seven-year period, the report will be maintained until such issues are resolved.

The financial and clinical records of the FQHC must be available for review by authorized personnel or agents of MDHHS, the Health Care Fraud Division of the Michigan Department of Attorney General, and the U.S. Department of Health & Human Services (HHS) in conformity with the provisions of the Social Security Act.



SECTION 6 – AUDITS, RECONCILIATIONS AND APPEALS

6.1 QUARTERLY ADVANCES AND RISK CONTRACTS

The FQHC's quarterly advances will be reconciled annually on the reconciliation report. Risk contracts will not be reconciled.

6.2 RECONCILIATION AND SETTLEMENTS

6.2.A. INITIAL SETTLEMENTS OF FQHCs

An initial settlement is calculated annually. Calculations are determined from the filed FQHC Medicaid Reconciliation Report and Medicaid paid claims information. An initial settlement will be completed generally within three months of the receipt of a complete and acceptable reconciliation report. MDHHS retains the right to withhold a portion of an initial payment based on individual circumstances.

6.2.B. FINAL SETTLEMENTS OF FQHCs

Final settlements for FQHCs are generally completed within one year of the FQHC fiscal year end using updated Medicaid data for the period covered by the FQHC Medicaid Reconciliation Report. This will allow sufficient time for all claims to clear the Medicaid payment system. Medicaid data will be updated using approved claims payment data, all other payments for Medicaid services, and Medicaid visits.

The Medicare intermediary field and/or desk audit may cause MDHHS to process an additional final settlement. After review of the revised cost report and any statistical and audit findings pertaining to it, MDHHS may process a revised Medicaid final settlement for the period covered by the reconciliation report.

6.2.C. UNDERPAYMENTS TO FQHCs

MDHHS staff process the full amount of the final settlement through a gross adjustment.

6.2.D. OVERPAYMENTS TO FQHCs

Once a determination of overpayment has been made, the amount determined is a debt owed to the State of Michigan and shall be recovered by MDHHS. The recovery will start approximately 30 days after notification to the FQHC. A credit gross adjustment will stop all payments to the FQHC physician(s) until the amount is recovered. This amount will be reflected on the Remittance Advice (RA).

Any issues left unresolved due to the Medicare audit and/or Medicare adjustment process must be appealed through the proper Medicare process before any changes can be made to the Medicaid settlements.



6.3 RESPONSE TO THE AUDIT ADJUSTMENT REPORT

MDHHS staff prepares the Audit Adjustment Report, which contains a descriptive list of all Medicaid data adjustments made to the Medicaid Reconciliation Report by MDHHS audit staff. The Audit Adjustment Report must be accepted or rejected by the FQHC within 30 calendar days of its mailing date.

The FQHC may take the following actions:

FQHC Accepts the Report	If the FQHC accepts the findings contained in the Audit Adjustment Report, an appropriate officer of the FQHC must sign the report and mail it to the MDHHS HCRD. (Refer to the Directory Appendix for contact information.) A Notice of Amount of Program Reimbursement will be mailed to the FQHC. No further administrative appeal rights will be available for the adjustments contained in the Audit Adjustment Report.
FQHC Does Not Respond	If the FQHC does not respond within this time period, MDHHS shall issue a Notice of Amount of Program Reimbursement, which is the final determination of an adverse action. No further administrative appeal rights are available.
FQHC Rejects the Report	If the FQHC rejects any or all of the findings contained in the Audit Adjustment Report, the FQHC may request a Post-Audit Conference within 30 calendar days from the date of receipt of the Audit Adjustment Report.

The Notice of Amount of Program Reimbursement is the notice of final determination of an adverse action and is considered the offer of settlement for all reimbursement issues for the reporting period under consideration.

6.4 MEDICAID APPEALS

Medicaid providers have the right to appeal any adverse action taken by MDHHS unless that adverse action resulted from an action over which the MDHHS had no control (e.g., Medicare termination, license revocation). The appeal process is outlined in the General Information for Providers Chapter of this manual and in the MDHHS Medicaid Provider Reviews and Hearings rules, Michigan Administrative Code R400.3402 through R400.3425, amended, and filed with the Secretary of State on May 19, 2016. Any questions regarding this appeal process should be directed to the Michigan Office of Administrative Hearings and Rules (MOAHR). (Refer to the Directory Appendix for contact information.)



SECTION 7 – MI CARE TEAM (PRIMARY CARE HEALTH HOME BENEFIT)

7.1 GENERAL INFORMATION

Effective July 1, 2016, MDHHS implemented a new care management and care coordination primary care Health Home benefit called the MI Care Team. The goals of the program are to ensure seamless transitions of care and to connect eligible beneficiaries with needed clinical and social services. MDHHS expects the benefit will enhance patient outcomes and quality of care, while simultaneously shifting people from emergency departments and hospitals to a primary care setting. The MI Care Team has an operations guide for providers called the MI Care Team Handbook. In addition, the MI Care Team has a website with provider resources. (Refer to the Directory Appendix for website information.)

Note: The benefit will continue as program evaluations are completed.

7.2. BENEFICIARY ELIGIBILITY

Eligible beneficiaries meeting geographic area requirements cited in the Provider Eligibility Requirements subsection of this policy include those enrolled in Medicaid, the Healthy Michigan Plan, or MICHild who have a diagnosis of depression and/or anxiety in addition to a diagnosis of one of the following:

- Asthma
- Diabetes
- Hypertension
- Heart Disease
- Chronic Obstructive Pulmonary Disease

7.3 BENEFICIARY ENROLLMENT

7.3.A. ENROLLMENT PROCESSES

The MI Care Team uses a two-pronged enrollment approach where both MDHHS and Health Home providers participate. The process is as follows:

- MDHHS will identify potential eligible beneficiaries using claims data and send each beneficiary a letter notifying them of their eligibility. MDHHS will also provide a list of potential eligible beneficiaries to designated MI Care Team providers with whom they have an established relationship. The list of eligible beneficiaries will be updated and maintained on a monthly basis. Enrollment is contingent on beneficiary consent (refer to the Beneficiary Consent subsection), and beneficiary assignment will occur only after a beneficiary visits a MI Care Team provider, fills out the enrollment and consent forms, and establishes a Health Action Plan (an individualized care plan). These steps must be documented.
- MI Care Team providers are permitted to recommend potential eligible beneficiaries for enrollment to MDHHS. MI Care Team providers must provide documentation that indicates that a prospective MI Care Team beneficiary meets all eligibility for the benefit, including presence of qualifying conditions, consent, and establishment of an



individualized care plan. MDHHS shall authorize all beneficiary eligibility and process approved enrollments.

7.3.B. BENEFICIARY CONSENT

Beneficiaries must provide a signed MI Care Team Beneficiary Enrollment/Disenrollment form (MSA-1030) and a signed Consent to Share Behavioral Health Information form (MDHHS-5515) to enroll and receive the MI Care Team benefit. Signed enrollment and consent forms must be collected and retained in the beneficiary's health record. Providers are responsible for verifying receipt of signed enrollment and consent forms and providing proper documentation to MDHHS. All documents must be maintained in compliance with MDHHS record-keeping requirements.

In cases when such consent is required, the Consent to Share Behavioral Health Information (form MDHHS-5515) must be used for all providers requesting release of information for behavioral health and/or substance use disorder related information. The consent is required to be accepted, honored and used for all Fee for Service (FFS), Managed Care and Prepaid Inpatient Health Plan (PIHP) beneficiaries both from and to any of those providers or entities. The MDHHS-5515 is maintained and updated on the MDHHS website. (Refer to the Directory Appendix for website information.)

An interpreter must be provided to assist the individual if the individual does not understand the language used on the consent form or the language used by the person obtaining the consent. Services of an interpreter cannot be billed as separate services or billed to the beneficiary.

Providers receiving federal funding under the Victims of Crime Act, Violence Against Women Act, and/or Family Violence Prevention and Services Act should not use the MDHHS-5515 because they are subject to stringent consent requirements under these federal laws that are not satisfied by the form. These requirements are in place to address the heightened safety and privacy concerns that victims of domestic violence, sexual assault, stalking, or other crimes may have. These individuals may need additional safeguards for their behavioral health information.

For guidance on addressing issues related to consent and the provision of services for domestic violence, sexual assault, stalking, or other crimes, refer to the MDHHS website.

7.3.C. MI CARE TEAM BENEFIT PLAN ASSIGNMENT

Once the steps outlined above are completed, the beneficiary will be assigned a benefit plan of HHMICARE associated to their Medicaid member ID in CHAMPS. It is incumbent upon MI Care Team providers to verify a beneficiary's HHMICARE assignment prior to rendering services. Beneficiaries without the benefit plan assignment of HHMICARE are not eligible for MI Care Team payment.

7.3.D. BENEFICIARY DISENROLLMENT

Beneficiaries may disenroll from the MI Care Team benefit at any time. Beneficiaries who decline enrollment initially may elect to enroll at a later date contingent on meeting



eligibility requirements. Beneficiaries who decline services or disenroll may do so without jeopardizing their access to other medically necessary services.

Other than beneficiary-initiated disenrollment, disengaged beneficiaries will be categorized into the following two groups which have unique disenrollment processes:

- Beneficiaries who have moved out of an eligible geographic area, died, or are otherwise no longer eligible for Medicaid program benefits will have their eligibility files updated per the standard MI Bridges protocol. Providers will receive updated files accordingly.
- Beneficiaries who are unresponsive for reasons other than moving or death. Providers must make three unsuccessful beneficiary contact attempts within three consecutive months for MDHHS to deem a beneficiary as unresponsive. Providers will not receive payment for unsuccessful contacts. Providers must provide documentation for each unsuccessful contact attempt. After the final unsuccessful attempt, providers will recommend disenrollment to MDHHS with proper documentation.

Providers should process disenrollments by completing the disenrollment section of the MI Care Team Beneficiary Enrollment/Disenrollment form (MSA-1030). Moreover, providers must document disenrollments in the Waiver Support Application. MDHHS requires that providers try to re-establish contact with disenrolled beneficiaries at least bi-annually, as applicable.

7.3.E. BENEFICIARY CHANGING MI CARE TEAM PROVIDERS

To maximize continuity of care and the patient-provider relationship, MDHHS expects beneficiaries to establish a lasting relationship with their chosen MI Care Team provider. However, beneficiaries may change MI Care Team providers, and should notify their current MI Care Team provider immediately if they intend to do so. The current and future MI Care Team providers must discuss the timing of the transfer and communicate transition options to the beneficiary. Additionally, the beneficiary must complete new enrollment and consent forms (MI Care Team Beneficiary Enrollment/Disenrollment form [MSA-1030] and a signed Consent to Share Behavioral Health Information form [MDHHS-5515]). The MI Care Team provider change should occur on the first day of the next month with respect to the new provider's appointment availability. Only one MI Care Team provider may be paid per beneficiary per month. The new MI Care Team provider will also not be eligible for the initial "Access and Health Action Plan" payment if that one-time payment was already made to another MI Care Team provider. (Refer to the MI Care Team Payment subsection of this policy for additional information.)



7.4 COVERED SERVICES

MI Care Team services provide integrated, person-centered, and comprehensive care to eligible beneficiaries to successfully address the complexity of comorbid physical and behavioral health conditions. These services include the following:

- **Comprehensive Care Management**, including but not limited to:
 - Assessment of each beneficiary, including behavioral and physical health care needs;
 - Assessment of beneficiary readiness to change;
 - Development of a Health Action Plan;
 - Documentation of assessment and Health Action Plan in the Electronic Health Record; and
 - Periodic reassessment of each beneficiary's treatment, outcomes, goals, self-management, health status, and service utilization.
- **Care Coordination and Health Promotion**, including but not limited to:
 - Organization of all aspects of a beneficiary's care;
 - Management of all integrated primary and specialty medical services, behavioral health services, physical health services, and social, educational, vocational, housing, and community services;
 - Information sharing between providers, patient, authorized representative(s), and family;
 - Resource management and advocacy;
 - Maintaining beneficiary contact, with an emphasis on in-person contact (although telephonic contact may be used for lower-risk beneficiaries who require less frequent face-to-face contact);
 - Appointment-making assistance, including coordinating transportation;
 - Development and implementation of a Health Action Plan;
 - Medication adherence and monitoring;
 - Referral tracking;
 - Use of facility liaisons;
 - Use of patient care team huddles;
 - Use of case conferences;
 - Tracking of test results;
 - Requiring discharge summaries;
 - Providing patient and family activation and education;
 - Providing patient-centered training (i.e., diabetes education, nutrition education, etc.); and



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- Connection of beneficiary to resources (i.e., smoking cessation, substance use disorder treatment, nutritional counseling, obesity reduction and prevention, disease-specific education, etc.).
- **Comprehensive Transitional Care**, including but not limited to:
 - Connecting the patient to health services;
 - Coordinating and tracking the patient's use of health services;
 - Providing and receiving notification of admissions and discharges;
 - Receiving and reviewing care records, continuity of care documents, and discharge summaries;
 - Post-discharge outreach to assure appropriate follow-up services;
 - Medication reconciliation;
 - Pharmacy coordination;
 - Proactive care (versus reactive care);
 - Specialized transitions when necessary (i.e., age, corrections); and
 - Home visits.
- **Patient and Family Support**, including but not limited to:
 - Reducing barriers to the beneficiary's care coordination;
 - Increasing patient and family skills and engagement;
 - Use of community supports (i.e., community health workers, peer supports, support groups, self-care programs, etc.);
 - Facilitating improved adherence to treatment;
 - Advocating for individual and family needs;
 - Assessing and increasing individual and family health literacy;
 - Use of advance directives;
 - Providing assistance with maximizing beneficiary's level of functioning; and
 - Providing assistance with development of social networks.
- **Referral to Community and Social Support Services**, including but not limited to:
 - Providing beneficiaries with referrals to support services;
 - Collaborating/coordinating with community-based organizations and key community stakeholders;
 - Emphasizing resources closest to the beneficiary's home
 - Emphasizing resources which present the fewest barriers;
 - Identifying community-based resources;
 - Providing resource materials pertinent to patient needs;
 - Assisting in attaining other resources, including benefit acquisition;



- Providing referral to housing resources; and
- Providing referral tracking and follow up.
- **Use of Health Information Technology to link services**, including but not limited to:
 - Use of an Electronic Health Record with meaningful use attainment;
 - Use of CareConnect360 for care coordination, transition and planning; and
 - Use of telemedicine as needed.

7.5 PROVIDER ELIGIBILITY REQUIREMENTS

Eligible providers are selected by MDHHS through its Invitation-to-Bid (ITB) process. Applicants are selected on the basis of meeting the requirements outlined in the ITB. Selected MI Care Team providers will assure that all requirements are met and maintained. Failure to meet and maintain these requirements can result in loss of MI Care Team eligibility.

7.5.A. GEOGRAPHIC AREA

Eligible providers must implement the MI Care Team in geographic areas determined by the ITB process.

7.5.B. PROVIDER TYPES

Eligible provider types for the MI Care Team are Federally Qualified Health Centers (FQHCs), including Section 330 grantees and FQHC Look-Alikes, and Tribal Health Centers (THCs).

7.5.C. PROVIDER REQUIREMENTS

Providers must meet the requirements indicated in the ITB, the MOU, and the MI Care Team Handbook. (Refer to the Directory Appendix for website information.)

7.5.D. PROVIDER INFRASTRUCTURE REQUIREMENTS

MI Care Team providers will assure beneficiary access to an interdisciplinary care team that addresses the beneficiary's behavioral and physical health needs. The on-site care team must consist of, at a minimum, the following:

- Primary Care Provider
 - Must be a primary care physician, physician's assistant, or nurse practitioner with appropriate credentials to practice in Michigan (i.e., full licensure and certification, as applicable)
- Behavioral Health Consultant
 - Must be a licensed master's level social worker in Michigan
- Nurse Care Manager
 - Must be a licensed registered nurse in Michigan



- Community Health Worker (CHW)
 - Must be at least 18 years of age
 - Must possess a high school diploma or equivalent
 - Must be supervised by licensed professional members of the care team
 - MDHHS strongly encourages the completion of a CHW Certificate Program
- Health Home Coordinator
 - Must be an administrative staff person employed by the eligible provider
- Access to a Psychiatrist/Psychologist for consultation purposes (can be off-site)
 - Must be a doctoral level licensed psychiatrist or psychologist in Michigan

In addition to the above required provider infrastructure, eligible providers should coordinate care with the following professions:

- Dentist
- Dietician/Nutritionist
- Pharmacist
- Peer support specialist
- Diabetes educator
- School personnel
- Others as appropriate

7.6 PROVIDER ENROLLMENT AND MI CARE TEAM DESIGNATION

All providers selected through the ITB process and meeting the requirements in the Provider Eligibility Requirements subsection of this policy may enroll as a designated MI Care Team provider contingent upon adherence to this policy and the MI Care Team MOU. MDHHS will provide, in writing, the MOU and any other contingencies needed to obtain or preserve MI Care Team designation. Providers must sign and attest to adhere to this policy and the MOU and return to MDHHS. Only after MDHHS receives this signed attestation will a provider become a designated MI Care Team provider.

7.6.A. TRAINING AND TECHNICAL ASSISTANCE

MDHHS requires provider participation in state-sponsored training and technical assistance as a standard condition for continued MI Care Team designation. A readiness assessment will be completed for each designated MI Care Team site which will provide a basis for training and technical assistance needs.

7.6.B. USE OF APPLICABLE HEALTH INFORMATION TECHNOLOGY (HIT)

MDHHS requires MI Care Team providers to utilize appropriate HIT for enrollment, health service documentation, and care coordination purposes. Training on specific HIT resources will be provided by MDHHS.



7.7 PROVIDER DISENROLLMENT

To maximize continuity of care and the patient-provider relationship, MDHHS expects MI Care Team providers to establish a lasting relationship with enrolled beneficiaries. However, designated MI Care Team providers wishing to discontinue MI Care Team services must notify MDHHS at least six months in advance of ceasing MI Care Team operations. MI Care Team services may not be discontinued without MDHHS approval of a provider-created cessation plan and protocols for beneficiary transition.

7.8 MI CARE TEAM PAYMENT

Payment for MI Care Team services is contingent on designated MI Care Team providers meeting the requirements laid out in this policy and in the MOU, and as determined by MDHHS. Failure to meet these requirements may result in loss of MI Care Team provider designation.

7.8.A. GENERAL PROVISIONS FOR MI CARE TEAM PAYMENT

To provide MI Care Team services and bill Medicaid, a provider must be enrolled in the Community Health Automated Medicaid Processing System (CHAMPS), including enrollment as a billing agent or utilization of an existing billing agent to bill for and receive the MI Care Team payments. Designated MI Care Team providers have their own CHAMPS identifier which must be used to submit encounters for MI Care Team Services. This identifier is only used for documenting MI Care Team services. The Group (Type 2 - Organization) National Provider Identifier (NPI) number must be used as the billing provider on all MI Care Team service encounters submitted. The billing provider loop or field is mandatory to complete. The Provider (Type 1 - Individual) NPI number of the provider who performed the service encounter, or the supervising physician, should be entered as the rendering provider. If the provider who performed the service is not enrolled in CHAMPS (e.g., CHW), then a supervising primary care provider must be entered as the rendering provider (i.e., primary care physician, nurse practitioner, physician's assistant). Designated MI Care Team providers should use their standard NPI for payment of regular (non-MI Care Team) clinical services.

Designated MI Care Team providers are paid one of two monthly case rates, which are as follows:

- **Health Action Plan Rate**

The MI Care Team uses a once-in-a-lifetime-per-beneficiary Health Action Plan rate to be paid only for the first month that a beneficiary participates in the MI Care Team program. This once-in-a-lifetime-per-beneficiary rate represents reimbursement for certain actions and services including, but not limited to, initial care plan development. This service must be delivered in person.

- **Ongoing Care Coordination Rate**

For all subsequent months following the Health Action Plan payment, the Ongoing Care Coordination rate will be paid for eligible MI Care Team beneficiaries.



Details and guidance regarding applicable service encounter and diagnosis codes can be found in the MI Care Team Handbook. (Refer to the Directory Appendix for website information.)

Payment for MI Care Team services is in addition to the existing fee-for-service payments, encounters, or daily rate payments for direct clinical services. MDHHS payment methodology is designed to only reimburse for the cost of MI Care Team staff for the delivery of Health Home services that are not covered by any other currently available Medicaid reimbursement mechanism.

7.8.B. RECOUPMENT OF PAYMENT

The monthly payment is contingent on a MI Care Team beneficiary receiving a MI Care Team service during the month. The payment is subject to recoupment if the beneficiary does not receive a MI Care Team service during the calendar month. The recoupment lookback will occur four months after the monthly payment is made. Thus, four months after the month a payment is made (for example, in November, MDHHS would look back at July's payment), CHAMPS will conduct an automatic recoupment process that will look for an appropriate code. If a core MI Care Team service is not provided during a calendar month, that month's payment is subject to recoupment by MDHHS. Once a recoupment has occurred, there is no further opportunity to submit a valid MI Care Team encounter code and/or claim.

7.9. MI CARE TEAM AND MANAGED CARE BENEFICIARIES

MI Care Team providers and Medicaid Health Plans are expected to work together to coordinate services for eligible members who wish to enroll in the MI Care Team benefit. Both the providers and the health plans will be given a list of their members deemed eligible for the MI Care Team program. MDHHS requires providers and health plans confer to optimize communication to beneficiaries. MI Care Team providers are primarily responsible for conducting outreach to eligible beneficiaries.



HEALTHY MICHIGAN PLAN

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SECTION 1 – GENERAL INFORMATION

This chapter applies to all providers.

The Healthy Michigan Plan provides health care coverage for a category of eligibility authorized under the Patient Protection and Affordable Care Act and Michigan Public Act 107 of 2013 that began April 1, 2014. The benefit design of the Healthy Michigan Plan ensures beneficiary access to quality health care, encourages utilization of high-value services, and promotes adoption of healthy behaviors.

Information contained in this chapter is to be used in conjunction with other chapters of this manual, including the Billing & Reimbursement Chapters as well as the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter.

1.1 ELIGIBILITY

The Healthy Michigan Plan provides health care coverage for individuals who:

- Are 19-64 years of age
- Have income at or below 133% of the federal poverty level under the Modified Adjusted Gross Income (MAGI) methodology
- Do not qualify for or are not enrolled in Medicare
- Do not qualify for or are not enrolled in other Medicaid programs
- Are not pregnant at the time of application
- Are residents of the State of Michigan

Eligibility for the Healthy Michigan Plan is determined through the MAGI methodology, coordinated through the Michigan Department of Health and Human Services (MDHHS). All criteria for MAGI eligibility must be met to be eligible for the Healthy Michigan Plan. For additional information on program eligibility, refer to the Beneficiary Eligibility Chapter of this manual.

1.2 BENEFIT ADMINISTRATION

All Healthy Michigan Plan beneficiaries, with the exception of some beneficiaries (e.g., Native Americans), are required to enroll in a health plan. Enrollees will select their health plan with assistance from MI Enrolls. In addition, behavioral health and substance use disorders will be administered in accordance with the current service delivery model.

1.2.A. MEDICAID HEALTH PLANS

MDHHS contracts with Medicaid Health Plans (MHPs) to provide services to Medicaid beneficiaries. MHPs must operate consistently with all applicable published Medicaid coverage and limitation policies. (Refer to the Medicaid Health Plans Chapter of this manual for additional information.)



Although MHPs must provide the full range of covered services, MHPs may also choose to provide services over and above those specified. MHPs are allowed to develop prior authorization (PA) requirements and utilization management and review criteria that differ from Medicaid requirements.

1.2.B. PREPAID INPATIENT HEALTH PLANS

Pursuant to Michigan's Medicaid State Plan and federally approved Section 1115 waiver, community-based mental health and substance use disorder services and supports are covered by the Healthy Michigan Plan when delivered under the auspices of an approved Prepaid Inpatient Health Plan (PIHP).

1.2.C. FEE FOR SERVICE

Prior to enrollment in a health plan, beneficiaries are eligible to receive Healthy Michigan Plan services through the fee-for-service (FFS) system. Providers must submit claims through the Community Health Automated Medicaid Processing System (CHAMPS).

Covered services that are carved out of the MHP and PIHP delivery systems will be reimbursed through FFS consistent with applicable Medicaid policy.

Unless noted in Medicaid provider-specific chapters, service coverage and authorization requirements for FFS beneficiaries enrolled in the Healthy Michigan Plan mirror those required for Medicaid.



SECTION 2 – HEALTHY MICHIGAN PLAN AND HEALTHY BEHAVIORS

The benefit design of the Healthy Michigan Plan ensures beneficiary access to quality health care, encourages utilization of high-value services, and promotes adoption of healthy behaviors. To promote the overall health and well-being of Healthy Michigan Plan beneficiaries, MDHHS developed a Health Risk Assessment which, when completed, provides health plan beneficiaries the opportunity to earn incentives for actively engaging with the health care system. In addition, Healthy Michigan Plan beneficiaries are exempt from select cost-sharing requirements for services and medications that promote or maintain health.

In addition to the Healthy Michigan Plan HRA, there are two additional ways to participate in a healthy behavior.

2.1 INITIAL APPOINTMENT WITH PRIMARY CARE PROVIDER

Healthy Michigan Plan beneficiaries are required to contact their primary care provider within 60 days of enrollment in a health plan to schedule an appointment. When contacted by the beneficiary, providers are expected to make reasonable efforts to promptly schedule an initial appointment. The initial appointment may include completion of a Health Risk Assessment as described below.

The HRA Provider Profile in CHAMPS allows providers to view shared beneficiary HRA data, attest online to a beneficiary's HRA, and see historical HRA data.

2.2 HEALTH RISK ASSESSMENT

2.2.A. HEALTH RISK ASSESSMENT – FOR HEALTH PLAN BENEFICIARIES

For Healthy Michigan Plan beneficiaries enrolled in a health plan, a standard Health Risk Assessment (HRA) must be completed annually. The Healthy Michigan Plan HRA (available through the health plan or the MDHHS website) assesses a broad range of health issues and behaviors including, but not limited to, the following:

- Physical activity
- Nutrition
- Alcohol, tobacco, and substance use
- Mental health
- Flu vaccination
- Chronic conditions
- Recommended cancer or other preventive screenings

Beneficiaries will receive a HRA form in their Healthy Michigan Plan health plan new member packet. Beneficiaries and providers may also obtain a copy of the HRA form from their health plans or online from the MDHHS website. (Refer to the Directory Appendix for website information.)



Beneficiaries enrolled in a health plan may complete a portion of the assessment on their own, with the assistance of MI Enrolls, or with assistance from their health plan. The final portion of the HRA must be completed in the beneficiary's primary care provider office and include provider attestations of beneficiary healthy behaviors and/or changes.

Once complete, the primary care provider must give the beneficiary a copy of their HRA and securely submit a copy to the beneficiary's health plan. Each health plan has developed submission instructions, including a process for secure transmission of the HRA.

All Healthy Michigan Plan health plans offer beneficiaries the opportunity to receive a reduction in cost-sharing, an incentive, or both based on submission of a completed HRA. Beneficiaries may complete more than one HRA a year, but are only eligible for one incentive per year. Attestations from primary care providers are the basis upon which eligibility for reductions in cost-sharing is based. Beneficiaries may be eligible for reductions in cost-sharing only when an HRA is completed and received by the beneficiary's health plan.

- A cost-sharing reduction, incentive, or both may apply to Healthy Michigan Plan health plan beneficiaries who agree to address or maintain healthy behaviors. In addition, beneficiaries who acknowledge that changes are necessary, but who have significant physical, mental or social barriers to addressing them at the time, may also be eligible for this reduction, incentive, or both.
- Healthy Michigan Plan health plan beneficiaries who do not complete a HRA, or who complete it but decline to engage in addressing health risk behaviors, are not eligible for the cost-sharing reduction or incentive. However, these individuals may become eligible if they return to the provider, complete the assessment, and agree to address one or more behavior changes, as attested to by their primary care provider.

All Healthy Michigan Plan health plans have an incentive for providers who complete and return the HRA form for their Healthy Michigan Plan beneficiaries. These incentives vary by health plan. Providers should contact the health plans they participate with for details regarding provider incentives and questions related to the HRA.

For provider incentives related to HRAs completed for beneficiaries not yet enrolled in a health plan, refer to the Health Risk Assessment – For Fee-for-Service Beneficiaries section below.

2.2.B. HEALTH RISK ASSESSMENT – FOR FEE-FOR-SERVICE BENEFICIARIES

Healthy Michigan Plan beneficiaries may receive services, including the initial primary care provider appointment and completion of the HRA, with a Fee-for-Service provider prior to enrolling in a health plan. When this occurs, the health plan and the provider are responsible for working together to ensure that the HRA is received by the health plan. Fee-for-Service providers should give each beneficiary a copy of their completed HRA at the initial appointment and forward a copy to the beneficiary's health plan after enrollment. Providers should periodically check CHAMPS for health plan enrollment information. Beneficiaries who complete the HRA during the Fee-for-Service period are



eligible for the health plan cost-sharing reduction, incentive, or both upon enrollment in a health plan.

The HRA incentives do not apply to beneficiaries who do not enroll in a health plan and remain in Fee-for-Service. However, these beneficiaries and their providers may choose to complete the HRA to identify health risks and opportunities for healthy behavior change. HRAs that are completed for these individuals do not need to be submitted to MDHHS and can remain in the medical file.

Fee-for-Service will reimburse providers for covered services provided to the beneficiary prior to the effective date of enrollment in a health plan. However, health plans are required to disburse the provider incentive for HRA forms completed during the Fee-for-Service period when the HRA form is submitted to the health plan after beneficiary enrollment. Incentives to non-network providers will be at the discretion of the health plans. Providers must utilize the date of submission of the HRA form to the health plans as the date of service in order to be eligible for provider incentives.

2.2.C. HEALTH RISK ASSESSMENT – WEB-BASED TRAINING MODULE FOR PROVIDERS

MDHHS has a voluntary, web-based training for providers on the Healthy Michigan Plan HRA, incentives, and associated processes. (Refer to the Directory Appendix for website information.)

2.3 PREVENTIVE HEALTH SERVICE

MDHHS will use claims and encounter data to document healthy behaviors for managed care beneficiaries who utilize preventive and wellness services that meet the following criteria.

- Make and keep an appointment for any of the following:
 - Annual preventive visit
 - Preventive dental services
 - Appropriate cancer screening
 - Tobacco cessation
 - ACIP recommended vaccination(s)
 - Other preventive screening

2.4 HEALTHY MICHIGAN PLAN HEALTH AND WELLNESS PROGRAM PARTICIPATION

All managed care plans must ensure their beneficiaries have access to evidence based/best practices wellness programs to reduce the impact of common risk factors such as obesity or hypertension. These programs can take many forms such as evidence-based tobacco cessation support, health coaching services, and free or reduced cost gym memberships. Managed care plan health and wellness programs must be approved by MDHHS to be eligible for inclusion in the Healthy Behaviors Incentives Program.



SECTION 3 – COST SHARING INFORMATION

The Healthy Michigan Plan has beneficiary cost-sharing obligations. Cost-sharing includes both copays and contributions based on income, when applicable.

Copayments for services may apply to Healthy Michigan Plan beneficiaries. Prior to enrollment in a health plan, beneficiaries are eligible to receive Healthy Michigan Plan services through the Fee-for-Service system where copays are collected at the point of service (with the exception of chronic conditions and preventive services, as described below). Healthy Michigan Plan beneficiaries who are exempt from cost-sharing requirements by law (e.g., individuals receiving hospice care, pregnant women receiving pregnancy-related services) are exempt from Healthy Michigan Plan cost-sharing obligations. Similarly, services that are exempt from any cost-sharing by law (e.g., preventive and family planning services) are also exempt for Healthy Michigan Plan beneficiaries. For general information on copayment requirements and exemptions, providers should refer to the Billing Beneficiaries Section of the General Information for Providers Chapter of this manual. Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.) Beneficiaries may not be denied care or services based on inability to pay a copayment, except as outlined in that section.

3.1 MANAGED CARE MEMBERS – MI HEALTH ACCOUNTS

Healthy Michigan Plan managed care members are required to satisfy cost-sharing contributions through a MI Health Account. Cost sharing requirements, which include copays and additional contributions based on a beneficiary's income level, will be monitored through the MI Health Account by the health plan. These requirements begin after the beneficiary has been enrolled in a health plan for six months. Beneficiaries enrolled in a health plan will have the opportunity for reductions and/or elimination of cost sharing responsibilities to promote access to care if certain healthy behaviors are attained. If the amount contributed by the beneficiary is less than the amount due for a service received, the provider will still be paid in full for the services provided.

3.2 FEE-FOR-SERVICE BENEFICIARIES

For Healthy Michigan Plan beneficiaries who are exempt from enrollment in managed care plans or who have yet to enroll in a managed care plan, copayments for services may apply. FFS beneficiaries will not be assigned a MI Health Account.

Copayments may be required and due at the point of service for beneficiaries age 21 years and older.

The MDHHS Healthy Michigan Plan Copay Requirements table, available on the MDHHS website, provides detailed information regarding the specific services to which the copays are applied. (Refer to the Directory Appendix for website information.)

3.3 COPAY EXCEPTIONS FOR SERVICES RELATED TO CHRONIC CONDITIONS

The Healthy Michigan Plan seeks to promote greater access to services that prevent the progression of, and complications related to, chronic diseases. A specified list of chronic conditions and related drug classes has been identified for the Healthy Michigan Plan. This applies to all Healthy Michigan Plan beneficiaries whether they are in a health plan or Fee-for-Service. When services that are generally subject to copays are related to a specified chronic condition, the service will be exempt from copays. Specifically, if the beneficiary's visit is related to one of the program-specified chronic conditions and any



diagnosis on the claim header (for institutional invoices) or any diagnosis on the claim line (for professional/dental invoices) reflects this chronic condition, there is no copay for the service. Providers are expected to submit claims in compliance with the International Classification of Diseases (ICD) coding guidelines and conventions.

The list of chronic condition diagnosis codes and associated drug class and treatment categories subject to the copay exemption is maintained on the MDHHS website. (Refer to the Directory Appendix for website information.)

3.4 COPAY EXCEPTIONS RELATED TO PREVENTIVE SERVICES

For all Healthy Michigan Plan beneficiaries, both Fee-for-Service and those enrolled in a health plan, there is no copay for preventive services. MDHHS considers preventive services to include those cited in the Preventive Services subsection.



SECTION 4 – COVERAGE

The table below outlines beneficiary coverage under the Healthy Michigan Plan. Refer to the Special Coverage Provisions Section for additional coverage information.

Service	Coverage
Ambulatory patient services	<ul style="list-style-type: none"> ▪ Primary care provider services ▪ Specialist/Referral care services ▪ Outpatient hospital services, including Ambulatory Surgical Center (ASC) services ▪ Home health care services ▪ Hospice care ▪ Podiatry care ▪ Chiropractic services
Emergency services	<ul style="list-style-type: none"> ▪ Emergency room services ▪ Emergency transportation/ambulance ▪ Urgent Care Centers (UCC) or facilities
Hospitalization	<ul style="list-style-type: none"> ▪ Inpatient hospital services (e.g., hospital stay, physician and surgical services)
Laboratory services	<ul style="list-style-type: none"> ▪ Laboratory testing services
Maternity care	<ul style="list-style-type: none"> ▪ Prenatal and postpartum care ▪ Delivery and inpatient services for maternity care
Mental health and substance use disorder services, including behavioral health treatment	<ul style="list-style-type: none"> ▪ Mental/behavioral health inpatient services ▪ Mental/behavioral health outpatient services (includes treatment in approved residential programs, peer delivered supports and services, and other program defined community based services) ▪ Substance use disorder inpatient services (acute detoxification in medical setting) ▪ Substance use disorder outpatient services (includes treatment in approved residential programs, peer delivered supports and services, and other program defined community based services)
Pediatric services, including oral and vision care (19 and 20 year olds)	<ul style="list-style-type: none"> ▪ General pediatric care ▪ Vision screening ▪ Eyeglasses and dental check-up services



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Service	Coverage
<p>Prescription drugs</p>	<ul style="list-style-type: none"> ▪ Prescription drugs and supplies. (Refer to the MDHHS website and the Pharmacy Benefits Manager (PBM) website for lists of prescription drugs that are carved-out of health plans. Providers must collect co-pays for these carved-out drugs at the point-of-sale. Refer to the Directory Appendix for website information.)
<p>Preventive and wellness services and chronic disease management</p>	<ul style="list-style-type: none"> ▪ All United States Preventive Services Task Force grade A and B services ▪ Advisory Committee on Immunization Practices recommended vaccines ▪ Institute of Medicine recommended preventive services for women ▪ For 19 and 20 year olds, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services as defined in the current periodicity schedule by the American Academy of Pediatrics <p>(Additional information is available on websites for the organizations identified above. Refer to the Directory Appendix for website information.)</p>
<p>Rehabilitative and habilitative services and devices</p>	<ul style="list-style-type: none"> ▪ Inpatient rehabilitation services ▪ Outpatient rehabilitation and habilitative services ▪ Skilled Nursing Facility (consistent with 42 CFR §440.315(f)) ▪ Durable medical equipment, medical supplies, prosthetics and orthotics
<p>Additional services</p>	<ul style="list-style-type: none"> ▪ Services provided in a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) ▪ Non-Emergency Medical Transportation ▪ Family planning and reproductive health services and supplies ▪ Vision and optometrist services (e.g., eyeglasses, therapies, refractions) ▪ Hearing services (e.g., hearing aids and adjustments) ▪ Home Help services/personal care services ▪ Adult dental services ▪ Nursing facility services (consistent with 42 CFR §440.315(f)) ▪ Maternal Infant Health Program (MIHP) ▪ Program of All Inclusive Care for the Elderly (PACE) (consistent with 42 CFR §440.315(f))



SECTION 5 – SPECIAL COVERAGE PROVISIONS

This section provides general information regarding Healthy Michigan Plan coverage requirements for certain services. Additional information regarding these services may be contained in other relevant chapters of this manual, as applicable.

5.1 DENTAL

Beneficiaries enrolled in a health plan will receive their dental coverage through their health plan. Each health plan contracts with a dental provider group or vendor to provide dental services administered according to the contract. The contract is between the health plan and the dental provider group or vendor, and beneficiaries must receive services from a participating provider to be covered. Questions regarding eligibility, prior authorization or the provider network should be directed to the beneficiary's health plan. It is important to verify eligibility at every appointment before providing dental services. Dental services provided to an ineligible beneficiary will not be reimbursed.

For those beneficiaries who are not enrolled in a health plan, dental services will be provided by enrolled dental providers through the Medicaid FFS program.

For dental program coverage policy, refer to the Dental Chapter of this manual. The Dental Chapter also contains information on the *Healthy Kids Dental* benefit, as applicable.

5.2 HABILITATIVE SERVICES

Michigan adopted the National Association of Insurance Commissioners definition of habilitative services, which are described as services that help a person keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapy and speech-language pathology services provided in an outpatient hospital setting for people with disabilities.

5.2.A. COVERED SERVICES AND LIMITS

All services must be provided under the written order of a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), or other qualified health professional as defined by law according to a written treatment plan established by that provider.

Physical and occupational therapy services provided in a private practice or outpatient setting will be limited to 144 units (15-minute increments) in a calendar year period without PA. Evaluations and re-evaluations will be limited to two per year without PA.

Speech therapy services provided in a private practice or outpatient setting will be limited to 36 visits in a calendar year period without PA. Evaluations and re-evaluations will be limited to two per year without PA.

The habilitative services modifier must be reported in addition to the procedure code for all habilitative services submitted either on PA requests or for claim adjudication to ensure proper payment. Refer to the Billing & Reimbursement chapters for additional therapy modifier information.



5.2.B. NON-COVERED SERVICES

Respite care, day care, recreational care, residential treatment, social services, custodial care, and services for vocational or educational purposes are not covered as habilitative services.

NOTE: Habilitative services provided as part of a mental health or substance use disorder person-centered planning process are subject to the Mental Health Specialty Services and Supports program criteria.

5.2.C. PRIOR AUTHORIZATION

When billing FFS, providers must obtain PA to continue therapy beyond the maximum benefit. Requests for PA must be submitted on the Occupational Therapy-Physical Therapy-Speech Therapy Prior Approval Request/Authorization form (MSA-115). (Refer to the Forms Appendix for additional information.)

PA requirements for beneficiaries enrolled in a health plan may differ from those described in this policy for FFS. Providers should contact the individual plans regarding their authorization requirements.

5.2.D. PLACE OF SERVICE

Habilitative services may be provided to beneficiaries of all ages by properly qualified and credentialed professionals in the outpatient hospital setting.

5.3 HEARING AIDS [CHANGE MADE 10/1/20]

The Healthy Michigan Plan covers hearing aid services for all beneficiaries when provided by a licensed hearing aid dealer, hearing center, or audiologist. Providers should refer to the Hearing **Services and Devices (revised 10/1/20)** Chapter for additional guidance regarding hearing aid coverage.

5.4 NURSING FACILITY SERVICES

Beneficiaries eligible for the Healthy Michigan Plan have comprehensive nursing facility coverage consistent with the policies and procedures established by the traditional Medicaid Program. This benefit is included for individuals in accordance with 42 CFR 440.315(f). Providers should refer to the Nursing Facility Chapter for additional guidance regarding nursing facility services covered for beneficiaries.

Healthy Michigan Plan beneficiaries who are receiving nursing facility services in a licensed nursing facility are excluded from enrollment in a health plan. Healthy Michigan Plan beneficiaries who begin receiving nursing facility services after enrollment in a health plan may be disenrolled from the health plan under certain conditions. Providers should refer to the Medicaid Health Plans Section of the Beneficiary Eligibility Chapter for additional guidance regarding nursing facility services provided to health plan enrollees.

5.5 PREVENTIVE SERVICES

Preventive services consistent with the following guidelines are covered benefits for the Healthy Michigan Plan.

- All United States Preventive Services Task Force grade A and B services



- Advisory Committee on Immunization Practices recommended vaccines
- Institute of Medicine recommended preventive services for women
- For 19 and 20 year olds, EPSDT services as defined in the current periodicity schedule by the American Academy of Pediatrics

(Additional information is available on websites for the organizations identified above. Refer to the Directory Appendix for website information.)

It is the provider's responsibility to review these websites for current guidelines for preventive services.

One preventive medicine Evaluation and Management service is covered for all adult beneficiaries annually. For beneficiaries less than 21 years of age, Early and Periodic Screening, Diagnosis and Treatment services are covered according to the American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care and the Centers for Medicare & Medicaid Services requirements.

In addition, the Healthy Michigan Plan covers breastfeeding equipment and supplies as a preventive service benefit. For covered equipment and supplies, refer to the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)

Providers submitting claims for services in accordance with the United States Preventive Services Task Force (USPSTF) grade A and B recommendations are to identify the service with the appropriate International Classification of Diseases (ICD) diagnosis code(s). Providers are encouraged to include HCPCS Modifier 33, Preventive Services. (Refer to the Billing & Reimbursement for Professionals Chapter for specific information.)

5.6 BEHAVIORAL HEALTH SERVICES

Healthy Michigan Plan beneficiaries have an array of behavioral health services available to treat mental health and substance use disorders.

5.6.A. MENTAL HEALTH SERVICES

Health plans will provide mental health services under the Mental Health Outpatient benefit consistent with the policies and procedures established by the traditional Medicaid Program. For mental health needs that do not meet established criteria, health plans must coordinate with the appropriate PIHP to ensure that medically necessary mental health services are provided. Refer to the Medicaid Health Plans and the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapters of this manual for additional information.

Beneficiaries who are not enrolled in a health plan will receive their outpatient mental health services through Fee-for-Service and may include Prepaid Inpatient Health Plan services as described in this manual.

Additional mental health services (e.g., inpatient hospitalization, intensive crisis stabilization, etc.) are covered benefits consistent with the policies and procedures established by the Medicaid program.



5.6.B. BEHAVIORAL HEALTH COMMUNITY-BASED SPECIALTY SERVICES

This section applies to Behavioral Health supports and services providers. Behavioral Health, as referenced in this section, is inclusive of mental health disorders, substance use disorders and intellectual/developmental disabilities. Information contained in this section is to be used in conjunction with other chapters of the Medicaid Provider Manual (e.g., the Billing & Reimbursement Chapters, the Practitioner Chapter and the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter) as well as the related procedure code databases located on the MDHHS website. (Refer to the Directory Appendix for website information.)

Pursuant to Michigan’s Medicaid State Plan and federally approved Section 1115 waiver, community-based behavioral health supports and services are covered by the Healthy Michigan Plan when delivered under the auspices of an approved Prepaid Inpatient Health Plan (PIHP).

The requirements and information found in the General Information Section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter also apply to the provision of the Healthy Michigan Plan behavioral health supports and services.

In addition to the Definition of Terms found in the General Information Section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, the following definitions are applicable to the Healthy Michigan Plan.

5.6.B.1. DEFINITION OF TERMS

American Society of Addiction Medicine (ASAM) Criteria	The clinical guide designed by ASAM to improve assessment and outcomes-driven treatment and recovery services. It is also used to match patients to appropriate types and levels of care. In general, the purpose of the ASAM Criteria is to enhance the use of multidimensional assessments to develop patient-centered service plans and to guide clinicians, counselors, and care managers in making objective decisions about patient admission, continuing care, and transfer/discharge for various levels of care for addictive, substance-related, and co-occurring conditions.
Behavioral Health	A categorical description that is inclusive of mental health disorders, substance use disorders and intellectual/developmental disabilities.
Behavioral Health Professional	For purposes of the Healthy Michigan Plan Chapter, this is a categorical description used to refer to the individuals who provide mental health and/or substance use disorder services that are identified in the Provider Qualifications chart. (The Provider Qualifications chart is posted on the MDHHS website. Refer to the Directory Appendix for website information.)
Covered Services	For purposes of the Healthy Michigan Plan chapter, Healthy Michigan Plan Specialty Behavioral Health Services.

5.6.B.2. PROGRAM REQUIREMENTS

Refer to the Program Requirements Section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter. These requirements are consistent with the expectations for the Healthy Michigan Plan.



Additionally, as the Healthy Michigan Plan provides a behavioral health benefit, certain support services that are part of the Healthy Michigan Plan specialty behavioral health benefit do not require substance use disorder program licensure or accreditation to provide that service. Beneficiaries with a substance use disorder may receive these supports from a provider if the beneficiary meets the eligibility criteria outlined in each description. Those services are:

- Assistive Technology
- Community Living Supports
- Enhanced Pharmacy
- Environmental Modifications
- Fiscal Intermediary
- Housing Assistance
- Occupational Therapy
- Peer Specialist Services (recovery coach)
- Personal Care in Licensed Specialized Residential Care Settings
- Physical Therapy
- Respite Care
- Skill Building Assistance
- Support and Service Coordination
- Speech, Hearing and Language Therapy
- Transportation

5.6.B.3. COVERED SUPPORTS AND SERVICES

The following behavioral health supports and services are covered under the Healthy Michigan Plan. Supports and services with program changes specific to the Healthy Michigan Plan are explained in the following subsections. Information for supports and services marked with an * may be found in the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter.

The following supports and services are designed to assist those with physical, cognitive and/or functional impairments. These supports and services shall be provided to beneficiaries with a substance use disorder diagnosis who meet the medical necessity criteria in the identified area. The supports and services would be indicated as part of the beneficiary's plan of service.

Some interventions listed below (i.e., Assertive Community Treatment, Clubhouse, Hospital-Based Psychiatric Services, Intermediate Care Facilities, Peer Operated Drop In Centers and Supported Employment) are only indicated for a specified population (mental health or intellectual/developmental disability) and do not apply to those with a substance use disorder diagnosis, in which case beneficiaries would not be considered eligible for those services. Likewise, beneficiaries with a mental health or intellectual/developmental disability diagnosis would not be eligible for the services



identified for substance use disorders (i.e., Residential, Sub-Acute Detoxification and Treatment Approved Pharmacological Supports).

- Assertive Community Treatment *
- Assessments *
- Assistive Technology *
- Behavior Treatment Review *
- Clubhouse Psychosocial Rehabilitation Programs *
- Community Living Supports *
- Crisis Services
- Enhanced Pharmacy *
- Environmental Modifications *
- Family Support and Training
- Fiscal Intermediary Services *
- Hospital-Based Psychiatric Services *
(Refer to the Inpatient Psychiatric Hospital Admissions Section and the Outpatient Partial Hospitalization Services Section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter.)
- Housing Assistance *
- Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Services *
- Medication Administration *
- Medication Review *
- Occupational Therapy *
- Outpatient Counseling and Therapy
- Peer-Delivered or Peer-Operated Support Services
- Personal Care in Licensed Specialized Residential Settings *
- Physical Therapy *
- Prevention-Direct Service Model
- Residential Substance Use Disorder Treatment *
(Refer to the Residential Treatment subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter.)
- Respite Care Services *
- Skill-Building Assistance *
- Speech, Hearing and Language *
- Sub-Acute Detoxification *
- Support and Service Coordination *
- Supported/Integrated Employment Services *



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- Targeted Case Management
- Transportation *
- Treatment (DPT/CSAT) Approved Pharmacological Supports *
- Treatment Planning *

5.6.B.4. CRISIS SERVICES

Crisis Interventions	<p>Crisis Interventions are unscheduled activities conducted for the purpose of resolving a crisis situation requiring immediate attention. Activities include crisis response, crisis line, assessment, referral, and direct therapy.</p> <p>The standard for whether or not a crisis exists is a "prudent layperson" standard. That means that a prudent layperson would be able to determine from the beneficiary's symptoms that crisis services are necessary. Crisis means a situation in which an individual is experiencing the signs and symptoms of a serious behavioral health disorder, and one of the following applies:</p> <ul style="list-style-type: none"> ▪ The individual can reasonably be expected within the near future to physically injure himself or another individual, either intentionally or unintentionally; ▪ The individual is unable to provide himself food, clothing, or shelter, or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the individual or to another individual; or ▪ The individual's judgment is so impaired that he is unable to understand the need for treatment and, in the opinion of the behavioral health professional, his continued behavior as a result of the behavioral health disorder can reasonably be expected in the near future to result in physical harm to the individual or to another individual. <p>If the beneficiary developed a crisis plan, the plan is followed with permission from the beneficiary.</p>
Crisis Residential Services	<p>Crisis residential services are intended to provide a short-term alternative to inpatient psychiatric services for beneficiaries experiencing an acute psychiatric crisis when clinically indicated. Services may be used to avert an inpatient psychiatric admission or to shorten the length of an inpatient stay. Additionally, these services are designed for a subset of beneficiaries who meet the ASAM Criteria for Level 3.7 Medically Monitored Intensive Inpatient Services admission criteria or are at risk of admission, but who can be appropriately served in settings less intensive than a hospital. This service is also designed for beneficiaries who are intoxicated and at risk of admission to an acute setting or another level of care but can be appropriately served in this less intensive setting. The goal of crisis residential services is to facilitate reduction in the intensity of those factors that lead to crisis residential admission through a person-centered/individualized and recovery-oriented approach.</p>



- **Population:** Services are designed for a subset of beneficiaries who meet psychiatric inpatient/substance use disorder residential admission criteria or are at risk of admission to a high level of care setting but who can be appropriately served in a less intensive setting.
- **Covered Services:** Services must be designed to resolve the immediate crisis and improve the functioning level of the beneficiary to allow them to return to less intensive community living as soon as possible. Covered crisis residential services include:
 - Psychiatric supervision (for programs providing mental health services and/or co-occurring disorders);
 - Therapeutic support services;
 - Medication management/stabilization and education;
 - Behavioral services;
 - Milieu therapy; and
 - Nursing/medical services (on-site nursing services are required for those beneficiaries who are in the detoxification process, and who require medications to manage the current crisis).

Beneficiaries who are admitted to crisis residential services must be offered the opportunity to explore and learn more about crises, mental health disorders, substance use disorders, identity, values, choices and choice-making, recovery and recovery planning. Recovery and recovery planning is inclusive of all aspects of life, including relationships, where to live, training, employment, daily activities, and physical well-being.

The program must include on-site nursing services (Registered Nurse [RN] or Licensed Practical Nurse [LPN] under appropriate supervision).

- For settings of 6 beds or fewer: on-site nursing must be provided at least one hour per day, per resident, seven days per week, with 24-hour availability on-call.
- For 7-16 beds: on-site nursing must be provided eight hours per day, seven days per week, with 24-hour availability on-call.



- **Provider Criteria:** The PIHP must seek and maintain MDHHS approval for the crisis residential program in order to use Healthy Michigan Plan funds for program services. Healthy Michigan Plan crisis residential programs may choose to provide a program for serious mental illness, intellectual/developmental disabilities, substance use disorders or a combined program. A program offering services for substance use disorders must be licensed for residential substance use disorder treatment services per the Administrative Rules for Substance Use Disorder Programs and appropriately accredited through one of the organizations identified in the Substance Abuse Services subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter. A combined program, one offering services for serious mental illness/intellectual and developmental disabilities and substance use disorders, must also be approved by MDHHS as a “co-occurring enhanced crisis residential program” (consistent with PA 338 of 2018). A co-occurring enhanced crisis residential program must be able to demonstrate that it can address the mental health needs, substance use disorder needs, or both of an individual through enhanced programming and staffing patterns. Established mental health residential programs that purport to offer this service for individuals with substance use disorders will be required to seek re-approval of the program by MDHHS when appropriate licensing and accreditation has been obtained. Programs currently approved to provide services for mental health and/or intellectual/developmental disabilities by MDHHS through the delivery of Medicaid State Plan, Habilitation Supports Waiver (HSW), or additional/B3 services do not require re-approval.

- **Qualified Staff:** Treatment services must be clinically supervised by a psychiatrist. A psychiatrist need not be present when services are delivered but must be available by telephone at all times. The psychiatrist shall provide psychiatric evaluation or assessments at the crisis residential home or at an appropriate location in the community. A psychiatric evaluation completed by a treating psychiatrist that resulted in the admission to the program fulfills this requirement as long as the program psychiatrist has consulted with that physician as part of the admission process. Medication reviews performed at the crisis residential home must be performed by appropriately licensed medical personnel acting within their scope of practice and under the clinical supervision of the psychiatrist. The covered crisis residential services must be supervised on-site eight hours a day, Monday through Friday (and on call at all other times). Supervision must be by a behavioral health professional (Mental Health Professional [MHP] and/or a Substance Abuse Treatment Specialist [SATS] depending on the scope of services being provided) possessing at least a master’s degree in human services and one year of experience providing behavioral health services to individuals with serious mental illness and/or substance use disorders; or a bachelor’s degree in human services and at least two years of experience providing behavioral health services to individuals with serious mental illness and/or substance use disorders.

Treatment activities may be carried out by paraprofessional staff who have at least one year of satisfactory work experience providing behavioral health services to individuals with mental illness and/or substance use disorders, or who have successfully completed a PIHP/ MDHHS-approved training program for working with individuals with mental illness and/or substance use disorders.

Peer support specialists and/or recovery coaches may be part of the multidisciplinary team and can facilitate some of the activities based on their scope of practice, such as facilitating peer lead support groups, assisting in transitioning beneficiaries to less intensive services, and by mentoring beneficiaries towards recovery.



- **Location of Services:** Services must be provided to beneficiaries in licensed crisis residential foster care, group home settings not exceeding 16 beds in size, or in a licensed substance use disorder residential treatment program (when providing services for substance use disorders). Homes/settings must have appropriate licensure from the State and must be approved by MDHHS to provide specialized crisis residential services. Services must not be provided in a hospital or other institutional setting.
- **Admission Criteria:** Crisis residential services may be provided to beneficiaries who are assessed by, and admitted through, the authority of the local PIHP. Beneficiaries must meet psychiatric inpatient admission or residential substance use disorder level of care criteria but have symptoms and risk levels that permit them to be treated in such alternative settings. Services are designed for beneficiaries with mental health or substance use disorders, beneficiaries with a co-occurring mental health and substance use disorder, or beneficiaries with intellectual/developmental disabilities. For beneficiaries with a concomitant disorder with an intellectual/developmental disability, the primary reason for service must be mental illness or substance use disorder.
- **Duration of Services:** Services may be provided for a period up to 14 calendar days per crisis residential episode. Services may be extended and regularly monitored, if justified by clinical need, as determined by the interdisciplinary team. For substance use disorders, beneficiaries should be moved to another ASAM Level of Care within 14 days; however, services may be extended if justified by clinical need, medical necessity, and as determined by the interdisciplinary team.
- **Individual Plan of Service/Treatment Plan:** Services must be delivered according to an Individual Plan of Service (IPOS) or appropriate treatment plan process for substance use disorder beneficiaries (refer to the Treatment Planning subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter) based on an assessment of immediate need. The IPOS/treatment plan must be developed within 48 hours of admission and signed by the beneficiary (if possible), the guardian, the psychiatrist, and any other professionals involved in the treatment planning process as determined by the needs of the beneficiary. If the beneficiary has an assigned case manager, the case manager must be involved in the treatment as soon as possible, and must also be involved in follow-up services.

The IPOS/treatment plan must contain:

- Clearly stated goals and measurable objectives, derived from the assessment of immediate need, stated in terms of specific observable changes in behavior, skills, attitudes, or circumstances, structured to resolve the crisis;
- Identification of the activities designed to assist the beneficiary to attain his goals and objectives; and
- Discharge plans, the need for aftercare/follow-up services, and the role of, and identification of, the case manager.

If the length of stay in the crisis residential program exceeds 14 days, an interdisciplinary team must develop a subsequent plan based on comprehensive assessments. The team is comprised of the beneficiary, the guardian, the psychiatrist, the case manager and other professionals whose disciplines are relevant to the needs of the beneficiary, including the individual Assertive Community Treatment (ACT) team, outpatient services provider, when applicable. If the beneficiary did not have a case manager prior to initiation of the intensive crisis residential service and the crisis episode exceeds 14 days, a case manager must be assigned and involved in treatment and follow-up care. (The case manager may be assigned prior to the 14 days according to need.)



Intensive Crisis Stabilization Services

Individuals between 19-21 years of age could be served under EPSDT utilizing the intensive crisis stabilization team for children. (Refer to the Intensive Crisis Stabilization Services section in the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter for additional information.)

Intensive crisis stabilization services are structured treatment and support activities provided by a multidisciplinary team and designed to provide a short-term alternative to inpatient psychiatric services and/or substance use disorder residential treatment in a community setting. Services may be used to avert a psychiatric admission, residential substance use disorder admission, or to shorten the length of an inpatient or substance use disorder residential stay when clinically indicated.

Crisis situation means a situation in which an individual is experiencing the signs and symptoms of a serious behavioral health disorder, and one of the following applies:

- The individual can reasonably be expected within the near future to physically injure himself or another individual, either intentionally or unintentionally;
- The individual is unable to provide himself food, clothing, or shelter, or to attend to basic physical activities such as eating, toileting, bathing, grooming, dressing, or ambulating, and this inability may lead in the near future to harm to the individual or to another individual; or
- The individual's judgment is so impaired that he is unable to understand the need for treatment and, in the opinion of the behavioral health professional, his continued behavior as a result of the behavioral health disorder can reasonably be expected in the near future to result in physical harm to the individual or to another individual.
- **Approval:** The PIHP must seek and maintain MDHHS approval for the intensive crisis stabilization services in order to use Healthy Michigan Plan funds for program services. A program that will be offering services for substance use disorders must be licensed for outpatient substance use disorder treatment services per the Administrative Rules for Substance Use Disorder Programs and appropriately accredited through one of the organizations identified in the Substance Abuse Services subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter. Established crisis stabilization service programs that purport to offer this service for individuals with substance use disorders will be required to seek re-approval of the program by MDHHS when appropriate licensing and accreditation has been obtained. Programs currently approved to provide services for mental health and/or intellectual/developmental disabilities by MDHHS through the delivery of Medicaid State Plan, Habilitation Supports Waiver (HSW), or additional/B3 services do not require re-approval.
- **Population:** These services are for beneficiaries who have been assessed to meet criteria for psychiatric hospital admissions and/or substance use disorder residential/inpatient treatment but who, with intense interventions, can be stabilized and served in their usual community environments. These services may also be provided to beneficiaries leaving inpatient psychiatric services and/or substance use disorder residential/inpatient treatment if such services will result in a shortened stay. Beneficiaries must have a diagnosis of mental illness, substance use disorder or mental illness with a co-occurring substance use disorder, or intellectual/developmental disability.
- **Services:** Intensive crisis stabilization services are intensive treatment interventions delivered by an intensive crisis stabilization treatment team under the supervision of a psychiatrist. Component services include:
 - Intensive individual counseling/psychotherapy;



- Assessments (rendered by the treatment team);
- Family therapy;
- Psychiatric supervision; and
- Therapeutic support services by trained paraprofessionals.

- **Qualified Staff:** Intensive crisis stabilization services must be provided by a treatment team of behavioral health professionals under the supervision of a psychiatrist. The psychiatrist need not provide on-site supervision at all times, but must be available by telephone at all times. The treatment team providing intensive crisis stabilization services must be Mental Health Professionals and/or Substance Abuse Treatment Specialists. Nursing services/consultation must be available.

The treatment team may be assisted by trained paraprofessionals under appropriate supervision. Trained paraprofessionals must have at least one year of satisfactory work experience providing services to individuals with behavioral health disorders. Activities of trained paraprofessionals include assistance with therapeutic support services. In addition, the team may include one or more peer support specialists and/or recovery coaches.

- **Location of Services:** Intensive crisis stabilization services may be provided where necessary to alleviate the crisis situation, and to permit the beneficiary to remain in, or return more quickly to, his usual community environment. Intensive crisis stabilization services must not be provided exclusively or predominantly at residential programs.

Exceptions: Intensive crisis stabilization services may not be provided in:

- Inpatient settings;
- Jails or other settings where the beneficiary has been adjudicated; or
- Crisis residential settings.

- **Individual Plan of Service/Treatment Plan:** Intensive crisis stabilization services may be provided initially to alleviate an immediate behavioral health crisis. However, following resolution of the immediate situation (and within no more than 48 hours), an intensive crisis stabilization services IPOS or appropriate treatment plan process for substance use disorder beneficiaries (refer to the Treatment Planning subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter) must be developed. The intensive crisis stabilization IPOS/treatment plan must be developed through a person-centered planning process in consultation with the psychiatrist. Other professionals may also be involved if required by the needs of the beneficiary. The case manager (if the beneficiary receives case management services) must be involved in the treatment and follow-up services.



	<p>The IPOS/treatment plan must contain:</p> <ul style="list-style-type: none">➤ Clearly stated goals and measurable objectives, derived from the assessment of immediate need, and stated in terms of specific observable changes in behavior, skills, attitudes, or circumstances structured to resolve the crisis.➤ Identification of the services and activities designed to resolve the crisis and attain the beneficiary's goals and objectives.➤ Plans for follow-up services (including other behavioral health services where indicated) after the crisis has been resolved. The role of the case manager must be identified, where applicable.
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5.6.B.5. FAMILY SUPPORT AND TRAINING

Family-focused services are provided to the family (natural or adoptive parents, spouse, children, siblings, relatives, foster family, in-laws, and other unpaid caregivers) of beneficiaries with behavioral health disorders for the purpose of assisting the family in relating to and caring for a relative with a behavioral health disorder. The services target the family members who are caring for and/or living with the beneficiary who is receiving behavioral health services. The service is to be used in cases where the beneficiary is hindered or at risk of being hindered in his ability to achieve goals of:

- Performing activities of daily living;
- Perceiving, controlling, or communicating with the environment in which he lives; or
- Improving his inclusion and participation in the community or productive activity, or opportunities for independent living.

The training and counseling goals, content, frequency and duration of the training must be identified in the beneficiary's IPOS/treatment plan, along with the beneficiary's goals that are being facilitated by this service.

Coverage includes:

- Education and training, including instructions about treatment regimens, and use of assistive technology and/or medical equipment needed to safely maintain the beneficiary at home as specified in the IPOS/treatment plan.
- Counseling and peer support provided by an appropriately trained counselor or appropriately trained peer. This can be in a one-on-one or group setting to provide assistance with identifying coping strategies for successfully caring for or living with a person who has a behavioral health disorder.
- Family Psycho-Education (SAMHSA model) for individuals with serious mental illness and their families. This evidence-based practice includes family educational groups, skills workshops, and joining.

5.6.B.6. OUTPATIENT COUNSELING AND THERAPY

Outpatient counseling and therapy is a non-residential treatment service that can take place in an office-based location with clinicians educated/trained in providing professionally directed behavioral health treatment or in a community-based location with appropriately educated/trained staff. The treatment occurs in regularly scheduled



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sessions, usually totaling fewer than nine contact hours per week but, when medically necessary and determined by individual need, can total over 20 hours in a week. Individual, family or group treatment services may be provided separately or in combination.

Treatment must be person-centered/individualized based on an appropriate assessment/evaluation and contain a diagnostic impression and beneficiary characteristics, including age, gender, culture, and development. Authorized decisions on length of stay, including continued stay, change in level of care and discharge, must be based on medical necessity and/or the ASAM Criteria. Beneficiary participation in referral and continuing care planning must occur prior to discharge and should be based on the needs of the beneficiary in order to support sustained recovery. Referral, continuing stay, and recovery support needs must be identified through the person-centered/individualized treatment planning process.

<p>Provider Qualifications</p>	<p>Substance use disorder outpatient service providers are required to be licensed as an organization. A program offering services for substance use disorders must be licensed for outpatient substance use disorder treatment services per the Administrative Rules for Substance Use Disorder Programs and appropriately accredited through one of the organizations identified in the Substance Abuse Services subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter. Substance use disorder outpatient providers offering the adjunct support services of case management, early intervention, integrated treatment for persons with mental health and substance use disorders, and/or peer recovery and recovery support must have these areas added to their outpatient substance use disorder license as approved service categories.</p> <p>All behavioral health organizations/providers of outpatient services must have appropriately licensed and credentialed staff and provide treatment that is within their established scope of practice. (Refer to the Provider Qualifications Chart that supports the Medicaid Provider Manual. The Provider Qualifications chart is posted on the MDHHS website. Refer to the Directory Appendix for website information.)</p>
<p>Eligibility</p>	<p>Outpatient counseling and therapy may be provided only when:</p> <ul style="list-style-type: none"> ▪ The service meets medical necessity criteria; ▪ It meets the person-centered service planning requirement; ▪ The current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is used to determine an initial diagnostic impression (also known as provisional diagnosis); ▪ The service is based on individualized determination of need through the state established needs-based criteria; ▪ The service is cost effective; ▪ The ASAM Criteria are used in the determination of substance use disorder treatment placement/admission and/or continued stay needs; and



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	<ul style="list-style-type: none"> ▪ The substance use disorder service is supported by a level of care determination using the six assessment dimensions of the current ASAM Criteria: <ul style="list-style-type: none"> ➢ Withdrawal potential; ➢ Medical conditions and complications; ➢ Emotional, behavioral or cognitive conditions and complications; ➢ Readiness to change; ➢ Relapse, continued use, or continued problem potential; and ➢ Recovery/living environment. <p>This service is limited to those beneficiaries who will benefit from treatment and have been determined to have:</p> <ul style="list-style-type: none"> ▪ An acceptable readiness to change level; ▪ Minimal or manageable medical conditions; ▪ Minimal or manageable withdrawal risks; ▪ Emotional, behavioral and cognitive conditions that will not prevent the beneficiary from benefiting from this level of care; ▪ Minimal or manageable relapse potential; and ▪ A minimally to fully supportive recovery environment.
<p>Allowable Services</p>	<p>Once the above criteria have been satisfied and the beneficiary has demonstrated a willingness to participate in treatment, the following behavioral health services can be provided in the outpatient setting.</p> <ul style="list-style-type: none"> ▪ Individual Assessment: A face-to-face service for the purpose of identifying functional, treatment, and recovery needs of a behavioral health disorder and a basis for formulating the person-centered/individualized treatment planning process. ▪ Individual Treatment Planning: Refer to the Treatment Planning subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter. ▪ Individual Therapy: Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control or restore normalized psychological functioning, reality orientation, re-motivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. Evidence-based practices, such as Integrated Dual Disorder Treatment for Co-Occurring Disorders (IDDT/COD) and Dialectical Behavior Therapy (DBT), are included in this coverage. Individual therapy is provided by a Behavioral Health Professional practicing within their scope of practice and within the guidelines of the Provider Qualifications Chart. ▪ Group Therapy: Face-to-face counseling with three or more beneficiaries, and can include didactic lectures, therapeutic interventions/counseling, and other group related activities. Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control or restore normalized psychological functioning, reality orientation, re-motivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. Evidence-based practices (such as IDDT/COD and DBT) are included in this coverage. Group therapy is provided by a Behavioral Health Professional practicing within their scope of practice and within the guidelines of the Provider Qualifications Chart.



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	<ul style="list-style-type: none"> ▪ Family Therapy: Family Therapy is therapy for a beneficiary and family member(s), or other person(s) significant to the beneficiary, for the purpose of improving the beneficiary/family function. Family therapy does not include individual psychotherapy or family planning (e.g., birth control) counseling. Family therapy is provided by a Behavioral Health Professional practicing within their scope of practice and within the guidelines of the Provider Qualifications Chart. (The Provider Qualifications chart is posted on the MDHHS website. Refer to the Directory Appendix for website information.) ▪ Crisis Intervention: Refer to the Crisis Interventions subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter. ▪ Referral/Linking/Coordinating/Management of Services: For the purpose of providing adjunct support for ensuring follow-through with identified providers, providing additional support in the community if primary services are to be provided in an office setting, addressing other needs identified as part of the assessment, and/or establishing the beneficiary with another provider and/or level of care. This service may be provided individually or in conjunction with other services based on the needs of the beneficiary. ▪ Peer Support Specialist/Recovery Coach and Recovery Support: For the purpose of providing adjunct support to outpatient services. Refer to the Peer-Delivered or Peer-Operated Support Services subsection of this chapter for additional information. ▪ Compliance Monitoring: For the purpose of identifying abstinence or relapse when it is a part of the treatment plan or an identified part of the treatment program (excludes laboratory drug testing). Also includes tracking the appropriate use of prescribed medications. ▪ Early Intervention: Includes stage-based interventions for beneficiaries with substance use disorders and beneficiaries who may not meet the threshold of abuse or dependence but are experiencing functional/social impairment as a result of use. ▪ Detoxification/Withdrawal Monitoring: For the purpose of preventing/alleviating medical complications as they relate to no longer using a substance. ▪ Division of Pharmacologic Therapies/Center for Substance Abuse Treatment (DPT/CSAT) Approved Pharmacological Supports: Refer to the Treatment (DPT/CSAT) Approved Pharmacological Supports subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter.
<p>Admission Criteria</p>	<p>Outpatient services should be authorized based on the number of hours and/or types of services that are medically necessary. Reauthorization or continued treatment should take place when it has been demonstrated that the beneficiary is benefiting from treatment but additional covered services are needed for the beneficiary to be able to sustain recovery independently. Reauthorization of services can be denied in situations where the beneficiary has:</p> <ul style="list-style-type: none"> ▪ Not been actively involved in their treatment, as evidenced by repeatedly missing appointments; ▪ Not been participating/refused to participate in treatment activities; or ▪ Continued use of substances and other behavior that is deemed to violate the rules and regulations of the program providing the services.



	Beneficiaries may also be terminated from treatment services based on these violations.
<p>Level of Care Criteria for Substance Use Disorders</p>	<p>Medically necessary outpatient services for beneficiaries with substance use disorders correspond to the frequency and duration of services established by the ASAM criteria and are referred to as follows:</p> <ul style="list-style-type: none"> ▪ Level 0.5 – Early Intervention ▪ Level 1 – Outpatient ▪ Level 2.1 – Intensive Outpatient ▪ Level 2.5 – Partial Hospitalization Services <p>Outpatient services can include any variety of the covered services and are dependent on the individual needs of the beneficiary. The assessment, treatment plan, and recovery support preparations are the only components that are consistent throughout the outpatient levels of care as each beneficiary must have these as part of the authorized treatment services. As a beneficiary’s needs increase, more services and/or frequency/duration of services may be utilized if these are medically necessary. The ASAM criteria correspond with established hours of services that take place during a week.</p> <ul style="list-style-type: none"> ▪ ASAM Level 0.5: Services are not subdivided by the number of hours received during a week. The amount and type of services provided are based on individual needs based on the beneficiary’s motivation to change and other risk factors that may be present. ▪ ASAM Level 1: Services from one hour to eight hours during a week. ▪ ASAM Level 2.1: Services from nine to 19 hours in a week. The services are offered at least three days a week to fulfill the minimum nine-hour commitment. ▪ ASAM Level 2.5: Services that are offered 20 or more hours in a week. <p>The medically necessary outpatient services for beneficiaries with a mental illness and/or a concomitant substance use disorder or intellectual/developmental disability correspond with the frequency and duration of the evidenced-based practice, promising practice, or the specialty-focused service provided. The guidelines for these practices, along with the individual needs of the beneficiary, will establish the frequency, duration, and type of treatment service.</p>

5.6.B.7. PEER-DELIVERED OR PEER-OPERATED SUPPORT SERVICES

Peer-delivered or peer-operated support services are programs and services that provide beneficiaries with opportunities to learn and share coping skills and strategies, move into more active assistance and away from passive roles, and to build and/or enhance self-esteem and self-confidence.

Peer specialist and recovery coach services provide individuals with opportunities to support, mentor and assist beneficiaries to achieve community inclusion, participation, independence, recovery, resiliency and/or productivity. Peers are individuals who have a unique background and skill level from their experience in utilizing behavioral health supports and services to achieve their personal goals of community membership, independence and productivity. Peers have a special ability to gain trust and respect of other beneficiaries based on shared experiences and perspectives with disabilities, and with planning and negotiating human services systems.



- Vocational assistance provides support for beneficiaries seeking education and/or training opportunities, finding a job, achieving successful employment activities, and developing self-employment opportunities (reported as skill-building or supported employment).
- Housing assistance provides support locating and acquiring appropriate housing for achieving independent living; finding and choosing roommates; utilizing short-term, interim, or one-time-only financial assistance in order to transition from restrictive settings into independent integrated living arrangements; making applications for Section 8 Housing vouchers; managing costs of room and board utilizing an individual budget; purchasing a home; etc. (reported as Supports Coordination).
- Supports and services planning and utilization assistance provides assistance and partnership in:
 - The person-centered planning process (reported as either Treatment Planning or Supports Coordination);
 - Developing and applying arrangements that support self-determination;
 - Directly selecting, employing or directing support staff;
 - Sharing stories of recovery and/or advocacy involvement and initiative for the purpose of assisting recovery and self-advocacy;
 - Accessing entitlements;
 - Developing health and wellness plans;
 - Developing advance directives;
 - Learning about and pursuing alternatives to guardianship;
 - Providing supportive services during crises;
 - Developing, implementing and providing ongoing guidance for advocacy and support groups;
 - Integration of physical and mental health care; and
 - Developing, implementing and providing health and wellness classes to address preventable risk factors for medical conditions.

Activities provided by peer specialists are completed in partnership with beneficiaries for the specific purpose of achieving increased beneficiary community inclusion and participation, independence, recovery and productivity.



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<p>Peer Support Specialist and Recovery Coach Services</p>	<p>Individuals providing Peer Support Services must be able to demonstrate their experience in relationship to the types of guidance, support and mentoring activities they will provide. Individuals providing these services should be those who are generally recognized and accepted to be peers. Beneficiaries utilizing Peer Support Services must freely choose the individual who is providing Peer Support Services.</p> <p>Individuals who are functioning as Peer Support Specialists serving beneficiaries with mental illness must:</p> <ul style="list-style-type: none"> ▪ Have a serious mental illness; ▪ Have received public mental health services in the past or are currently receiving services; ▪ Provide at least 10 hours per week of services described above, with supported documentation written in the IPOS/treatment plan; and ▪ Meet the MDHHS application approval process for specialized training and certification requirements. <p>Individuals who are functioning as a Recovery Coach serving beneficiaries with a substance use disorder must:</p> <ul style="list-style-type: none"> ▪ Have a minimum of two years of recovery from a substance use disorder; ▪ Receive specialized training and certification approved by MDHHS; ▪ Be employed through a substance use disorder treatment program or a Recovery Community Organization under contract with the PIHP; and ▪ Recognize that there are many pathways to recovery.
<p>Drop-In Centers</p>	<p>Peer-Run Drop-In Centers provide an informal, supportive environment to assist beneficiaries with mental illness in the recovery process. If a beneficiary chooses to participate in Peer-Run Drop-In Center services, such services may be included in an IPOS if medically necessary for the beneficiary. Peer-Run Drop-In Centers provide opportunities to learn and share coping skills and strategies, to move into more active assistance and away from passive beneficiary roles and identities, and to build and/or enhance self-esteem and self-confidence. Under no circumstances may Peer-Run Drop-In Centers be used as respite for caregivers (paid or non-paid) or residential providers of beneficiaries.</p> <p>PIHPs must seek approval from MDHHS prior to establishing new drop-in programs. Programs currently approved to provide services by MDHHS through the delivery of Medicaid State Plan, HSW, or additional/B3 services do not require re-approval.</p> <p>Proposed drop-in centers will be reviewed against the following criteria:</p> <ul style="list-style-type: none"> ▪ Staff and board of directors of the center are 100% primary consumers; ▪ PIHP actively supports consumers’ autonomy and independence in making day-to-day decisions about the program; ▪ PIHP facilitates consumers’ ability to handle the finances of the program; ▪ The drop-in center is at a non-CMH site; ▪ The drop-in center has applied for 501(c)(3) non-profit status; ▪ There is a contract between the drop-in center and the PIHP or its subcontractor identifying the roles and responsibilities of each party; and ▪ There is a liaison appointed by the PIHP to work with the program.



	<p>Some beneficiaries use drop-in centers anonymously and do not have a drop-in center listed as a service in their IPOS. For those beneficiaries who do have drop-in service specified in their IPOS, it must be documented to be medically necessary and identify:</p> <ul style="list-style-type: none"> ▪ Goals and how the program supports those goals; and ▪ The amount, scope and duration of the services to be delivered. <p>The individual clinical record provides evidence that the services were delivered consistent with the plan.</p>
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5.6.B.8. PREVENTION-DIRECT SERVICE MODEL

<p>Children of Adults with Behavioral Health Disorders/ Integrated Services</p>	<p>Designed to prevent emotional and behavioral disorders among children whose parents are receiving services from the specialty behavioral health service system and to improve outcomes for beneficiaries who are parents. The Integrated Services approach includes assessment and service planning for the beneficiary related to their parenting role and their children's needs. Treatment objectives, services, and supports are incorporated into the IPOS/treatment plan through a person centered planning process for the beneficiary who is a parent. Linking the beneficiary and child to available community services, respite care, and providing for crisis planning are essential components.</p> <p>Provider qualifications:</p> <ul style="list-style-type: none"> ▪ Mental Health Professional; and/or ▪ Substance Abuse Treatment Specialist.
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5.6.B.9. TARGETED CASE MANAGEMENT

Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes.

Targeted case management services must be available for all Healthy Michigan Plan beneficiaries with a behavioral health disorder who have multiple service needs, have a high level of vulnerability, require access to a continuum of behavioral health services from the PIHP, and/or are unable to independently access and sustain involvement with needed services.

Beneficiaries must be provided choice of available, qualified case management staff upon initial assignment and on an ongoing basis.



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<p>Provider Qualifications</p>	<p>Providers must demonstrate the capacity to provide all core requirements specified below and have a sufficient number of staff to meet the needs of the target population. Providers must document initial and ongoing training for case managers related to the core requirements and applicable to the target population served. Caseload size and composition must be realistic for the case manager to complete the core requirements as identified in the IPOS developed through the person-centered planning process.</p> <p>Additionally, providers serving beneficiaries with a substance use disorder must be licensed for outpatient substance use disorder treatment services per the Administrative Rules for Substance Abuse Services, with the case management service category and appropriately accredited through one of the organizations identified in the Substance Abuse Services subsection of the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter. If a program is serving beneficiaries with a co-occurring mental health and substance use disorder, the outpatient license must also have the added service category of "integrated treatment for persons with mental health and substance use disorders". Established targeted case management programs that purport to offer this service for individuals with substance use disorders will be required to seek re-approval of the program by MDHHS when appropriate licensing and accreditation has been obtained. Programs currently approved to provide services for mental health and/or intellectual/developmental disabilities by MDHHS through the delivery of Medicaid State Plan, Habilitation Supports Waiver (HSW), or additional/B3 services do not require re-approval.</p>
<p>Determination of Need</p>	<p>The determination of the need for case management must occur at the completion of the intake process and through the person-centered planning process for beneficiaries receiving supports and services. Justification as to whether case management is needed or not must be documented in the beneficiary's case record.</p>
<p>Core Requirements</p>	<p>Targeted case management services must:</p> <ul style="list-style-type: none"> ▪ Assure that the person-centered planning process takes place and that it results in the development of the IPOS/treatment plan; ▪ Assure that the IPOS/treatment plan identifies what supports and services will be provided, who will provide them, and how the case manager will monitor (i.e., interval of face-to-face contacts) the supports and services identified under each goal and objective; ▪ Oversee implementation of the IPOS/treatment plan, including supporting the beneficiary's dreams, goals, and desires for optimizing independence; promoting recovery; and assisting in the development and maintenance of natural supports; ▪ Assure the participation of the beneficiary on an ongoing basis in discussions of his plans, goals, and status; ▪ Identify and address gaps in service provision; ▪ Coordinate the beneficiary's supports and services with all providers, make referrals, and advocate for the beneficiary; ▪ Assist the beneficiary to access programs that provide financial, medical, and other assistance, such as Home Help and Transportation services; ▪ Assure coordination with the beneficiary's primary and other health care providers to assure continuity of care; ▪ Coordinate, and assist the beneficiary in, crisis intervention and discharge planning, including community supports after hospitalization;



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	<ul style="list-style-type: none"> ▪ Facilitate the transition (e.g., from inpatient to community services, school to work, dependent to independent living) process, including arrangements for follow-up services; ▪ Assist the beneficiary with crisis planning; and ▪ Identify the process for after-hours contact.
Assessment	<p>The provider must have the capacity to perform an initial written comprehensive assessment addressing the beneficiary’s needs/wants, barriers to needs/wants, supports to address barriers, and health and welfare issues. Assessments must be updated when there is significant change in the condition or circumstances of the beneficiary. The IPOS/treatment plan must also reflect such changes.</p>
Documentation	<p>The beneficiary’s record must contain sufficient information to document the provision of case management, including the nature of the service, the date, and the location/type of contacts between the case manager and the beneficiary, including whether the contacts were face-to-face. The frequency of face-to-face contacts must be dependent on the intensity of the beneficiary’s needs.</p> <p>The case manager must review services at intervals defined in the IPOS/treatment plan. The IPOS/treatment plan shall be kept current and modified when indicated (reflecting the intensity of the beneficiary’s health and welfare needs). A beneficiary or his/her guardian or authorized representative may request and review the IPOS/treatment plan at any time. A formal review of the plan shall not occur less often than annually to review progress toward goals and objectives and to assess beneficiary satisfaction.</p>
Monitoring	<p>The case manager must determine, on an ongoing basis, if the supports and services have been delivered and if they are adequate to meet the needs/wants of the beneficiary. Frequency and scope (face-to-face and telephone) of case management monitoring activities must reflect the intensity of the beneficiary’s health and welfare needs identified in the IPOS/treatment plan.</p> <p>Targeted case management shall not include direct delivery of ongoing day-to-day supports and/or training or provision of Medicaid services. Targeted case managers are prohibited from exercising the funding agency’s authority to authorize or deny the provision of services. Targeted case management shall not duplicate services that are the responsibility of another program.</p>
Staff Qualifications	<p>A primary case manager for beneficiaries with a mental health or intellectual/developmental disability must be a Qualified Mental Health Professional (QMHP) or Qualified Intellectual Disabilities Professional (QIDP); or, if the case manager has only a bachelor’s degree but is without the specialized training or experience, they must be supervised by a QMHP or QIDP who does possess the training or experience. A primary case manager for beneficiaries with a substance use disorder must be appropriately trained and supervised by a SATS. For beneficiaries with concomitant behavioral health disorders, the case manager must have the appropriate training or experience and/or be supervised by someone who does possess the training or experience for the concomitant disorder in question.</p>



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HEARING SERVICES AND DEVICES

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SECTION 1 – GENERAL INFORMATION

This chapter applies to audiology providers, hearing aid dealers, and cochlear implant manufacturers. Information contained in this chapter is to be used in conjunction with other chapters of this manual, including the Billing & Reimbursement chapters, as well as the related procedure code databases and fee schedules located on the Michigan Department of Health and Human Services (MDHHS) website. (Refer to the Directory Appendix for website information.)

Medicaid covers audiology services and devices, including hearing tests, diagnostic services, auditory rehabilitation, hearing aids, cochlear implants, and bone anchored hearing devices (BAHDs), when ordered/referred by a Medicaid enrolled physician or qualified non-physician practitioner (i.e., physician assistant (PA) or advanced practice registered nurse (APRN)). Medicaid covers the least costly alternative that meets the beneficiary's medical need for medical supplies, durable medical equipment, or orthotics/prosthetics.

The term Medicaid throughout this chapter refers to all programs administered by MDHHS unless specifically stated otherwise. Providers should refer to the Children's Special Health Care Services chapter of this manual for information specific to Children's Special Health Care Services (CSHCS)-only beneficiaries.

1.1 PROVIDER REQUIREMENTS

1.1.A. LICENSED AUDIOLOGISTS

Licensed audiologists may enroll with Medicaid for reimbursement of audiology and hearing aid services. Out-of-state audiologists must be licensed and/or certified by the appropriate standard-setting authority in the state they are practicing. (Refer to the Out of State/Beyond Borderland Providers subsection of the General Information for Providers chapter for more information.)

Services performed by licensed audiologists must be provided at the service/practice address identified on the Medicaid provider enrollment application or may be provided to nursing facility residents at a Medicaid-enrolled nursing facility.

1.1.B. COCHLEAR IMPLANT MANUFACTURERS

Cochlear implant manufacturers may enroll with Medicaid for reimbursement of cochlear implant and BAHDs, parts, accessories, and repairs. Manufacturers must be licensed in the state in which they conduct business if that state requires licensure.

1.1.C. COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES AND OUTPATIENT REHABILITATION AGENCIES

Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Agencies (Rehab Agencies) may enroll with Medicaid for reimbursement of audiology services provided by qualified professionals. All CORFs and Rehab Agencies must provide proof of Medicare certification when enrolling in Medicaid.



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Services must be provided at the service/practice address identified on the provider enrollment application or may be provided to nursing facility residents at a Medicaid-enrolled nursing facility.

1.1.D. HEARING AID DEALERS

Hearing aid dealers licensed in the state of Michigan and conforming to the standards of practice described in the current Michigan Occupational Code (Act 299 of 1980, Article 13) may enroll with Medicaid for reimbursement of hearing aid devices and services. This provider type must enroll as a Facility/Agency/Organization with a Type 2 Billing National Provider Identifier (NPI).

1.1.E. HEARING CENTERS

Freestanding hearing centers may enroll with Medicaid for reimbursement of audiology services. The freestanding hearing center must not be part of, or owned by, a hospital, CORF, Rehab Agency, or university graduate education program.

1.1.F. INDEPENDENT DIAGNOSTIC TESTING FACILITIES

Medicare certified Independent Diagnostic Testing Facilities (IDTFs) may enroll with Medicaid for reimbursement of audiology related diagnostic testing services. The IDTF must be an independent facility not associated with a physician's office or hospital. Refer to the Independent Diagnostic Testing Facilities and Portable X-ray Suppliers chapter for information and requirements related to IDTFs.

1.1.G. MEDICAL SUPPLIER

Medical Suppliers may enroll with Medicaid for reimbursement of disposable hearing aid batteries. Refer to the Medical Supplier chapter for information and requirements related to Medical Suppliers.

1.1.H. OUTPATIENT HOSPITAL

Audiology services may be provided to beneficiaries in the outpatient hospital.

1.1.I. PHYSICIANS AND CLINICS

A physician, Federally Qualified Health Center, Rural Health Clinic, Tribal Health Center, or Local Health Department that provides hearing services may enroll with Medicaid for reimbursement.

1.1.J. UNIVERSITY AFFILIATED AUDIOLOGY GRADUATE EDUCATION PROGRAMS

University affiliated audiology graduate education programs accredited by the American Speech-Language-Hearing Association's (ASHA) Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA) or doctor of audiology programs accredited by the American Academy of Audiology (AAA) Accreditation Commission for Audiology Education (ACAE) may enroll with Medicaid for reimbursement of audiology



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services provided by qualified professionals. The university program must be freestanding and not part of, or owned by, a hospital, CORF, or Rehab Agency. All university programs must provide proof of their current ASHA-CAA or AAA-ACAE when enrolling in Medicaid.

1.1.K. SPEECH-LANGUAGE PATHOLOGISTS

Speech-Language Pathologists (SLPs) may enroll with Medicaid for reimbursement of audiological rehabilitation and speech-language therapy services. SLPs must possess a current license and be authorized by ASHA to use Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP) credentials. Refer to the Therapy Services chapter for information and requirements related to SLPs.

1.2 HEALTHCARE COMMON PROCEDURE CODING SYSTEM CODES, PARAMETERS AND MODIFIERS

Providers should refer to the current edition of the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) manuals published by the American Medical Association (AMA) for the appropriate procedure code to use when billing Medicaid. The descriptor assigned to a code represents the definition of the item/service that can be billed using that code. If no established procedure code adequately describes the item, use the appropriate Not Otherwise Classified (NOC) HCPCS procedure code. All NOC codes require prior authorization (PA).

For specifics regarding the HCPCS and CPT codes used to denote covered services, refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers chapter or the Medicaid Code and Rate Reference tool for more information. (Refer to the Directory Appendix for website information.)

The "LT" or "RT" modifier must be reported for all earmolds, sound processors, devices (including monaural hearing aids, BAHDs, and cochlear implants), and monaural dispensing services to designate either the left or right side of the body. When the same service is provided for both the left and right ears on the same date of service (DOS), the service should be reported on two separate claim lines with the appropriate modifier on each line.

1.3 DOCUMENTATION IN BENEFICIARY FILE

Hearing services providers must maintain all applicable documentation in the beneficiary's file for seven years. For audit purposes, the beneficiary's medical record must substantiate the medical necessity of the item or service supplied.

1.4 CSHCS REQUIREMENTS

The following information is regarding beneficiaries who are enrolled in CSHCS only. These requirements do not apply to services provided to Medicaid-only or dual Medicaid/CSHCS beneficiaries.

Once a beneficiary is enrolled in the CSHCS program for a condition that requires audiology services, a pediatric subspecialist is authorized by CSHCS to serve the beneficiary. CSHCS does not cover audiology services that are unrelated to the beneficiary's qualifying diagnosis. Prescriptions for hearing devices and supplies must be signed by the authorized subspecialist.



The pediatric subspecialist coordinates hearing treatment and services relating to the beneficiary's CSHCS qualifying diagnosis. However, a diagnostic evaluation by an audiologist does not require a referral by the pediatric subspecialist. Before billing for audiology services, the enrolled provider(s) must verify that they have been authorized to provide services to the beneficiary. (Refer to the Children's Special Health Care Services chapter for further CSHCS information.)

1.5 COPAYMENTS

A copayment for a hearing aid may be required for beneficiaries age 21 years and older. Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)

When calculating reimbursement, Medicaid deducts the copayment from the amount approved, when applicable. If the provider deducts the copayment from his claim, an underpayment results. Addition of the copayment amount to the acquisition cost is not allowed.

Refer to the Billing Beneficiaries section of the General Information for Providers chapter of this manual for additional information regarding copayment requirements.

1.6 PRACTITIONER SIGNATURES

In all documentation requiring a signature, the signature must be handwritten by the practitioner or submitted electronically. A stamped signature, second party signature, or statement of "signature on file" will not be accepted. An electronic signature must specifically identify and authenticate the individual practitioner. This applies to signatures for ordering, referring, and treating practitioners.

1.7 REIMBURSEMENT

Reimbursement is based on the provider's enrollment type. Reimbursement methodologies include the MDHHS Outpatient Prospective Payment System (OPPS) and Medicaid fee screens. (Refer to the Medicaid Code and Rate Reference tool in the Community Health Automated Medicaid Processing System [CHAMPS] or the MDHHS Hearing Services and Hearing Aid Dealers Fee Schedules on the MDHHS website.) For NOC codes or covered codes without established fee screens, the authorized reimbursement amount is indicated on the approved PA request.

The date of delivery of the hearing aid must be reported as the DOS. When there is a loss of eligibility or a change in eligibility status between the time a hearing aid is ordered and delivered, the DOS should be reported as the order date rather than the delivery date.

1.8 OTHER INSURANCE

If the beneficiary has another insurance plan (e.g., Medicare or commercial insurance) and the service is a covered benefit, the provider must follow the requirements of the other insurance plan(s) including, but not limited to, prescription, PA, and provider qualifications. (Refer to the Coordination of Benefits chapter for more information.)



SECTION 2 – COVERAGE OVERVIEW

2.1 SERVICE PROVIDERS

Audiology services may be provided by Medicaid enrolled, properly credentialed/licensed or appropriately supervised providers in the following settings:

- Hospital
- Hearing Center
- Comprehensive Outpatient Rehabilitation Facility (CORF)
- Outpatient Rehabilitation Agency
- CAA or AAA Accredited University Affiliated Audiology Graduate Education Program
- Licensed Audiologist Office/Clinic
- Physician's Office/Clinic including, but not limited to, a Federally Qualified Health Center, Rural Health Clinic, Tribal Health Center, or Local Health Department.
- Independent Diagnostic Testing Facility

Audiology services and hearing aid evaluations may be performed by the following Medicaid enrolled, properly credentialed/licensed or appropriately supervised providers:

- Licensed Audiologist
- Supervised Limited License Audiologist completing his/her post graduate clinical experience or having completed all requirements but has not obtained a full license
- Audiology Student completing his/her clinical experience under the direct supervision of (i.e., in the presence of) a licensed audiologist

Hearing aid selection, fitting, and conformity evaluations may be performed by the following Medicaid enrolled, properly credentialed/licensed or appropriately supervised providers:

- Licensed Audiologist
- Supervised Limited License Audiologist completing his/her post graduate clinical experience or having completed all requirements but has not obtained a full license
- Audiology Student completing his/her clinical experience under the direct supervision of (i.e., in the presence of) a licensed audiologist
- Hearing Aid Dealer

2.2 DIAGNOSTIC AND AMPLIFICATION SERVICES

The following diagnostic and amplification services may be provided to all eligible beneficiaries:

- Air and/or bone conduction audiogram
- Basic hearing evaluation (includes pure-tone audiometry, speech audiometry and report)



- Diagnostic audiologic evaluations
- Earmold fabrication
- Electroacoustic analysis of hearing aid
- Aided performance assessment with the beneficiary's hearing aid
- Hearing aid evaluation and selection
- Hearing aid orientation/training or hearing therapy

Standards of practice must conform to those published in the current version of ASHA's Preferred Practice Patterns for the Profession of Audiology or AAA's Standards of Practice for Audiology. Audiologic test equipment and hearing aid test equipment used must conform to current, applicable American National Standards Institute (ANSI) criteria.

2.3 NEWBORN HEARING SERVICES

All Medicaid-covered newborns must be screened using the auditory brainstem response (ABR) method and/or the evoked otoacoustic emissions (EOAE) method. Audiology newborn hearing screening tests must be performed by staff trained in the screening of infant hearing via the ABR or EOAE method. Medicaid requires appropriate interaction with parents/guardians and the medical team, and the proper reporting of hearing results with the MDHHS monitoring program.

Coverage for the EOAE and ABR newborn hearing screenings is included within the applicable diagnosis related group (DRG) payment for the newborn's inpatient stay. If the birthing facility is not equipped for ABR or EOAE, the child's APRN, physician, or PA must refer the newborn to an audiologist or hearing center for screening prior to one month of age.

Equipment must be available to audiologists providing a comprehensive diagnostic evaluation to infants less than six months of age. Infant evaluation services include, but are not limited to:

- Tone Burst ABR or Auditory Steady State Response (ASSR) Test
- Click ABR
- Bone Conduction ABR
- High Frequency Acoustic Immittance Measures
- Otoacoustic Emissions

Equipment must be available to audiologists providing hearing aid evaluation, selection, and follow-up services to infants less than six months of age. Infant hearing aid services include, but are not limited to:

- Infant Predictive Method (e.g., Desired Sensation Level)
- Real-Ear to Coupler Difference

Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter for additional information.



2.4 HEARING AID SERVICES AND SUPPLIES

Medicaid covers hearing aid devices, repairs, earmolds, batteries, supplies, and accessories provided by a Medicaid enrolled licensed hearing aid dealer or audiologist. Batteries may also be provided by an enrolled Medical Supplier.

Hearing aids are only a benefit when:

- The recommended hearing aid meets United States Food and Drug Administration (FDA) and Federal Trade Commission (FTC) requirements;
- Medical documentation indicates that the conductive hearing loss is not transient in nature due to a treatable medical middle ear effusion or that surgery is not planned within the next year;
- The beneficiary has not received a Medicaid covered hearing aid(s) within the last five years;
- A manufacturer's warranty of 24 months covering parts and labor and a 12-month warranty covering loss or damage are included. These warranties apply to all hearing aids, including those not covered under the MDHHS volume purchase contract.

MDHHS participates in a volume purchase contract agreement for hearing aid devices. Providers must purchase hearing aids directly from the manufacturers that are part of the MDHHS volume purchase contract whenever possible. The Hearing Aid Contract Vendor listing is maintained on the MDHHS website. (Refer to the Directory Appendix for website information.) Providers should refer to the Hearing Aids section of this chapter for complete information on hearing aid services and devices.

2.5 ASSISTIVE LISTENING DEVICES

An Assistive Listening Device (ALD) is a benefit when the patient management of a personal hearing aid is considered unrealistic or the frequency specific audiometric data cannot be obtained in each ear. The ALD is provided for situations involving one-on-one conversation and is not designed primarily for recreational or educational use. An ALD is covered when Medicaid has not covered any hearing aid(s) or ALD dispensed to the beneficiary within the last three years. Providers should refer to the Other Hearing Devices section, Assistive Listening Devices subsection of this chapter for additional information.

2.6 SPEECH SERVICES

Evaluation and treatment of speech, language, cognition, voice, and auditory processing is covered when performed by a SLP. Refer to the Therapy Services chapter for information and requirements related to speech therapy services.

2.7 AUDITORY REHABILITATION

Auditory rehabilitation is covered when medically necessary for beneficiaries who have received an implanted hearing device, hearing aid, or who have pre-lingual or post-lingual hearing loss. Auditory rehabilitation services are designed to optimize the benefit provided by the hearing device and improve the communication relationships affected by the beneficiary's loss of hearing. Aural rehabilitation focuses on auditory signal utilization, speech perception, and communication and listening skills development.

Auditory rehabilitation can be provided by a licensed audiologist or SLP who has training and expertise in the procedures. Evaluations for auditory rehabilitation may be provided up to two times per year, and a



maximum of 36 visits per year of aural rehabilitation are allowed. SLPs should refer to the Therapy Services chapter for documentation requirements. If additional visits are needed, PA is required.

2.8 COCHLEAR IMPLANTS

Cochlear implantation and associated mapping/calibration are covered and reimbursable under Medicaid and CSHCS programs for eligible beneficiaries using FDA approved implants. Cochlear implants are covered with PA for beneficiaries with pre- or post-lingual deafness who meet the implantation criteria. Providers should refer to the Other Hearing Devices section, Cochlear Implants subsection of this chapter for complete information.

2.9 BONE ANCHORED HEARING DEVICES

Medicaid covers FDA approved implantable and non-implantable BAHDs as an assistive hearing instrument for those who can benefit when there is no other suitable aid. Beneficiaries must have a unilateral or bilateral conductive or mixed hearing loss, or a unilateral profound sensorineural hearing loss. Providers should refer to the Other Hearing Devices section, Bone Anchored Hearing Devices subsection of this chapter for additional information.



SECTION 3 – PRIOR AUTHORIZATION

PA is required for certain services before the services are rendered. To determine which service requires PA, refer to the prior authorization subsections throughout this chapter and the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)

PA is required for the following situations:

- Services or devices for which the beneficiary does not meet the Medicaid Standards of Coverage as outlined in this policy
- Any hearing aids that are not covered under the MDHHS volume purchase contract
- ALDs
- Cochlear implant devices or processors (unilateral or bilateral)
- BAHDs or processors (bilateral only)
- Services and items that exceed quantity limits, frequency limits, or established fee screens
- Use of a NOC code

3.1 PRIOR AUTHORIZATION FORM AND COMPLETION INSTRUCTIONS

Requests for PA must be submitted on the Special Services Prior Approval-Request/Authorization form (MSA-1653-B). (Refer to the Forms Appendix or the MDHHS website for a copy of the form.) Medical documentation (e.g., medical clearance, audiogram, and hearing aid recommendation from an audiologist) must accompany the MSA-1653-B.

Providers requesting PA for items without an established fee screen must also include a copy of the manufacturer's invoice that lists the acquisition cost for the item. Manufacturer quotes or dealer list prices are not accepted as documentation of the cost. Modified manufacturer invoices will not be accepted. If the manufacturer's invoice is not included with the initial PA request, the MDHHS determination letter will indicate an approved fee of \$0.01 for PA purposes; the reimbursement fee will be updated once the actual invoice is submitted to MDHHS for pricing.

The information on the MSA-1653-B must be:

- Typed – All information must be clearly typed in the designated boxes of the form;
- Thorough – Complete information, including manufacturer, model, and style of the hearing device requested (if applicable), and the appropriate HCPCS procedure codes with applicable modifiers must be provided on the form. The MSA-1653-B and all documentation must include the beneficiary's name and **mihealth** card identification (ID) number, provider name, address, and National Provider Identification (NPI) number.

A sample of the MSA-1653-B with additional instructions is available in the Forms Appendix of this manual.

For all Medicaid Fee-for-Service (FFS) beneficiaries, the MSA-1653-B must be mailed or faxed to the MDHHS Program Review Division. Providers can check the status of a PA request in CHAMPS or by



contacting the MDHHS Program Review Division via telephone. (Refer to the Directory Appendix for website and contact information.)

PA requests may also be submitted electronically via FFS Direct Data Entry (DDE) in CHAMPS. (Refer to the General Information for Providers chapter of this manual for additional information.) A copy of the MSA-1653-B must be attached to each electronic PA request.

A copy of the PA determination letter must be retained in the beneficiary's medical record.

3.2 RETROACTIVE PRIOR AUTHORIZATION

Hearing services or devices provided before PA is requested will not be covered unless the beneficiary was not eligible on the DOS and a subsequent eligibility determination was made retroactive to the DOS. If the MDHHS eligibility file does not show that retroactive eligibility was approved, then the request for retroactive PA will be denied.

3.3 BENEFICIARY ELIGIBILITY

Approval of a service on the MSA-1653-B confirms that the service is authorized for the beneficiary. Approval of a PA request does not guarantee beneficiary eligibility or payment. To assure payment, it is recommended providers verify the beneficiary's eligibility on the DOS. Providers should refer to the Beneficiary Eligibility chapter of this manual for additional information.

3.4 REIMBURSEMENT AMOUNTS

Many items have established fee screens that are published in the MDHHS Hearing Services or Hearing Aid Dealers Fee Schedules. For NOC codes and all codes without established fee screens, the approved reimbursement amount is indicated on the authorized MSA-1653-B.

3.5 BILLING AUTHORIZED SERVICES

After PA is issued, the information (e.g., PA number, HCPCS/CPT code, modifier, and quantity) that was approved must match the information submitted on the claim form. (Refer to the Billing & Reimbursement chapters of this manual for complete billing instructions.)



SECTION 4 – HEARING AIDS

4.1 DEFINITIONS

The following definitions are used for purposes of administering and clarifying Medicaid coverages and limitations for hearing aid dealers:

Hearing Aid	A hearing aid is a wearable instrument or device designed to deliver amplified sound in order to compensate for a hearing loss. Models include body worn, behind the ear, in the ear, in the canal, and bone conduction. The hearing aid usually consists of a microphone, an amplifier, and a receiver.
Contralateral Routing System Hearing Aid	A hearing aid with a microphone worn on an unaidable ear with a receiver or additional microphone worn on the better ear.
Digital Hearing Aid	A hearing aid that uses digitized sound processing (DSP) to convert sound waves into digital signals.

4.2 COVERED SERVICES AND ITEMS

Medicaid covers the following services and items when medically necessary and provided by a licensed hearing aid dealer, hearing center, or audiologist.

- Hearing aids and delivery
- Hearing aid repairs and modifications
- Replacement earmolds
- Hearing aid supplies and accessories
- Replacement of hearing aid batteries
- Assistive listening devices (ALDs)

Disposable hearing aid batteries may also be provided by a medical supplier.

4.3 NONCOVERED SERVICES AND ITEMS

Noncovered services and items include, but are not limited to, the following:

- Hearing aids that do not meet FDA requirements
- Spare equipment (e.g., an old hearing aid in working condition for back-up use in emergencies)
- Personal FM Amplification Systems
- Alerting devices
- Hearing aids requested solely or primarily for the elimination of tinnitus
- Equipment requested solely or primarily for cosmetic reasons or package features relative to cosmetics



- Devices (i.e., hearing aids and non-surgical BAHDs) ordered for eligible beneficiaries but delivered more than 30 days after a beneficiary became ineligible for Medicaid
- Services rendered or devices dispensed before PA is approved
- Services or devices required to be provided by another public agency or program (e.g., school-based services, etc.)

NOTE: Federal EPSDT regulations require coverage of medically necessary treatment for children under 21 years of age, including medically necessary habilitative services. Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter for additional information.

4.4 HEARING AID CONTRACT

MDHHS participates in a volume purchase contract agreement for hearing aids. Providers must purchase hearing aids directly from the manufacturers that are part of the MDHHS volume purchase contract whenever possible. The Hearing Aid Contract Vendor listing is maintained on the MDHHS website. (Refer to the Directory Appendix for website information.) Providers must bill and are reimbursed the contract price for the hearing aid which cannot be further reduced or altered.

4.5 MEDICAL CLEARANCE

A medical clearance is a written statement signed by the physician, physician assistant, or advanced practice registered nurse indicating that:

- A medical evaluation was performed within six months prior to the beneficiary obtaining a hearing aid; and
- There are no contraindications to the use of a hearing aid.

For Medicaid beneficiaries under age 18, a Medicaid enrolled otolaryngologist or other appropriate specialty physician must complete the medical clearance.

For Medicaid beneficiaries age 18 years or older, the medical clearance may be completed by a Medicaid enrolled primary care provider, otolaryngologist, or other appropriate specialty care provider.

The medical clearance must include the beneficiary's name, birth date, address, **mihealth** card identification (ID) number, the services provided, the DOS, the provider's name, and provider NPI number.

For beneficiaries eligible for CSHCS coverage only, the following additional requirements apply:

- The hearing aid prescription must be related to the CSHCS qualifying diagnosis.
- The otolaryngologist signing the medical clearance must be a CSHCS enrolled provider.

4.6 EVALUATION AND SELECTION

Audiologists may perform hearing aid evaluations and selections with medical concurrence from the primary care provider, otolaryngologist, or other appropriate specialty care provider. After the appropriate audiologic procedures have been completed and it is determined that the beneficiary requires a hearing aid, a recommendation for the hearing aid must be completed and signed by the audiologist.



The recommendation, as well as a copy of the medical clearance, is given to the beneficiary along with a list of Medicaid-enrolled hearing aid dealers in the area. Beneficiaries must be given freedom of choice of any Medicaid-enrolled hearing aid dealer when obtaining their hearing aid, even when the licensed audiologist is also enrolled with Medicaid to dispense hearing aids.

4.7 MEASURABLE BENEFITS/CONFORMITY CHECK

Any delivered hearing aid is expected to demonstrate measurable benefit, established either at the time of fitting or follow-up. Benefit may be established by one, or a combination of, commonly used procedures, including:

- Measures of aided hearing and understanding of speech;
- Functional gain measures;
- Probe-microphone measurements; and/or
- (Minimally) the subjective impressions of the beneficiary, the beneficiary's family members or guardian, or attending staff.

Benefit may be demonstrated in cases of severe to profound hearing loss by at least one of the following measures:

- Improved functional or insertion gain in the speech frequencies.
- Increased awareness of speech and/or environmental sounds.
- Improved word recognition performance at average or slightly raised conversational levels with or without visual cues.
- Beneficiary's or family member's subjective report of speech benefit in everyday listening situations.

Hearing aid dealers must instruct beneficiaries to return to the evaluating audiologist for the conformity evaluation to allow for the return of the device, if necessary, within 90 days of the hearing aid dispensing date. When a delivered hearing aid does not provide benefit, as defined above, providers are expected to return it to the manufacturer within 90 days for modifications, remake, exchange, or credit as recommended by the evaluating audiologist. The hearing aid dealer must notify the beneficiary of this when the hearing aid is dispensed.

All full or partial refunds made by a manufacturer to the hearing aid dealer when a hearing aid is returned within the 90-day trial period and replaced with a less costly aid must be returned to Medicaid via a claim replacement.

Hearing aid conformity evaluations for beneficiaries with an existing hearing aid may be provided up to two times per year if necessary.

4.8 DISPENSING FEE

The hearing aid dealer may only bill the dispensing fee when providing direct patient contact in delivering and instructing beneficiaries on the use and care of the hearing aid. The dispensing fee is billed separate from the hearing aid using the appropriate HCPCS code. Components of the dispensing fee are not to be billed separately. With the exception of adjustments required within the manufacturer's warranty period,



the dispensing fee covers all services and products listed below for a period of 90 days. Reimbursement for the hearing aid dispensing fee includes, but is not limited to:

- Hearing aid delivery
- Adjustments required within the manufacturer's warranty period
- Fitting, orientation, and checking of the hearing aid
- Instructions on use and care of the hearing aid
- Initial earmolds and impressions
- All necessary components that may include cords, tubing, connectors, receivers, and huggies
- One 90-day supply of batteries per aid (or charger for rechargeable models)
- A 90-day trial/adjustment period with exchange/return privilege. Hearing aids that do not prove satisfactory to a user are to be returned to the manufacturer within 90 days from the date the hearing aid is provided to the beneficiary at no cost to MDHHS, the hearing aid dealer, hearing center, or the licensed audiologist.

Providers may not receive a dispensing fee for hearing aids returned during the 90-day trial period. Any dispensing fees paid to providers for hearing aids subsequently returned during the 90-day trial period must be returned to MDHHS via a claim replacement. If the hearing aid is returned, MDHHS will reimburse for hearing aid fitting/checking services or earmolds provided during the 90-day trial period.

4.9 MANDATORY MANUFACTURER'S WARRANTY

Medicaid requires that all hearing aids include a manufacturer's equipment warranty that includes parts and labor for all repairs and modifications for a 24-month period, and loss and/or damaged replacements for a 12-month period. This warranty must be provided at no cost to the beneficiary or to Medicaid. Manufacturers may not charge for packing, shipping, invoicing, postage, insurance, or handling while the hearing aid is under warranty.

Repairs required after the hearing aid repair warranty has expired are reimbursed based on the contracted rate and will have a new warranty period specified per the contract. The manufacturer is also responsible for all shipping costs on non-warranty equipment repairs.

4.10 HEARING AID CHECKS AND PROGRAMMING

Hearing aid checks performed by a hearing aid dealer or audiologist are billable services only after the hearing aid trial period. Hearing aid check services may include, but are not limited to, device inspection and cleaning, resetting volume, reprogramming, listening checks, and other electro acoustic testing. Hearing aid checks may be billed up to a maximum of two times per year without PA.

4.11 REPLACEMENT

Medicaid covers one (monaural) or two (binaural) hearing aids once every five years. PA is required when a hearing aid is needed more frequently.



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If a hearing aid is lost or damaged beyond repair within five years of the dispensing date and the 12-month loss and damage warranty has expired, Medicaid will pay for the replacement of the aid **one** time. Beneficiaries age 21 years and under may be eligible for additional replacements. PA is required.

Medicaid will not replace a hearing aid when lost or damaged beyond repair as a result of misuse or abuse by the beneficiary or caregiver. If loss or damage to a hearing aid is the result of theft or car accident, attempts should be made to collect the full or partial payment from the third party's insurance company, if applicable. A copy of the police or fire report must be submitted with the MSA-1653-B. All liable insurance coverage should be sought before requesting replacement by Medicaid.

4.12 DIGITAL HEARING AIDS

4.12.A. STANDARDS OF COVERAGE – UNILATERAL HEARING LOSS

Age Under 21 Years	<p>A digital monaural hearing aid is covered for beneficiaries with unilateral hearing loss documented by one of the following:</p> <ul style="list-style-type: none"> ▪ An audiogram showing hearing loss of 25 dB HL or greater using the four-frequency average of 500, 1000, 2000 and 4000 Hz in the ear to be aided with normal hearing in the better ear. Normal hearing is defined as a Pure Tone Average (PTA) air-conduction hearing threshold of better than or equal to 20 dB HL; or ▪ Results of a complete diagnostic audiological evaluation (e.g. ABR, EOAE, sound field testing, pure tone audiometry, or any combination of these) indicating a hearing loss of 25 dB HL or greater.
Age 21 Years or Over	<p>A digital monaural hearing aid is covered when all the following apply:</p> <ul style="list-style-type: none"> ▪ Unilateral hearing loss documented by an audiogram showing a hearing loss of 30 dB HL or greater using the four-frequency average of 500, 1000, 2000 and 4000 Hz in the ear to be aided with normal hearing in the better ear. Normal hearing is defined as a PTA air-conduction hearing threshold of better than or equal to 20 dB HL; ▪ A Hearing Handicap Inventory for Adults, Hearing Handicap Inventory for the Elderly, Abbreviated Profile of Hearing Aid Benefit, or similar inventory indicates a need for amplification; and ▪ Hearing loss interferes with or significantly restricts functional communication, routine activities of daily living, education, and/or employment.

4.12.B. STANDARDS OF COVERAGE – BILATERAL HEARING LOSS

Age Under 21 Years	<p>A digital monaural or binaural hearing aid is covered for beneficiaries with bilateral hearing loss documented by one of the following:</p> <ul style="list-style-type: none"> ▪ An audiogram showing a hearing loss of 25 dB HL or greater in both ears using the four-frequency average of 500, 1000, 2000 and 4000 Hz; or ▪ Results of a complete diagnostic audiological evaluation (e.g. ABR, EOAE, sound field testing, pure tone audiometry, or any combination of these) indicating a hearing loss of 25 dB HL or greater.
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Age 21 Years or Over	<p>A digital monaural or binaural hearing aid is covered when all the following apply:</p> <ul style="list-style-type: none"> ▪ Bilateral hearing loss documented by an audiogram showing hearing loss of 30 dB HL or greater in both ears using the four-frequency average of 500, 1000, 2000, and 4000 Hz or the two-frequency average of 2000 and 4000 Hz; and ▪ Hearing loss interferes with or significantly restricts functional communication, routine activities of daily living, education, and/or employment.
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4.12.C. PRIOR AUTHORIZATION REQUIREMENTS

PA is not required for either monaural or binaural digital hearing aids included in the MDHHS volume purchase contract if all other hearing aid requirements are met and restrictions, i.e., frequency of replacement, are not exceeded.

PA is required for the following:

- Any hearing aid not included in the MDHHS volume purchase contract
- Replacement aids within five years

All Ages	<p>For beneficiaries of all ages, the following documentation must be submitted with the MSA-1653-B:</p> <ul style="list-style-type: none"> ▪ Audiological evaluation and assessment results, signed and dated by the audiologist within the previous six months, demonstrating the specific standards of coverage have been met (i.e., audiogram and amplification inventory). ▪ A medical clearance signed and dated by the primary care or specialty provider within six months prior to prescribing the hearing aid. ▪ Recommended manufacturer, model, and style of hearing aid. ▪ For hearing aids not covered under the MDHHS volume purchase contract, documentation from the manufacturer showing invoice price, discounts, and shipping and handling charges. ▪ If applicable, documentation indicating whether the child is receiving deaf or hard of hearing services from the educational system.
Age 21 Years or Over	<p>In addition to the above documentation, providers must submit the following for beneficiaries 21 years or older:</p> <ul style="list-style-type: none"> ▪ Documentation demonstrating hearing loss interferes with or significantly restricts functional communication, routine activities of daily living, education, and/or employment.

4.12.D. DOCUMENTATION

Applicable documentation to be maintained in the beneficiary record includes:

- Audiological evaluation and assessment results, signed and dated by the audiologist within the previous six months, demonstrating the specific standards of coverage have been met (i.e., audiogram and amplification inventory);



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- A medical clearance signed and dated by the primary care provider or otolaryngologist within six months prior to prescribing the hearing aid;
- Recommendation of the make, model, and type of hearing aid;
- For hearing aids not covered under the MDHHS volume purchase contract, a copy of the manufacturer’s invoice showing the hearing aid model, serial number, invoice price, applicable discounts, and shipping and handling charges; and
- If applicable, documentation indicating whether the child is receiving deaf or hard of hearing services from the educational system including, but not limited to, letters of support from the classroom teacher, the deaf or hard of hearing teacher consultant, and/or the educational audiologist.

4.12.E. PAYMENT RULES

Most items have established fee screens that are published in the MDHHS Hearing Aid Dealers Fee Schedule or MDHHS volume purchase contract. For codes without established fee screens, the approved reimbursement amount is indicated on the approved PA request.

4.13 CONTRALATERAL ROUTING SYSTEMS

4.13.A. STANDARDS OF COVERAGE

All Ages	<p>A contralateral routing hearing aid is covered when one of the following applies:</p> <ul style="list-style-type: none"> ▪ An audiogram indicates profound hearing loss in the poorer ear (unaidable) as demonstrated by greater than 90 dB HL and indicates thresholds less than or equal to 30 dB HL in the better ear using the four-frequency average of 500, 1000, 2000, and 4000 Hz; or ▪ An audiogram indicates profound hearing loss in the poorer ear (unaidable) as demonstrated by greater than 90 dB HL and indicates a hearing loss greater than 25 dB HL in the better ear using the four-frequency average of 500, 1000, 2000, and 4000 Hz.
Age 21 Years or Over	<p>In addition to the above, beneficiaries age 21 years or over must have all the following:</p> <ul style="list-style-type: none"> ▪ A Hearing Handicap Inventory for Adults, Hearing Handicap Inventory for the Elderly, Abbreviated Profile of Hearing Aid Benefit, or similar inventory that indicates a need for amplification; and ▪ A hearing loss that interferes with or significantly restricts functional communication, routine activities of daily living, education, and/or employment.

4.13.B. PRIOR AUTHORIZATION REQUIREMENTS

PA is not required for monaural or binaural contralateral routing hearing aids included in the MDHHS volume purchase contract if all other hearing aid requirements are met and restrictions (i.e., frequency of replacement) are not exceeded.



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PA is required for the following:

- Any hearing aid not included in the MDHHS volume purchase contract.
- Replacement aids within five years.

All Ages	<p>When PA is needed, the following documentation must be submitted with the MSA-1653-B:</p> <ul style="list-style-type: none"> ▪ Audiological evaluation and assessment results, signed and dated by the audiologist within the previous six months, demonstrating the contralateral routing system’s standards of coverage have been met (e.g., audiogram and amplification inventory); ▪ A medical clearance signed and dated by the physician within six months prior to prescribing the hearing aid; ▪ Hearing aid recommended manufacturer, model, and style; ▪ For hearing aids not covered under the MDHHS volume purchase contract, documentation from the manufacturer showing invoice price, discounts, and shipping and handling charges; and ▪ If applicable, documentation indicating whether the child is receiving deaf or hard of hearing services from the educational system including, but not limited to, letters of support from the classroom teacher, the deaf or hard of hearing teacher consultant, and/or the educational audiologist.
Age 21 Years or Over	<p>In addition to the above, providers must submit the following documentation for beneficiaries age 21 years or over:</p> <ul style="list-style-type: none"> ▪ Documentation demonstrating hearing loss interferes with or significantly restricts functional communication, routine activities of daily living, education, and/or employment.

4.13.C. DOCUMENTATION

Applicable documentation to be maintained in the beneficiary record for a contralateral routing hearing aid includes:

- Audiological evaluation and assessment results, signed and dated by the audiologist within the previous six months, demonstrating the contralateral routing system’s standards of coverage have been met (i.e., audiogram and amplification inventory);
- A medical clearance signed and dated by the physician within six months prior to prescribing the hearing aid;
- Recommendation of the make, model, and type of hearing aid;
- For hearing aids not covered under the MDHHS volume purchase contract, a copy of the manufacturer’s invoice showing the hearing aid model, serial number, invoice price, applicable discounts, and shipping and handling charges; and
- If applicable, documentation indicating whether the child is receiving deaf or hard of hearing services from the educational system, including letters of support from the classroom teacher, the deaf or hard of hearing teacher consultant, and/or the educational audiologist.



4.13.D. PAYMENT RULES

Each of the HCPCS codes for contralateral routing systems covers both the transmitter and the receiver/hearing aid. Monaural codes should be used when providing one contralateral routing device to a beneficiary who already wears a Contralateral Routing of Signals (CROS) compatible hearing aid in the better ear. Providers should choose the procedure code that corresponds to the appropriate model being fit on the poorer ear. Binaural codes should be used when providing one hearing aid and one contralateral routing device. No other hearing aid device procedure code may be billed in addition to the specific contralateral routing systems code used.

Most devices have established fee screens that are published in the MDHHS Hearing Aid Dealers Fee Schedule or indicated on the MDHHS volume purchase contract. For codes without established fee screens, the approved reimbursement amount is indicated on the approved PA request.

4.14 NON-CONTRACT HEARING AIDS

Hearing aid providers must provide hearing aids available through the MDHHS volume purchase contract whenever possible. If the provider prescribes a non-contract hearing aid, the hearing aid provider must obtain PA.

In addition to the required documents listed under the Digital Hearing Aids – Prior Authorization Requirements or the Contralateral Routing Systems - Prior Authorization Requirements subsections (as applicable) of this chapter, a letter of medical necessity must be submitted with the MSA-1653-B. The letter must identify the specific medical reason(s) why a contracted hearing aid will not meet the beneficiary's needs.

4.14.A. PAYMENT RULES

Payment for a non-contract hearing aid may not exceed Medicaid's maximum allowable amount unless the documentation submitted with the MSA-1653-B supports the need for the more advanced technology found with a non-contract hearing aid. When documentation of the need for a non-contract hearing aid is provided, the payment is the acquisition cost for the non-contract hearing aid. Acquisition cost consists of the manufacturer's invoice price, minus any discounts, and includes actual shipping costs.

Medicaid requires all non-contract hearing aids to include a manufacturer's equipment warranty that covers parts and labor for all repairs and modifications for a 24-month period, and loss and/or damaged replacements for a 12-month period. The warranty is included in the hearing aid's acquisition cost and should not be charged separately.



SECTION 5 – HEARING AID SUPPLIES, ACCESSORIES, AND REPAIRS

5.1 STANDARDS OF COVERAGE

Hearing aid supplies and accessories are a covered benefit when medically necessary. A list of approved supplies, accessories, and maximums is available on the Hearing Aid Supplies and Accessories list located on the MDHHS website. (Refer to the Directory Appendix for website information.)

5.2 PRIOR AUTHORIZATION REQUIREMENTS

PA is required for the following hearing aid supplies and accessories:

- Any single item billed with requested payment amounts over the maximum fee as identified on the MDHHS Hearing Aid Dealers Fee Schedule.
- An item that exceeds the frequency standards of coverage.
- Items when the sum of all payments for supplies/accessories billed within the past year is over the maximum fee as identified on the MDHHS Hearing Aid Dealers Fee Schedule.
- Battery charger or rechargeable battery.

A list of supplies/accessories provided within the past year and a copy of the manufacturer's invoice showing the invoice price of the supplies/accessories, applicable discounts, and shipping charges must be submitted with the MSA-1653-B.

5.3 DOCUMENTATION

Applicable documentation to be maintained by the provider includes:

- A list of hearing aid supplies/accessories provided to the beneficiary within the past year.
- A copy of the manufacturer's invoice showing the invoice price of the supplies/accessories, applicable discounts, and shipping charges.

5.4 PAYMENT RULES

Refer to the MDHHS Hearing Aid Dealers Fee Schedule for maximum payment limits.

5.5 DISPOSABLE HEARING AID BATTERIES

5.5.A. STANDARDS OF COVERAGE

Medicaid covers replacement of disposable hearing aid batteries, as appropriate, up to a quantity of 36 batteries per hearing aid per DOS when dispensed by a hearing aid dealer, audiologist, hearing center, or medical supplier. A maximum of 72 batteries per aid per year is covered.

All batteries must be dispensed in the original packaging and must be dispensed at least one year before the expiration date shown on the package. The establishment of a "battery club," where batteries are automatically mailed to a beneficiary regardless of



need, is not allowed. Hearing aid dealers and medical suppliers may not bill for replacement of disposable batteries for cochlear implant devices.

5.5.B. PRIOR AUTHORIZATION REQUIREMENTS

PA is required for quantities exceeding the standards of coverage. Documentation must accompany the MSA-1653-B to substantiate the need for additional batteries.

5.5.C. PAYMENT RULES

Refer to the MDHHS Hearing Aid Dealers Fee Schedule for maximum payment limits.

5.6 REPLACEMENT EARMOLDS

Beneficiaries who use hearing aids that require custom earmolds are eligible for replacement earmolds after the 90-day dispensing period. PA is not required when the earmold standards of coverage are met.

5.6.A. STANDARDS OF COVERAGE

Age 3 Years or Under	Up to four times per 12 months
Age 3 to 21 Years	Up to two times per 12 months
Age 21 Years or Over	Once every 12 months

5.6.B. PRIOR AUTHORIZATION REQUIREMENTS

PA is required for replacements exceeding the standards of coverage. Documentation must accompany the MSA-1653-B to substantiate the need for additional earmold replacements.

5.6.C. PAYMENT RULES

Refer to the MDHHS Hearing Aid Dealers Fee Schedule for maximum payment limits.

5.7 HEARING AID REPAIRS AND MODIFICATIONS

5.7.A. STANDARDS OF COVERAGE

Providers may bill for repairs and modifications only to the most recently dispensed out-of-warranty hearing aid. Repairs required after the hearing aid repair warranty has expired are reimbursed based on the contracted rate and will have a new warranty period specified per the contract. MDHHS volume purchase contract vendors must continue to honor the repair pricing of the contract under which the hearing aid was sold for the life of the hearing aid. The vendor is responsible for all shipping costs related to



warranty and non-warranty equipment repairs. When a warranty covered hearing aid requires a repair by the manufacturer, MDHHS will not reimburse the hearing aid dealer/audiologist for hearing aid fitting/checking services.

Repairs are not covered for back-up aids or devices.

The replacement of a hearing aid will be considered when the cost of the equipment repair is greater than the replacement. When submitting a PA request for the replacement, the provider must provide a statement regarding the cost to repair the aid/device versus replacement.

5.7.B. PRIOR AUTHORIZATION REQUIREMENTS

PA **is** required for repairs and modifications to out-of-warranty hearing aids if any of the following apply:

- The requested payment amount is over the maximum payment limit as published on the MDHHS Hearing Aid Dealers Fee Schedule. (Refer to the Directory Appendix for website information.)
- More than two separate repairs or modifications have been billed within the previous year.
- The hearing aid was not purchased under the MDHHS volume purchase contract.

Documentation must be submitted with the MSA-1653-B. If the manufacturer's invoice is not included with the initial PA request, the MDHHS determination letter will indicate an approved fee of \$0.01 for PA purposes; the reimbursement fee will be updated once the actual invoice is submitted to MDHHS for pricing. A repair processing fee of \$19.20 per aid may be added to the repair cost for hearing aids that are not covered under any warranty.

The repair or modification of a hearing aid not purchased by Medicaid may be covered only when all the following apply:

- The beneficiary's hearing level, as supported by an audiogram, meets Medicaid coverage criteria; and
- The aid itself meets Medicaid coverage criteria.

The MSA-1653-B for this type of repair or modification must include the date of purchase, warranty expiration date, and the current audiogram.

5.7.C. DOCUMENTATION

Applicable documentation to be maintained in the beneficiary's record includes an itemization of materials used to repair the hearing aid and related labor costs.



5.7.D. PAYMENT RULES

Medicaid's payment for hearing aid repairs or modifications includes no more than the actual repair cost plus a \$19.20 processing fee per aid. Actual repair cost consists of acquisition cost of materials used for the repair, related labor costs, and shipping costs. The \$19.20 processing fee may only be added to repairs that are not covered under a warranty. The maximum payment limit is published on the MDHHS Hearing Aid Dealers Fee Schedule.

Non-warranty repair pricing for hearing aids purchased under the MDHHS volume purchase contract are fixed rates established by the contract under which the hearing aid was sold. These rates apply for the life of the hearing aid.



SECTION 6 – OTHER HEARING DEVICES

6.1 ASSISTIVE LISTENING DEVICES

An Assistive Listening Device (ALD) is defined as a special purpose electro-acoustic device designed to enhance receptive communication (e.g., Pocket Talker).

6.1.A. STANDARDS OF COVERAGE

All Ages	<p>ALDs are a benefit for beneficiaries when all the following conditions are met:</p> <ul style="list-style-type: none"> ▪ Patient management of a personal hearing aid is considered unrealistic and/or frequency specific audiometric data cannot be obtained in each ear; ▪ The beneficiary has not received a Medicaid covered ALD within the last three years; ▪ The ALD is provided for situations involving one-on-one conversation.
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6.1.B. PRIOR AUTHORIZATION REQUIREMENTS

PA is required for all ALDs.

All Ages	<p>The following documentation must be submitted with the MSA-1653-B:</p> <ul style="list-style-type: none"> ▪ A manufacturer’s invoice showing the item acquisition cost; ▪ A letter from the audiologist delineating why a personal hearing aid is inappropriate and the recommended type of ALD; ▪ An audiogram signed and dated by the audiologist within six months prior to dispensing the device, or documentation showing that frequency-specific audiometric data could not be obtained in each ear within six months prior to dispensing the device.
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6.1.C. DOCUMENTATION

Applicable documentation to be maintained in the beneficiary's record includes all the following:

- A letter from the audiologist demonstrating why a personal hearing aid is inappropriate and the recommended type of ALD;
- An audiogram signed and dated by the audiologist within six months prior to dispensing the device, or documentation showing that frequency-specific audiometric data could not be obtained in each ear; and
- A copy of the manufacturer’s invoice showing the ALD model, serial number, invoice price, applicable discounts, and shipping charges.



6.1.D. PAYMENT RULES

Medicaid’s payment for an ALD includes the provider’s acquisition cost plus a percentage over cost. Acquisition cost consists of the manufacturer’s invoice price, minus any discounts, and includes actual shipping costs. Medicaid does not reimburse providers for a separate dispensing fee for ALDs.

6.2 COCHLEAR IMPLANTS

Cochlear implants are devices that replace the function of the cochlear structures and provide electrical energy to auditory nerve fibers. They require a surgically placed internal device and external hardware. The surgery must be performed by a licensed medical doctor (MD) or doctor of osteopathy (DO) who specializes in otolaryngology and has training and expertise in the surgical procedure.

Cochlear implantation may be an option to improve communication skills for adults with a moderate to profound hearing loss and for children with a severe to profound hearing loss who receive limited or no benefit from hearing aids.

6.2.A. STANDARDS OF COVERAGE

Unilateral and bilateral cochlear implantation is covered with PA for beneficiaries meeting the standards of coverage and audiological criteria. Implants must be FDA approved and used according to FDA labeled indications. Cochlear implants are covered for pre- or post-lingual deafness.

Hearing aids, hearing aid services, and accessories may be covered after the beneficiary has received a unilateral cochlear implant with PA. Documentation must be submitted to support improvement in speech perception abilities using a hearing aid in the opposite ear. Documentation of hearing aid audibility measures (i.e., speech mapping) on prescriptive hearing aid measurements may be submitted for beneficiaries who are unable to participate in speech perception testing.

All Ages	<p>In addition to meeting the cochlear implant audiological criteria, all the following requirements must be met for unilateral and bilateral implantation:</p> <ul style="list-style-type: none"> ▪ A letter from the treating otolaryngologist establishing medical necessity and recommending implantation. ▪ Limited benefit demonstrated with consistent use of appropriately fitted hearing aid(s) over a minimum of a three-month period. The trial period may be waived or shortened with appropriate documentation of medical necessity. ▪ Evidence of a functioning auditory nerve. ▪ An accessible cochlear lumen structurally suited to implantation. No evidence of lesions in the auditory nerve and acoustic areas of the central nervous system. This may be demonstrated by an appropriate radiological evaluation. ▪ Freedom from middle ear infection or any other active disease. ▪ No medical or behavioral health contraindications for anesthesia or surgery. ▪ Cognitive ability to use auditory cues.
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	<ul style="list-style-type: none"> Psychological development, motivation of the beneficiary, and/or commitment of the beneficiary and family/caregiver(s) to undergo a program of prosthetic fitting, training, and long-term rehabilitation. Realistic expectations of beneficiary and/or family/caregiver(s) for post-implant educational/vocational rehabilitation, as appropriate. Reasonable anticipation by treating providers that the cochlear implant(s) will confer awareness of speech at conversational levels. Documented intervention or school placement, as appropriate. Documentation may include the Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP) involving individuals with specialization in the education of children who are deaf or hard of hearing.
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6.2.A.1. AUDIOLOGICAL CRITERIA

Under 24 Months	<ul style="list-style-type: none"> Diagnosis of bilateral severe to profound sensorineural hearing loss (PTA equal to or greater than 70 dB HL, or level appropriate for model to be implanted, averaged over 500-4000 Hz, ANSI 1989) in an unaided condition. Electrophysiological assessment must corroborate behavioral testing. Lack of auditory skills development and minimal hearing aid benefit documented by results or outcomes of parent questionnaire (i.e., Infant Toddler-Meaningful Auditory Integration Scale [IT-MAIS]) or other age appropriate developmental tests.
Age 24 Months through 17 Years	<ul style="list-style-type: none"> Diagnosis of bilateral severe to profound sensorineural hearing loss (PTA equal to or greater than 70 dB HL, or level appropriate for model to be implanted, averaged over 500-4000 Hz, ANSI 1989) in an unaided condition. Lack of auditory skills development and minimal hearing aid benefit documented by word recognition scores less than or equal to 60 percent on open set tests (i.e., Multisyllabic Lexical Neighborhood Test or Lexical Neighborhood Test) or other age appropriate developmental tests in the best aided condition.
Age 18 Years and Older	<ul style="list-style-type: none"> Diagnosis of bilateral moderate to profound sensorineural hearing loss (PTA equal to or greater than 40 dB HL, or level appropriate for model to be implanted, averaged over 500-4000 Hz, ANSI 1989) in an unaided condition. Minimal hearing aid benefit documented by a score of less than or equal to 50 percent under best-aided conditions on an open-set sentence recognition test (i.e., Hearing in Noise Test [HINT] Sentences or AzBio Sentences).

6.2.B. PRIOR AUTHORIZATION

Unilateral and bilateral cochlear implantation require PA. All audiological evaluations must be signed and dated by the audiologist and performed within one year of the date of the PA request unless otherwise specified.



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All Ages	<p>The following documentation must be submitted with the MSA-1653-B:</p> <ul style="list-style-type: none"> Documentation of complete audiologic evaluation that defines the type and degree of hearing loss in each ear and applicable assessment results (e.g., speech recognition test scores and/or parent questionnaire) confirming the audiological criteria standards of coverage (as defined above) applicable to the beneficiary have been met. A letter from the treating otolaryngologist, with evaluation supporting medical necessity and treatment recommendations. Documentation of appropriately fitted hearing aids (for the trial period) verified through prescriptive measurements (e.g., aided audiograms). Documentation of minimal or no benefit from appropriate amplification (e.g., hearing aids) following an adequate period of auditory training (minimally three months) using the best ear responses. The trial period may be waived or shortened with appropriately submitted medical documentation. Documentation of an accessible cochlear lumen structurally suited to implantation (e.g., no evidence of lesions in the auditory nerve and acoustic areas of the central nervous system). This must be demonstrated by an appropriate radiological evaluation. Identification of the cochlear manufacturer of the internal device, with the model of the external processor. Identification of the anticipated side to be implanted (unilateral only).
Age 12 Months Through 17 Years	<p>In addition to the documentation for beneficiaries of all ages, the following must also be submitted for beneficiaries aged 12 months through 17 years:</p> <ul style="list-style-type: none"> Speech and language evaluation report; and Documented intervention or school placement, as appropriate. Documentation may include the IFSP or IEP involving individuals with specialization in the education of children who are deaf or hard of hearing.

6.2.C. DOCUMENTATION

Applicable documentation to be maintained in the beneficiary's record includes:

- Complete audiologic evaluation that defines the type and degree of hearing loss in each ear and applicable assessment results (e.g., speech recognition test scores and/or parent questionnaire) confirming the audiological criteria standards of coverage applicable to the beneficiary have been met.
- A letter from the treating otolaryngologist, with evaluation supporting medical necessity and treatment recommendations.
- Documentation of appropriately fitted hearing aids verified through prescriptive measurements (e.g., aided audiograms).
- Aided speech perception test battery results.



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- Documentation of minimal or no benefit from appropriate amplification (i.e., hearing aids) following an adequate period of auditory training (minimally three months) using the best ear responses. The trial period may be waived or shortened with medical documentation.
- Documentation of an accessible cochlear lumen structurally suited to implantation. No evidence of lesions in the auditory nerve and acoustic areas of the central nervous system. This must be demonstrated by an appropriate radiological evaluation.
- Identification of the cochlear manufacturer of the internal device and model of the external processor.
- Identification of the anticipated side to be implanted (unilateral only).

6.2.D. PROGRAMMING/MAPPING

Cochlear implant mapping is the programming of the speech processor to the specifications and needs of its user following cochlear implant surgery. Mapping is used to analyze sound and convert the speech information into electrical impulses to the implanted electrodes. An initial post-operative session may be billed once per beneficiary per implant. Subsequent programming/mapping sessions may be billed up to five per year per implant. If additional sessions are needed, PA is required.

6.2.E. REPAIRS, ACCESSORIES, AND REPLACEMENT PARTS STANDARDS OF COVERAGE

Cochlear implant repairs, accessories, replacement parts, internal implants, and external speech processors may be covered when dispensed by a cochlear implant manufacturer and the applicable standards of coverage have been met. Charges should reflect no more than the usual and customary (U&C) charge to the general public.

Replacement of the internal cochlear implant device is covered with PA in cases when the audiologist or physician (e.g., otolaryngologist) indicates the function of the internal device has failed and is no longer under warranty. A letter from the manufacturer corroborating the internal device failure is required.

Replacement of the cochlear implant external speech processor with a new same generation or new upgraded speech processor is covered with PA when documentation from the licensed audiologist or physician substantiates the need for the replacement processor. Payment for the speech processor includes an initial supply of batteries.

<p>Internal Cochlear Implant or Speech Processor Repair or Replacement</p>	<p>Internal cochlear implant devices and external speech processors may be repaired or replaced when all the following apply:</p> <ul style="list-style-type: none"> ▪ The device was in continuous use prior to the repair or replacement. ▪ A licensed audiologist or physician substantiates the functional need for the repair or replacement. ▪ The device is FDA approved. ▪ Replacements only: the device is out of warranty and worn for at least four years, or the device is irreparable or lost.
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	For replacement of a speech processor with an upgraded model, documentation must substantiate that the current model is obsolete or newer generation technology provides additional capacity for functional auditory-based improvement.
Accessories and Replacement Parts	<p>Accessories and replacement parts may be covered when all the following apply:</p> <ul style="list-style-type: none"> ▪ The accessory or replacement part is no longer covered by the manufacturer’s warranty. ▪ A licensed audiologist or physician substantiates the need for the item. ▪ The item will be used on a cochlear implant device that was in continuous use prior to dispensing the item. ▪ The item will be used on an FDA-approved cochlear implant device.

6.2.F. REPAIRS, ACCESSORIES, AND REPLACEMENT PARTS PRIOR AUTHORIZATION REQUIREMENTS

PA is required for the following repairs, accessories, and replacement parts:

- External sound processors;
- Cochlear repairs, accessories, or implant parts when the sum of all charges exceeds the daily reimbursement maximum published on the MDHHS Hearing Services Fee Schedule;
- Cochlear repairs, accessories, or implant parts when the sum of all charges within the past year exceeds the yearly reimbursement maximum published on the MDHHS Hearing Services Fee Schedule; and
- Items exceeding the frequency maximums published on the MDHHS Cochlear Implant Replacement Parts and Accessories list. (Refer to the Directory Appendix for website information.)

Some replacement parts are not subject to these reimbursement maximums. Refer to the MDHHS Cochlear Implant Replacement Parts and Accessories list. (Refer to the Directory Appendix for website information.)

All Ages	<p>When PA is required, the following documentation must be submitted with the MSA-1653-B:</p> <ul style="list-style-type: none"> ▪ Documentation from the licensed audiologist or physician, signed and dated within the previous six months, that substantiates the need for the part(s) and/or repair; and ▪ Manufacturer’s invoice itemizing the materials used to repair the device and the rationale for any related labor costs.
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6.2.G. REPLACEMENT PARTS AND ACCESSORIES LIST

A list of approved cochlear implant replacement parts and accessories is available on the MDHHS website. (Refer to the Directory Appendix for website information.)



6.2.H. NON-COVERED ITEMS

Repair or replacement of spare equipment (e.g., old parts and accessories in working condition for back-up use in emergencies) is not covered.

6.3 BONE ANCHORED HEARING DEVICES

Some beneficiaries may have physical or medical conditions that prevent them from wearing traditional hearing aids. A BAHD is an alternative hearing instrument for those who can benefit when there is no other suitable aid.

6.3.A. IMPLANTABLE

A BAHD or aid, also known as an auditory osseointegrated device, is an implantable bone-conduction hearing aid that allows direct bone-conduction of sound through an implant. The device has both implanted and external components. The implanted component is attached to the skull bone behind the ear. The external component is a speech processor connected to an implanted abutment or internal magnet. The surgically implanted components and initial external speech processor are covered as a bundled procedure at the hospital benefit level.

All device repairs and replacements, including the processor and batteries, are covered as specified on the MDHHS Hearing Services Fee Schedule.

6.3.B. NON-IMPLANTABLE

BAHD sound processors can also be used without surgery when they are attached to the head by a headband device or adhesive adapter placed behind the ear. A headband system is the option for beneficiaries who meet the BAHD audiological criteria but are not appropriate surgical candidates and need hearing assistance via bone conduction.

6.3.C. STANDARDS OF COVERAGE

Unilateral and bilateral implantable and non-implantable BAHDs are covered for beneficiaries meeting the standards of coverage and audiological criteria. An air conduction hearing aid must also be contraindicated, failed, or not appropriate for the beneficiary's medical condition. Conditions not meeting these criteria are considered investigational/experimental and are not covered. Beneficiaries must be five years of age or older for surgically implanted BAHDs.



All Ages	<ul style="list-style-type: none"> ▪ Has documented unilateral or bilateral conductive or mixed hearing loss or unilateral profound sensorineural hearing loss as defined under BAHD audiological criteria. ▪ Use of an FDA-approved device in accordance with its labeled indications. ▪ Has at least one of the following conditions: <ul style="list-style-type: none"> ➢ Congenital malformation(s) of the middle/external ear or microtia; ➢ Severe chronic otitis externa and/or chronic suppurative otitis media with chronic drainage preventing use of conventional air conduction hearing aids; ➢ Conductive hearing loss due to ossicular disease and is not appropriate for surgical correction; ➢ Tumors of the external ear canal and/or tympanic cavity; ➢ Unilateral sensorineural hearing loss (single-sided deafness); or ➢ Condition that contraindicates an air conduction hearing aid.
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6.3.C.1. AUDIOLOGICAL CRITERIA

Unilateral or Bilateral Conductive or Mixed Hearing Loss	<ul style="list-style-type: none"> ▪ PTA bone conduction threshold less than or equal to 65 dB HL or level appropriate for model to be implanted using the four-frequency average of 500, 1000, 2000 and 4000 Hz in ear to be implanted; and ▪ Speech recognition scores less than or equal to 60 percent using age appropriate speech recognition testing or other age appropriate developmental testing in the best aided condition.
Unilateral Sensorineural Hearing Loss	<ul style="list-style-type: none"> ▪ Confirmed profound hearing loss (greater than or equal to 90 dB HL using the four-frequency average of 500, 1000, 2000 and 4000 Hz) in one ear, with normal hearing (defined as a PTA air-conduction hearing threshold of better than or equal to 20 dB HL) on the contralateral side.
Bilateral Implantation or Devices	<ul style="list-style-type: none"> ▪ Bilateral symmetrical conductive or mixed hearing loss with a PTA bone conduction threshold less than or equal to 65 dB HL, or level appropriate for model to be implanted, in each ear using the four-frequency average of 500, 1000, 2000 and 4000 Hz; and ▪ Bone conduction threshold of less than or equal to 15 dB HL average difference between ears.

6.3.D. PRIOR AUTHORIZATION

Bilateral device implantation or dispensing requires PA.

All Ages	<p>The following documentation, dated within six months prior to the surgical implantation or dispensing of the device, must be submitted with the MSA-1653-B:</p> <ul style="list-style-type: none"> ▪ Complete audiology report (i.e., pure-tone audiogram) that defines the type and degree of hearing loss in each ear.
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	<ul style="list-style-type: none"> ▪ History of hearing aid use or documentation supporting inability to use an air-conduction hearing aid. ▪ Letter from treating otolaryngologist stating medical need.
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6.3.E. DOCUMENTATION

Applicable documentation to be maintained in the beneficiary's record includes:

- Complete audiology report (e.g., pure-tone audiogram) that defines the type and degree of hearing loss in each ear.
- History of hearing aid use or documentation supporting inability to use an air-conduction hearing aid.
- Letter from treating otolaryngologist stating medical need.

6.3.F. REPAIRS, ACCESSORIES, AND REPLACEMENT PARTS STANDARDS OF COVERAGE

Replacement of the internal implanted BAHD or external sound processor is covered in cases when the audiologist or physician (i.e., otolaryngologist) indicates the function of the device has failed and is no longer under warranty. Documentation from the licensed audiologist or physician to substantiate the need for the replacement must be submitted with the MSA-1653-B. Payment for the sound processor includes an initial supply of batteries.

BAHD accessories, replacement parts, and repairs may be covered when dispensed by a cochlear implant manufacturer and applicable standards of coverage have been met. All charges for BAHD accessories, replacement parts, and repairs are to reflect no more than the usual and customary (U&C) charge to the general public.

Implant or Sound Processor Repair or Replacement	<p>Implants and external sound processors may be repaired or replaced when all the following apply:</p> <ul style="list-style-type: none"> ▪ The device was in continuous use prior to the repair or replacement. ▪ A licensed audiologist or physician substantiates the functional need for the repair or replacement. ▪ The device is FDA-approved. ▪ Replacements only: the device is out of warranty and worn for at least four years, or the device is irreparable or lost. <p>For replacement of a sound processor with an upgraded model, documentation must substantiate that the current model is obsolete or newer generation technology provides additional capacity for functional auditory-based improvement.</p>
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Accessories and Replacement Parts	<p>Accessories and replacement parts may be covered when all the following apply:</p> <ul style="list-style-type: none"> ▪ The accessory or replacement part is no longer covered by the manufacturer’s warranty. ▪ A licensed audiologist or physician substantiates the need for the item. ▪ The item will be used on a BAHD that was in continuous use prior to dispensing the item. ▪ The item will be used on an FDA-approved BAHD.
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6.3.G. REPAIRS, ACCESSORIES, AND REPLACEMENT PARTS PRIOR AUTHORIZATION REQUIREMENTS

Replacement of a BAHD external sound processor is not covered more frequently than once every four years. Replacements are not covered during the warranty period.

PA is required for the following repairs, accessories, or replacement parts:

- Bilateral external sound processors;
- BAHD repairs, accessories, or replacement parts when the sum of all charges for parts and repairs exceeds the daily reimbursement maximum published on the MDHHS Hearing Services Fee Schedule;
- BAHD repairs, accessories, or replacement parts when the sum of all charges for parts and repairs within the past year exceeds the yearly reimbursement maximum published on the MDHHS Hearing Services Fee Schedule;
- Items exceeding the frequency maximums indicated on the Bone Anchored Hearing Device Replacement Parts and Accessories list. (Refer to the Directory Appendix for website information.)

Some replacement parts are not subject to these reimbursement maximums. Refer to the Bone Anchored Hearing Device Replacement Parts and Accessories list. (Refer to the Directory Appendix for website information.)

All Ages	<p>The following documentation, dated within six months prior to the dispensing of the part or repair, must be submitted with the MSA-1653-B:</p> <ul style="list-style-type: none"> ▪ Documentation from the licensed audiologist and/or other medical professional to substantiate the need for the part(s) and/or repair. ▪ Manufacturer’s invoice itemizing the materials used to repair the device and the rationale for any related labor costs.
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6.3.H. REPLACEMENT PART MAXIMUMS

A list of approved BAHD replacement parts and maximums is available on the MDHHS website. (Refer to the Directory Appendix for website information.)



6.3.I. NON-COVERED ITEMS

Repair or replacement of spare equipment (e.g., old parts and accessories in working condition for back-up use in emergencies) is not covered.



HOME AND COMMUNITY BASED SERVICES

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SECTION 1 – GENERAL INFORMATION

1.1 OVERVIEW

On January 16, 2014, the Centers for Medicare & Medicaid Services (CMS) released the Home and Community Based Services (HCBS) Final Rule (CMS 2249-F/2296-F). The HCBS Final Rule specifies requirements for programs offering HCBS under the 1915(c), 1915(i), 1915(k), some 1915(b)(3) and 1115 authorities of the Social Security Act. These requirements, as further specified in this chapter, aim to improve the quality of the lives of individuals, allowing them to live and receive services in the least restrictive setting possible with full integration in the community. The Michigan Department of Health and Human Services (MDHHS) is responsible for ensuring all requirements are met.

The HCBS Final Rule includes the following:

- Requirements for the person-centered planning process to ensure individuals are involved in planning their services and supports to the maximum extent possible and that their wishes are reflected in the person-centered service plan.
- Requirements for HCBS and the settings in which they are provided. Settings in which individuals live (residential) and settings where individuals go to receive services (non-residential) are affected by the HCBS Final Rule. The settings requirements aim to ensure community integration and to ensure individuals receiving Medicaid HCBS have the same opportunities as individuals in those settings who are not receiving Medicaid HCBS.
- Allows CMS to approve or renew demonstration and waiver programs for five years if individuals are dually eligible for Medicare and Medicaid.
- Requires a 30-day public notice and comment period, including at least one non-electronic form of communication, for:
 - Substantive changes, including but not limited to, revisions to services available under the waiver including: elimination or reduction of services, or reduction in the scope, amount, and duration of any service; a change in the qualifications of service providers; changes in rate methodology; or a constriction in the eligible population; and
 - Any significant proposed change in its methods and standards for setting payment rates for services in accordance with federal law.
- Allows states to combine target groups based on diagnosis, disability, Medicaid eligibility groups, and/or age under one waiver authority.
- Provides requirements for independent assessment. This is a face-to-face assessment, conducted by a conflict-free individual or agency. The assessment is based on the individual's needs and strengths and is part of the person-centered planning process. Telemedicine is an acceptable method of assessment. Federal statute requires the State to provide for an independent assessment of need to establish a person-centered service plan. The assessment must be conducted at least every 12 months, or as requested by the individual or his/her representative, and/or as needed when there is a significant change in the individual's services or support needs. The individual's person-centered service plan must be updated to reflect this change in needs. For more information, refer to the federal regulation.



- Clarifies the scope of the term “individual representative.” An individual representative may be:
 - The individual’s legal guardian or other person authorized by state law to represent the individual in decision-making related to the individual’s care or well-being. CMS offers that, in instances where state law gives decision-making authority to an individual representative, the individual receiving services will lead the person-centered planning process where possible and the individual representative will participate as needed and desired by the individual receiving services;
 - Any other person authorized under federal law or state policy to represent the individual, including but not limited to a parent, family member, or other advocate; and
 - If the representative is authorized by the state, the state must have policies in place that describe the authorization process, the extent of the decision-making authority, and safeguards to ensure the representative is acting on behalf of the individual with exceptions in cases where the individual’s wishes cannot be determined or if the individual’s wishes would be harmful.

1.2 EFFECTIVE DATE

The HCBS Final Rule was effective March 17, 2014. With the exception of the Home and Community Based (HCB) settings requirements, all topics covered by the HCBS Final Rule were effective on this date. The HCBS Final Rule requires programs approved by CMS after March 17, 2014, to be in immediate compliance with the entire HCBS Final Rule, including the settings requirements. The MI Health Link HCBS Waiver was initially approved by CMS for January 1, 2015, and must be in immediate compliance with the HCBS Final Rule.

Programs in existence before March 17, 2014 must be compliant with the federal HCB Settings Requirement on or before March 17, 2022:

- MI Choice Waiver
- Habilitation Supports Waiver
- Children’s Waiver Program
- Children with Serious Emotional Disturbance Waiver Program
- Managed Specialty Services and Supports Waiver Program

Providers should refer to the relevant program chapter in this manual for requirements unique to that program.



SECTION 2 – PERSON-CENTERED PLANNING

The HCBS Final Rule provides guidance regarding the person-centered planning process. The HCBS Final Rule requires the individual to direct the process and lead it to the extent possible and desired by the individual, with participation of people chosen by the individual and to the extent desired by the individual. The individual's representative, if applicable, should have a participatory role as needed and defined by the individual unless decision-making authority has been granted to the representative by State law. The person-centered planning process must:

- Occur in a timely manner and at times and locations of the individual's choosing;
- Provide information and support to the individual in order to ensure maximum direction from the individual and to enable informed choice;
- Provide an informed choice of supports and identify who provides them;
- Include a mechanism to request updates in the plan;
- Document alternative(s) considered but not chosen;
- Include strategies for resolving disputes and identifying conflicts of interest; and
- Be free from conflict of interest, meaning those persons who have an interest in or are employed by a provider of HCBS for the individual must not be involved in case management or development of the person-centered service plan, except when the State demonstrates that the entity is the only willing and qualified entity available to complete these functions and also provide HCBS.

The person-centered service plan must be in written format and signed by the individual and his/her representative, as applicable, and providers responsible for the implementation of the plan (at a minimum, this includes the person or entity responsible for coordinating the individual's services and supports). The person-centered service plan must be distributed to the individual and any others involved in the plan. The plan must be reviewed at least every 12 months, or more frequently if the individual chooses or has a change in service needs.

The person-centered service plan must:

- Reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need;
- Include what is important to the individual regarding their preferences for the delivery of the services and supports;
- Reflect that the individual has chosen the setting in which he or she resides, also including non-disability specific settings;
- Reflect the individual's strengths and preferences;
- Reflect the clinical and support needs as identified through an assessment of functional need;
- Include individually identified goals and desired outcomes;
- Reflect services and supports that will assist the individual to achieve the identified goals, and identify the providers of those services and supports;



- Reflect risk factors and measures in place to minimize them, including backup plans and strategies;
- Identify the person or entity responsible for monitoring the plan;
- Be finalized and agreed to with the informed consent of the individual;
- Include self-directed services;
- Prevent the provision of unnecessary or inappropriate services and supports;
- Document that any modifications of the HCB settings requirements are based upon a specific assessed health and safety need and justified in the person-centered service plan:
 - Identify the specific assessed need(s);
 - Document the positive interventions and supports used previously;
 - Document less intrusive methods that were tried and did not work, including how and why they did not work;
 - Include a clear description of the condition that is directly proportionate to the assessed need;
 - Include regular collection and review of data to measure the effectiveness of the modification;
 - Include established time limits for periodic review of the modification;
 - Include informed consent of the individual; and
 - Include assurances that the modifications will cause no harm to the individual.

The person-centered service plan must be written in plain language that is easily understood by the individual and others supporting him/her. The language in the service plan must also be understandable by individuals with disabilities and those with limited English proficiency, in accordance with federal law.



SECTION 3 – HOME AND COMMUNITY BASED SETTINGS

3.1 CHARACTERISTICS OF A HOME AND COMMUNITY BASED SETTING

Through the HCBS Final Rule, CMS imposed certain requirements for HCB settings which consist of those settings where individuals live (residential settings) and those where individuals go to receive services (non-residential settings). All HCB settings where people live or receive Medicaid HCBS must have the following characteristics to the same extent as those individuals not receiving Medicaid HCBS:

- Be integrated in, and support full access to, the greater community, including opportunities to seek competitive and integrated employment, control of personal resources, and access to community services;
- Be selected by the individual from among a variety of setting options and, for residential settings, consistent with the individual's available resources to pay for room and board;
- Ensure individuals have the right to privacy, dignity and respect, as well as freedom from coercion and restraint;
- Optimize but not regiment the individual's autonomy and independence in making life choices regarding what they participate in and with whom; and
- Facilitate the individual's choice of services and supports, as well as who provides them.

When an individual chooses to receive Medicaid HCBS in a provider-owned and/or -controlled setting where the provider is paid a single rate to provide a bundle of services, the individual is choosing that provider, and cannot choose an alternative provider, to deliver all services that are included in the bundled rate. For any services that are not included in the bundled rate, the individual may choose any qualified provider, including the provider who controls or owns the setting, if the provider offers the service separate from the bundle. Any home owned or leased by a provider must adhere to the additional requirements described in federal law.

Settings that are presumed to not meet the HCB settings requirements are:

- Those in a publicly- or privately-owned facility providing inpatient treatment;
- On the grounds of, or adjacent to, a public institution; or
- Any that otherwise have the effects of isolating individuals from the broader community of individuals who are not receiving Medicaid HCBS.

Settings that are on the grounds of, or adjacent to, a private institution are not automatically presumed to have the characteristics of an institution. However, if the setting isolates the individual from the broader community (or otherwise has the characteristics of an institution) or fails to meet the characteristics of an HCB setting, the setting would **not** be considered to be compliant with the regulation.



All settings, including facility- or site-based settings (e.g. pre-vocational services in a facility-based setting such as a sheltered workshop or dementia-specific adult day care centers) must demonstrate the qualities of HCB settings, ensure the individual's experience is HCB and not institutional in nature, and does not isolate the individual from the broader community. In particular, if the setting is designed specifically for people with disabilities, or individuals in the setting are primarily or exclusively people with disabilities and on-site staff provides many services to them, the setting may be isolating unless the setting facilitates and encourages people going out into the broader community.

3.1.A. REQUIREMENTS FOR RESIDENTIAL SETTINGS

The requirements for residential settings apply to provider-owned or controlled settings. An individual's private home is presumed to be compliant with the HCB requirements. Individuals receiving Medicaid HCBS shall enjoy the same rights, protections and assurances in all living arrangements as those not receiving Medicaid HCBS.

3.1.A.1. MEALS

Individuals must have access to food at any time. This does not mean the residential setting must be prepared to make a full meal at any time, but the individual must have access to some type of food when he/she chooses. The type of food offered must be something that the individual likes to eat.

3.1.A.2. VISITORS

Individuals must be allowed to have visitors of their choosing at any time.

3.1.A.3. LOCKABLE DOORS

Residential settings must have bedroom and bathroom doors that are lockable by the individual, with only appropriate staff having keys to the doors. The doors must be lockable from the inside of the room and equipped with positive-latching, non-locking-against-egress hardware. This means the door should open from the inside in one single motion such as the turn of the knob or handle. If a setting has private bedrooms that include private bathrooms, only the main door to the bedroom/unit must be lockable, though MDHHS encourages that both the bedroom door and bathroom door be lockable.

3.1.A.4. FREEDOM TO FURNISH AND DECORATE ROOM

Individuals must have the freedom to furnish and decorate their room however they choose. In the case of a shared room, the furnishings and decor may be a collaborative effort with roommates.

3.1.A.5. CHOICE OF ROOMMATE

Individuals must have their choice of roommate if possible. In some circumstances, there may only be limited beds available at the residence so if the individual chooses that setting, he/she may also be choosing that bed without the ability to choose the roommate. Different arrangements may be made as the individual continues to live in that setting.



3.1.A.6. FREEDOM TO CONTROL SCHEDULE, ACTIVITIES AND RESOURCES

Individuals must have freedom to control their own schedules, activities and resources to the extent they desire. If they choose to receive assistance, that should be provided as needed and desired by the individual.

3.1.A.7. PRIVACY

Individuals must have privacy in their unit. This includes physical privacy as well as keeping any of the individual's confidential information private. Protected health information and other confidential personal information must not be kept in an open, common, unlocked area.

3.1.A.8. ACCESSIBILITY

Each setting must be physically accessible to the individuals residing there so the individuals may function as independently as they wish. Individuals must be able to move around in the setting without physical barriers getting in their way. This is especially true for individuals utilizing wheelchairs or who require walking aids. Furniture must be placed in such a way that individuals can easily move around it, with pathways large enough for a wheelchair, scooter or walking aids to navigate easily if individuals with these types of mobility aids reside in the setting.

3.1.A.9. EVICTIONS AND APPEALS

Individuals receiving services must have a lease or other legally enforceable agreement that offers comparable responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city or other locality.

For settings in which landlord/tenant laws do not apply, MDHHS or its designee must ensure that a lease or other written agreement is in place for each individual and that the lease or agreement provides protections that address eviction processes and appeals similar to that of landlord/tenant laws.

3.1.A.10. HOUSE RULES

Although house rules are optional under State of Michigan licensing rules for Adult Foster Care and Homes for the Aged, for the purposes of the HCBS Final Rule, house rules will not be permitted.

3.1.A.11. CONTROL OF PERSONAL RESOURCES

The HCBS Final Rule requires that individuals be able to control their personal resources.

3.1.B. REQUIREMENTS FOR NON-RESIDENTIAL SETTINGS

The requirements of non-residential settings apply to provider-owned or -controlled settings. Individuals receiving Medicaid HCBS shall enjoy the same rights, protections and assurances as others receiving the same service.



3.1.B.1. SKILL-BUILDING ASSISTANCE

Skill-building assistance must provide opportunities for regular meaningful non-work activities in integrated community settings for the period of time desired by the individual. This service assists individuals in increasing their self-sufficiency or to develop the skills needed to engage in meaningful community-based activities such as school, work or volunteer activities.

3.1.B.2. COMMUNITY LIVING SUPPORTS

Community Living Supports (CLS) must promote community inclusion and participation and facilitate an individual's independence and productivity. Services should provide opportunities for integration with the community and participation in activities comparable to activities for individuals of similar age or with similar interests who do not receive Medicaid HCBS.

3.1.B.3. SUPPORTED EMPLOYMENT

Supported employment provides a combination of ongoing support and paid employment that enables the individual to work in the community. Setting options offered should include community-based, integrated work settings where individuals with disabilities work alongside other individuals who do not have disabilities.

3.1.B.4. ADULT DAY CARE

Adult day care programs must offer activities for individuals receiving Medicaid HCBS that are comparable to those tasks and activities for individuals of similar age and ability who are not receiving Medicaid HCBS. There also must be interaction between individuals receiving Medicaid HCBS and those not receiving Medicaid HCBS. Services must provide an opportunity for integration with the larger community. Individuals must not be kept from moving around inside or outside of the non-residential setting. If individuals require supervision to move about the setting or go outside, that supervision must be provided.

3.2 SETTINGS NOT COMPLIANT WITH THE HCBS FINAL RULE REQUIREMENTS

Some settings have been identified by CMS as not HCB due to institutional status and will never be considered HCB. These settings are:

- Nursing facilities
- Institutions for mental disease
- Intermediate care facilities for individuals with intellectual disabilities
- Hospitals
- Other locations that have characteristics of an institution (e.g., Child Caring Institutions)



3.3 REVERSE INTEGRATION

According to the HCBS Final Rule, reverse integration does not make a setting HCB. Reverse integration is when the setting brings providers into the setting from the community instead of taking the individual out to the provider. For example, medical providers, members of clergy, hairstylists, or nail artists, among others, are brought into the setting. While it is acceptable to have providers such as these come into the setting, this must not be the only contact with community providers allowed for individuals receiving services. Individuals must also have the option to go out into the community and participate with providers of their choosing.

3.4 REMEDIATION OF SETTINGS AND RELOCATION OF INDIVIDUALS

Based on review by MDHHS, some residential and non-residential settings that are not institutions may be considered to be non-compliant with the HCBS Final Rule due to not meeting the characteristics of an HCB setting as defined by CMS. The State and its contracted entities will work with these settings to bring them into compliance if the setting owner chooses to be compliant. If the setting owner declines to come into compliance with the HCBS Final Rule, the State and its contracted entities will work with affected individuals to transition to a different setting that is compliant. As applicable, individuals must be provided with compliant residential or non-residential options from which to choose. If the individual does not want to move to a different, compliant setting, he/she will be disenrolled from the Medicaid HCBS program.

Timeframes for relocation of individuals and continued program participation are dependent on the aforementioned CMS requirements for whether the specific program is considered new or existing as of the effective date of the HCBS Final Rule. Refer to the program chapter of this manual for specific requirements unique to that program.

3.5 HEIGHTENED SCRUTINY

The State and CMS have a process for "heightened scrutiny" which consists of further review of any settings that wish to participate and are considered compliant with the HCBS Final Rule with all characteristics except some, such as location of the setting close or connected to an institution. This will involve MDHHS and its contracted entities gathering evidence of potential compliance and submitting this to CMS for final approval.

MDHHS is responsible for determining if a setting qualifies for the "heightened scrutiny" process through its assessments of the setting that appears to have qualities which are HCB and does not have qualities that are institutional in nature. MDHHS will request that this type of setting go through the "heightened scrutiny" process with CMS. Only a setting that can comply 100 percent with the federal HCB Settings Requirement will be submitted to CMS for "heightened scrutiny" process.

A setting that will require heightened scrutiny has at least one of the following characteristics:

- Settings located in a building that is also a publicly- or privately-operated facility that provides inpatient institutional treatment.
- Settings in a building on the grounds of, or immediately adjacent to, a public institution.
- Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS.



3.6 NEW SETTINGS

All new settings (either newly established or new to the specific program) must be immediately compliant with the HCBS Final Rule. Determination of a new setting's compliance with the HCBS Final Rule must be determined after the setting is built and has been operational with residents or individuals receiving services in order for the evaluating entity to have a full understanding of the individual's experience while participating with the setting.

3.7 NEW PROVIDERS

Effective October 1, 2017, any new HCBS provider and their provider network must be in immediate compliance with the federal HCBS Final Rule in order to render services to Medicaid beneficiaries. This requirement does not apply to existing providers and their provider networks who rendered HCBS to Medicaid beneficiaries before the effective date of this requirement. The Michigan Department of Health and Human Services (MDHHS) will continue to work with existing providers towards coming into compliance with the federal HCBS Final Rule as specified in the State Transition Plan.

In order to comply with the federal HCBS Final Rule, new providers must:

- Ensure individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Enhance independence;
- Enhance independence in making life choices;
- Enable choice regarding services and who provides them; and
- Ensure that the setting is integrated in, and supports full access to, the greater community.

New residential providers must demonstrate that services are delivered within a setting affording the beneficiary sufficient opportunity and choice to engage with the broader community by ensuring that the:

- Setting is selected by the individual from among setting options;
- Individual has a lease or other legally enforceable agreement providing similar protection;
- Individual has privacy in his/her unit, including lockable doors;
- Individual has a choice of roommates (if applicable) and freedom to furnish or decorate the unit;
- Individual controls his/her own schedule, including access to food at any time;
- Individual can have visitors at any time; and
- Setting is physically accessible.

New non-residential providers must demonstrate that services are delivered within a setting affording the beneficiary sufficient opportunity and choice to engage with the broader community by ensuring that the setting:

- Does not isolate the individual from the broader community; and
- Is not institutional in nature or has the characteristics of an institution.



3.8 ONGOING MONITORING

The State and its contracted entities are responsible for conducting ongoing monitoring activities to ensure settings remain in compliance with the HCBS Final Rule. Refer to the program chapter of this manual for specific requirements unique to that program.



HOME HEALTH

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SECTION 1 – GENERAL INFORMATION

This chapter applies to Home Health providers.

Home health is a covered Medicaid benefit for beneficiaries whose conditions do not require continuous medical/nursing and related care but do require health services on an intermittent basis for the treatment of an injury, illness, or disability. Medicaid covered services may be provided in any setting in which normal life activities take place. 'Normal life activities' refers to activities that could occur in or out of an individual's home. Except as detailed in this chapter, the beneficiary's primary need must be for nursing care, physical therapy and/or home health aide services rather than personal care or physician's care.

A Home Health Agency (HHA) is an organization that provides home care services, such as skilled nursing care, physical therapy (PT), occupational therapy (OT), speech therapy (ST) and care by home health aides. The HHA must be Medicare certified to enroll as a Medicaid provider and must comply with the Medicare/Medicaid Conditions of Participation (42 CFR § 484) and the policies outlined in this manual.

Services solely to prevent an illness, injury or disability are only covered for women/newborns following delivery. For postpartum/newborn follow-up nurse visits, a nursing diagnosis can be used to establish medical necessity. Otherwise, a medical diagnosis is required to establish medical necessity. Medicaid beneficiaries are expected to be an active participant in the planning for their home health care. For beneficiaries enrolled in a Medicaid Health Plan (MHP) or Integrated Care Organization (ICO), the HHA must contact that health plan for authorization to provide services to their members.

Medicaid home health services must be ordered, in writing, by the beneficiary's attending physician (MD, DO) as part of a written plan of care (POC) and reviewed by this physician every 60 days. The physician's order and POC must be only for functions that are within the scope of his current medical practice and Medicaid guidelines.

This chapter includes information about services covered for Medicaid and Children's Special Health Care Services (CSHCS) beneficiaries unless otherwise noted.

Private Duty Nursing (PDN) is not covered under the Home Health benefit.

1.1 FACE-TO-FACE ENCOUNTER

A physician certifying eligibility for home health services must provide documentation of a face-to-face encounter with the beneficiary within 90-days prior to or 30-days after the start of care. The face-to-face encounter may occur through telehealth in compliance with Section 1834(m) of the Social Security Act.

NOTE: The face-to-face encounter requirement pertains only to initial certification for home health services.

Only a physician may order home health services and certify a beneficiary's eligibility for the benefit. The face-to-face encounter ensures that the orders and certification for home health services are based on



current knowledge of the beneficiary's clinical condition, and will identify the primary reason for home health services.

In a situation where a physician orders home health services based on a new condition that was not evident during a visit within the 90-days prior to the start of care, the certifying physician or non-physician practitioner (NPP) must see the beneficiary within 30 days of admission to home health services.

The certifying physician must document the face-to-face encounter regardless of whether the physician or a permitted NPP performed the encounter. When the face-to-face encounter is performed by a NPP, he/she must document the clinical findings of the face-to-face encounter and communicate those findings to the physician; the physician must then sign the certification.

Permitted NPPs include:

- A nurse practitioner or clinical nurse specialist (as defined in section 1861(aa)(5) of the Social Security Act) who is working in collaboration with the physician in accordance with state law;
- A certified nurse-midwife (as defined in section 1861(gg) of the Social Security Act, as authorized by State law); or
- A physician assistant (as defined in section 1861(aa)(5) of the Social Security Act) under the supervision of the physician.

Documentation of the face-to-face encounter must reflect the certifying practitioner's assessment of the beneficiary and include:

- Date of the encounter,
- Primary reason for the encounter (medical condition),
- Clinical findings that support the need for skilled nursing, therapy, or home health aide services, and
- Clinical findings that support home health eligibility.

An addendum may consist of clinical documents from a hospital or post-acute facility (e.g., emergency visit record or discharge summary). It is allowable for the certifying physician to use such a document as an addendum for the face-to-face encounter if:

- The addendum contains all the documentation requirements for face-to-face documentation; and
- The certifying physician signs and dates the addendum, demonstrating that the certifying physician received that information from the allowed NPP or physician who performed the face-to-face encounter, and that the certifying physician is using that addendum document as his/her documentation of the face-to-face encounter.

While typically the same physician will certify, establish and sign the POC, it is allowable for physicians who attend to the beneficiary in the acute and post-acute settings to certify the need for home health care based on their face-to-face contact, initiate the orders (POC) for home health services, and "hand off" the beneficiary's care to the community-based physician to review and sign off on the plan of care.



SECTION 2 – SERVICE SETTING

Home health services are intended for beneficiaries who are unable to access services (nursing, OT, PT, speech and language pathology therapy [ST]) in an outpatient setting. However, it is not required that beneficiaries be totally restricted to their home but may be provided, as appropriate, in any setting in which normal life activities take place. A determination and documentation are required by the HHA to validate the beneficiary's eligibility and need for home health services. Home health services are **not** provided solely on the basis of convenience.

All covered home health services may be rendered in a beneficiary's home or any setting in which normal life activities take place, except for those services listed below. Home may be the beneficiary's owned/rented home, an apartment, Assisted Living Facility, Adult Foster Care (AFC) facility, or home of another family member (secondary residence of the beneficiary, i.e., joint custody situation for a minor child).

- Home Health aide services are not a covered benefit for beneficiaries who reside in a Home for the Aged (HFA) or AFC facility as this would be duplication of personal care services already provided by staff of these facilities.
- Michigan Department of Health and Human Services (MDHHS) does not cover any Home Health services rendered to a beneficiary in a hospital, nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Intermediate Care Facility for the Mentally Ill (ICF/MI), school, adult day care, or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

To determine if home health services, rather than outpatient services, are most appropriate, consider the following:

- Are home health services necessary for the adaptation, training or teaching of nursing or treatment procedures, plans, equipment, appliances or prosthetics?
- Are home health services necessary to prevent undue exposure to infection and/or stress for the beneficiary as identified and documented by a health care professional?
- Is leaving the home medically contraindicated, as identified and documented by a health care professional?
- Are home health services necessary to prevent a documented problem with access to services, continuity of care or provider, or coordination of services, as documented by a health care professional?
- Are home health services the most cost-effective method to provide care?

Services must be appropriate and medically necessary for the treatment of an identified illness, injury or disability. The services provided must be consistent with the nature and severity of the beneficiary's illness, injury or disability, particular medical needs, and accepted standards of medical practice. Beneficiaries with established frail conditions may need assessments by skilled nurses to prevent further decline of the frail condition.



SECTION 3 – PLAN OF CARE

The plan of care (POC) must include the mandatory elements required under Medicare CoP regulations at 42 CFR §484.60. The Medicare CoP POC elements represent the minimum information that must be included in each home health beneficiary's POC.

MDHHS requires home health providers must also include the following:

- Date of the first visit the HHA made for the new admission.
- Start date of care when the HHA began providing home care and the certification period. (This date remains the same on subsequent POCs until the beneficiary is discharged from home health care services.)
- Other identified resources used by the beneficiary (e.g., Area Agency on Aging, Protective Services, Home Help services, MI Choice Waiver).
- Name, address and provider NPI number of the HHA, and beneficiary's name, date of birth, and Medicaid ID number.
- The attending physician's signature and date of signature. The POC must be signed and dated by the beneficiary's attending physician before the HHA submits a claim to MDHHS for payment.
- Specific circumstances, conditions, or situations that require services to be provided in the home and not in a physician's office or outpatient clinic.

If the physician orders Home Health aide services and the beneficiary is also receiving personal care through another entity (Home Help Program, MI Choice Waiver), there must be a coordination between the two entities and documentation in the POC to verify there is no duplication of services. (Refer to the Personal Care Section of this chapter for additional information.)

- Date of most recent hospitalization, if applicable.

If Home Health aide services are ordered, an assessment of the family's ability and willingness to perform the services must be made and included in the POC. If the family is unable to perform the services, the reason must be stated on the POC.

- Role of family or support person.
- Any additional items the home health agency or physician chooses to include.

If the attending physician signs the POC after the service(s) is rendered, there must be a pre-existing written or verbal order for the service(s) to be covered by Medicaid. If the service(s) is rendered prior to the date the physician dated the POC and there is no pre-existing written or verbal order, Medicaid does not cover the service(s) provided. The verbal order obtained from the ordering physician must contain the signature of the HHA staff person who obtained the verbal order and the date the verbal order was



received. All verbal orders must be countersigned and dated by the ordering physician before the claim is submitted to MDHHS for payment.

Ordering physicians must determine that medical/health services are medically necessary and/or appropriate. The authorization and subsequent provision of home health services will continue to be based on medical necessity, not the setting. Any increase in the frequency of services, addition of new services, or modifications of treatment during a certification period must be authorized by the attending physician and documented in the beneficiary's medical record by way of a verbal order or written order prior to the provision of the increased, additional, or modified treatment.

The POC signed by the attending physician, along with any written or verbal orders as needed, and progress notes must be retained in the beneficiary's medical record.



SECTION 4 – TRANSFERS AND DISCHARGE PLANNING

The HHA must develop a transfer or discharge plan at the time of admission to home health services. As identified in the Medicare CoP (42 CFR §484.50), the beneficiary shall be discharged from the Home Health program by the admitting HHA under the following conditions:

- The beneficiary acuity exceeds the HHA’s capabilities;
- The beneficiary or payer will no longer pay for home health services;
- The beneficiary no longer meets the criteria for medical necessity because the measurable outcomes and goals identified in the POC have been achieved;
- The beneficiary refuses services or elects to be transferred or discharged; OR
- The HHA provider cannot safely service the beneficiary in accordance with 42 CFR §484.50(d)(5).

It is the responsibility of the HHA to ensure continuity of care during transition or discharge to another HHA or entity (e.g., Home Help, MI Choice Waiver). The HHA’s strategies for a safe transition or discharge must be documented in the beneficiary’s medical record. The beneficiary’s medical record must also identify the HHA or other entity from which the transition or discharge occurred.

In some cases, the beneficiary may receive home health aide services and start receiving services concurrently from other entities (e.g., Home Help, MI Choice Waiver). In such instances, the HHA must document in the medical record other resources used by the beneficiary in the POC.



SECTION 5 – COORDINATION OF SERVICES

The HHA must ensure coordination in the delivery of services through an integrated process across all aspects of home health services. Integrated services encompass communication from all physicians and disciplines (e.g., skilled nursing and therapy services) as well as other entities (e.g., Home Help, MI Choice Waiver). The HHA must also provide ongoing training and education for the beneficiary and caregiver with respect to the care and services identified in the POC, as well as for the safe transfer into or discharge from the community services.

Throughout the care planning process, it is the responsibility of the HHA to ensure coordination of care and to avoid duplication of services (e.g., Home Help, MI Choice Waiver).



SECTION 6 – OUTCOME AND ASSESSMENT INFORMATION SET

The Centers for Medicare & Medicaid Services (CMS) requires Medicare certified HHAs to use a standard assessment data set, referred to as the Outcome and Assessment Information Set (OASIS). The requirement to collect and submit OASIS clinical data applies to all beneficiaries receiving Medicare and/or Medicaid home health services. This means beneficiaries under Medicaid traditional fee-for service (FFS), MHP, ICO, Children’s Waiver, Home and Community Based Services Waiver for the Elderly and Disabled (MI Choice Waiver), Habilitation Supports Waiver, Healthy Michigan Plan, and CSHCS who receive home health services are to have OASIS information collected by the HHA. Assessments for all beneficiaries are to be conducted in compliance with Medicare certification requirements.

The OASIS requirements do not apply if the HHA is providing only housekeeping/ chore services, prepartum and postpartum services, or if the beneficiary is under 18 years of age.

HHAs are also required to electronically transmit the OASIS data to the designated state agency responsible for collecting OASIS data in accordance with CMS specifications. MDHHS contracts with a vendor to provide OASIS transmission assistance. HHAs needing assistance with transmitting data to the state repository should contact the MDHHS contractor. (Refer to the Directory Appendix for contact information.)

The CMS rules for OASIS are published in the Federal Registers that are available online at the OASIS website. (Refer to the Directory Appendix for website information.)



SECTION 7 – POST-PAYMENT REVIEW

Ordering physicians must determine that medical/health services are medically necessary and/or appropriate. All home health services ordered are subject to review for conformity with accepted medical practice and Medicaid coverage and limitations. Post-payment reviews of paid claims may be conducted to assure that the services provided, as well as the type of provider and setting, were appropriate, necessary, and compliant with Medicaid policy. Post-payment review also includes verification that appropriate procedure codes were used to bill the services provided.

Post-payment review includes verification that all third-party resources were utilized to their fullest extent prior to billing MDHHS. If post-payment review reveals that MDHHS was billed prior to utilizing these resources and the HHA knew the beneficiary had other insurance coverage for the service rendered, it may be considered fraud.

The General Information for Providers Chapter of this manual contains additional information regarding post-payment review and fraud.



SECTION 8 – NURSING SERVICES

Nursing services are covered on an intermittent (separated intervals of time) basis when provided by, or under the direct supervision of, a registered nurse (RN). Nursing care provided by a licensed practical nurse (LPN) must be under the supervision of an RN, and the RN must co-sign the LPN's documentation.

A nursing visit may include, but is not limited to, one or more of the following nursing services:

- Administering prescribed medications that cannot be self-administered.
- Changing an indwelling catheter.
- Applying dressings that require prescribed medications and aseptic techniques.
- Teaching the beneficiary, available family member, willing friend or neighbor, or caregiver (paid or unpaid) to carry out all or some of the services, as detailed below.
- Observation and evaluation, as detailed below.

Intermittent (separated intervals of time) nurse visits are intended for beneficiaries who generally require nursing services on a short-term basis (typically 60 days or less) for the treatment of an acute illness, injury, or disability and who cannot receive these services in an outpatient setting. Intermittent nursing visits may last from 15 minutes to one or two hours and are reimbursed at a flat rate (i.e., Medicaid fee screen for a visit) regardless of the length of the visit.

Intermittent nurse visits are not covered for a beneficiary receiving Private Duty Nursing Services.

Intensive care (for cases that require five or more visits per week or beyond 60 days) may be reviewed by MDHHS during post-payment audit to determine if home care was medically appropriate and a cost effective alternative to institutional care.

Nursing services must be provided through the State Plan Medicaid program in accordance with established policy. MI Choice nursing services shall not duplicate services available through the Medicaid State Plan home health benefit, and under no circumstance shall the beneficiary receive both MI Choice and State Plan services concurrently. Waiver agencies cannot authorize payment for services that are (already) offered under the State Plan.

8.1 COVERED NURSING SERVICES

The following nursing services are covered home health care services. Limitations, conditions and special considerations are noted when applicable. (Refer to the Billing & Reimbursement for Institutional Providers Chapter of this manual for billing information.)

8.1.A. BLADDER TRAINING

When use of a catheter is temporary, visits made by the nurse to change the catheter must also include instruction to the beneficiary in bladder training methods. The actual bladder training (e.g., forcing fluids or other measures) does not require the skills of a nurse. After the catheter is removed, a limited number of visits (maximum two visits per month) are allowed to observe and evaluate the effectiveness with which the bladder training has been accomplished (e.g., the degree to which the bladder is emptying).



8.1.B. ENEMAS

Giving enemas usually does not require the skills of a nurse, and Medicaid does not cover such visits unless the physician has ordered that a nurse give the enema because of clinical indications.

8.1.C. EYE DROPS AND TOPICAL OINTMENTS

Two nurse visits are allowed to teach the administration of eye drops and topical ointments. Nurse visits solely to perform these services are not covered.

8.1.D. INTRAVENOUS INFUSIONS

If the beneficiary is in need of intravenous infusion and an infusion clinic or ancillary Medicaid provider (who has no nurse) does not cover the service, or family member/care giver will not accept this task, the HHA may perform this service and bill accordingly. Medicaid will reimburse claims for professional services (e.g., nursing services) associated with the administration of Medicare Part D drug(s) to dually eligible Medicaid/Medicare beneficiaries.

8.1.E. NEONATAL JAUNDICE

Nurse visits related to neonatal jaundice require supporting documentation in the beneficiary's medical record that the nurse visits are required for a specific medical condition. Supporting documentation should include pertinent laboratory values.

8.1.F. OBSERVATION/EVALUATION

If the attending physician determines that the beneficiary's condition is unstable and that significant changes may occur, Medicaid covers nurse visits for observation/evaluation. Once the beneficiary's condition has stabilized and there has been no significant change (e.g., no change in medication or vital signs, no recent exacerbation in the beneficiary's condition) for a period of three weeks, and no other necessary nursing services are being furnished, nursing visits solely for observation/evaluation are no longer covered.

Visits for observation/evaluation to ensure stability of a beneficiary who has an established disability or frail condition are covered by Medicaid if circumstances, conditions, or situations exist that prevent the beneficiary from obtaining services from a physician's office or outpatient clinic as described in the Home Setting Section of this chapter. Such visits are limited to two visits per month.

Nurse visits for observation/evaluation to insure stability of a beneficiary's condition cannot be billed within a 30-day period of an initial/subsequent postpartum/newborn follow-up nurse visit, suspected abuse nurse visit or aide visit.



If the beneficiary is enrolled in the MI Choice Waiver, a nurse visit for observation and evaluation to insure stability is not a home health covered service but a responsibility of the waiver staff. (Refer to the Directory Appendix for the website containing the regional map and addresses of the MI Choice Waiver agents.)

8.1.G. ORAL MEDICATIONS

Administration of oral medications does not usually require the skills of a nurse in the home setting. Visits are covered only if the complexity of the beneficiary's condition and/or the number of drugs prescribed require the skill or judgment of a nurse to detect and evaluate side effects (adverse reactions) and/or provide necessary teaching and instruction.

Placing medication in envelopes/cups, giving reminders, etc., to assist the beneficiary in remembering to take them does not constitute a nursing service.

8.1.H. POSTPARTUM/NEWBORN FOLLOW-UP NURSE VISIT

Home visits for assessment, evaluation and teaching are covered for women and newborns following delivery when a physician has determined the mother or newborn may be at risk. The goals of these services include:

- Fostering a positive outcome for the mother and newborn by detecting medical complications manifested during the postpartum/newborn period;
- Instructing the mother in newborn care; and
- Identifying situations that may require intervention with medical and community resources.

The HHA must assess and document, in writing, that the beneficiary is receiving services by a Maternal Infant Health Program (MIHP) provider. If the HHA is also an enrolled MIHP provider, services for the mother and newborn cannot be billed as home health care but must be billed as MIHP services. If the beneficiary is receiving MIHP services from another provider and the HHA is also providing services, the POC must clearly identify why home health services are needed in addition to MIHP and that the two providers do not duplicate services.

Medicaid allows one initial postpartum visit, one initial newborn visit, and one subsequent visit to mother and newborn for a total of three visits per pregnancy.

- The initial postpartum visit must be billed using the mother's Medicaid ID number.
- The initial newborn visit must be billed using the newborn's Medicaid ID number.
- The subsequent visit may be billed under either the mother's ID number or newborn's ID number, based on the most time spent with each beneficiary.



8.1.I. PRENATAL NURSE VISIT

Medicaid covers home visits for a specific pregnancy related medical condition provided by a HHA.

Home visits provided for preventive health services which address psychosocial issues, provide education, provide transportation, etc. and that do not provide treatment for an illness or injury are a covered service of the MIHP, not Home Health.

8.1.J. ROUTINE PROPHYLACTIC AND PALLIATIVE SKIN CARE

The recognized stages of decubitus ulcers are classified as:

- Stage I - Inflammation or redness of the skin;
- Stage II - Superficial skin break with erythema of surrounding area;
- Stage III - Skin break with deep tissue involvement; and
- Stage IV - Skin break with deep tissue involvement with necrotic tissue present.

The existence of Stage III or IV decubiti or other widespread skin disorders may necessitate the skills of a nurse. The physician's orders for treating the skin determine the need for this service.

The presence of Stage I or II decubiti, rash, or other relatively minor skin irritations do not indicate a need for nursing care unless ordered by a physician. Bathing the skin, applying creams, etc. are not covered nursing services.

8.1.K. SUSPECTED ABUSE/NEGLECT

If there is reasonable cause to suspect that a beneficiary may be in danger of abuse, neglect, exploitation, cruelty, or other hazards, the HHA must report the suspected abuse to the Adult or Child Protective Services Unit of the local MDHHS office. (Refer to the General Information for Providers Chapter of this manual for additional information.)

Once suspected abuse is reported, the local MDHHS office can request supplemental home health visits to complement the protective services from MDHHS. Medicaid covers up to two home health visits for this purpose. The HHA must document in the beneficiary's medical record the county and the name of the individual MDHHS staff member who approved the request.

Approved visits must be ordered by the attending physician and documented in the beneficiary's medical record.

A nursing visit for suspected abuse cannot be billed within 30 days of an aide visit, an observation/evaluation, or an established disability or frail condition visit.



8.1.L. TEACHING AND TRAINING ACTIVITIES

HHA services are not covered if the beneficiary has a willing, available, and competent designated caregiver (e.g., family member, friend, neighbor, Home Help provider) that can demonstrate the ability for the beneficiary and/or designated caregiver to provide appropriate care. Medicaid does cover HHA teaching and training activities to enable the beneficiary to become independent of skilled care. The teaching of a procedure or service is covered if it is reasonable and necessary for the treatment of a specific illness, injury or disability.

If a beneficiary or available family member is mentally/physically able to be taught and utilize a particular procedure, and the nurse has completed the teaching but the beneficiary or available family member is subsequently noncompliant, a maximum of three additional teaching visits are allowed for reinforcement teaching. (Medicaid defines noncompliance as the failure or refusal to follow instructions related to improving or stabilizing a condition.)

Teaching visits are not covered if a beneficiary, family member, friend, or neighbor is not mentally or physically able to be taught and utilize a procedure or service as documented in the POC. In these cases, as well as when a caregiver could be taught but is not available or willing to be taught, aide visits (not nurse visits) may be covered to perform these services as long as other Medicaid coverage criteria are met.

Teaching and training activities covered by Medicaid include, but are not limited to:

- Giving an injection
- Prefilling insulin syringes
- Inserting/irrigating a catheter
- Administering eyedrops/topical ointments
- Caring for a colostomy or ileostomy
- Administering oxygen
- Preparing and following of a therapeutic diet
- Applying dressings to wounds that require prescription medications and aseptic techniques
- Bladder training
- Bowel training (e.g., bowel incontinency, constipation due to beneficiary's immobility)
- Performing activities of daily living (e.g., dressing, eating, personal hygiene) for the beneficiary through use of special techniques and adaptive devices where the beneficiary has suffered a loss of function
- Aligning and positioning a bed-bound beneficiary
- Performing transfer activities (e.g., from bed to chair or wheelchair, wheelchair to bathtub)
- Ambulating by means of crutches, walker, cane, etc.



Medicaid reimbursement for teaching visits is based on whether the teaching provided in the home is a reinforcement of previous teaching or is initial instruction. If teaching constitutes reinforcement of training previously received, fewer visits should normally be required than for initial training.

Visits made solely to remind or emphasize to the beneficiary, family member, friend, or neighbor the need to follow the instructions are not covered services. However, visits to supervise and evaluate the practical application of training require the skills of a nurse and are considered reasonable and necessary where the complexity of the service being taught indicates such visits are warranted (e.g., insulin injections or preparation of formula feedings for gastrectomy beneficiaries).

Whether the teaching is reinforcement or initial, the nurse must establish the goal(s) or intended outcome(s) for the beneficiary and a reasonable period of time to attain them and document these in the POC. The beneficiary must be encouraged to become independent of skilled services in his home whenever feasible.

Visits for teaching and training activities solely to ensure stability or solely to prevent an illness, injury, or disability are only covered for beneficiaries who have an established or frail condition or for women/newborns following delivery, as detailed in previous sections.

Except as detailed above, visits solely for teaching designed to prevent an illness, injury, or disability are not covered. Visits for teaching must be necessary for the treatment of a specific illness. For example, instruction in the importance of good nutritional habits, exercise regimens, and good hygiene are not covered services in the absence of a specific supporting diagnosis of illness, injury, or disability.

8.2 NONCOVERED NURSING SERVICES

The following services are not covered as home health nursing services. As noted, they may be covered under another service.

8.2.A. BATHING

Bathing does not require the skills of a nurse and is not covered by the Medicaid home health benefit.

8.2.B. PREFILLING INSULIN SYRINGES

If the sole purpose of a nurse visit is to prefill insulin syringes, this service is not covered as a nursing visit.

This service is covered as an aide visit with a maximum of two visits per month. The Remarks section of the claim must state that the visit was for prefilling insulin syringes.

8.2.C. PSYCHIATRIC NURSING VISIT

Nursing visits for the primary purpose of providing a psychiatric nursing service are not a Home Health benefit covered by Medicaid, but may be covered under another Medicaid



program. Examples of noncovered nurse visits include psychiatric evaluation, psychotherapy, administration of psychotropic drugs, assessment of beneficiary's adjustment to a psychotropic drug, venipuncture to obtain specimen for psychiatric medication review, and nurse visit to prefill medication cups/boxes, giving reminders, etc., to assist the beneficiary in remembering to take psychiatric medication.

8.2.D. ROUTINE FOOT CARE

Medicaid does not cover nursing visits solely to provide routine foot care (e.g., removal of corns, calluses, trimming of nails). Nursing visits for the debridement of mycotic nails are not covered by the Medicaid home health benefit.



SECTION 9 – THERAPIES (OCCUPATIONAL, PHYSICAL AND SPEECH)

Medicaid covers home occupational therapy (OT) and physical therapy (PT) when medically necessary, reasonable, and necessary to help the beneficiary return to a previous functional level or to a functional level that is appropriate to a stable medical status. Under certain circumstances, home speech therapy (ST) is covered for children enrolled in Children's Special Health Care Services (CSHCS). Refer to the Therapy Services Chapter of this manual for additional information.



SECTION 10 – HOME HEALTH AIDES

Home health aide services may be rendered independently, and not contingent upon the need of skilled nursing or therapy services. Home health aide services are covered only when ordered by the attending physician and authorized according to Medicaid policy. The services provided by the home health aide must be medically necessary. Medicaid would not cover home health aide services solely for personal care needs, or for the convenience of the beneficiary. The POC must clearly outline the duties to be performed by the home health aide.

The HHA must identify the availability of other caregiver(s) (e.g., family member or another caregiver). The availability of the caregiver(s) must be identified in the POC. When a caregiver is providing services that adequately meet the member's needs, it is not medically necessary for the HHA to provide services. If the family or other entity is unable to perform the service, the reason must be fully documented in the POC. (Refer to the Personal Care Section in this chapter for additional information.)

10.1 HOME HEALTH AIDE PRIOR AUTHORIZATION

Home health aide services for Medicaid beneficiaries must be authorized by the MDHHS Program Review Division after the initial 90 days, and every 90 days thereafter if continued services are deemed medically necessary.

Prior authorization is required each time services are requested for:

- continuation of services beyond the initial 90 days;
- continuation of services beyond the end date of the current authorization period (renewal);
- an increase in services; or
- a decrease in services.

After the initial 90 days, home health aide services may be provided up to a maximum of 36 visits within 90 consecutive calendar days. If the beneficiary's attending physician orders home health aide services, the HHA must assess the availability of the family or another entity (e.g., Home Help Program or MI Choice Waiver) to perform the services. Physicians ordering home health aide services must determine that medical services are medically necessary and appropriate for continuation of services beyond the initial 90 days, and for each PA request thereafter.

In some cases, the beneficiary's attending physician may order home health aide services that extend beyond the maximum of 36 visits within 90 consecutive calendar days. For requests that extend beyond 36 or more visits within 90 consecutive calendar days, the PA request will be reviewed for medical appropriateness, the availability of the family or another entity (e.g., Home Help Program or MI Choice Waiver), and the cost effectiveness of other programs available for the beneficiary.

Following receipt and review of the Home Health Aide Prior Approval Request/ Authorization form (MSA-181) and the required documentation by the Program Review Division, a determination notification is sent to the HHA and beneficiary or primary caregiver indicating the outcome of the review. (Refer to the Forms Appendix for a copy of MSA-181.) If approved, the notification letter will contain the PA number and approved authorization dates.



It is important to include this PA number on every claim and in all other communications to the MDHHS Program Review Division.

If a beneficiary receiving home health aide services continues to require the services after the initial authorization period, a new MSA-181 must be submitted by the HHA along with the required documentation to support medical necessity for continuation of services beyond the approved authorization dates. This request must be received by the Program Review Division no less than 15 business days before the end of the current authorization period. Failure to do so may result in a delay of authorization for continued services which, in turn, may result in delayed services or no payment for services rendered without authorization. The length of each subsequent authorization period will be determined upon review by the Program Review Division and will be specific to each beneficiary based on several factors, including the beneficiary's medical and functional needs, personal care services through another entity (e.g., Home Help Program, waiver services, or other community services), and family or caregiver support.

10.1.A. DOCUMENTATION REQUIREMENTS

The following documentation is required for all initial PA requests for home health aide services and must accompany the MSA-181:

- documentation of the face-to-face encounter;
- all components of the POC as identified in 42 CFR §484 and MDHHS policy;
- OASIS; and
- other documentation as requested by MDHHS.

The documentation listed above is also required at subsequent 12-month intervals. The anniversary date is the date 12 months from the date services were first provided.

- For services beyond the initial authorized 90 days and for subsequent requests, the MSA-181, an updated POC complete with all components, and other documentation as requested by MDHHS must be submitted to the Program Review Division for review.
- If a beneficiary's condition changes during an authorization period warranting an increase or decrease in the number of approved hours or discontinuation of services, the HHA must report the change to the Program Review Division. It is important that the HHA report all changes as soon as they occur, as well as properly update the POC and written instructions for the home health aide.
- To request an increase in hours, the following are required:
 - an updated MSA-181 indicating the increase in hours;
 - an updated and signed POC; and
 - documentation from the attending physician.
- To request a decrease in hours, the following are required:
 - an updated MSA-181 indicating the decrease in hours; and
 - an updated and signed POC.



PA and documentation requirements apply to all Medicaid beneficiaries.

10.1.B. MEDICAL NECESSITY

Home health aide services must be reasonable to support the beneficiary's medical and functional needs based on the beneficiary's medical condition and associated symptoms. Documentation to support medical necessity must include the beneficiary's progress or lack of progress, medical condition, functional losses, and treatment goals (e.g., the POC). MDHHS identifies criteria for medical necessity as one or more of the following that directly impact the beneficiary's medical and functional needs:

- New onset or acute exacerbation of diagnosis (supportive documentation must include the date of the new onset or acute exacerbation);
- New or changed prescription medications (e.g., newly prescribed medications within the last 30 days or changed dosage, frequency, or route of administration within the last 60 days, including but not limited to diagnosis such as diabetes or hypertension);
- Recent hospitalizations (must include the date and reason for the hospitalization);
- Recent discharge from an acute or post-acute setting (e.g., skilled nursing facility);
- Change in caregiver status, absence of a caregiver, or unstable caregiving situation; or
- Complicating factors (e.g., presence of Stage III or IV decubiti).

The beneficiary's medical necessity must be clearly identified by the physician and documented in the POC. All PA requests will be considered on an individualized basis to determine medical necessity, reasonableness for home health aide services, and consistency with MDHHS policy.

10.1.C. BENEFICIARY ELIGIBILITY

Approval of the MSA-181 confirms that the service is authorized for the beneficiary. The approval does not guarantee that the beneficiary is eligible for Medicaid. If the beneficiary is not eligible on the date of service, MDHHS will not reimburse the provider for services provided and billed. To ensure payment, the HHA must verify beneficiary eligibility monthly at a minimum.

10.1.D. RETROACTIVE PRIOR AUTHORIZATION

Services provided before PA is approved will not be covered unless the beneficiary was not Medicaid eligible on the date of service but became eligible retroactively. If MDHHS eligibility information does not demonstrate retroactive eligibility, then the request for retroactive PA will be denied.

10.2 SUPERVISORY VISIT

The supervisory visit of the home health aide must be completed every 14 days to provide a more reliable and frequent supervision schedule with documentation of the supervisory visit in the beneficiary's medical record. The HHA RN must assign a home health aide to each beneficiary. It is the responsibility of the RN or other appropriate skilled professional (e.g., physical therapist, [PT], occupational therapist



[OT], speech therapist [ST]) to prepare written instructions for the beneficiary's care and to conduct home health aide supervisory visits every 14 days as follows:

- If the beneficiary is receiving skilled nursing services, the RN must complete the supervisory visit;
OR
- If the beneficiary is receiving only therapy services, the supervisory visit must be completed by the appropriate skilled professional (e.g., PT, OT, ST).

In some cases, the beneficiary may not be receiving skilled nursing or therapy services. In such cases, the RN must complete the supervisory visit of the home health aide no less than every 60 days. It is the responsibility of the supervising RN to co-sign all documentation completed by the Home Health aide. Each supervisory visit by the RN or other appropriate skilled professional must be documented in the beneficiary's medical record.

In accordance with 42 CFR §484.80, the HHA must ensure that the qualifications and training of the home health aide are sufficient to meet the individual needs of the beneficiary.



SECTION 11 – PERSONAL CARE

If the physician orders home health aide services and the beneficiary is also receiving personal care services through another entity (e.g., Home Help Program, MI Choice Waiver), there must be coordination between the two providers and documentation in the POC to verify that there is no duplication of personal care services.

It is the responsibility of the HHA to identify other services the beneficiary may be receiving to ensure the services of the home health aide and personal care services through another entity (e.g., Home Help, MI Choice Waiver) and to assess the ability of the family or caregiver to perform personal care services. For beneficiaries enrolled with another entity (e.g., Home Help Program or MI Choice Waiver), the HHA must contact the adult services specialist or the waiver agent to ensure coordination and verify services are not duplicative in nature, nor occur simultaneously.

11.1 HOME HELP PROGRAM

The Home Help Program provides unskilled personal care services (i.e., assistance with ADLs, IADLs) and other services allowed by the Home Help Program to assist eligible beneficiaries who are blind, disabled, or otherwise functionally limited. The beneficiary's adult services worker at the local MDHHS office arranges for these services with the personal care provider. The Home Health POC must clearly identify why the HHA services are required along with Home Help. Medicaid covers occasional follow-up HHA visits made to observe, evaluate and document the beneficiary's progress if ordered by the attending physician.

11.2 HOME AND COMMUNITY BASED SERVICES WAIVER FOR THE ELDERLY AND DISABLED

Medicaid's Home and Community Based Services Waiver for the Elderly and Disabled (MI Choice Waiver) covers those services to aged and disabled individuals (age 18 and over) who, without the provision of waiver services, would require nursing facility care. Examples of services are chore, respite, and emergency response systems.

MI Choice beneficiaries are identified in the eligibility response with the Benefit Plan ID of MI Choice-MC. (Refer to the Beneficiary Eligibility chapter for additional information.)



SECTION 12 – DURABLE MEDICAL EQUIPMENT (DME)/SUPPLIES

Durable Medical Equipment (DME), certain medical supplies, orthotic and prosthetic appliances, shoe supplies, and oxygen (gas and equipment) are covered services for HHA beneficiaries when providing medically necessary skilled nursing or aide services. HHAs are required to provide medically necessary equipment and supplies either directly or through arrangement with DME providers. These items must be supplied and billed by a Medicaid enrolled medical supplier, orthotist, prosthetist, shoe supplier, or oxygen supplier, except as noted below. The beneficiary's attending physician (MD, DO, DPM) must order these items in writing. These providers may have to obtain PA for certain services, and the services provided must be in accordance with Medicaid policies.

MDHHS encourages the HHA to submit the beneficiary's POC to the medical supplier to help support the need for the item.

Routine medical supply items are included in the reimbursement for the HHA's nurse or aide visit. No separate reimbursement for such supplies is allowed. These supplies include, but are not limited to:

- Band-aids
- Enema kits (e.g., Fleet)
- Gloves (sterile, nonsterile), up to four pair
- Simple dressing (including 10 4x4's and one roll of tape)
- Skin cleansers - swabs or wipes (e.g., iodine, alcohol, Betadine)
- Sterile solutions (up to 30 ml.)
- Syringes and needles
- Thermometers
- Cotton swabs, balls
- Specimen cups
- Suture removal kits
- Gowns

If the treatment regimen requires quantities beyond those listed above for gloves, simple dressings, or sterile solutions, the HHA or the medical supplier may bill separately for the additional quantities. The need for additional supplies must be documented in the medical record. These are items that may be left in the beneficiary's home between visits where repeated applications are required, and the applications will be performed by the beneficiary, family member, nurse, etc. Supplies billed to Medicaid must be dispensed to a specific beneficiary and must be ordered by the attending physician as part of a written POC.

The MDHHS Home Health Database, available on the MDHHS website, contains a list of medical supply items that may be billed separately from the nurse or aide visit. If the quantity needed is beyond what is listed on the Home Health Database, the supplies must be billed by a DME/Medical Supplier. (Refer to the Directory Appendix for website information.) HHAs choosing to provide routine medical supplies beyond what is listed on the MDHHS Home Health Database and other medically necessary equipment



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and medical supplies directly to beneficiaries receiving home health services must enroll with Medicaid as DME providers. (Refer to the General Information for Providers chapter and the Medical Supplier chapter for additional information).



SECTION 13 – NONCOVERED SERVICES

The services listed below are **not** covered under the home health program.

13.1 HOME UTERINE ACTIVITY MONITOR

Home health services related to the use of a home uterine activity monitor (HUAM) are not separately reimbursable. Reimbursement is made on a per diem rate to a medical supplier approved by MDHHS to provide this service. All equipment, perinatal nursing services, technical services, and supplies necessary for the provision of the HUAM are included in the rate.

13.2 DRUGS AND BIOLOGICALS

The cost of drugs and biologicals are not HHA benefits but may be covered by Medicaid. For information on PA for certain prescribed drugs, contact the MDHHS Pharmacy Benefits Manager (PBM). (Refer to the Directory Appendix for contact information.)

13.3 EVALUATION VISITS

Nursing or PT evaluation visits to assess the acceptance of the beneficiary by the HHA are not covered (e.g., adequacy of the environment for providing nursing care or PT in the home, ability and willingness of family members to meet the beneficiary's medical needs in the home setting, if the beneficiary meets Medicaid home health policy criteria). When the agency makes such an initial evaluation visit, the cost of the visit is considered an administrative cost of the agency and is not covered as a visit because the beneficiary has not been accepted for care by the HHA.

If, however, during the course of this initial evaluation visit the beneficiary is accepted by the HHA for care, and is also furnished the first service as ordered under the physician's POC, the visit becomes the first billable visit.

13.4 HOSPICE

MDHHS does not separately reimburse HHAs for services related to the beneficiary's terminal illness when the beneficiary is enrolled in a hospice program. All HHA services related to the beneficiary's terminal illness are either arranged for (contractual agreement), or provided by, the hospice program.

13.5 MEDICAL SOCIAL SERVICES

Medical social services are not a Medicaid covered HHA service.

13.6 MISSED VISITS

Missed visits are not covered. If a beneficiary is not home when HHA staff arrives to provide a service, MDHHS does not reimburse the agency for the missed visit. The HHA may not charge the beneficiary for a missed visit unless it is the HHA's normal practice to charge everyone for missed visits. (The HHA must notify the beneficiary, in advance, that the beneficiary is required to pay for missed visits.)



13.7 OXYGEN

The administration of oxygen is included in the cost of the nurse or aide visit and is not separately reimbursable.

Oxygen gas and equipment are Medicaid benefits when supplied and billed by an enrolled pharmacy, oxygen supplier, or medical supplier in accordance with Medicaid policy.



HOSPICE

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SECTION 1 - INTRODUCTION

This chapter applies to Hospice providers.

Hospice is a health care program designed to meet the needs of terminally ill individuals when the individual decides that the physical and emotional toll of curative treatment is no longer in their best interest. These individuals choose palliative care, which is not a cure, but ensures comfort, dignity and quality of life. Hospice is intended to address the full range of needs of the individual with a terminal illness, while also considering family needs. Care must be consistent with the individual's values, regardless of the location where care is provided.

The primary objective of the Medicaid Hospice Program is to ensure that essential medical/health services are available to those who would not otherwise have the financial resources to purchase them. Medicaid policies are designed to achieve this objective with fiscal responsibility. Hospice providers must verify eligibility before providing services. Hospice beneficiaries are identified in the eligibility response with the Benefit Plan ID of Hospice. (Refer to the Beneficiary Eligibility chapter for additional information.)



SECTION 2 - PROVIDER REQUIREMENTS

Hospice providers are bound to all rules, regulations, and policies specified in this chapter for program participation/enrollment of Medicaid beneficiaries. Hospice providers must also comply with the Medicare Conditions of Participation (42 CFR § 418) which generally apply to non-Medicare beneficiaries as well as to Medicare beneficiaries.

Additional information regarding federal Hospice requirements and guidelines is contained in the Centers for Medicare & Medicaid Services (CMS) State Operations Manual 2083.

The exceptions are 42 CFR § 418.60 and 42 CFR § 418.98(c) conditions that apply only to Medicare beneficiaries.

Michigan Department of Health and Human Services (MDHHS) requires Hospice agencies to be licensed in Michigan by the state-licensing agency, certified by Medicare, and enrolled in Medicaid. (Refer to the General Information for Providers Chapter of this manual for additional information.)

Hospice providers cannot engage in any of the following marketing-related practices:

- Provide cash, gift incentives, or rebates to prospective covered persons;
- Claim superior medical care or provider skills; or
- Make untruthful statements regarding the merits of the hospice.

The use of marketing practices that mislead, confuse, or defraud either the beneficiary or MDHHS is considered grounds for terminating the hospice from participation in Medicaid. Such actions may also result in investigation leading to possible prosecution under applicable State and Federal statutes.



SECTION 3 - BENEFICIARY ADMISSION

3.1 BENEFICIARY ADMISSION DETERMINATION

A terminally ill Medicaid beneficiary who lives in a hospice service area and whose life expectancy is six months or less (if the illness runs its normal course), as determined by a licensed physician and the Hospice Medical Director, has the option for admission into a hospice program. A representative, such as a spouse, parent, legal guardian, or other authorized adult, may act on behalf of the beneficiary.

Medicaid does not cover Hospice services if the following conditions exist:

- The individual is not eligible for the Medicaid benefit.
- The beneficiary does not meet the hospice's admission criteria.
- If the beneficiary is currently enrolled in a Medicaid Health Plan (MHP), the hospice services must be arranged and reimbursed by the MHP.

All Hospice admission activities must be conducted according to MDHHS policies and in such a manner as to maximize the beneficiary's ability to make a choice between admission into hospice or maintaining current active treatment with Medicaid coverage. Such activities must assure that the beneficiary fully understands how to use hospice services and that all care must be received from or through the hospice (except those services not related to the terminal illness or services provided by his attending physician).

It is imperative that the Hospice provider review the Conditions of Admission with the beneficiary and answer any questions raised by the beneficiary and/or authorized representative.

3.2 BENEFICIARY ADMISSION PROCESS

Hospice providers are responsible for admitting beneficiaries for hospice services in the Admission Information Section in CHAMPS. The admission process must be electronically completed in CHAMPS. A downloaded copy of the beneficiary's admission must be signed by the beneficiary and/or authorized representative, with a copy given to the beneficiary and/or authorized representative and the original copy retained in the beneficiary's record. Completion of the hospice beneficiary's admission in CHAMPS will result in real-time changes to the National Provider Identification (NPI) and the beneficiary's Program Enrollment Type (PET).

Hospice providers have the ability to track their current beneficiaries in CHAMPS via the Member Enrollment/Admission List screen. This roster screen will allow the provider to view beneficiary admission information and Medicaid status. Hospice providers must complete the hospice admission in a timely manner in CHAMPS in order to maintain an accurate roster, and to ensure the beneficiary has the correct PET and benefit plan assigned for correct payment.

A copy of the following information must be retained in the beneficiary's record:

- The original, signed copy of the Admission Certification.
- Hospice identification card (if the hospice chooses to issue one to their beneficiaries).



3.3 BENEFICIARY NOTIFICATION

Hospice providers must provide Medicaid beneficiaries with the following materials and written information within ten days of the effective date of admission into hospice:

- Conditions of admission, including:
 - Scope, content, and duration of coverage;
 - Beneficiary grievance procedure; and
 - Beneficiary responsibility for reporting coverage by any other insurance.
- Procedures for obtaining health care, including:
 - Address, telephone number, and service hours of the health care providers;
 - Emergency medical care (other than for the treatment of the terminal illness); and
 - Health care provision outside of the hospice.

3.4 PLACE OF SERVICE

3.4.A. BENEFICIARY'S HOME

A beneficiary eligible for hospice may receive hospice services in their home. If the beneficiary is eligible for hospice services but does not have family or friends to provide the necessary home care, the beneficiary may live in a residential setting that may include an Adult Foster Care (AFC) facility, boarding home, Home for the Aged (HFA), or assisted living facility. The setting must be appropriate for the type of care required by the beneficiary. Medicaid does not pay room and board in these settings.

Beneficiaries may receive hospice services in these settings. The hospice is responsible for developing and implementing a coordinated plan of care to avoid duplication of services. These care settings are available for Medicare, Medicaid, and dually eligible beneficiaries.

3.4.B. NURSING FACILITY

When a dually enrolled Medicare/Medicaid beneficiary enters a nursing facility (NF), the beneficiary can elect the Medicare hospice benefit if that NF has hospice services available. In this case, the beneficiary revokes the 100 days of Medicare reimbursement for skilled NF care.

Revocation of the 100-day NF skilled care is a beneficiary's decision and should not be influenced by the NF's funding source for the bed.

The CHAMPS application process is used to complete the beneficiary's election for hospice and create the correct PET (e.g., HOS-NFAC) for Medicaid eligible beneficiaries. This does not mean that the beneficiary has revoked the Medicare benefit for services not related to their terminal illness. The beneficiary remains eligible for Medicare, but has elected to use only the hospice portion of the Medicare benefit.



If the NF contracts to make hospice services available, the hospice must complete the admission in CHAMPS for all Medicaid, Medicare and dually eligible beneficiaries. The facility must provide room and board for the beneficiary, and the hospice must provide its normal services.

The Pre-Admission Screening/Annual Resident Review (PASARR) form (DCH-3877) must be completed for a hospice patient entering a NF unless the hospice beneficiary is entering for a five-day respite period. The DCH-3877 is not required for the respite period. The DCH-3877 is to identify individuals who may have a mental illness, intellectual/developmental disability or a related condition. If the patient is on antipsychotic or antidepressant medications for purposes of pain control/symptom relief for end of life, it should be noted on the DCH-3877. This allows the Community Mental Health Services Program (CMHSP) worker to better evaluate the need for further (Level II) screening. If the patient is on any of the above mentioned psychotropic medications for a related mental illness, the CMHSP will determine the need for a Level II screening.

Medicaid will reimburse the hospice for room and board for a hospice beneficiary who resides in a NF (including a beneficiary for whom a complex care authorization has been approved) or in a Ventilator Dependent Care Unit (VDCU). The hospice then reimburses the NF. The Medicaid reimbursement to the hospice for NF room and board is equal to 95% of the total Medicaid NF rate. For Class I, III, and V facilities, reimbursement also includes 100% of the Quality Assurance Supplement (QAS) amount due the NF through the Quality Assurance Assessment Program (QAAP). QAS funds are not included in the reimbursement for Hospital Swing Beds as they are not eligible for that program.

Per Medicare guidelines, the term "room and board" in a NF includes the performance of personal care services that a family caregiver would provide if the individual were at home. This includes assistance in the activities of daily living such as bathing, grooming, toileting, dressing, meal service, socializing, companionship, hobbies, administration of medication, maintaining the cleanliness of the beneficiary's bed and room, and supervising/assisting in the use of durable medical equipment (DME) and prescribed therapies (e.g., range of motion, speech and language exercises). The NF may not include hospice staff to meet its staffing requirements.

Hospice covered beneficiaries residing in the NF must not experience any lack of NF services or personal care due to their status as a hospice beneficiary. NFs must offer the same drugs, services, medical supplies and DME to all residents who have elected the hospice benefit in the same manner that services are provided to other residents in the facility who have not elected hospice care. If a service is normally furnished as part of the facility's per diem, the service must also be provided to hospice beneficiaries. If services are provided for needs associated with a non-terminal illness and are normally furnished and billed by another provider, that practice would continue.



3.4.C. HOSPITAL INPATIENT CARE

Medicaid hospice reimbursement includes payment for any hospitalizations related to the terminal illness. The hospice must contract with, and reimburse, a hospital for medically necessary inpatient services related to the beneficiary's terminal illness. Medicaid does not reimburse the hospital separately unless the hospitalization is not related to the terminal illness.

3.5 DURATION OF COVERAGE

Based on hospice eligibility criteria, the duration of hospice services is generally six months or less. There is no minimum period of hospice admission. A change in the beneficiary's prognosis could eliminate the need for hospice care. A beneficiary may cancel his admission in the hospice at any time and without cause. Beneficiaries who become ineligible for Medicaid while admitted in a hospice also become ineligible for Medicaid reimbursement for hospice services.



SECTION 4 - BENEFICIARY DISCHARGE

A beneficiary may be discharged from hospice as noted below. The provider must complete the Discharge webpage in CHAMPS. The discharge must indicate the type of discharge, date of the discharge, reason, and details of the beneficiary's residence after discharge. A downloaded copy of the beneficiary's discharge (voluntary or involuntary) must be signed by the beneficiary and/or authorized representative as proof of notification (unless the beneficiary has expired). A copy must be given to the beneficiary and/or authorized representative after he/she signs it.

Terminations generated by the hospice are subject to the appeal procedures, as required by licensure requirements.

Completion of the hospice beneficiary's discharge in CHAMPS will result in real-time changes to the National Provider Identification (NPI) and the beneficiary's PET.

Hospice providers must complete the hospice discharge (voluntary or involuntary) in a timely manner in CHAMPS in order to maintain an accurate roster, and to ensure the beneficiary has the correct PET and benefit plan assigned for correct payment.

4.1 BENEFICIARY DIES

When a beneficiary dies while admitted in hospice, the hospice must complete the discharge in CHAMPS indicating the date the beneficiary expired.

4.2 BENEFICIARY ELECTS TO VOLUNTARY DISCHARGE/REVOKES THEIR HOSPICE BENEFIT

A beneficiary may elect voluntary discharge from, or revoke their election of, hospice care at any time during an election period. The hospice must obtain written documentation, signed and dated by the beneficiary or their authorized representative, stating they are revoking the hospice benefit for the remainder of that election period. The voluntary discharge or revocation is effective with the date of the beneficiary's/representative's signature. The hospice must complete the discharge in CHAMPS, give a copy of the discharge notice to the beneficiary or authorized representative after he/she signs it, and retain the original copy in the beneficiary's record.

4.3 HOSPICE REVOCATION OR DISCHARGE WHEN BENEFICIARY IS HOSPITALIZED

A beneficiary should **not** revoke or be discharged from hospice for the purpose of admission to the hospital for care related to the hospice diagnosis. Medicaid does not reimburse the hospital separately unless the hospitalization is **not** related to the terminal illness. When this is the case, the hospice may continue to provide care to the beneficiary under the routine hospice care benefit.

4.4 BENEFICIARY NO LONGER MEETS ADMISSION CRITERIA

A beneficiary may have a change in condition and no longer qualify for hospice services. If the beneficiary is discharged for this reason, the hospice must complete the discharge in CHAMPS, provide the date of the discharge, and indicate the reason in the Remarks section of the webpage for the



discharge. A copy of the discharge must be downloaded, printed, and provided to the beneficiary and/or their authorized representative.

4.5 BENEFICIARY BECOMES INELIGIBLE FOR MEDICAID

The hospice is responsible for verifying the beneficiary's continued Medicaid eligibility once he is enrolled. Medicaid does not reimburse hospice services rendered to a Medicaid ineligible beneficiary. Once the beneficiary is deemed no longer eligible for hospice services, the hospice must complete the discharge in CHAMPS and indicate in the Remarks section the reason why the beneficiary is no longer eligible for hospice services. A copy of the discharge must be downloaded, printed, and provided to the beneficiary and/or their authorized representative.

4.6 BENEFICIARY MOVES OUTSIDE THE HOSPICE SERVICE AREA

At the time of the hospice admission, beneficiaries must be told to notify the hospice and their local MDHHS worker if their place of residence changes. If the new residence is located in the hospice's normal service area, or if the hospice agrees to continue to provide services to the beneficiary, the move creates no changes except an address change. If the move is too far for the hospice to continue services for the beneficiary, the hospice must arrange a transfer of care for the beneficiary to another Medicaid enrolled hospice. The two hospices must work together to assure that no lapse occurs in services to the beneficiary.

The first hospice must complete the discharge webpage and indicate the planned date of admission for the second hospice in the Remarks section. It is then the responsibility of the second hospice to complete the admission application in CHAMPS. Each hospice must place an explanation in the Remarks section stating the reason for the transition.

4.7 HOSPICE ELECTS TO TERMINATE THE BENEFICIARY'S ADMISSION

The hospice may discharge a beneficiary if the beneficiary violates any of the conditions of membership in the hospice. The decision to discharge a beneficiary and the effective date of the discharge are determined on an individual basis by the hospice Medical Director.

The hospice may request discharge of a beneficiary for any of the following reasons:

- Fraud;
- Abuse (including repeated instances of willfully and knowingly obtaining health care services for the terminal illness from non-hospice providers); or
- Misconduct (including violence that interferes with or interrupts the provider's proper delivery of health care to the patient or other patients)



SECTION 5 - MEDICARE CONDITIONS OF PARTICIPATION

5.1 HOSPICE ELECTION PERIODS

The duration of hospice coverage is measured in election periods, also known as benefit periods. A beneficiary may elect to receive hospice care during one or more of the following election periods:

- An initial 90-day period;
- A subsequent 90-day period; or
- An unlimited number of subsequent 60-day periods.

5.2 CERTIFICATION OF THE TERMINAL ILLNESS

A hospice must obtain written certification of the terminal illness for each election period before a claim for services is submitted. If the hospice is unable to obtain a written certification within three days of initiation of hospice care, a verbal certification must be obtained, documented, and signed by the person receiving the certification. Statements covering a beneficiary's initial certification must be obtained from the hospice medical director or the physician member of the Interdisciplinary Group (IDG), and the beneficiary's attending physician if the beneficiary has an attending physician. The hospice medical director or the physician member of the IDG certifies the terminal illness for all subsequent election periods.

Each written certification must include:

- A statement that the beneficiary's life expectancy is six months or less if the terminal illness runs its normal course;
- Specific clinical findings and other documentation as needed to support the life expectancy of six months or less;
- A brief narrative summary;
- An explanation why the clinical findings of the face-to-face encounter support a life expectancy of six months or less (beginning with the third benefit period and thereafter); and
- Physician signature(s), date signed, and specific election period dates covered by the certification or recertification.

Documentation of all written/verbal certifications must be prepared no more than 15 calendar days prior to the effective date of election and must be kept in the beneficiary's medical record.

5.3 NARRATIVE SUMMARY

Each hospice certification and recertification must be accompanied by a brief narrative describing the clinical findings supporting the beneficiary's life expectancy of six months or less. Each narrative must reflect the clinical circumstances and should not contain checkboxes or non-specific, standard language.



5.4 FACE-TO-FACE ENCOUNTER

A hospice physician, hospice-employed nurse practitioner (NP), or hospice-employed physician assistant (PA) must have a face-to-face encounter with every hospice beneficiary prior to the 180th day of recertification of the beneficiary's terminal illness for the purpose of determining continued eligibility. The 180th day recertification is defined as the recertification that occurs at the start of the third benefit (election) period or the benefit period following the second 90-day benefit period. Additionally, a face-to-face must be conducted at each subsequent recertification (every 60 days thereafter) for as long as the beneficiary is in hospice. Face-to-face encounters must occur no more than 30 calendar days prior to the start of the third benefit period and no more than 30 calendar days prior to each subsequent benefit period thereafter.

The hospice physician, NP, or PA must attest in writing to the face-to-face encounter with the beneficiary and include the date of the visit. A NP or PA is allowed to perform and attest to the face-to-face encounter; however, the hospice physician must certify and recertify the terminal illness.

Failure to meet the face-to-face encounter requirements results in a failure by the hospice to meet the recertification of the terminal illness requirement. This results in the beneficiary no longer being eligible for the hospice benefit. If this should occur, the hospice must complete the admission in CHAMPS, with the last date of the benefit period as the effective discharge date. A comment in the Remarks Section on the Discharge webpage is required to explain the reason for the discharge.

It is the responsibility of the first hospice to complete the discharge in CHAMPS before the second hospice can complete the admission in CHAMPS when:

- the beneficiary discharges from one provider for admission to a new provider;
- the beneficiary revokes the services of a provider; or
- the provider discharges the beneficiary.

The new hospice provider may begin their care within the beneficiary's first benefit period.

In the event a hospice provider is resuming care for a beneficiary formerly served by their hospice, the resuming hospice provider must have previously completed the discharge in CHAMPS at the time hospice services originally ended. To resume care, the hospice must complete a new admission in CHAMPS. The resumption of care starts in the next or subsequent benefit period.



SECTION 6 - HOSPICE SERVICES

6.1 CORE SERVICES

The hospice must provide all or substantially all of the core services applicable for the terminal illness in the beneficiary's home. (Home may include the beneficiary's private dwelling, apartment, boarding home, assisted living facility, AFC facility, HFA, NF or hospice-owned NF.)

These core services are:

- Physician care
- Nursing care
- Social work
- Counseling
 - Bereavement
 - Spiritual
 - Dietary

6.2 OTHER HOSPICE COVERED SERVICES

Other services that may be necessary due to the terminal illness and must be available but are not considered core services are:

- Drugs*/Biologicals
- Home Health Aide services
- Homemaker services
- Medical Supplies/Durable Medical Equipment (DME)
- Occupational Therapy
- Physical Therapy
- Short-Term Inpatient care
- Speech Therapy

***Although the drug AZT (Retrovir) is related to the terminal illness of AIDS, MDHHS reimburses the pharmacy separately for a hospice beneficiary receiving AZT.**

These other services may be provided by contractual agreement or provided by the hospice directly and are not reimbursed separately.



6.3 SUSPECTED ABUSE/NEGLECT

If there is reasonable cause to suspect that a beneficiary may be in danger of abuse, neglect, exploitation, cruelty, or other hazards, the hospice must report the suspected abuse to the Adult or Child Protective Services Unit of the local MDHHS office. (Refer to the General Information for Providers Chapter of this manual for additional information.)

6.4 TRANSPORTATION

6.4.A. HOME SETTING

Non-emergency transportation related to the terminal illness is the responsibility of the hospice agency.

Routine, non-emergency transportation to obtain Medicaid covered services not related to the terminal illness is available through the local MDHHS office for beneficiaries who do not reside in a nursing facility (NF). The beneficiary/responsible party should contact the MDHHS worker to determine the appropriate mode of non-emergency transportation and make the necessary arrangements. The transportation provider, not the hospice, bills the local MDHHS office for the transportation provided.

Non-emergency transportation by ambulance not related to the terminal illness requires a physician's signed order to allow the ambulance provider to bill Medicaid directly.

Emergency transportation related to the terminal illness is the responsibility of the hospice agency.

Emergency ambulance transportation not related to the terminal illness may be billed directly to Medicaid by the ambulance provider.

6.4.B. NURSING FACILITY SETTING

Non-emergency transportation related to the terminal illness is the responsibility of the hospice agency.

Routine, non-emergency transportation not related to the terminal illness must be provided by the NF as part of their per diem.

Non-emergency ambulance transportation not related to the terminal illness requires a signed physician's order and may be billed directly to Medicaid by the ambulance provider. If the NF does not have a physician's order, neither the NF nor the ambulance provider can bill Medicaid, the beneficiary, the beneficiary's family, or use the offset to the patient pay amount. Arrangement for payment is between the NF and the ambulance provider.

Emergency transportation related to the terminal illness is the responsibility of the hospice agency.

Emergency ambulance transportation not related to the terminal illness may be billed directly to Medicaid by the ambulance provider.



6.5 HOSPICE SERVICE LOG

The hospice must complete a detailed monthly service log that indicates the services provided to the beneficiary and whether an employee or a volunteer provided them. Each service (e.g., nursing, social work, hospice aide) must be logged by the date on which it took place.

The log must be retained as part of the beneficiary’s medical record. However, if the hospice maintains this information electronically in a secure, yet readily understood format, it is not necessary to maintain a paper copy of the log.

6.6 CATEGORIES OF CARE

There are four categories of hospice care:

Routine Home Care	Routine Home Care is defined as hospice home care that is not continuous.
Continuous Home Care	Continuous Home Care is defined as short-term in-home care that is reflective of at least half of the hours predominantly being nursing care provided by either a registered nurse or licensed practical nurse in a crisis situation. Home health aide or homemaker services may be provided in addition to nursing care. A minimum of eight hours of care per day must be provided to qualify as continuous home hospice care. Payment is made for the hours of continuous care provided, up to 24 hours in one day.
Inpatient Respite Care	Inpatient Respite Care is defined as short-term inpatient care to relieve the primary caregiver(s) providing at-home hospice care for the beneficiary. Hospice care may be provided in a licensed hospice residence, hospital, or NF meeting hospice standards for staffing and patient areas. The length of stay may not exceed five consecutive days.
General Inpatient Care	General inpatient care is covered when the beneficiary’s condition is such that their symptoms cannot be adequately treated under the routine hospice care benefit. It is defined as short-term inpatient care provided in a licensed hospice residence, hospital, or NF meeting hospice standards for staffing and patient areas. This brief episode of care is usually for pain control, or acute or chronic symptom management, that cannot be reasonably treated in another setting. General inpatient care is not to be used solely if a beneficiary requires care in a facility setting. Michigan Medicaid provides payment for room and board in a nursing facility if the beneficiary’s hospice care would be more appropriately provided in this setting under the routine hospice benefit.

Guidelines for core and other services (as detailed above) apply to all categories of care.

6.7 PLAN OF CARE

After admission in the hospice, a person-centered plan of care (POC) must be developed before the beneficiary can receive services. It is also the responsibility of the hospice provider to determine if the beneficiary is receiving services from another program such as Home Help, MI Choice Waiver, or Private Duty Nursing (PDN). If another program is identified, the hospice provider must contact the other program(s) and develop a joint POC to coordinate services. The beneficiary and/or authorized representative or primary caregiver and the Interdisciplinary Group (IDG), as defined by federal



regulations, must also participate in the development of the plan. The beneficiary's attending physician should be encouraged to attend as well. The hospice is responsible for implementing the POC for hospice services.

6.7.A. ADULT FOSTER CARE FACILITY/HOME FOR THE AGED

The Adult Foster Care Facility/Home for the Aged (AFC/HFA) is responsible for care related to the non-terminal needs of the beneficiary who resides in their facility. There is to be no duplication of services by either staff.

6.7.B. ASSISTED LIVING FACILITY

The hospice is responsible for implementation of the POC for hospice services provided in this setting.

6.7.C. NURSING FACILITIES

The NF and hospice are responsible for performing their respective functions, which have been agreed upon and included in the jointly developed POC. The joint POC must include directives for managing pain and other uncomfortable symptoms, and be revised and updated as necessary to reflect the beneficiary's current status. The hospice retains overall professional management and responsibility for directing the implementation of the POC.

The joint POC should reflect the participation of the hospice, NF, and the beneficiary to the extent possible. The hospice and NF must communicate with each other when any changes to the POC are indicated, and each provider must be aware of the other's responsibilities in implementing the POC. There must be evidence of this coordination of care in the clinical records of both providers. All aspects of the joint POC must reflect the hospice philosophy. NF services must be consistent with the POC developed in coordination with the hospice.

6.7.D. ADULT HOME AND COMMUNITY BASED WAIVER BENEFICIARIES (MI CHOICE)

If the beneficiary is enrolled in the waiver program, the hospice must contact the beneficiary's waiver coordinator/agent. A joint POC must be retained in the beneficiary's record by both the hospice and the waiver coordinator. The hospice is the primary provider and manages the joint POC. The POC must clearly identify the services the beneficiary receives, which entity is responsible for providing the services, and the frequency of the services to be provided. Each waiver service included in the POC should be accompanied by documentation stating why the service is not covered under hospice. The waiver coordinator must understand the hospice philosophy so that the two agencies work for a common goal and eliminate duplicate services. Ongoing communication and coordination must occur regularly between the two providers during the time they are serving the same beneficiary. Written documentation of this ongoing communication and coordination must be kept in the beneficiary's record at each agency.

Beneficiaries may receive services from both types of providers concurrently as long as the services are not duplicative.



If the beneficiary is receiving hospice and becomes eligible to receive waiver services, the waiver agency contacts the hospice to establish the first date of service for the waiver services. It is the responsibility of the waiver agent to complete the beneficiary's MI Choice waiver enrollment in CHAMPS. However, if the beneficiary is receiving waiver services and becomes eligible for hospice, it is the responsibility of the hospice to complete the hospice admission in CHAMPS. The appropriate Program Enrollment Type (PET) identifies a beneficiary receiving hospice services and Adult Home and Community Based Waiver for the Elderly and Disabled (MI Choice Waiver) services concurrently (e.g., MIC-HOSP or MIC-HSSP). The waiver agency and the hospice provider must discuss and coordinate services in order to prevent delays in access of care.

Hospice services must be used to the fullest extent before additional waiver services of the same type are provided. Post-payment review may be employed to monitor services. If inappropriate (e.g., duplicative) waiver services were provided, MDHHS will seek recovery of Medicaid funds paid for those services from the waiver coordinator.

MDHHS maintains a list of MI Choice waiver coordinators and contact information on the MDHHS website. (Refer to the Directory Appendix for website information.) Habilitation Supports waiver coordinators may be contacted through the local Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) provider.

6.7.E. PRIVATE DUTY NURSING

If a beneficiary receiving private duty nursing (PDN) becomes eligible for hospice, the hospice is required to notify the MDHHS Program Review Division before a claim is submitted for the services. (Refer to the Directory Appendix for contact information.)

The hospice must provide the following information on agency letterhead to the Program Review Division:

- beneficiary name and Medicaid ID number;
- a request for a case review and approval of hospice services;
- a statement confirming that the beneficiary has been certified terminally ill with six months or less to live, signed by the hospice medical director and the beneficiary's attending physician; and
- name, e-mail address, and telephone number of the contact person.

Program Review Division staff may request additional medical record documentation for their review. If services are approved, the hospice must work with the PDN agency to develop a coordinated plan of care. Both the hospice and PDN staff must ensure that duplication of services does not occur. While hospice maintains the lead in coordinating the services, the PDN agency must continue to obtain prior authorization from MDHHS for the PDN services.

This does not apply to beneficiaries receiving PDN services under the Habilitation Supports Waiver (HSW) and over 21, or the MI Choice Waiver. For beneficiaries under the HSW, providers should contact the beneficiary's case manager to inform them of



hospice eligibility. If the beneficiary is under the MI Choice Waiver, providers should contact the MI Choice Waiver Supports Coordinator.

6.8 CONCURRENT HOSPICE AND CURATIVE CARE FOR CHILDREN

Children under 21 years of age may receive hospice care concurrently with curative treatment of the child’s terminal illness. This allows the beneficiary or beneficiary’s representative to elect the hospice benefit without forgoing any curative service to which the child is entitled under Medicaid for treatment of the terminal condition. The need for hospice care must be certified by a physician and the hospice medical director.

Under concurrent curative care policy, curative care is defined as medically necessary care that serves to eliminate the signs and symptoms of a disease with the goal of a cure or long-term disease-free state.

Medicaid will reimburse for the curative care separately from the hospice services. Medicaid will not reimburse for these types of treatments when they are used palliatively. Palliative care under hospice is defined as an active patient and family-centered interdisciplinary approach to pain and symptom management of the terminal illness. Palliative care is always a part of hospice and included in the hospice per diem reimbursement. The term "palliative care" cannot be separately billed or reimbursed by Medicaid.

A child receiving hospice will continue to receive appropriate early and periodic screening, diagnosis and treatment (EPSDT) services to the extent these services are medically necessary.

Pediatric Subspecialist	A pediatric subspecialist must direct the curative care related to the beneficiary’s terminal diagnosis. For purposes of this policy, a pediatric subspecialist is a physician who is board certified, or board eligible for subspecialty certification, in a pediatric subspecialty including, but not limited to, neurology, cardiology, pulmonology, endocrinology, or oncology. In most cases, a general pediatrician will not be considered a pediatric subspecialist relative to this policy, but a general pediatrician may assume the role of pediatric subspecialist and direct the child’s curative care if they have acted as the primary care provider and treated the child’s terminal condition prior to the election of hospice. NOTE: Beneficiaries with CSHCS-only coverage, meaning no Medicaid coverage and receiving hospice related to the CSHCS qualifying condition, must have a pediatric subspecialist for that condition manage the concurrent curative treatment of the terminal condition.
Coordination of Care	The hospice provider and pediatric subspecialist must work together to ensure a collaborative approach to the care of the beneficiary. The hospice Plan of Care (POC) must demonstrate coordination of care between the hospice and the pediatric subspecialist. It is the responsibility of each provider working collaboratively to determine whether a service is curative or palliative (hospice). The hospice record must contain a signed statement or attestation from the pediatric subspecialist explaining the course of treatment and acknowledging the physician is aware the beneficiary is receiving hospice services concurrently with curative treatment. The attestation must be dated and present in both the hospice and pediatric subspecialist records within 30 days after the beneficiary is admitted into hospice. The signature, printed name, and National Provider Identifier (NPI) number of the physician ordering and coordinating the concurrent curative treatment must be documented on the attestation. For a beneficiary enrolled in a Medicaid Health Plan (MHP), the hospice provider and pediatric subspecialist must also work with the MHP to ensure that the MHP authorization and documentation requirements are met.



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Billing and Reimbursement	<p>Hospice services and curative treatment are billed and reimbursed separately under this policy. Prior to billing, it is important that providers differentiate between services that are palliative and therefore included in hospice reimbursement, and those that are curative and separately reimbursable under Medicaid. MDHHS recognizes the challenge this poses for providers, and each child's circumstances will need to be taken into consideration when making this distinction. The table below provides examples of treatment and related service categories but is not all-inclusive or intended to represent fixed parameters for decision making. Caution should be taken to avoid billing both the hospice and Medicaid for the same service as this represents double billing and may constitute fraud.</p>
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Examples of Treatment and Service Categories

Treatment	Hospice Service	Concurrent Curative Service	Both Hospice and Concurrent Curative Services	Comments
Pain/Symptom Management				
Narcotics, Analgesics	X			
Antiemetics	X			
Nutrition				
Tube Feeding			X	Hospice = Continuation of previous tube feedings. Concurrent = Tube placement; initiating feedings.
Intravenous (IV) Fluids		X		Concurrent = Surgical central line placement
Total Parenteral Nutrition (TPN)		X		
Respiratory Support				
Oxygen	X			
Bilevel Positive Airway Pressure (BiPAP)			X	Hospice = <72 hrs. Concurrent = Acute event not related to terminal illness
Continuous Positive Airway Pressure (CPAP)			X	
Ventilator		X		



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Treatment	Hospice Service	Concurrent Curative Service	Both Hospice and Concurrent Curative Services	Comments
Respiratory Vests			X	
Cough Assist Device(s)			X	
Pharmacy				
Antibiotics	X			Antibiotic administration through available access
Chemotherapy		X		
Intravenous immunoglobulin		X		
Blood Products		X		
Supports				
Spiritual Support	X			
Psychological/Social Support	X			
Bereavement Support	X			
Radiation		X		
Durable Medical Equipment (DME)				
Specialized Seating		X		
Wheelchairs	X			

6.9 SPECIAL PROGRAMS

6.9.A. HOME AND COMMUNITY BASED WAIVER BENEFICIARIES (CHILDREN’S WAIVER, HABILITATION SUPPORTS WAIVER)

If waiver services are not related to the terminal illness, the hospice should send the MDHHS waiver program coordinator an explanation of the situation when enrolling the beneficiary. The hospice agency should contact the waiver case manager or supports coordinator at the PIHP/CMHSP to coordinate care and to develop a combined POC.



6.9.B. CHILDREN'S SPECIAL HEALTH CARE SERVICES (TITLE V)

Refer to the Children's Special Health Care Services chapter, Hospice Benefit section, for policy information.

6.9.C. CHILDREN'S SPECIAL HEALTH CARE SERVICES/MEDICAID (TITLE V/XIX)

Hospice services for children covered under Children's Special Health Care Services (CSHCS) and determined Medicaid eligible (Title V/XIX) follow Medicaid policy outlined in this chapter.

6.9.D. MI HEALTH LINK

Beneficiaries enrolled in MI Health Link are dually eligible for both Medicare and Medicaid. While hospice is not a benefit offered by MI Health Link, beneficiaries in the program may still elect hospice and begin receiving hospice services at any time.

Effective November 1, 2016, individuals enrolled in the MI Health Link program who elect hospice services may remain enrolled in the MI Health Link program if they choose.

(Refer to the MI Health Link Chapter for additional details regarding hospice services under the MI Health Link program.)

6.10 HOME HELP/PERSONAL CARE

Home Help/personal care may be available to the hospice beneficiary living at home (e.g., not residing in a hospice residence, NF, AFC, etc.). It is important that hospice services be utilized first, prior to Home Help services. Home Help services may be in addition to hospice care and must not duplicate hospice services. Home Help/personal care services are assistance with eating, toileting, bathing, grooming, dressing, transferring, self-administered medication, meal preparation, shopping/errands, laundry and light housekeeping. Some examples of when these services are appropriate are:

- The caregiver is too frail or otherwise unable to provide all of the needed personal care.
- There is no unpaid caregiver available and the beneficiary wishes to remain at home.
- The beneficiary is new to hospice but has been receiving personal care services through Home Help.

If hospice services duplicate or replace personal care services, payment is not approved for Home Help/personal care.

The hospice must contact the beneficiary's MDHHS adult services worker or ask for the assignment of an adult services worker if the beneficiary does not already have one. The adult services worker determines which personal care services may be provided in addition to hospice care. This determination may require the hospice to submit a POC for the worker's review.



SECTION 7 - BILLING & REIMBURSEMENT

7.1 MEDICARE/MEDICAID BENEFICIARIES

If a beneficiary is dually enrolled in Medicare and Medicaid, he must receive hospice coverage under the Medicare benefit. (Medicaid is the payer of last resort.) If the beneficiary resides in a NF, Medicare may pay hospice services, with NF room and board paid for by Medicaid. When a beneficiary is receiving services through the Medicare hospice benefit, Medicaid does not pay for curative or duplicative services.

The hospice provider must complete the admission in CHAMPS prior to submission of a Medicaid claim (i.e., coinsurance, deductibles, and room and board in the NF or hospice-owned NF). The hospice provider must also complete the beneficiary's discharge (voluntary or involuntary) or upon notification of the beneficiary's demise. (Refer to other applicable Sections for details regarding admission and discharge guidelines.)

If the hospice benefit is revoked under Medicare, the beneficiary cannot use the Medicaid hospice benefit as a replacement. Hospices should carefully explain this situation to the dually eligible beneficiary, especially during the fourth Medicare benefit period.* However, if the dually eligible beneficiary is no longer appropriate for hospice care and is discharged as a hospice beneficiary, that beneficiary is eligible for re-admittance with the hospice for the Medicaid benefit period if he becomes eligible for hospice again.

7.2 MEDICAID HEALTH PLAN ENROLLEES

Hospice services are included in the Medicaid Health Plan (MHP) covered services package for Medicaid enrollees. If the terminally ill enrollee requests and meets the criteria for hospice services, the MHP must cover the requested hospice services. If the terminally ill enrollee does not request hospice services, the MHP may provide its own array of services for the terminally ill. If the beneficiary is enrolled in a MHP (eligibility response indicates the Benefit Plan ID of CSHCS-MC, MA-HMP-MC, MA-MC or MME-MC), the hospice must contact the MHP immediately to receive prior authorization (PA) from the MHP before furnishing services. The MHP may require its enrollees to receive hospice services through a contracted hospice with which they have made arrangements. MHPs are responsible for the hospice care arrangement and payment if the eligibility response indicates a Benefit Plan ID of CSHCS-MC, MA-HMP-MC, MA-MC or MME-MC for the beneficiary.

If a fee-for-service (FFS) Medicaid beneficiary is automatically enrolled in a MHP while receiving hospice care, the beneficiary or his representative should contact the MDHHS Hospice Enrollment Coordinator if he wishes to continue receiving services from his current hospice provider. (Refer to the Directory Appendix for contact information.) The Hospice Enrollment Coordinator initiates the process of disenrollment from the MHP. It is not the intent of MDHHS to disrupt a hospice beneficiary's care through automatic enrollment in a MHP. If the beneficiary is subsequently discharged from hospice care, the beneficiary may be offered the opportunity to join a MHP.

* The fourth Medicare benefit period is the subsequent extension period during the beneficiary's lifetime that occurs after the first two 90-day periods, and subsequent 60-day period, have been utilized.



If the MHP enrollee requires hospice services in a NF or hospice-owned NF, the MHP pays a negotiated rate for room and board in addition to the payment for the hospice services. The hospice must contact the MHP prior to admitting the beneficiary for hospice services to request authorization by the MHP.

7.3 REIMBURSEMENT

MDHHS employs the following standards when reimbursing for hospice care:

7.3.A. RATE METHODOLOGY

MDHHS uses the Medicaid hospice payment base rates established and provided by CMS and applies the appropriate local wage adjustors provided by CMS for the four categories of hospice care in each Core Based Statistical Area (CBSA). Effective for dates of service on or after January 1, 2016, a severity intensity add-on (SIA) rate will be reimbursed for a minimum of 15 minutes but not more than four hours daily during the last seven days of a beneficiary's life for in-person visits made by an RN and/or Social Worker when the beneficiary is receiving routine home care. (This payment is made in addition to the routine home care rate for the day.) However, the total of combined time rendered by an RN and Social Worker will not be reimbursed for more than four hours a day. Medicaid Fee for Service hospice providers who have not submitted required quality data to the Centers for Medicare & Medicaid Services (CMS) in compliance with the Hospice Quality Reporting Program (HQRP) will receive reduced reimbursement. Medicaid publishes and implements rate updates each fiscal year or when directed by CMS. (Refer to the MDHHS Hospice Reimbursement Rates on the MDHHS website.)

7.3.B. COINSURANCE

When a Medicaid beneficiary is receiving hospice services under Medicare, the hospice may bill Medicaid for the coinsurance, as well as room and board, if the beneficiary resides in a NF or hospice-owned NF. Coinsurance and/or room and board cannot be billed to a Medicaid beneficiary, his family, or his representative.

7.3.C. DATE OF DISCHARGE

Hospice services are reimbursable for day of discharge if services were rendered, regardless of the setting in which the services were provided. This includes the transfer of the beneficiary from one hospice provider to another as long as services were provided by both agencies. (This will be randomly verified by post payment audit and as indicated.) If the beneficiary has hospice as of 12:01 am, the hospice is responsible for the payment of services provided to the beneficiary until midnight. The hospice will continue, for payment purposes, as the primary provider for the full day of discharge.

Room and board for a hospice/nursing facility (NF) resident is reimbursable on the day of discharge if the discharge is due to resident death or the resident is discharged from hospice but remains in the NF. Room and board reimbursement for the day of discharge from the NF for any other reason is not covered.



7.3.D. PHYSICIAN SERVICES

Reimbursement for administrative duties performed by the Medical Director is included in normal hospice rates. Direct patient care provided by the Medical Director, hospice-employed physician or consulting physician may be billed by the hospice and is separately reimbursable based on the lesser of Medicaid's maximum allowable amount for the service or the charge. Claims must reflect the Healthcare Common Procedure Coding System (HCPCS) procedure codes for the physician's direct patient care.

7.3.E. PATIENT-PAY AMOUNT

If the Medicaid beneficiary residing in a NF has a patient-pay amount (PPA), the hospice must collect that amount each month and apply it toward the beneficiary's Medicaid covered services, and non-covered services as allowed by Medicaid. While the hospice is responsible for collecting the PPA, this duty may be delegated to the NF (via contract with the hospice) as long as the amount is applied to the room and board bill. The PPA must be exhausted each month (even if services do not span the entire month) before any Medicaid payment can be made. Whenever the hospice collects a PPA, a receipt must be given to the beneficiary (or family).

The provider must bill Medicaid for services rendered even if the PPA exceeds the Medicaid reimbursement rate resulting in a zero dollar payment. The Hospice Claim Completion Section of the Billing & Reimbursement for Institutional Providers Chapter contains examples of the application of the PPA.

CHAMPS handles the PPA in the following manner: When a beneficiary has a monthly PPA and a corresponding nursing facility and hospice PET (i.e., HOS-NFAC), the PPA will be deducted from the first claim received in CHAMPS, resulting in deduction of the higher PPA amount. If the PPA is greater than the amount of the first submitted claim, the difference will be applied to subsequent claims until the total PPA for that month is met. The PPA must be exhausted each month before any Medicaid payment will be made. The nursing facility and hospice must bill in sequence according to the location of the beneficiary at the first of the month. This will prevent the PPA from being deducted from the wrong claim.

Providers have the ability to verify the PPA on the Member Eligibility Detail page in CHAMPS.

7.3.F. PAYMENT FOR NONCOVERED SERVICES

For necessary medical or remedial care recognized under State law but not covered by Medicaid, the Medicare Catastrophic Coverage Act of 1988, Public Law 100-360, allows NF beneficiaries to access their patient-pay amount to pay for these services as allowed by Medicaid. If Medicare covers the beneficiary's need for medical services, then Medicaid continues to cover the Medicare deductible and coinsurance in the event it does not exceed the Medicaid fee screen.



7.3.G. MEDICAID DEDUCTIBLE

The hospice must verify eligibility before providing hospice services to the beneficiary in a home setting. (Refer to the Beneficiary Eligibility chapter for additional information.) If the eligibility response indicates a Benefit Plan ID of Spend-down, the hospice should ask the beneficiary or their responsible person for a copy of the MDHHS letter sent the first of each month which indicates the dollar amount the beneficiary must spend before becoming Medicaid-eligible for services. Medicaid may not be billed until the Medicaid deductible obligation is met and the eligibility response indicates a Benefit Plan ID of MA or MA-HMP.

7.3.H. ROOM AND BOARD TO NURSING FACILITIES [CHANGE MADE 4/1/20]

When Medicaid reimburses the hospice for room and board in a NF, the beneficiary must be placed in a bed certified by Medicaid (i.e., a Medicare/Medicaid certified bed or one certified Medicaid-only). If the beneficiary is not placed in a bed certified for Medicaid, MDHHS does not pay for any services. Except for State Veterans' Homes, MDHHS pays the hospice 95 percent of the individual or specific facility's Medicaid rate for room and board plus 100 percent of the nursing facility's Quality Assurance Supplement (QAS) rate. Hospice reimbursement to the NF for room and board must be outlined in the contract established between the hospice and the NF.

- **Holding a Bed (Hospital Leave and Therapeutic Leave).** For NF beneficiaries on hospice, Medicaid reimburses the hospice for holding a NF bed as indicated below.

Hospice reimbursement to the NF for bed holds must be outlined in the contract between the NF and the hospice.

Family members/responsible parties for the hospice/NF beneficiary must be informed of the bed hold and readmission policy of the NF. If the beneficiary refuses to have a family member/responsible party notified, this must be documented in the beneficiary's medical record.
- **Hospital Leave Days.** For Hospital Leave Days, Medicaid will pay to hold a beneficiary's bed only when the facility's total available bed occupancy is at 98 percent or more on the day the beneficiary leaves the facility. Facilities at 97.5 percent occupancy may round up to 98 percent. Medicaid reimburses during a beneficiary's temporary absence (up to 10 days) from the NF for admission to the hospital for emergency medical treatment as documented by the attending physician in the beneficiary's medical record. The facility must hold the bed, and the hospice may bill Medicaid, if the attending physician documents a reasonable expectation at the point of admission to the hospital that the beneficiary will return to the NF by the end of the 10th day.

The beneficiary must return to the NF within 10 days for the hospice to bill for hospital leave days. If the beneficiary is in the hospital for more than 10 days, the NF is released from its obligation to hold the bed and the hospice cannot bill Medicaid for any leave days. Reimbursement to the hospice is at 100 percent of the class wide NF hospital leave day rate. This rate, determined annually by MDHHS, is available on the MDHHS website. (Refer to the Directory Appendix for website information.)



If the beneficiary is expected to be in the hospital for 10 days or fewer, and dies while in the hospital, the hospice may bill Medicaid for the hospital leave days up to the day before the beneficiary died.

If the beneficiary returns to the NF under Medicare coverage and still elects hospice care, the hospice may bill Medicaid for the hospital leave days if the emergency hospitalization was for no more than 10 consecutive days.

Patient-pay amounts and billing methods are not affected by this hospital leave day policy. The hospice/NF should continue to collect any patient-pay amount, typically on the first day of the month, and indicate the amount collected on the Medicaid claim. CHAMPS automatically deducts the patient-pay amount and reimburses the provider for the balance. If the hospice bills Medicaid for hospital leave days that occur at the beginning of the month, then the hospice should collect the patient-pay amount as usual. The hospice should charge the amount against the patient-pay that Medicaid pays for that day. For example, if a beneficiary has a patient-pay of \$200 and is in the hospital for an emergency condition for the first five days of the month (the stay totals no more than 10 consecutive days), the hospice should collect the patient-pay amount from the beneficiary and then submit a Medicaid claim. Medicaid reimburses the hospice for the hospital leave day per diem rate, minus the patient-pay amount. The hospice reimbursement, based on 2003 rates, would be \$132.80 [(\$66.56 x 5) - \$200].

There is no annual limit to the number of hospital leave days per beneficiary that may be billed to Medicaid as long as there are no more than 10 consecutive leave days per hospital stay.

- **Therapeutic Leave Days.** If the beneficiary has a temporary absence from the NF for therapeutic reasons approved by the attending physician, the hospice may be reimbursed by Medicaid to hold the bed open for up to a total of 18 days during a 365-day period. Therapeutic leave is for nonmedical reasons such as overnight stays with friends/relatives, Make-a-Wish Foundation trips, etc. The beneficiary's POC must provide for such absences. There is no limit to the number of therapeutic leave days that may be reimbursed at one time as long as the total does not exceed 18 days in a 365-day period. If a beneficiary does not return from a therapeutic leave, the beneficiary must be discharged on the date he left the facility. The date of admission and the date of discharge may not be billed as therapeutic leave days.

Reimbursement is at 95 percent of the individual or specific NF's daily per diem rate, just as the customary room and board rate is reimbursed.

- **Hospice Revocation or Decertification.** If a Medicaid hospice beneficiary who resides in a NF revokes his hospice services or is deemed no longer certifiable for the Medicaid hospice benefit, the hospice may bill for services on the day of revocation/decertification, as well as the hospice/NF room and board, as long as the beneficiary is in the facility at the midnight census.
- **Ventilator Dependent Care Unit (VDCU) or Complex Care Case.** Refer to the Place of Service subsection of this chapter for information regarding payment of room and board for these hospice beneficiaries.
- **State Veterans' Homes.** MDHHS pays the hospice 100 percent of the beneficiary-specific Patient Driven Payment Model (PDPM) (revised per bulletin MSA 19-24) Medicaid rate for room and board in a State Veterans' Home, and payments will be made through



gross adjustments. In addition to standard billing practices, hospice providers must follow the State Veterans' Homes billing policy found in the Billing & Reimbursement for Institutional Providers chapter. The hospice must submit a separate claim from other services for the room and board provided in a State Veterans' Home. Hospice reimbursement for room and board must be outlined in the contract established between the hospice and the State Veterans' Home.

7.3.I. ADULT FOSTER CARE FACILITIES/HOME FOR THE AGED FACILITIES

Medicaid does not reimburse for room and board in these settings. Reimbursement is made directly to the facility provider in the normal manner (i.e., Supplemental Security Income, Personal Care/Supplemental Payment). This payment is made in full. The AFC or HFA cannot seek additional restitution from the beneficiary or the hospice provider.

7.3.J. BOARDING HOMES

Medicaid does not reimburse for room and board in these settings.

7.3.K. ASSISTED LIVING FACILITY

Medicaid does not reimburse for room and board in these settings.

7.4 REIMBURSEMENT LIMITS

Medicaid does not apply an aggregate dollar capitation. (The Medicare program establishes the maximum total dollar amount per year that Medicare pays for hospice services. Medicaid does not apply this policy to beneficiaries receiving hospice care.)

Medicaid applies the same number of inpatient respite days as Medicare (i.e., no more than five consecutive days are allowed). If more than five consecutive days are billed, the number is reduced to five days, and the excess days must be billed as routine care by the hospice.

Reimbursement for routine, non-emergent transportation is included in the per diem (room and board amount) negotiated between the hospice and the NF.



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SECTION 1 – GENERAL INFORMATION

This chapter applies to services provided to Fee for Service (FFS) beneficiaries in an inpatient and/or outpatient hospital setting unless otherwise indicated. Medically necessary services provided to Medicaid beneficiaries by an enrolled hospital are generally covered by Medicaid, administered through the Michigan Department of Health and Human Services (MDHHS). The attending physician (MD or DO) is responsible for determining medical necessity and appropriateness of service within the scope of current medical practice and Medicaid guidelines. Services described in this chapter must also be available to Medicaid Health Plan (MHP) enrollees; however, the MHPs may implement different authorization and service criteria. For billing purposes, a revenue code is identified as a specific accommodation, ancillary service or billing calculation for all institutional claims.

The appropriate revenue code from the National Uniform Billing Committee (NUBC) and/or State Uniform Billing Committee (SUBC) manuals must be used on each claim line for all institutional claims. If a procedure code is required, a Healthcare Common Procedure Coding System (HCPCS) code(s) must be used.

Prior authorization (PA) information in this chapter pertains to FFS Medicaid and FFS Children's Special Health Care Services (CSHCS) only. If the beneficiary is enrolled in a MHP, the hospital must obtain any required PA from the beneficiary's MHP when providing services.

1.1 INPATIENT HOSPITAL

An inpatient hospital is defined as a facility, other than psychiatric, which primarily provides medically necessary diagnostic, therapeutic (both surgical and nonsurgical) or rehabilitation services to inpatients. Services provided to inpatients include bed and board; nursing and other related services; use of facility; drugs and biologicals; supplies, appliances and equipment; diagnostic, therapeutic and ancillary services; and medical or surgical services. Services of professionals (e.g., physician, oral-maxillofacial surgeon, dental, podiatric, optometric) are not included and must be billed separately. Inpatient hospital services are:

- Ordinarily furnished in a facility for the care and treatment of inpatients.
- Furnished under the direction of a physician (MD or DO) or a dentist.
- Furnished in a facility that is:
 - Maintained primarily for the care and treatment of inpatients with disorders other than mental diseases;
 - Licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and
 - Medicare-certified to provide inpatient services.

An inpatient is an individual who has been admitted to a hospital for bed occupancy with the expectation that he will remain at least overnight, even when it later develops that he can be discharged or is transferred to another hospital and does not use the bed overnight. Days of care provided to a beneficiary are in units of full days, beginning at midnight and ending 24 hours later. Medicaid covers the day of admission but not the day of discharge. If the day of admission and the day of discharge are the same, the day is considered an admission day and counts as one inpatient day.



1.2 OUTPATIENT HOSPITAL

An outpatient hospital (OPH) is defined as a portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require inpatient hospitalization. Outpatient hospital services are:

- Furnished under the direction of a physician (MD or DO) or a dentist.
- Furnished in a facility that is certified as a provider, or as having provider-based status, by Medicare.

To facilitate coordination of benefits, MDHHS follows Medicare's coverage policies as closely as possible and appropriate. Differences in coverage policy are described in this chapter.

1.3 THIRD PARTY LIABILITY

Federal regulations require that all identifiable financial resources available for payment, including Medicare, be billed prior to billing Medicaid. (Refer to the Coordination of Benefits chapter for additional information.)

1.3.A. MEDICARE-RELATED SERVICES

MDHHS reimburses for Medicare-covered services up to the beneficiary's financial obligation to pay or the Medicaid fee screen, whichever is less. This limitation also applies if the beneficiary is eligible for, but not enrolled in, Medicare. Medicare benefits must be used prior to billing MDHHS or any Medicaid-capitated plan (MHP, PIHP/CMHSP) for any portion of the claim.

MDHHS reimburses Medicare coinsurance and deductible amounts subject to Medicaid's reimbursement limitations on all Medicare-approved claims, even if Medicaid does not normally cover the service. Lifetime Reserve Days (LRD) must be used, if available.

1.3.B. OTHER INSURANCE

Medicaid and CSHCS beneficiaries may have insurance coverage, either traditional health insurance or a Health Maintenance Organization (HMO), through private and/or employer-based commercial policies. The other insurance is always primary, and the rules of that insurer must be followed. This includes, but is not limited to, PA requirements, provider qualifications, and receiving services through the insurer's provider network. MDHHS does not pay for services denied by the primary insurer because the primary insurer's rules were not followed.

Medicaid covers the appropriate copay and deductibles up to the beneficiary's financial obligation to pay or the Medicaid fee screen, whichever is less. If the primary insurer has negotiated a rate for a service that is lower than the Medicaid fee screen, MDHHS cannot be billed more than the negotiated rate. MDHHS reimburses Medicaid-covered services that are not included in the primary insurer's plan up to the Medicaid fee screen if all Medicaid coverage rules have been followed. If a beneficiary is enrolled in a MHP or is receiving services through a PIHP/CMHSP, the MHP/PIHP/CMHSP is responsible for payment.



1.4 COPAYMENTS

Copayments may be required for inpatient hospital stays, outpatient hospital visits, and non-emergency visits to the Emergency Department for beneficiaries age 21 years and older. Refer to the General Information for Providers Chapter for information about copayments. Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)

Copayments for the first day of an inpatient stay apply to the DRG or first day per diem payment. A 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.

Federal regulations at 42 CFR §447.54 specify the cost-sharing requirements for services provided in a hospital emergency department. To impose cost sharing for non-emergency services provided in a hospital emergency department, the hospital must:

- Perform appropriate medical screening under 42 CFR §489.24 Subpart G to determine the individual does not need emergency services.
- Before providing nonemergency services:
 - inform the individual of the amount of cost sharing responsibility for non-emergency service(s);
 - provide the individual with the name and location of an available and accessible alternative non-emergency services provider;
 - determine that the alternative provider can provide services in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the person is otherwise exempt from cost sharing; and
 - provide a referral to coordinate scheduling for treatment with the alternative provider.

Hospitals providing emergency department services are expected to develop cost sharing policies and procedures consistent with the federal requirement.

Refer to the Billing Beneficiaries Section of the General Information for Providers Chapter of this manual for additional information regarding copayment requirements. Beneficiaries may not be denied care or services based on inability to pay a copayment, except as outlined in that section.

1.5 MISCELLANEOUS

1.5.A. ABUSE

Providers with reasonable cause to suspect that a child or vulnerable adult may have been abused or neglected are required by law to immediately report it to the appropriate Protective Services Unit of the local MDHHS office. Inpatient hospital stays for suspected abuse or neglect are covered if the attending physician determines the beneficiary



requires further assessment and treatment. Inpatient stays for the sole purpose of custodial or protective care are not a covered benefit.

1.5.B. ADMINISTRATIVE SERVICES

Interns, resident physicians, dentists, or medical staff who are functioning in an administrative, teaching, or learning capacity for the hospital cannot bill MDHHS for their professional services as these costs are included in the hospital's Graduate Medical Education (GME) payments. This includes physician-owners or other staff paid by the hospital. Staff meetings for any purpose are not reimbursable. Reimbursement for administrative services is included in the Diagnosis Related Group (DRG) payment, as well as the MDHHS Outpatient Prospective Payment System (OPPS).

1.5.C. COMMUNICABLE DISEASE

Cases of communicable disease, such as tuberculosis, hepatitis, meningitis, and enteric disease, must be reported to the local health department (LHD). For additional information, contact the LHD.

1.5.D. EDUCATIONAL COSTS FOR PROFESSIONAL EDUCATION

Payments for educational costs are made directly to hospitals for health professional education in both the inpatient and outpatient hospital setting according to the requirements and formulas in the Hospital Reimbursement Appendix of this chapter.

1.5.E. HOSPITAL-BASED PROVIDER

A hospital-based provider (HBP) is defined as a hospital-employed MD, DO, Certified Registered Nurse Anesthetist (CRNA), physician's assistant (PA), advanced practice registered nurse (APRN) [including certified nurse practitioner (NP), certified clinical nurse specialist (CNS) or certified nurse midwife (CNM)], dentist, podiatrist, or optometrist. HBPs must be enrolled separately as Medicaid providers and bill MDHHS directly using their own provider NPI number for any covered professional service(s) that they provide. (Refer to the appropriate provider-specific chapter and the Billing & Reimbursement for Professionals Chapter of this manual for additional information.)

1.5.F. HOSPITAL PERSONNEL PROVIDING AMBULANCE TRANSPORT ASSISTANCE

Only enrolled ambulance, including hospital-owned ambulance service, providers may provide ambulance services. MDHHS does not reimburse hospitals for staff personnel who assist with an ambulance transport. The cost of all hospital personnel is considered part of the normal hospital operation (included in the cost center) and may not be billed to MDHHS or to the beneficiary.

1.5.G. PHARMACY

Pharmaceutical products (drugs and biologicals) provided to inpatients are covered as a component of the inpatient DRG and are not reimbursed separately.



MDHHS follows Medicare's coverage policies related to outpatient hospital pharmacy services.

Take-home drugs require a prescription or prescription order that includes the prescriber's NPI and are covered only when provided by a Medicaid-enrolled pharmacy. All prescriptions or prescription orders must comply with state and federal laws.

(Refer to the Pharmacy Chapter of this manual for additional information.)

An emergency room practitioner must report his individual NPI with a prescription order. Each practitioner at a teaching hospital must report his individual NPI with a prescription order that is submitted to the dispensing pharmacy.

1.5.H. OUTPATIENT AMBULATORY SURGERY AND EMERGENCY SERVICES PROVIDED ON DATE OF AN INPATIENT HOSPITAL ADMISSION

Outpatient ambulatory surgery and ED services provided at the same hospital resulting in an inpatient admission must be included as part of the inpatient stay and are reimbursed as part of the DRG payment. Charges for emergency services or ambulatory surgery that result in admission must be reflected on the inpatient claim for that episode of care. The date of admission should be reported as the date the physician wrote the order to admit the beneficiary.

1.5.I. SERVICES THAT MUST BE BILLED BY OTHER PROVIDERS

The following services may not be provided and billed as an outpatient hospital service. These services may be provided and billed by the appropriate enrolled provider:

- Advanced Practice Registered Nurse (APRN)*
- Certified Registered Nurse Anesthetist (CRNA)
- Chiropractor
- Dentist
- Durable medical equipment
- Hearing aids
- Home health
- Medical supplies (take-home)
- Optical
- Oxygen (take-home)
- Orthotics
- Pharmacy (take-home)
- Physician
- Physician Assistant*
- Podiatrist
- Prosthetics
- Shoes

* If not an employee of the hospital.

1.5.J. TECHNICIAN CALLS

Overtime or holiday pay to technicians who are required to be at the hospital outside of their normal work hours are not separately billable to beneficiaries or to Medicaid. These charges are included in the hospital's standard charge structure.



SECTION 2 - PRIOR AUTHORIZATION

MDHHS requires prior authorization (PA) for certain procedures to validate the medical need for the service. The following chart, intended for reference only, indicates services provided in the hospital setting that require PA, who must obtain it, how to obtain the PA, and the documentation required when the claim is submitted. Hospital services requiring PA include:

Service	PA Obtained By	Obtained Via	Documentation for Claim
* Cosmetic Surgery	Attending Physician	Practitioner Special Services Prior Approval – Request/Authorization Form (MSA-6544-B)	Prior Authorization (PA) Number
Freestanding Rehabilitation	Hospital	ACRC	Billing Authorization Number
Long Term Acute Care Hospital (LTACH)	Hospital	ACRC	Billing Authorization Number
Inpatient Psychiatric Admissions/Continued Stay	Hospital or Attending Physician	Phone call to local PIHP/CMHSP	Reimbursed by the PIHP/CMHSP, not MDHHS
* Outpatient Occupational Therapy (OT) (after the initial 12 months of treatment or 144 units)	Hospital	Occupational Therapy - Physical Therapy – Speech Therapy Prior Approval Request/Authorization (MSA-115)	PA number and, in Remarks, the From and Through dates of the PA number
* Physical Therapy (PT) (after the initial 12 months of treatment or 144 units)	Hospital	Occupational Therapy - Physical Therapy – Speech Therapy Prior Approval Request/Authorization (MSA-115)	PA number and, in Remarks, the From and Through dates of the PA number
* Outpatient Speech-Language Pathology (after the initial 12 months of treatment or 36 visits)	Hospital	Occupational Therapy - Physical Therapy – Speech Therapy Prior Approval Request/Authorization (MSA-115)	PA number and, in Remarks, the From and Through dates of the PA number
Outpatient Psychiatric Partial Hospitalization	Hospital	Phone call to PIHP/CMHSP	Reimbursed by the PIHP/CMHSP, not MDHHS
* Services for Weight Reduction (e.g., Surgery)	Attending Physician	Practitioner Special Services Prior Approval – Request/Authorization Form (MSA-6544-B)	PA Number
* Organ Transplants	Attending Physician	Contact the OMA	PA Number
* Pediatric Multi-Channel Recording (if more than two per year considered medically necessary)	Attending Physician	Practitioner Special Services Prior Approval – Request/Authorization Form (MSA-6544-B)	PA Number
* Off Label Use of Drugs	Attending Physician	Contact the OMA	PA number



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Service	PA Obtained By	Obtained Via	Documentation for Claim
*If the beneficiary is enrolled in a MHP, providers must contact the individual MHP to verify PA requirements.			

PA does not guarantee payment or beneficiary eligibility. The provider must check the beneficiary's Medicaid eligibility prior to rendering services. (Refer to the General Information for Providers and the Beneficiary Eligibility Chapters of this manual for additional information.)

PA is not required if the beneficiary is receiving Medicare benefits for a Medicare-approved service.



SECTION 3 – COVERED SERVICES

Hospital services requiring additional information are listed below in alphabetical order. Some services have coverage limitations and/or PA requirements.

For outpatient hospital services, MDHHS follows Medicare's coverage policies as closely as possible and appropriate. Differences or clarifications of coverage are described in this section.

3.1 ABORTIONS

Medicaid only covers an abortion performed by a physician and related hospital charges (e.g., room, supplies) when it has been determined medically necessary to save the life of the mother or the pregnancy is the result of rape or incest. Medicaid funding is not available for any elective therapeutic abortion or service related to the performance of such abortion unless one of these criteria has been met.

Physicians must certify on a completed Certification for Induced Abortion form (MSA-4240) that, for medical reasons, an abortion was necessary to save the life of the mother or the beneficiary's medical history indicates that the terminated pregnancy was the result of rape or incest.

The physician who completes the MSA-4240 must also ensure completion of the Beneficiary Verification of Coverage form (MSA-1550) and is responsible for providing copies of the forms for billing purposes to any other provider (e.g., anesthesiologist, hospital, laboratory) that would submit claims for services related to the abortion.

Copies of the MSA-4240 and the MSA-1550 are not required for claims for ectopic pregnancies or spontaneous, incomplete, or threatened abortions.

Providers may attach copies of the MSA-4240 and the MSA-1550 to the claim or submit them via fax.

Federal regulations require that these forms be submitted to Medicaid before reimbursement can be made for any abortion procedure.

The medical record must include a complete beneficiary history, including the medical condition that made the abortion necessary to save the life of the mother. When the pregnancy is the result of rape or incest, the medical record must include the circumstances of the case and that the pregnancy was the result of rape or incest.

(Refer to the Forms Appendix for copies of MSA-4240 and MSA-1550. The forms are also available on the MDHHS website. Refer to the Directory Appendix for website and contact information.)

3.2 ACCOMMODATIONS

Medicaid covers private, semi-private, three-bed, or four-bed accommodations. The hospital's inpatient accommodation rate includes all charges associated with routine services (e.g., linens, nursing services, etc.) rendered during the inpatient stay. All dietary services, including special diets, are included in the accommodation rate and are not allowable under any other cost center.



3.2.A. INTENSIVE CARE

Intensive care provided in an intensive care unit(s) is covered for the treatment of critically ill beneficiaries. Neonatal intensive care unit accommodations may be billed only if medically necessary, the infant is treated in this setting, and the neonatal unit has been approved by MDHHS to provide this level of service.

3.3 AMBULANCE

MDHHS coverage policies related to hospital-owned ambulance services are contained in the Ambulance Chapter of this manual.

3.4 ANESTHESIA

Medicaid policy coverage includes anesthesia services when provided by qualified practitioners in conjunction with surgical services or other procedures when medically necessary.

Medicaid does not cover anesthesia services related to the treatment of infertility.

Physician, CRNA, or AA professional charges may not be billed on the outpatient hospital claim format. These professional charges must be billed on a CMS 1500 claim form. (Refer to the Billing & Reimbursement for Professionals and the Practitioner Chapters of this manual for additional information.)

3.5 APHERESIS

MDHHS follows Medicare's coverage and guidelines for therapeutic apheresis in an outpatient hospital. Therapeutic apheresis is defined as a continuous autologous procedure and is covered as follows:

- Plasma exchange for acquired myasthenia gravis;
- Leukapheresis in the treatment of leukemia;
- Plasmapheresis in the treatment of primary macro-globulinemia (Waldenstrom);
- Treatment of hyperglobulinemia, including (but not limited to) multiple myelomas, cryoglobulinemia, and hyperviscosity syndromes;
- Plasmapheresis or plasma exchange in the last resort treatment of thrombotic thrombocytopenic purpura (TTP);
- Plasmapheresis or plasma exchange in the last resort treatment of life-threatening rheumatoid vasculitis;
- Plasma perfusion of charcoal filters for treatment of pruritus of cholestatic liver disease;
- Plasma exchange in the treatment of life-threatening forms of Goodpasture's Syndrome;
- Plasma exchange in the treatment of glomerulonephritis associated with antiglomerular basement membrane antibodies and advancing renal failure or pulmonary hemorrhage;
- Treatment of chronic relapsing polyneuropathy for beneficiaries with severe or life-threatening symptoms who have failed to respond to conventional therapy;



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- Treatment of life-threatening scleroderma and polymyositis when the beneficiary is unresponsive to conventional therapy;
- Treatment of Guillain-Barre Syndrome; and
- Treatment of life-threatening Systemic Lupus Erythematosus (SLE) when conventional therapy has failed to prevent clinical deterioration.

Apheresis is not a covered service when a beneficiary donates blood preoperatively and, at a later date, the blood is transfused back to the beneficiary.

3.6 APNEA MONITORS

Monitors must be provided by a Durable Medical Equipment (DME)/Medical Supply provider and may be covered on a rental basis without PA for up to three months from the date of discharge from the hospital for symptomatic infants discharged on a monitor. The hospital medical record must document that the infant was discharged on a monitor. The medical supplier must also note in their records that the child was discharged on a monitor, and a hospital discharge planner arranged for the apnea monitor rental. (Refer to the Medical Supplier Chapter of this manual for additional information.)

3.7 BENEFICIARY EDUCATION

Beneficiary education in the inpatient setting is included in the DRG payment. Beneficiary education services are covered in an outpatient setting as follows:

3.7.A. CHILDBIRTH EDUCATION

MDHHS covers childbirth education programs for pregnant women. The prenatal care provider must make written referrals for the pregnant woman, and the program must be provided by qualified educators in a Medicaid-enrolled outpatient hospital or by a certified Maternal Infant Health Program (MIHP) provider. This service is not covered if rendered by a prenatal care provider in the office setting. MDHHS covers childbirth education (also referred to as birthing education) as a complete program. MDHHS does not separately cover on-line (a type of distance learning) education classes.

Childbirth education includes, but is not limited to, the following topics:

Pregnancy	<ul style="list-style-type: none"> ▪ Health care during pregnancy ▪ Physical and emotional changes during pregnancy ▪ Nutrition
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Labor and Delivery	<ul style="list-style-type: none"> ▪ Signs and symptoms of labor, including information regarding pre-term labor ▪ Breathing and relaxation exercises ▪ Analgesia and anesthesia ▪ Avoiding complications ▪ Coping skills ▪ Types of deliveries ▪ Episiotomy ▪ Support techniques ▪ Hospital tour
Infant Care	<ul style="list-style-type: none"> ▪ Preparation for breast feeding ▪ Infant feeding ▪ Immunizations ▪ Infant carseat use ▪ Parenting
Postpartum	<ul style="list-style-type: none"> ▪ Postpartum physical and emotional changes, including depression ▪ Feelings of partner ▪ Potential stress within the family ▪ Sexual needs ▪ Exercise ▪ The importance of family planning

3.7.B. DIABETES SELF-MANAGEMENT EDUCATION (DSME) TRAINING PROGRAM

DSME is intended to educate beneficiaries in the successful self-management of their diabetes. MDHHS covers DSME when ordered by a physician or qualified non-physician medical practitioner responsible for the beneficiary’s diabetic care and provided by diabetes educators (e.g., nurse, dietitian) in a Medicaid-enrolled outpatient hospital or Local Health Department (LHD) that meets one of the following requirements:

- Certified as a DSME program by MDHHS, Population Health Administration; or
- American Association of Diabetes Educators (AADE) accreditation by the Diabetes Education Accreditation Program (DEAP); or
- American Diabetes Association (ADA) recognition by the Education Recognition Program (ERP).

DSME program requirement information must be provided to MDHHS via the CHAMPS Provider Enrollment on-line system. (Refer to the Directory Appendix for contact information.) DSME services may not be rendered to eligible beneficiaries or billed for payment until the appropriate requirement information is on file and approved.



The physician or qualified non-physician medical practitioner treating the beneficiary's diabetes must maintain a documented diabetes diagnosis in the medical record for initial and follow-up education and training. They must also document any special needs supported by medical necessity.

MDHHS aligns with Medicare's DSME training billing guidelines when possible. Medical Nutrition Therapy (MNT) is not a separately covered or reimbursed DSME Medicaid covered service.

Medicaid-enrolled DSME programs are expected to submit the MDHHS Annual Statistical Data Report following the reporting requirements located on the MDHHS website. This information is used for statewide reporting of statistical information to the Centers for Disease Control and Prevention (CDC). (Refer to the Directory Appendix for website information.)

DSME is not covered if rendered by a physician in the office setting, rendered by a nonenrolled provider, or rendered by a provider who does not meet Michigan Medicaid DSME program requirements.

3.7.C. KIDNEY DISEASE EDUCATION (KDE) SERVICES

MDHHS covers kidney disease education (KDE) of beneficiaries diagnosed with stage IV chronic kidney disease (CKD). If KDE is done in the outpatient hospital (OPH), only the OPH or physician (qualified person) may bill for services on the same day, same beneficiary.

MDHHS follows Medicare's coverage and reimbursement policies related to KDE.

3.8 BLOOD PRODUCTS

MDHHS coverage aligns with Medicare OPPS coverage and billing guidelines as closely as possible for Blood Processing/Storage in an outpatient hospital. Providers must bill appropriately following the Medicare coding and reporting requirements.

3.9 CHEMOTHERAPY TREATMENT

MDHHS covers antineoplastic drugs. MDHHS does not cover antineoplastic agents that are investigational or experimental.

3.10 CLINIC SERVICES

Hospital Clinic services are covered if rendered in a clinic setting that is part of the licensed and Medicaid-enrolled hospital, and that satisfy Medicare requirements for provider-based status. Clinic services rendered in the outpatient hospital include non-emergency outpatient services that are provided to ambulatory beneficiaries.

MDHHS covers Urgent Care Clinics (as part of the Medicaid-enrolled hospital and that satisfy Medicare requirements for provider-based status) when the services provided are specific to urgent medical care



(i.e., suturing, most fracture care) and are medically necessary for a non-life threatening condition or injury, or illness that should be treated within 24 hours.

3.11 DENTAL SERVICES

Dental services are routinely rendered in the dental office unless the situation requires that the dental service be performed in the outpatient hospital setting. However, services are not covered in the outpatient hospital setting for the convenience of the dentist or beneficiary.

Non-emergency routine dental treatment provided in an outpatient hospital setting is covered only under the following conditions:

- A concurrent hazardous medical condition exists;
- The nature of the procedure requires hospitalization; or
- Other factors (e.g., behavioral problems due to mental impairment) necessitate hospitalization.

Hospitals should refer to the Dental Chapter of this manual for information regarding program limitations prior to rendering services.

The dentist/physician must document in the beneficiary's medical record the condition that required the dental service be done in the hospital setting.

3.12 DIALYSIS (HEMODIALYSIS AND PERITONEAL DIALYSIS)

MDHHS coverage and reimbursement is an all-inclusive rate for maintenance dialysis services for beneficiaries receiving hemodialysis or peritoneal dialysis. MDHHS follows the Medicare billing guidelines for hemodialysis and peritoneal dialysis. Individual services may not be billed separately. The rate is the same whether the beneficiary dialyzes in the facility or at home, and includes all necessary home and facility dialysis maintenance services, supplies, equipment and supportive services such as:

- Oxygen;
- Filters;
- Declotting of shunts;
- Staff time to administer blood or oxygen; and
- Routine parenteral items: Heparin, Protamine, Mannitol, saline, glucose, dextrose, topical anesthetics, and arrhythmics.

MDHHS reimburses the physician directly for professional services related to maintenance dialysis.

Nonroutine additional services must be billed using the appropriate supporting HCPCS code. The facility is responsible for making arrangements with a DME provider for supplies not available from the dialysis facility. MDHHS does not reimburse the medical supplier separately. The facility is responsible for payment to the supplier or independent lab for services provided.



3.12.A. DIALYSIS LABORATORY SERVICES

Payment for laboratory services related to maintenance dialysis is included in the composite rate regardless of whether the tests are performed in the facility or an independent laboratory. The following tests are considered to be a routine part of maintenance dialysis and may not be billed separately unless it is medically necessary to perform them in excess of the frequencies indicated.

Laboratory tests for Hemodialysis, Peritoneal Dialysis, and Continuous Cycling Peritoneal Dialysis (CCPD) that are included in the composite rate:

Per Treatment	Weekly	Monthly
<ul style="list-style-type: none"> ▪ All hematocrit or hemoglobin tests and clotting time tests 	<ul style="list-style-type: none"> ▪ Prothrombin time for patients on anticoagulant therapy ▪ Serum Creatinine ▪ BUN 	<ul style="list-style-type: none"> ▪ CBC, including platelet count and additional indices ▪ Serum Calcium ▪ Serum Chloride ▪ Serum Potassium ▪ Serum Bicarbonate ▪ Serum Phosphorus ▪ Total Protein ▪ Serum Albumin ▪ Alkaline Phosphatase ▪ SGOT ▪ LDH

Laboratory tests for Continuous Ambulatory Peritoneal Dialysis (CAPD) that are included in the composite rate on a monthly basis include:

- | | | |
|------------------------|---------------------|-----------------|
| ▪ Albumin | ▪ Creatinine | ▪ Potassium |
| ▪ Alkaline Phosphatase | ▪ Dialysate Protein | ▪ SGOT |
| ▪ AST | ▪ HCT | ▪ Sodium |
| ▪ BUN | ▪ Hgb | ▪ Total Protein |
| ▪ Calcium Magnesium | ▪ LDH | |
| ▪ CO2 | ▪ Phosphate | |

Laboratory tests not listed above may be separately billed by the dialysis facility or Clinical Laboratory Improvement Amendments (CLIA)-certified lab performing the test.

3.12.B. DIALYSIS SELF-CARE TRAINING

MDHHS reimburses for dialysis self-care training provided by outpatient dialysis clinics.



- A session is considered as one training day and a complete course is considered 10-15 sessions.
- Sessions must be documented in the beneficiary's medical record and are subject to post-payment review.

3.13 DIAGNOSTIC TESTING

MDHHS policy covers and reimburses for diagnostic testing to diagnose a disease or medical condition. Outcomes must be documented in the medical record. Diagnostic testing in an inpatient hospital is included in the inpatient DRG payment. Outpatient hospitals must bill appropriately under the MDHHS OPPS.

MDHHS policy coverage does not reimburse for:

- Routine screening, such as spirometry, holter monitor, Doppler flow-study or pelvic echography.
- Testing to establish baseline values.
- Testing for the general health and wellbeing of a beneficiary.
- Any test not generally recognized as relevant to the condition being investigated.

3.13.A. FETAL MONITOR - FETAL NONSTRESS TEST

A Fetal Nonstress Test is covered as a diagnostic test when performed as part of routine monitoring of an ongoing pregnancy. MDHHS does not cover a room charge in addition to the test when it is being performed as part of routine monitoring of an ongoing pregnancy.

3.13.B. PEDIATRIC MULTI-CHANNEL RECORDING

A pediatric multi-channel recording is a continuous and simultaneous recording of at least four channels and may include electrocardiogram (ECG), thoracic impedance, airflow measurements, oxygen saturation, esophageal pH, or strain gauge measurements. Additional channels may be appropriate and do not have to include an electroencephalogram (EEG).

MDHHS policy covers two multi-channel recordings per year per beneficiary under age 21 when provided by qualified personnel and interpreted by the physician. The physician must obtain PA if more than two tests per year are considered medically necessary and must provide a copy of the PA for the hospital's medical record.

Multi-channel recordings are not covered in the beneficiary's home.

3.14 EMERGENCY DEPARTMENT SERVICES

3.14.A. SCREENING EXAM AND STABILIZATION

MDHHS and its contracted health plans must follow the applicable requirements and definitions of the federal EMTALA 42USC§1395dd.



Medicaid policy covers the medical screening examination, any ancillary service(s) if performed in a hospital emergency department (ED) for the sole purpose of determining if an emergency medical condition exists, and any necessary stabilizing treatment.

For both Medicaid FFS and MHP beneficiaries, the screening examination and any physician-ordered procedures (e.g., x-rays, lab, etc.) necessary to determine the patient's condition are covered without PA. For Medicaid FFS beneficiaries, the screening examination and related diagnostic procedures are billed to MDHHS. For Medicaid beneficiaries enrolled in a MHP, these services are billed to the beneficiary's MHP.

Facility charges for the ED screening exam are included in the hospital inpatient admission when services occur at the same facility. If the patient is transported to another facility for a prior authorized inpatient admission, the first hospital's facility fees for the ED are reimbursed separately. In both instances, the professional fees for medical screening and stabilization in the emergency room are reimbursed separately from the facility fees.

3.14.B. TREATMENT OF EMERGENCY MEDICAL CONDITION

PA is not required for the treatment of emergency medical conditions.

An emergency medical condition is defined by the Balanced Budget Act of 1997 and its regulations.

An emergency may exist whether the patient is discharged from the ED or admitted to the inpatient hospital. This includes admissions where death occurs before a bed is occupied.

If an emergency medical condition exists, the medical findings must be fully documented in the patient's medical record.

3.14.C. TREATMENT OF NON-EMERGENCY MEDICAL CONDITION

If the medical findings from the screening determine that the patient's condition does not meet the definition of an emergency medical condition, but requires additional follow-up treatment, the following rules apply:

- MHP enrollees must be referred to their primary care provider for treatment, or the ED can contact the MHP to request authorization to provide the treatment. The hospital must document all telephone calls made to the enrollee's MHP for the purpose of requesting post-stabilization authorization. If the MHP fails to respond within one hour to the request for additional services beyond those required for stabilization, the request for authorization is deemed approved.
- FFS Medicaid beneficiaries with private health insurance must follow the rules of the private health insurance. Private insurances frequently require that the primary care provider for the private insurance perform follow-up treatment. If the private insurance refuses payment for treatment because their rules were not followed, MDHHS does not pay for services. Medically necessary services not covered by the primary insurer that



are covered by Medicaid are reimbursed if the Medicaid coverage requirements are followed.

- FFS Medicaid beneficiaries without private health insurance should be encouraged to obtain treatment from their primary care provider. However, treatment may be rendered in the ED and does not require PA.

3.14.D. PSYCHIATRIC SCREENING AND STABILIZATION SERVICES

Screening and stabilization of a psychiatric emergency does not require PA. A psychiatric emergency is defined as a situation in which an individual must be treated to protect him from inflicting injury to self or others as the result of a serious mental illness, emotional disturbance, or developmental disability or could reasonably be expected to intentionally or unintentionally injure himself or others in the near future. The emergency may result from an inability to provide food, clothing, or shelter for him or others, inability to attend to activities of daily living, or when judgment is so impaired the individual is unable to understand the need for treatment.

If the treating hospital determines that the beneficiary requires post-stabilization psychiatric services, the hospital must contact the Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) for PA. The need for PA includes, but is not limited to, inpatient psychiatric care, partial hospitalization, and/or specialty mental health services. If a beneficiary requires inpatient psychiatric hospitalization and is admitted directly from the ED to the same facility, the local PIHP/CMHSP must prior authorize the admission.

If the beneficiary is transported to another facility for a prior authorized inpatient admission, the first hospital's facility fees for the ED are reimbursed separately.

In both instances, the professional fees for medical screening and stabilization in the ED are reimbursed separately.

3.15 HEARING SERVICES

Hospitals may bill for speech and hearing evaluations, testing, and therapy for beneficiaries of all ages.

Audiology services other than newborn hearing screening tests must be provided by:

- A licensed audiologist.
- An audiologist candidate (i.e., in his clinical fellowship year or having completed all requirements but has not obtained a license) supervised by a licensed audiologist.
- An audiology student completing his clinical affiliation under the direct supervision of (i.e., in the presence of) a licensed audiologist.

Standards of practice must conform to those published in ASHA Preferred Practice Patterns for the Profession of Audiology. Audiologic test equipment and hearing aid test equipment used must conform to applicable American National Standards Institute (ANSI) criteria.



The following equipment must be available to audiologists providing services to infants less than six months of age:

- Infant Diagnostic Testing
 - Tone Burst ABR; and
 - Bone Conduction ABR; and
 - High Frequency Immittance; and
 - Otoacoustic Emissions
- Infant Hearing Aid Evaluation, Selection, and Follow-Up
 - Infant Predictive Method (e.g., Desired Sensation Level); and
 - Real-Ear to Coupler Difference

MDHHS requires that all Medicaid-covered newborns be screened using the auditory brainstem response (ABR) method and/or evoked otoacoustic emissions (EOAE) method as recommended by the American Academy of Pediatrics (AAP).

- Hospitals with 15 or more Medicaid deliveries per year must provide newborn hearing screening using the policies and procedures recommended by the AAP.
- Hospitals with less than 15 Medicaid deliveries per year may provide the service or advise the physician, physician assistant or advanced practice registered nurse to refer the newborn for the hearing screening prior to age one month.

For hospitals that provide EOAE and/or ABR newborn hearing screening, reimbursement is included in the calculation for the DRG. MDHHS recommends hospitals that provide delivery services have qualified staff to:

- Develop screening protocol.
- Appropriately train staff to perform screenings and, in matters of confidentiality, recognition of psychological stress for the parents or guardians, infection control practices, and established policies and procedures for handling newborns in the hospital.
- Develop a system for monitoring the performance of screenings.
- Inform parents/guardians about the procedure(s), potential risks of hearing loss, and the benefits of early detection and intervention.
- Allow parents/guardians an opportunity to decline screening. (Providers must document in the medical record if screening was declined.)
- Delineate responsibility for documenting screening results.
- Develop methods for communicating results in a sensitive and timely manner to the parents/guardians and the physician. If repeat screening is recommended following discharge, establish procedures for appropriate follow-up.
- Report critical data to the State's monitoring program.



3.16 HYPERBARIC OXYGEN THERAPY

Medicaid covers hyperbaric oxygen therapy when provided in a hyperbaric chamber for selected indication (e.g., decompression illness, gas gangrene, etc.). MDHHS follows Medicare's billing guidelines. It is not to be used as a replacement for standard medical management.

3.17 HYSTERECTOMY

Federal regulations prohibit Medicaid reimbursement for hysterectomies solely for the purpose of sterilization. Hysterectomies are also prohibited when performed for family planning purposes even when there are medical indications which, alone, do not indicate a hysterectomy.

A hysterectomy is covered only if the beneficiary has been informed orally, prior to surgery, that a hysterectomy will render her permanently incapable of reproducing. The beneficiary or her representative must sign a written acknowledgment of receipt of that information using the Acknowledgment of Receipt of Hysterectomy Information form (MSA-2218). All items on the MSA-2218 must be completed. The beneficiary (or representative) and the physician (MD or DO) must sign the form. (Refer to the Forms Appendix for a sample form.)

The Acknowledgment of Receipt of Hysterectomy Information form is not required if the beneficiary was already sterile before the hysterectomy.

Refer to the Practitioner Chapter of this manual for instructions regarding the completion and submission of the MSA-2218.

3.18 INJECTIONS/INTRAVENOUS INFUSIONS

MDHHS covers intramuscular, subcutaneous or intravenous injections and intravenous (IV) infusions when medically necessary. In the outpatient hospital (OPH) or Ambulatory Surgical Center (ASC), reimbursement generally follows CMS Outpatient Prospective Payment System (OPPS) guidelines. Injectables paid differently than CMS OPPS are listed on the MDHHS OPPS Wraparound Code List for OPH or ASC. (Refer to the Directory Appendix for website information.)

A list of outpatient physician-administered drugs and biological products carved out from MHPs is maintained on the MDHHS website. Information regarding prior authorization (PA) requirements is also available on the MDHHS website. (Refer to the Directory Appendix for website information. Refer to the Billing & Reimbursement for Institutional Providers chapter for billing instructions.)

Refer to the Pharmacy Chapter of this manual for information regarding Medicare Part D.

3.19 LABOR & DELIVERY/NURSERY

MDHHS covers the labor and/or delivery room(s) or when an active labor does not progress to delivery. During active labor, MDHHS covers a fetal contraction or fetal nonstress test in addition to the labor and delivery room charge. When there is no active labor, MDHHS does not cover labor and/or delivery room charges for fetal monitoring or treatment of other medical conditions.



In an inpatient hospital, services are included in the DRG payment. Inpatient newborn nursery services are covered and must be billed under the newborn's ID number. (Refer to the Billing & Reimbursement for Institutional Providers Chapter of this manual for additional information.)

3.19.A. ELECTIVE, NON-MEDICALLY INDICATED DELIVERY PRIOR TO 39 WEEKS COMPLETED GESTATION

To reduce the rate of elective, non-medically indicated delivery prior to 39 weeks completed gestation, it is the expectation of MDHHS that each Medicaid-enrolled birthing hospital in Michigan utilizes elective delivery evidence-based guidelines (EBGs).

To ensure that each Medicaid-enrolled birthing hospital in Michigan utilizes elective delivery EBGs, each hospital must have a completed Medicaid Enrolled Birthing Hospital Agreement for Elective, Non-Medically Indicated Delivery Prior to 39 Weeks Completed Gestation (MSA-1755) on file with MDHHS. A copy of the form is provided in the Forms Appendix and is also available on the MDHHS website. (Refer to the Directory Appendix for website information.)

Providers are expected to report the appropriate NUBC condition codes for gestational age on the mother's hospital claim when the delivery is related to cesarean sections or inductions.

3.20 LABORATORY

MDHHS follows Medicare's current OPSS coverage policies as closely as possible and appropriate. In those instances where program differences require coverage disparity, the differences will be reflected through the application of the MDHHS specific status indicator. Procedure codes associated with the identified services will appear on the MDHHS OPSS Wraparound Code List available on the MDHHS website. (Refer to the Directory Appendix for website information.)

MDHHS policy covers hospitals for medically necessary laboratory tests when:

- Performed in a laboratory certified by the Clinical Laboratory Improvement Amendments (CLIA);
- Needed to diagnose a specific condition, illness, or injury; and
- Ordered by physicians (MD or DO), physician assistants, podiatrists, dentists, or advanced practice registered nurses.

MDHHS requires medical record documentation of medical necessity. An explanation of the laboratory testing method or the results of diagnostic tests, whether normal or abnormal, is not considered documentation of medical necessity. For approval of payment, the laboratory procedure(s) must be specific and appropriate to the beneficiary's documented condition and diagnosis.

Reimbursement to the inpatient hospital is through the DRG payment.

Reimbursement for outpatient services is billed using the appropriate HCPCS code and includes the collection of the specimen(s), the analysis, and the lab test results. MDHHS performs pre- and/or post-payment reviews to monitor laboratory procedures for medical necessity and appropriate practitioner orders. Outpatient hospitals are subject to corrective action, including the recovery of funds, for laboratory services not specifically ordered by a practitioner.



MDHHS does not cover:

- Screening or routine laboratory testing, except as specified for EPSDT Program or by Medicaid policy;
- "Profiles", "batteries" or "panels" of tests that include tests not necessary for the diagnosis or treatment of the beneficiary's specific condition; or
- Multiple laboratory tests performed as a part of the beneficiary evaluation if the history and physical examination do not suggest the need for the tests.

Services performed by an outpatient hospital laboratory or its employees may not be billed to, or by, the ordering practitioner.

3.20.A. PREGNANCY-RELATED LABORATORY SERVICES

The obstetric profile must be ordered by the attending practitioner and billed as an all-inclusive panel of tests for required prenatal laboratory services. It must include the following:

- Blood count, complete (CBC), automated and automated differential WBC count, or Blood count, complete (CBC), automated and appropriate manual differential WBC count
- Hepatitis B surface antigen (HBsAg)
- Antibody, rubella
- Syphilis test, qualitative (e.g., VDRL, RPR, ART)
- Antibody screen, RBC, each serum technique
- Blood typing, ABO
- Blood typing, Rh(D)

Only AMA-approved organ- or disease-oriented panels may be billed. All tests within the panel must be medically necessary. Unless the complete panel is ordered and performed, bill as individual tests.

Testing for HIV is covered separately when determined to be medically necessary and ordered by the practitioner.

Only practitioners should order the serum or urine HCG qualitative method when the beneficiary requires preliminary pregnancy testing.

Nurse-midwives may order only the laboratory tests listed below. Hospitals are not reimbursed for any other tests ordered by a nurse-midwife.

- Acetone and diabetic acid (ketone bodies); qualitative; semi-quantitative
- Albumin; qualitative, semi-quantitative, quantitative (such as Esbach)
- Antibody titer Rh system; albumin, saline and/or AHG technique
- Blood count; RBC, WBC, Hemoglobin, Hematocrit, indices (MCV, MCH, MCHC)



- Blood typing; ABO, Rh(D), RBC antibody screening
- Culture, presumptive (screening), for Neisseria gonorrhoea, Candida, Hemophilus, or beta hemolytic Streptococcus group A, etc.
- Culture, urine, definitive; with or without colony count
- Cytopathology, vaginal and/or cervical smears (e.g., Papanicolaou type) screening (cytopathological examination for malignancy, microbial flora, inflammatory features and hormonal evaluation)
- Glucose; qualitative, quantitative, timed specimen, tolerance
- Hemoglobin, electrophoretic separation; qualitative
- Hepatitis B test
- Human immunodeficiency virus detection
- Pregnancy test
- Prenatal laboratory services; routine (Obstetric panel)
- Quantitative sediment analysis and quantitative protein (Addis count); 12- or 24-hour specimen Reticulocyte count, manual
- Rubella test; titer
- Sick cell slide test
- Skin test, tuberculosis, tine test
- Susceptibility (sensitivity) for aerobes by Kirby-Bauer procedure for specific pathogens, using 10-12 discs per pathogen; also for susceptibility (sensitivity) for anaerobes by generally accepted standard techniques using 5-12 discs per pathogen (specify number of pathogens)
- Syphilis testing, flocculation or precipitin (VDRL, RPR, etc.); qualitative
- Trepanema antibodies, fluorescent, absorbed (FTA-abs)
- Urinalysis, complete (physical appearance, pH, specific gravity, microscopic examination, qualitative chemistry with or without semi-quantitative confirmation)
- Wet mount, smear, tissue; direct microscopic examination

3.20.B. BLOOD HANDLING

MDHHS reimburses for blood handling only when a beneficiary is referred to an outpatient hospital for the sole purpose of drawing, packaging and mailing a blood sample to MDHHS for HIV-1 viral load analysis and/or CD4/CD8 enumeration. The State provides specimen containers and mailing kits for the analysis. (Requests for supplies and samples for analysis should be sent to the MDHHS Blood Lead Laboratory. Refer to the Directory Appendix for contact information.)



3.20.C. HEMATOLOGY STUDIES

A complete blood count (CBC) with white blood cell (WBC) differential includes the RBC and WBC count, Hgb, Hct, MCH, MCHC, MCV, RBC morphology, platelet estimate, and WBC differential only. If automated instrumentation yields additional test parameters, the results are not reimbursable unless medically necessary and specifically ordered by a practitioner.

3.20.D. MICROBIOLOGY STUDIES

MDHHS coverage and reimbursement for gram fluorescent/acid fast is included in the reimbursement for microbiology when performed on the same DOS for the same beneficiary.

3.20.E. PAP SMEAR

Pap smear screening by a technologist under the supervision of a pathologist is a covered service. If a suspect smear requires additional interpretation by a pathologist, this service is also covered. Only one Papanicolaou test within a 12-month period is covered for each beneficiary, unless medical necessity or history of abnormal findings requires additional studies.

3.20.F. SUBSTANCE ABUSE

For direct-billed laboratory services ordered by a PIHP, the referring provider NPI number must be appropriately reported on the appropriate paper or electronic claim format.

3.20.G. CREATININE BLOOD TESTS

Calculate and report the Glomerular Filtration Rate (eGFR) for tests processed for beneficiaries in outpatient settings and for beneficiaries 18 years of age and older. The eGFR test results must report two values on the lab report for beneficiaries: one for African-American and one for non-African-American, or one value if race is available and able to be used in calculating the value.

3.21 MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Most mental health services provided to Medicaid beneficiaries are covered through the local PIHP/CMHSP. PIHPs/CMHSPs are responsible for direct payment for inpatient psychiatric or partial hospitalization services, related physician services, and specialized community mental health clinical and rehabilitation services that the PIHP/CMHSP has prior authorized. Providers should not bill MDHHS for these services.

Medical/physical health care services (beyond the admission history and physical) and/or physician-ordered medical (nonpsychiatric) consultations required for Medicaid beneficiaries while they are receiving psychiatric inpatient or partial hospitalization services are not the responsibility of the PIHP/CMHSP. For FFS beneficiaries, these services are billed directly to MDHHS. For beneficiaries enrolled in a MHP, the services must be billed directly to the MHP. These services may require PA.



(Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of this manual for additional information.)

3.21.A. ACUTE INPATIENT MEDICAL DETOXIFICATION

Medically necessary inpatient detoxification services are covered only in a life-threatening situation. Medicaid does not cover inpatient detoxification if the beneficiary is simply incapacitated and not in a life-threatening situation. Acute medical detoxification services may be provided by a Medicaid-enrolled hospital without authorization from a PIHP. Acute detoxification services are reimbursed directly by MDHHS for both MHP enrollees and FFS beneficiaries.

For additional substance abuse services, hospitals must refer beneficiaries seeking inpatient acute detox services to the regional PIHP.

3.21.B. INPATIENT PSYCHIATRIC SERVICES

Inpatient stays in a psychiatric unit of a general hospital are covered for beneficiaries of any age. Coverage for inpatient treatment, including related psychiatric visits, in a freestanding psychiatric hospital, both private and state-owned, is limited to eligible beneficiaries under age 21 and age 65 and older. If the beneficiary was an inpatient immediately prior to attaining age 21, he would be eligible to continue as an inpatient until age 22. If the beneficiary is discharged at some time following his 21st birthday, coverage terminates on the discharge date.

All psychiatric admissions and continued stays must be authorized by the local PIHP/CMHSP. (Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of this manual for specific coverages and authorization requirements.)

3.21.C. PSYCHIATRIC PARTIAL HOSPITALIZATION

Psychiatric coverage includes partial hospitalization on a day-care or night-care plan for all beneficiaries, regardless of age. To be eligible for partial hospitalization, the beneficiary must be receiving active psychiatric treatment provided under the direction of a psychiatrist.

All partial hospitalization admissions and continued stays must be authorized by the local PIHP/CMHSP. (Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of this manual for specific coverages and authorization requirements.)

3.21.D. SUBSTANCE ABUSE SERVICES

Medicaid covers acute care detoxification in the inpatient hospital as a FFS benefit. Reimbursement is made directly by MDHHS for both FFS beneficiaries and MHP enrollees.



Admission to the acute care setting for a diagnosis of substance abuse must meet at least one of the following criteria as reflected in the physician's orders and patient care plan:

- Vital signs, extreme and unstable.
- Uncontrolled hypertension, extreme and unstable.
- Delirium tremens, (e.g., confusion, hallucinations, seizures) or a documented history of delirium tremens requiring treatment.
- Convulsions or multiple convulsions within the last 72 hours.
- Unconsciousness.
- Occurrence of substance abuse with pregnancy and monitoring the fetus is vital to the continued health of the fetus.
- Insulin-treated diabetes complicated by diabetic ketoacidosis.
- Suspected diagnosis of closed head injury based on trauma injury.
- Congestive heart disease, ischemic heart disease, or significant arrhythmia as examples of active symptomatic heart disease.
- Suicidal ideation and gestures necessitating suicidal precautions as part of treatment.
- Blood alcohol level 350 mg/dl with a diagnosis of alcohol abuse.
- Blood alcohol level 400 mg/dl with diagnosis of alcohol dependence.
- Active presentation of psychotic symptoms reflecting an emergent/urgent condition.

3.21.E. OTHER SUBSTANCE ABUSE SERVICES

Medicaid covers other substance abuse services provided to beneficiaries. These services are covered under capitation payments to the PIHPs/CMHSPs. (Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of this manual for specific coverages and authorization requirements.)

3.21.F. SUBSTANCE USE DISORDER SERVICES THROUGH PREPAID INPATIENT HEALTH PLANS

The regional PIHP may authorize the following specialized services:

- Outpatient Substance Abuse Treatment
- Assessment, Diagnosis, Beneficiary Placement and Referral
- Intensive Outpatient Counseling
- Approved Pharmacological Supports (Methadone)

Questions regarding substance abuse services should be directed to the regional PIHP.



3.22 ORGAN TRANSPLANTS

MDHHS requires PA from the Office of Medical Affairs (OMA) for organ transplants for all beneficiaries, donors, and potential donor services related to organ transplants except for cornea and kidney. (Refer to the General Information for Providers Chapter of this manual for additional information on prior authorization [PA].) PA is required if additional organ(s) transplantation is to occur during the same operative session, such as a cornea or kidney.

PA is not required if Medicare makes payment and Medicaid liability is limited to coinsurance and deductible. If a Medicare application is pending, the provider must indicate that on the PA request and notify MDHHS when the determination is made. All other insurance resources must be exhausted before Medicaid is billed. The denial notice(s) must be submitted with the claim.

Refer to the Hospital Reimbursement Appendix for information about MDHHS reimbursement for Transplant Services.

For other organ transplant services not described by a specific DRG, the hospital must provide a note/remark on the claim of the type of transplant (i.e., small bowel transplant) performed. All organ transplant claims suspend for manual review of documentation. A copy of the PA letter must be submitted with the claims. Providers must note "PA Letter submitted" in the Remarks section of the claim.

For those transplants requiring PA, MDHHS requires a beneficiary to be evaluated at an accepted transplant center approved by the OMA to determine if he is a good transplant candidate. If the transplant is to take place at a Medicaid-enrolled, in-state hospital, then only the transplant needs PA. If the transplant is to be performed at an out-of-state hospital, then both the evaluation and the transplant must be separately prior authorized. Results from the evaluation must be submitted to the OMA when requesting PA for the transplant.

If the beneficiary is Medicaid-eligible and the donor is not Medicaid-eligible, providers must bill all services under the beneficiary's ID Number and provide complete documentation. If the donor and beneficiary are both Medicaid-enrolled, providers must bill the services under their respective Medicaid ID numbers.

3.22.A. DONOR SEARCH

When the donor search does not result in an organ acquisition and transplant, MDHHS reimburses for a donor search and related charges. These services must be billed as outpatient services, and providers are required to submit a copy of the PA letter for transplant with the claim. Providers must make reference or remark on the claim format that the donor search failed at the time of claim submission.

3.22.B. TRANSPORTATION AND LODGING

MDHHS reimburses for transportation and lodging expenses associated with the evaluation and the transplant for the beneficiary and one accompanying individual (e.g., spouse, parent, guardian). If the beneficiary has CSHCS-only coverage, they must contact the CSHCS office in the LHD of the county where they reside to make travel arrangements. The beneficiary's local MDHHS office should be contacted to make travel



arrangements if the beneficiary has Medicaid-only coverage or they are dually enrolled in CSHCS and Medicaid. If the beneficiary is enrolled in an MHP, contact the MHP regarding transportation arrangements.

3.23 OUTPATIENT OBSERVATION SERVICES

Observation is a defined set of clinically appropriate specific services that include ongoing short-term treatment, assessment and reassessment before deciding whether a beneficiary requires further treatment as a hospital inpatient or discharge from the outpatient hospital. Observation services must also be reasonable and necessary to be covered.

MDHHS follows Medicare's coverage and reimbursement policies related to observation services.

3.24 PERSONAL ITEMS

Personal comfort and convenience items (e.g., toiletries, slippers, hospitality kits, etc.) cannot be billed to MDHHS.

3.25 PREADMISSION DIAGNOSTIC SERVICES

MDHHS follows Medicare policy for all preadmission diagnostic services and other preadmission services (outpatient services treated as inpatient) with a few exceptions in compliance with the law.

All non-diagnostic services rendered in the three-day window prior to the inpatient hospital admission may not be billed separately and must be bundled into the inpatient stay, unless the hospital can document they are unrelated services. MDHHS aligns with Medicare billing guidelines.

3.26 RADIOLOGY

MDHHS covers Medicaid enrolled hospitals for the following medically-necessary radiology services, including diagnostic imaging and radiation therapy and other imaging services:

- Necessitated by injury or disease, including benign or malignant conditions;
- Needed to diagnose a specific condition, illness, or injury; and
- Ordered by physicians (MD or DO), physician assistants, podiatrists, dentists, or advanced practice registered nurses.

The medical record must contain documentation of medical necessity to support all radiology services billed.

Reimbursement to the inpatient hospital is through the DRG payment.

Reimbursement for outpatient services follows Medicare Outpatient Hospital Prospective Payment System (OPPS) rules and includes the use of the facility, equipment, supplies, and attendant personnel required to provide the service. Prior authorization may be required. Refer to the CHAMPS Code Rate and Reference tool for guidance.



MDHHS reimburses for diagnostic imaging and radiation therapy services, including:

Computerized Axial Tomography (CT) Scanning	<p>CT scanning is not covered for routine screening, nonspecific diagnoses, or in situations where less costly diagnostic methods are appropriate.</p> <p>CT scanning procedures must be provided on equipment that has an approved Certificate of Need (CON) on file with MDHHS.</p>
Radiation Therapy	<p>Treatment must be provided on equipment and in locations that meet Federal and State regulatory requirements.</p>
Ultrasonography	<p>Ultrasound procedures are reimbursed when there is clinical evidence in the beneficiary's record to substantiate the medical need for such services. Ultrasound procedures are generally not covered when used as screening procedures or on a routine basis.</p> <p>When billing two ultrasound codes, the diagnosis must reflect the medical need for two procedures.</p> <p>Claims for diagnostic ultrasound procedures that are performed more than once must be documented for medical necessity. Documentation with the claim should clearly state the reason for the repeat procedure. Claims are rejected if the documentation does not support the need for the repeat diagnostic procedure.</p>

3.27 REHABILITATION SERVICES

MDHHS follows Medicare's coverage and reimbursement policies related to Cardiac Rehabilitation (CR), Intensive Cardiac Rehabilitation (ICR), and Pulmonary Rehabilitation (PR).

MDHHS reimburses covered services for CR and ICR services for beneficiaries with chronic and specific medical (diagnosis code specific) conditions, respectively. Hospitals and physicians, any combination of services, may provide the rehabilitation sessions. ICR programs must be approved and certified.

MDHHS reimburses covered services for PR for beneficiaries with obstructive pulmonary disease and other specific medical diagnosis.

3.28 STERILIZATION

MDHHS covers sterilization procedures when specific requirements are met. A sterilization procedure is defined as any medical procedure, treatment, or operation for the sole purpose of rendering an individual (male or female) permanently incapable of reproducing. Surgical procedures performed solely to treat an injury or pathology are not considered sterilizations under Medicaid's definition of sterilization, even though the procedure may result in sterilization (e.g., oophorectomy). The physician is responsible for obtaining the signed Consent for Sterilization (MSA-1959/HHS-687). (Refer to the Forms Appendix for a sample form and to the Directory Appendix for website information.)

Sterilizations are reimbursed only if:

- The beneficiary is at least 21 years of age at time of informed consent.
- The beneficiary is not legally declared to be mentally incompetent.
- The beneficiary is not institutionalized in a corrective, penal, or mental rehabilitation facility.



- Informed consent is obtained.
- Informed consent is not obtained while the beneficiary is in labor or childbirth; seeking to obtain or obtaining an abortion; or under the influence of alcohol or other substances that affect the beneficiary's state of awareness.
- Informed consent must be obtained not less than 30 days nor more than 180 days prior to sterilization.

The only exception is in the case of premature delivery or emergency abdominal surgery. If the premature delivery or emergency abdominal surgery occurred before the 30-day waiting period is over, at least 72 hours must have passed between the time of obtaining informed consent and the sterilization procedure.

- In some cases of premature delivery, informed consent must have been given at least 30 days before the expected delivery date. The consent form must indicate the expected date of delivery.
- In cases of abdominal surgery, the emergency nature of the surgery must be clearly identified, e.g., diagnosis, physician's statement, or hospital summary. The nature of the emergency must be included on the consent form.

Federal regulations require that the completed MSA-1959/HHS-687 must be submitted to MDHHS before reimbursement can be made for any sterilization procedure. A copy must be attached to the claim form unless submitted via fax prior to filing the claim. MDHHS allows for submission of MSA-1959/HHS-687 forms via fax to encourage electronic billing and reduce administrative burden. This process can also pre-confirm the acceptability of the completed consent form and reduce costly claim rejections. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for information regarding the completion and submission of the MSA-1959/HHS-687.

3.29 SURGERY

MDHHS reimburses for surgeries performed in an inpatient hospital through the DRG payment.

When an ambulatory surgery is performed in the inpatient hospital setting, the physician/dentist must provide exception rationale justifying the need for an inpatient setting. Acceptable rationale includes:

- A medical condition that requires prolonged postoperative observation by skilled medical personnel (e.g., heart disease, severe diabetes);
- A pre-existing condition that significantly increases the risk of using anesthesia;
- The beneficiary has been admitted to a hospital for another procedure or condition, and the surgeon determines that additional surgical procedures are necessary;
- An unrelated procedure is being done simultaneously which, by itself, requires hospitalization;
- Another surgical procedure is expected to follow the initial procedure (e.g., gynecological laparoscopy followed by an oophorectomy);



- Technical difficulties, as documented by admission or operative notes; or
- Adequate outpatient facilities are not available within a reasonable distance (i.e., 40 miles) requiring the surgery to be rendered on an inpatient basis. In this case, MDHHS allows a one-day inpatient hospital stay, unless a longer stay is medically necessary.

If the physician planned to perform the surgery on an outpatient basis, but more extensive surgery was needed or complications developed and the beneficiary had to be admitted, a Prior Authorization Certification Evaluation Review (PACER) number is not needed for the admission. This type of admission is considered urgent or emergent. The need for the admission is, however, subject to retrospective review by the ACRC.

MDHHS follows Medicare's Inpatient Only policy for outpatient surgeries.

MDHHS covers a second surgical opinion if the beneficiary or the physician/dentist requests one.

3.29.A. OPERATING ROOM

Inpatient coverage and reimbursement is through the DRG payment.

Outpatient providers must bill the appropriate HCPCS/CPT support code(s) operating room services and surgical supplies. The main payment methodology for the OPSS is the APC which is used by Medicare. Per Federal Regulations, the MDHHS OPSS 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.

3.29.B. RECOVERY ROOM

MDHHS policy covers routine supplies, anesthesia, and recovery room use. Most drugs are considered to be an integral part of a surgical procedure. Payment for these items is packaged into the APC payment for the surgical procedure.

Inpatient coverage and reimbursement is through the DRG payment.

Outpatient providers must bill appropriately for the Recovery Room. MDHHS follows Medicare's coverage and reimbursement policies for outpatient providers.

3.29.C. COSMETIC SURGERY

Hospital charges related to cosmetic surgery are not reimbursable without PA for the surgery. The physician/dentist must furnish the hospital with a copy of the PA letter for the surgery, as well as the PACER number for the admission.

3.30 OCCUPATIONAL THERAPY

Occupational Therapy services provided during an inpatient stay do not require PA for reimbursement. Refer to the Standards of Coverage and Service Limitations Section of the Therapy Services Chapter for criteria.



Refer to the Standards of Coverage and Service Limitations Section of the Therapy Services Chapter for therapy provided in the outpatient hospital setting. The MDHHS OPSS aligns as closely as possible with Medicare's billing and coverage guidelines for "sometimes therapy" services that may be reimbursed as non-therapy services for hospital outpatients. Refer to the therapy codes and their respective designations used for therapy services (i.e., "always therapy" and "sometimes therapy") found on the CMS website. (Refer to the Directory Appendix for website information.)

3.31 PHYSICAL THERAPY

Inpatient hospital physical therapy does not require PA for reimbursement. Refer to the Therapy Services Chapter of this manual for standards of coverage and service limitations for therapy provided in the outpatient hospital setting.

The MDHHS OPSS aligns as closely as possible with Medicare's billing and coverage guidelines for "sometimes therapy" services that may be reimbursed as non-therapy services for hospital outpatients. Refer to the therapy codes and their respective designations used for therapy services (i.e., "always therapy" and "sometimes therapy") found on the CMS website. (Refer to the Directory Appendix for website information.)

3.32 THERAPY, SPEECH-LANGUAGE PATHOLOGY

Speech-language pathology services provided during an inpatient admission do not require PA.

Refer to the Therapy Services Chapter of this manual for standards of coverage and service limitations for therapy provided in the outpatient hospital setting. The MDHHS OPSS aligns as closely as possible with Medicare's billing and coverage guidelines for "sometimes therapy" services that may be reimbursed as non-therapy services for hospital outpatients. Refer to the therapy codes and their respective designations used for therapy services (i.e., "always therapy" and "sometimes therapy") found on the CMS website. (Refer to the Directory Appendix for website information.)

3.33 TELEMEDICINE

A hospital can be either an originating or distant site for telemedicine services. Refer to the Billing & Reimbursement for Institutional Providers Chapter for specific billing instructions. Refer to the Telemedicine Section of the Practitioner Chapter for additional information regarding telemedicine services.

Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

3.34 WEIGHT REDUCTION

MDHHS policy covers obesity treatment when done for the purpose of controlling life-endangering complications such as hypertension and diabetes. This does not include treatment specifically for obesity, weight reduction and maintenance alone. The physician must request PA and document that other weight reduction efforts and/or additional treatment of conservative measures to control weight and manage the complications have failed.



The request for PA must include:

- The medical history;
- Past and current treatment and results;
- Complications encountered;
- All weight control methods that have been tried and failed; and
- Expected benefits or prognosis for the method being requested.

If surgical intervention is desired, a psychiatric evaluation of the beneficiary's willingness/ability to alter their lifestyle following surgical intervention must be included.

Mail requests to Office of Medical Affairs (OMA). (Refer to the Directory Appendix for contact information.)

If the request is approved, the provider receives an authorization letter for the service, including billing instructions. A copy of the authorization letter must be attached to all claims submitted to MDHHS for weight reduction services.



SECTION 4 – UTILIZATION REVIEW

4.1 NONCOVERED ADMISSIONS

For Medicaid reimbursement, all inpatient admissions must be medically necessary and appropriate. MDHHS does not cover inpatient hospital admissions for the sole purpose of:

- Cosmetic surgery (unless prior authorized)
- Custodial or protective care of abused children
- Diagnostic procedures that can be performed on an outpatient basis
- Laboratory work, electrocardiograms (ECGs), electroencephalograms (EEGs), diagnostic x-rays
- Observation
- Occupational therapy (OT)
- Patient education
- Physical therapy (PT)
- Routine dental care
- Routine physical examinations not related to a specific illness, symptom, complaint, or injury
- Speech pathology
- Weight reduction; weight control (unless prior authorized)

Inpatient claims with discharge date prior to October 1, 2014 where that stay has been denied as inappropriate or unnecessary may not be resubmitted to MDHHS as outpatient charges. Charges resubmitted as outpatient charges are monitored, and any payment made may be recovered during a post-payment audit. Any accommodations or ancillary services provided during nonallowable admissions or parts of stays will not be reimbursed.

Medically inappropriate or unnecessary admissions claims with dates of discharge on or after October 1, 2014 may be resubmitted as outpatient claims (Type of Bill 013x) for all outpatient services and any inpatient ancillary services performed during the inpatient stay.

Hospitals may not bill beneficiaries for any medical charges for goods and services provided during a nonallowable admission. The beneficiary is assumed to be following the physician's advice.

4.2 INPATIENT AND OUTPATIENT POST-PAYMENT REVIEWS

MDHHS and/or its audit contractor will perform automated reviews and medical record reviews on inpatient and outpatient services that have been paid. An automated review is a re-examination of a claim payment at the system level. These reviews will focus on errors in pricing, coverage, coding determinations and payment of duplicate claims. A medical record review is a more comprehensive comparison of a hospital's Medicaid claims against the hospital's medical records.

The objective of the MDHHS post-payment review process is to ensure that MDHHS reimbursement is for medically necessary care provided in the appropriate setting, that diagnostic and procedural information is valid, and that the care rendered meets current clinical and quality standards of practice. Cases are



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reviewed using Medicaid-approved Severity of Illness/Intensity of Services (SI/IS) criteria, clinical judgment and generic quality screens.

All reviews include consideration of medical necessity, appropriateness of setting, coding validity/accuracy, and the quality and intensity of care provided to the beneficiary. The audit will also ensure that the quality and intensity of hospital services conform to current and acceptable standards of medical practice and Medicaid policies, procedures, and coding guidelines.

4.3 CONFIDENTIALITY

As an agent of the State, the MDHHS audit contractor may access all records related to care provided to Medicaid beneficiaries and is subject to the same state and federal confidentiality requirements as Medicaid staff. The failure of a hospital to make all records available to the contractor will result in denial of that case and subjects that hospital to Medicaid participation sanctions.

(Refer to the Directory Appendix for MDHHS hospital audit contractor contact information.)



SECTION 5 – DISCHARGE PLANNING

As part of utilization review, the hospital should consider various alternatives for care of the beneficiary through discharge planning. The medical and social services personnel of the hospital should assist in this effort. If so requested by the hospital, the local MDHHS office assists in relocating the beneficiary. The following subsections explain possible alternatives for care.

5.1 HOME HELP

The beneficiary is able to remain in his own home. Home Help providers perform unskilled household and personal care tasks that the beneficiary cannot do himself. Home Help, Home Health, Home for the Aged, Adult Foster Care, and MI Choice Waiver services may be provided singly or in combination (excluding the combination of Home Help and MI Choice Waiver services) as defined in Medicaid policy.

5.2 HOME HEALTH

The beneficiary resides in his own home or other place of residence (e.g., foster care, home for the aged), is under a physician's (MD, DO) care, and requires intermittent nursing care for a specified period of time. Home Help, Home Health, Home for the Aged, Adult Foster Care, and MI Choice Waiver services may be provided singly or in combination as defined in Medicaid policy.

5.3 HOME FOR THE AGED

The beneficiary (age 62 or older) receives supervision and non-nursing care in a licensed home. Home Help, Home Health, Home for the Aged, Adult Foster Care, and MI Choice Waiver services may be provided singly or in combination, as defined in Medicaid policy.

5.4 ADULT FOSTER CARE HOME

The beneficiary is in a licensed home that provides supervision, assistance, protection, and personal care, in addition to room and board. This type of home does not provide continuous medical care. Home Help, Home Health, Home for the Aged, Adult Foster Care, and MI Choice Waiver services may be provided singly or in combination, as defined in Medicaid policy.

5.5 HOME AND COMMUNITY BASED WAIVER FOR THE ELDERLY AND DISABLED (MI CHOICE WAIVER PROGRAM)

The beneficiary must meet the eligibility criteria in the Michigan Medicaid Nursing Facility Level of Care Determination and require two waiver services, one of which must be Supports Coordination. Referrals are made to regional waiver providers who are responsible for screening and assessing the beneficiary for waiver eligibility. Once determined eligible, services are provided in the beneficiary's home to help the beneficiary remain as independent as possible. These services may include skilled nursing, respite care, counseling, etc.

Home Help, Home Health, Home for the Aged, Adult Foster Care, and MI Choice Waiver services may be provided singly or in combination, as defined in Medicaid policy.



Michigan Medicaid Nursing Facility Level of Care Determination

The Michigan Medicaid Nursing Facility Level of Care Determination form must be completed for every Medicaid beneficiary prior to admission to the MI Choice Waiver. The MI Choice Waiver program agent must verify beneficiary appropriateness for services by completing the electronic web-based version of the form. Beneficiaries who do not demonstrate functional/medical eligibility through the electronic web-based tool are not eligible for the MI Choice Waiver Program.

Information regarding the Michigan Medicaid Nursing Facility Level of Care Determination process, the form, and the Field Definition Guidelines are on the MDHHS website. (Refer to the Directory Appendix for website information.)

While the MI Choice Waiver agent is the actual entity that must complete and submit the form, hospitals are encouraged to assess a beneficiary's functional/medical eligibility for the MI Choice Waiver using a copy of the form. A hospital may also use the Telephone Intake Guidelines to conduct an initial assessment of potential eligibility for the program. The Guidelines are also available on the MDHHS website.

5.6 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

The Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) must be completed for every Medicaid beneficiary prior to admission to the PACE. The PACE agent must verify beneficiary appropriateness for services by completing the online version of the LOCD. Beneficiaries who do not demonstrate functional/medical eligibility through the online LOCD are not eligible for PACE.

Information regarding the LOCD process, the LOCD assessment, and the LOCD Field Definition Guidelines is on the MDHHS website. (Refer to the Directory Appendix for website information.)

While the PACE agency is the actual entity that must complete and conduct the online LOCD, hospitals are encouraged to assess a beneficiary's functional/medical eligibility for PACE using a copy of the LOCD. A hospital may also use the Telephone Intake Guidelines. The Guidelines are also available on the MDHHS website.

5.7 PRIVATE DUTY NURSING

The beneficiary requires more individualized and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of a hospital or skilled nursing facility. Private duty nursing (PDN) enables the beneficiary to remain in their home. This service is a benefit for beneficiaries under age 21.

If the beneficiary is enrolled in or receiving case management services from one of the following programs, the applicable program authorizes the PDN:

- Habilitation Supports Waiver (the Community Mental Health Services Program) and over age 21
- Home and Community-Based Services Waiver for the Elderly and Disabled (the MI Choice Waiver)

For a Medicaid beneficiary who is not receiving services from one of the above programs, the Program Review Division reviews the request for authorization and authorizes the services if the medical criteria and general eligibility requirements are met.



The Private Duty Nursing Prior Authorization – Request for Services form (MSA-0732) must be submitted when requesting PDN services for persons with Medicaid coverage. A copy of the form is provided in the Forms Appendix and is also available on the MDHHS website. (Refer to the Directory Appendix for website information.) This form is not to be used for beneficiaries enrolled in, or receiving case management services from, the Children's Waiver, Habilitation Supports Waiver, or MI Choice Waiver. Private Duty Nursing is not a benefit under CSHCS. Individuals with CSHCS coverage may be eligible for PDN under Medicaid.

For beneficiaries age 21 and older, this service is a waiver service that may be covered for qualifying individuals enrolled in the MI Choice Waiver or the Habilitation Supports Waiver.

5.8 NURSING FACILITY

If the beneficiary requires less than acute, continuous medical care, a nursing facility (NF) may be appropriate. This includes a nursing home, medical care facility, or hospital long-term care unit. The Beneficiary Eligibility Chapter of this manual contains information about the facility admission and discharge process. (Any other alternatives for care (e.g., Home Help) may not be provided to the beneficiary while he is in the nursing facility.)

Medicaid's reimbursement (per diem rate) to a nursing facility includes non-emergency transport of beneficiaries being admitted to a nursing facility from the hospital setting.

There are necessary components for determining eligibility for Medicaid nursing facility reimbursement.

- A physician-written order for nursing facility admission is required. By renewing orders, the physician certifies the need for continuous nursing facility care. The order must be signed and dated by the physician. A stamped signature is not acceptable.
- With the exception of beneficiaries 21 years of age or under residing in a psychiatric facility, a physician (MD or DO) must approve a beneficiary's need for long-term care not more than 30 calendar days prior to the beneficiary's admission to a nursing facility.
- Verification of Medicaid financial eligibility for nursing facility care as determined by MDHHS.
- A Pre-admission Screening/Annual Resident Review (PASARR) process must be performed prior to admission to a nursing facility. The purpose of the screening is to prevent placement of beneficiaries with mental illness, intellectual/developmental disability or a related condition into a nursing facility unless their medical needs clearly indicate that they require the level of care provided by a nursing facility. Level I screening is documented on the Preadmission Screening (PAS)/Annual Resident Review (ARR) (Mental Illness/Intellectual/Developmental Disability/Related Conditions Identification) form (DCH-3877). The Level I screening is part of the hospital discharge planning process and must be completed by a registered nurse, licensed Bachelor's or Master's Social Worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or physician.

The PASARR process is not required when:

- An individual is admitted to an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).



- An individual is admitted to, and residing in, a hospital swing bed. However, the PASARR process must be completed prior to admission if the individual transfers to a nursing facility.
- A resident is readmitted to a nursing facility after a hospital stay. If the Annual Resident Review date occurs during a period of hospitalization, the screening must be completed within 30 days of admission or readmission to the nursing facility.

All individuals identified by Level I screening as possibly having a mental illness, intellectual/developmental disability or a related condition (a "yes" response to any question on the DCH-3877) must receive a Level II evaluation, unless it is documented that they meet one of the exemption criteria outlined on the Mental Illness/Intellectual/Developmental Disability/Related Condition Exemption Criteria Certification form (DCH-3878) or MDHHS/CMHSP finds that the individual does not meet the criteria for a serious mental illness under the PASARR provisions.

(Refer to the Forms Appendix for a copy of the forms.)

- A Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) must be completed for every Medicaid beneficiary prior to admission to a nursing facility. The nursing facility must verify beneficiary appropriateness for nursing facility care by completing the online version of the LOCD. Beneficiaries who do not demonstrate functional/medical eligibility through the online LOCD are not eligible for nursing facility care. Refer to the Coverages portion of the Nursing Facility Chapter for additional information regarding the LOCD.

While the nursing facility is the actual entity that must complete and submit the LOCD, hospitals are encouraged to assess a beneficiary's functional/medical eligibility for nursing facility care using a hard copy of the LOCD. A hospital may also use the Telephone Intake Guidelines. The Guidelines are also available on the MDHHS website.

5.9 SPECIAL NURSING FACILITY PLACEMENT

5.9.A. MEDICAID VENTILATOR-DEPENDENT CARE

There may be occasions when a beneficiary no longer requires acute hospital care but requires specialized care in a Ventilator Dependent Care Unit (VDCU). Medicaid authorizes admission of ventilator dependent Medicaid beneficiaries to hospital and nursing facility ventilator units with which it has agreements to provide VDCU services.

A request for placement must show that:

- The beneficiary is dependent on life-supporting mechanical ventilating equipment for at least six hours per day.
- The beneficiary stay normally meets or exceeds the hospital high-day outlier threshold for DRG 207.

Approval for admission to a VDCU will not be given for a beneficiary who is only on CPAP or BIPAP.



If a beneficiary has weaning potential or requires other rehabilitative services (in addition to the respiratory care) and is enrolled in a Medicaid Health Plan (MHP), the MHP is responsible for the first 45 days reimbursement in the post-acute setting. If there is no weaning potential and the beneficiary does not require rehabilitative services, disenrollment from the MHP may occur at the time the beneficiary is discharged from the hospital.

The MHP is responsible for initiating disenrollment of a beneficiary by submitting the Request for Disenrollment Long Term Care form (MSA-2007) to MDHHS.

In situations where a beneficiary cannot immediately be placed in a nursing facility or hospital VDCU, Medicaid will cover nursing days in the inpatient hospital. The hospital cannot charge a beneficiary the difference between the hospital's charge and the MDHHS payment for nursing days.

When the beneficiary is in the hospital setting because a nursing facility placement is not available, Medicaid will cover the ancillary services provided by the hospital.

If a beneficiary refuses an appropriate placement to a VDCU, the beneficiary is responsible for all hospital charges incurred after the date of referral.

To begin the prior authorization process once a VDCU has agreed to accept the beneficiary, the hospital discharge planner must provide the following documentation to the VDCU:

- History and physical from the current hospital admission;
- All consults from the current hospital admission;
- Any labs, diagnostic testing or procedures pertaining to or impacting the beneficiary's respiratory status; and
- Two to three days of current ventilator flow sheets.

For status of the authorization, the hospital discharge planner should contact the VDCU. The VDCU will initiate the actual prior authorization with Medicaid.

5.9.B. COMPLEX CARE

The Complex Care Prior Approval-Request/Authorization for Nursing Facilities form (MSA-1576) is used to request prior approval (PA) for the placement of a Medicaid beneficiary for whom placement from a hospital has been, or could be, hindered due to the cost and/or complexity of nursing care or special needs. Prior authorization covers an individually negotiated reimbursement rate for the placement. Special individualized placement requests and payment arrangements are based on medical necessity and/or service/supply needs exceeding those covered by Medicaid reimbursement for routine nursing facility care.



Examples include, but are not limited to:

- Ventilator dependent care (for nursing facilities not contracted with MDHHS to provide ventilator dependent care)
- Multiple skin decubiti utilizing several treatment modalities
- Tracheostomy with frequent suctioning needs
- Beneficiaries who require intensive nursing care or treatment

Program requirements:

- Referrals must come from the nursing facility.
- Hospitals must document that at least ten (10) Medicaid certified nursing facilities within a 50 mile radius of the hospital refused to admit the beneficiary due to the complexity of the patient's care needs.

If it appears that a beneficiary, upon discharge, will require intensive nursing care, the hospital's discharge planning coordinator should initiate nursing facility contact as early in the beneficiary's hospital stay as possible to ensure a smooth transition to the nursing facility.

5.10 DIAPERS FOR HOME USE

The hospital should contact the Volume Purchase Contract vendor to determine if the beneficiary is currently receiving diapers through the Volume Purchase Contract. (Refer to the Directory Appendix for contact information.) If so, then no further action is required.

For beneficiaries who are not currently receiving diapers, the hospital must obtain a complete physician prescription. The hospital must fax the complete prescription to the contract vendor no later than 72 hours prior to discharge. A complete prescription must include:

- Medical diagnosis of condition causing incontinence (primary and secondary diagnosis)
- Specific type of diaper to be dispensed
- Duration of need
- Quantity of diapers needed for the first 30 days after discharge
- Required beneficiary information:
 - Full name
 - Medicaid and Medicare identification numbers
 - Full home address, including city, state and zip code
 - Home phone number
 - Name and phone number of contact person other than beneficiary to ensure delivery if beneficiary is not present



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Diapers are covered for individuals age three and older if the following criteria are both met:

- Beneficiary has a medical condition resulting in incontinence and has failed to respond to a bowel/bladder training program; and
- The medical condition being treated results in incontinence, and the beneficiary would not benefit from a bowel/bladder training program.



HOSPITAL REIMBURSEMENT APPENDIX

SECTION 1 – OUTPATIENT [CHANGE MADE 10/1/20]

Reimbursement to outpatient hospitals, including off-campus satellite clinics, hospital-owned ambulance services, freestanding dialysis centers (ESRDs), comprehensive outpatient rehabilitation facilities (CORFs), and rehabilitation agencies for outpatient services is made in accordance with Medicaid's Outpatient Prospective Payment System (OPPS). No facilities (i.e. critical access or children's hospitals) are excluded from Medicaid's Ambulatory Payment Classification reimbursement methodology. Payment made under OPPS is calculated utilizing current Medicare rates, with a MDHHS reduction factor applied, unless otherwise noted in this section. Separate OPPS reduction factors are established for Critical Access Hospitals (CAHs) and non-CAHs. (text added per bulletin MSA 20-39)

Reimbursement for outpatient hospital services will be monitored and adjustments will be made to the MDHHS reduction factor, as necessary, to ensure spending limits fall within the MDHHS appropriation. A wage index of 1.0 is applied for all hospitals. Medicare's APC weights are utilized. Services reimbursed at a percent of charges are paid a percentage of the individual hospital's charges for the service (i.e., pass-through payments). Updates of hospitals' cost-to-charge ratios are done in conjunction with updates to the inpatient operating ratios. The default cost-to-charge ratio is the average statewide outpatient cost-to-charge ratio for out-of-state ratios.

1.1 AMBULATORY PAYMENT CLASSIFICATION REIMBURSEMENT METHODOLOGY

The main payment methodology for the OPPS is the APC which is used by Medicare.

1.2 OUTPATIENT CODE EDITOR WITH AMBULATORY PAYMENT CLASSIFICATION

MDHHS uses Medicare's Outpatient Code Editor (OCE), including Medicaid National Correct Coding Initiative (NCCI), editing. Per Federal Regulations, the MDHHS OPPS uses Medicaid NCCI and MUE values for OPH claims processing. Medicaid NCCI and MUE values are reviewed with the quarterly file updates. The OCE is updated quarterly. The two main functions of the OCE are to identify errors and to assign APCs. In addition, the software performs the following functions when processing a claim:

- Edits a claim for accuracy of the submitted date;
- Assigns payment indicators;
- Determines if packaging is applicable;
- Determines the disposition of a claim based on generated edits;
- Computes discounts and outliers, if applicable;
- Determines payment adjustment, if applicable.

MDHHS uses proprietary edits that are not duplicated by the OCE to review beneficiary and provider eligibility, third party liability, quantity/frequency of services, diagnosis, and other information normally reviewed by the fiscal intermediary under the Medicare OPPS.



1.3 STATUS INDICATORS

MDHHS follows Medicare’s single character status indicator assigned to each individual CPT or HCPCS code to identify if a code will be paid and how it will be paid.

For categories of codes that MDHHS covers differently than Medicare under its OPPS (wraparound codes), the following alpha-numeric status indicators are used.

MDHHS Specific Status Indicators

Status Indicator	Description	Comments
A1	MDHHS covered	
A2	Series-billed dialysis service (revenue codes 82x, 83x, 84x, 85x)	Paid based on associated MDHHS fee schedule
A3	Hospital-owned ambulance services	Paid based on associated MDHHS fee schedule
A4	Non-Medicare covered services (e.g., family planning, dental, sterilization, abortion, etc.)	Paid based on associated MDHHS fee schedule
A5	Non-Medicare covered adult vaccines	Paid based on associated MDHHS fee schedule
A6	Vaccines For Children	Zero payment; Vaccines For Children (VFC) program
A7	State Plan Reimbursement	
A8	Healthy Michigan Plan Only	
R1	MDHHS non-allowed item or service (e.g., aquatic therapy, infertility services, etc.)	Items, codes, and services that are not covered by MDHHS

1.4 PACKAGED/BUNDLED SERVICES

MDHHS follows Medicare guidelines for packaged/bundled service costs. Services having a status indicator of "N" are considered packaged or bundled into other services. The costs of these services are allocated to the APC but are not paid separately.

Reimbursement to hospitals for outpatient services is made in accordance with Medicaid's maximum fee screens, the hospital's usual and customary (U&C) charges, or Medicare's reasonable costs, whichever is less.



1.5 PAYMENT CALCULATION

Payments made under the MDHHS OPPS methodology are calculated utilizing the current Medicare conversion factors/rates with an MDHHS reduction factor (RF) applied to the calculated payment (Medicare fee x RF = Medicaid fee).

The MDHHS payment is the lesser of:

- the Medicaid fee screen/allowable amount, minus any Medicare or other insurance payments, and any applicable Medicaid copayment, patient-pay, and/or deductible; or
- (for fee schedule items) the provider's charge, reduced by any contractual adjustments, minus any Medicare or other insurance payments, and any applicable Medicaid copayment, patient-pay, or deductible amount; or
- the beneficiary's liability for coinsurance, copayments, and/or deductibles.

For claims when a provider bills charges less than the OPPS/APC amount for non-fee schedule items, the MDHHS payment liability is the APC amount minus any Medicare or other insurance payments up to the coinsurance, copayment, and/or deductible amount reported.

Additional billing and reimbursement information is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

1.6 DISCOUNTED PROCEDURES

MDHHS follows Medicare rules for discounting payment for multiple, bilateral or discontinued procedures (OPPS status indicator "T").

1.7 OUTLIER PAYMENTS

MDHHS follows Medicare's APC outlier payment policy. The MDHHS reduction factor is not applied to outlier payments.

1.8 SERVICES PAID A PERCENT OF CHARGES

Services that are paid a percent of charges are paid at a percentage of the hospital's charges for that service (e.g., pass-through payments). Each hospital's current Medicaid outpatient cost-to-charge ratio is used for the initial OPPS implementation. Updates of the outpatient cost-to-charge ratios are done in step with inpatient operating ratio updates. For out-of-state hospitals, the default cost-to-charge ratio is the average statewide outpatient cost-to-charge ratio. The MDHHS reduction factor is not applied to services paid a percent of charge.

1.9 PASS-THROUGH PAYMENTS

Pass-through payments are generally for new drugs, biologicals, radiopharmaceutical agents, and medical devices. Drugs and devices having a status indicator of "G" or "H" receive a pass-through payment. In some instances, the procedure code may have an APC code assigned. The MDHHS reduction factor is not applied to drugs or devices with a status indicator of "H".



1.10 FEE SCHEDULES

MDHHS utilizes Medicare fee schedules with the MDHHS reduction factor applied, except as described above.



SECTION 2 - INPATIENT

2.1 SERVICES INCLUDED IN THE INPATIENT PAYMENT

The following services are included in the inpatient payment:

- All routine services (e.g., room and board, nursing).
- All diagnostic/ancillary services (e.g., radiology, pharmacy, therapists, supplies, pathology).
- While a patient is in the inpatient setting, the facility charges for any services performed by persons or entities other than the patient's hospital (e.g., an independent lab, a second hospital where no transfer occurs) are covered in the payment to the patient's hospital and must not be billed separately. All charges must be included on the inpatient claim of the patient's hospital. Any payments due to the second party are the responsibility of the patient's hospital.
- All pathology services that are performed by the pathologist but do not directly relate to the specific patient's care.
- All emergency room services provided by the hospital that result in an inpatient admission to that hospital. All charges must be included on the inpatient claim.
- An orthosis or prosthesis that is required for inpatient treatment, a surgical postoperative procedure or as a routine service of the hospital should be included as a supply on the inpatient claim and is reimbursed under the appropriate DRG.

Examples of items that are included in the inpatient payment are:

- Pacemakers
- Hip replacements
- Made-to-measure braces for compression fractures
- Compression stockings (TED, Jobst)
- Halos
- Immediate post-surgical or early fitting of prosthetic devices, etc.

2.2 SERVICES EXCLUDED FROM THE INPATIENT PAYMENT

The following services are excluded in the inpatient payment:

- An orthosis or prosthesis that is required for rehabilitation and will be utilized after discharge, and/or is required to address a long term, lifetime, permanent need. An orthotist/prosthetist must bill these items separately to Medicaid. Prior authorization (PA) must first be obtained for appropriate procedure codes.
- Except as noted above, outpatient services may not be separately billed while a beneficiary is in the inpatient setting. All charges must be included on the inpatient claim.



- Any services that are covered by Medicaid and excluded from the inpatient payment may be separately billed if the provider of the service is properly enrolled in the program and a claim is submitted appropriately.

The following are examples of services excluded from the inpatient payment. This list may not be all-inclusive:

- Anatomic pathology services provided directly by a pathologist.
- Orthoses/prostheses required for rehabilitation that will be utilized after discharge, and/or are required to address a long term, lifetime, permanent need. Additional examples of items that are excluded from the inpatient payment are a knee-ankle-foot orthosis or an ankle-foot orthosis.
- Professional services (e.g., practitioner, dental, podiatric, optometric).
- Services provided by a certified nurse midwife (CNM).
- Services provided by a certified registered nurse anesthetist (CRNA).
- Ambulance services.

2.3 ALL PATIENT REFINED DIAGNOSIS RELATED GROUPEr SYSTEM

Effective for inpatient discharges on or after October 1, 2015, the Medicaid diagnosis related grouper (DRG) reimbursement system uses the All Patient Refined Diagnosis Related Grouper (APR-DRG) system. The following sections apply to the APR-DRG reimbursement system.

2.3.A. REIMBURSEMENT FOR MEDICAL AND SURGICAL HOSPITALS

2.3.A.1. DESCRIPTION OF MEDICAL/SURGICAL EPISODE FILE

The episode file is comprised of the underlying data used to calculate the statewide rate, relative weights, and alternate weights. The costs associated with episodes from the episode file are standardized as described below. The episode file is comprised of two years of Medicaid and Children's Special Health Care Services fee for service (FFS) paid claims and managed care encounters.

Each claim or encounter from the episode file is assigned a DRG value using the APR-DRG Grouper in effect nationally on October 1 of the applicable rate year. The data are adjusted to:

- Eliminate episodes for dual Medicare/Medicaid eligible beneficiaries, unless paid a full Medicaid DRG.
- Eliminate certain transplants and low day outlier episodes assigned to DRGs reimbursed by multiplying a hospital's operating cost-to-charge ratio by charges.
- Eliminate episodes without any charges or days.
- Assign alternate weights for neonatal services. Two sets of weights are calculated for the DRG classifications representing neonatal services (DRGs 580x-640x). These alternate weights are calculated based on episodes that are assigned to one of these DRGs and include charges for services in a Neonatal Intensive Care Unit (NICU). The



remaining claims assigned to these DRGs are used for the base weights. No other alternate weights are assigned.

- Limit episodes to those from Michigan hospitals, including hospitals that are no longer in operation (provided that hospital cost report data is available).
- Limit episodes to those with a valid discharge status.
- Eliminate episodes with a zero dollar Medicaid liability.
- Eliminate episodes that qualify for the Short Hospital Stay rate.
- Determine the low day trim point and average length of stay. (Refer to the Relative Weights section of the Reimbursement for Medical/Surgical Hospitals section of the State Plan for additional information.)
- Limit episodes ending in a transfer to another acute setting to those whose length of stay was at least equal to the published average length of stay for the DRG. (Since DRGs 580x and 581x are transfer DRGs, all transfer costs are included within those DRGs).
- Inflate the first year of episodes to the second year through application of an inflation factor derived from IHS Global Insight.
- Recognize area cost differences by dividing the charges for each hospital by an area wage index. (Refer to the Area Wage Index section of the Reimbursement for Medical/Surgical Hospitals section of the State Plan for additional information regarding the area wage index.)
- Adjust charges for high cost outliers to remove the amount paid as an outlier. (Refer to the High Cost Outlier section of the Reimbursement for Medical/Surgical Hospitals section of the State Plan for additional information regarding cost outliers.)
- The adjusted cost for each episode is calculated by multiplying the adjusted charges for the episode by the inpatient operating cost-to-charge ratio. (Refer to the Cost-to-Charge Ratio section of the Reimbursement for Medical/Surgical Hospitals section of the State Plan for additional information regarding cost-to-charge ratios.)

2.3.A.2. STATEWIDE DRG RATES

Two statewide medical/surgical hospital DRG rates are developed by the state using the Episode File. For hospital DRG rate setting purposes, the medical/surgical Episode File is limited to those hospitals enrolled with the state as of October 1 of the applicable rate year. Two separate statewide rates are developed: one rate is developed for prospective payment system (PPS) hospitals and another rate is developed for hospitals designated as critical access by CMS as of October 1 of the applicable rate year. In the event a hospital status changes from PPS to critical access hospital (CAH), the state recognizes the hospital under CAH status as of the CMS effective date. The reverse is also true. If a hospital status changes from CAH to PPS, the state recognizes the hospital under PPS status as of the CMS effective date. Statewide rates are updated annually on October 1.

A budget neutrality factor is included in the hospital price calculation. Hospital prices are reduced by the percentage necessary so that total aggregate hospital payments using the new hospital prices and DRG relative weights do not exceed the total aggregate



hospital payments made using the prior hospital base period data and DRG Grouper relative weights. The estimate is based on one year's paid claims, including MHP encounter data with FFS rates applied. The calculated DRG prices are deflated by the percentage necessary for the total payments to equate to the amount paid prior to the change. Budget neutrality for CAHs is determined as a group, independent of PPS.

Hospitals' final DRG rates are calculated as follows:

- The case mix is calculated using the sum of all relative weights assigned to each hospital's claims during the base period, divided by the total number of episodes for the hospital during the same period.
- The case mix index adjusted cost for each hospital is summed.
- A hospital-specific standardized cost per discharge is computed.
 - Divide total adjusted costs by the total number of episodes.
 - Divide average costs by the case mix.
 - Multiply the result by the applicable inflation factor to bring costs to a common point in time. Costs are inflated through the rate period. For example, for FY 2015 rates, costs are inflated through September 30, 2016. Inflation factors are obtained from IHS Global Insight.
- The statewide rate per discharge is the weighted mean of all hospital-specific standardized costs.
- The statewide rate is adjusted by an Area Wage Index and Budget Neutrality Factor to determine the hospital's final DRG rate.

In developing the statewide DRG rate, the following data and calculations are used for each hospital:

- 1) Hospital's adjusted charges;
- 2) Inpatient cost-to-charge ratio;
- 3) Hospital's adjusted costs (line 1 x line 2);
- 4) Hospital's episodes;
- 5) Cost per discharge (line 3/line 4);
- 6) Hospital's case mix;
- 7) Standardized cost per discharge (line 5/line 6);
- 8) Establish statewide rate as weighted standardized cost per discharge $((\sum \text{line 7} \times \text{line 4}) / \sum \text{line 4})$;
- 9) Hospital's Area Wage Index;
- 10) Apply budget neutrality factor; and
- 11) Hospital's final DRG rate (line 8 x line 9 x line 10). The DRG rate is rounded to the nearest whole dollar amount.



The statewide rates are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.3.A.3. APR-DRG RELATIVE WEIGHTS [CHANGE MADE 10/1/20]

Michigan-specific relative weights are developed utilizing the adjusted costs from the Episode File. The average cost for episodes within each DRG is calculated by dividing the sum of the costs for the episodes by the number of episodes within the DRG. The relative weight for each DRG is calculated by dividing the average cost for episodes within each DRG by the average cost per episode for all episodes. A table showing the relative weights, average lengths of stay, and low day outlier threshold for each DRG is available on the MDHHS website. (Refer to the Directory Appendix for website information.) Relative weights are updated annually on October 1.

The state establishes alternate weights for neonatal services from episodes that are assigned to one of the DRGs in the following range: 580x-640x. Effective, July 1, 2020, the NICU alternate weight reimbursement will apply to episodes with a DRG within 580x-640x and a minimum of one day with revenue code 0173 or 0174. Revenue codes reported should reflect the level of care provided to the patient in accordance with NUBC billing guidance. (text added per bulletin MSA 20-45) These weights are utilized for services rendered in a NICU. The remaining claims assigned to these DRGs are used for the base weights (non-alternate weights). No other alternate weights are assigned.

To ensure each relative weight adequately reflects resource utilization for a particular DRG in the state, the state requires that each DRG have a minimum of 10 episodes. If a DRG does not have at least 10 episodes, an alternative solution is applied as follows:

State-Specific Relative Weight Methodology:

- If the episode count for a DRG is 10 or more, use the relative weight setting methodology outlined. Otherwise:
 - For severity levels 1 through 3 where the targeted severity level is equal to n :
 - If the episode count for the next greater severity level is 10 or more, the following calculation is completed: $(\text{MI DRG Severity}_{n+1} \text{ Relative Weight}) \times (\text{National DRG Severity}_n \text{ Relative Weight}) / (\text{National DRG Severity}_{n+1} \text{ Relative Weight}) = (\text{MI Relative Weight Factor}_n)$
 - Otherwise, $(\text{National DRG Severity}_n \text{ Relative Weight}) \times (\text{MI Case Mix Factor}_n)$
 - For severity level 4:
 - If the episode count for the prior severity level is 10 or more, the following calculation is completed: $(\text{MI DRG Severity}_{n-1} \text{ Relative Weight}) \times (\text{National DRG Severity}_n \text{ Relative Weight}) / (\text{National DRG Severity}_{n-1} \text{ Relative Weight}) = (\text{MI Relative Weight Factor}_n)$
 - Otherwise, $(\text{National DRG Severity}_n \text{ Relative Weight}) \times (\text{MI Case Mix Factor}_n)$



- Where:
 - $(\text{MI Case Mix Factor}_n) = \frac{\text{sum of Michigan specific relative weights multiplied by the number of episodes if the number of episodes is 10 or more}}{\text{sum of National relative weights multiplied by the number of episodes if the number of episodes is 10 or more}}$
 - $(\text{MI Alternate Weight Case Mix Factor}) = \frac{\text{Average of (MI Alternate Weight DRG Severity)}}{(\text{MI DRG Severity Relative Weight})}$ for DRGs with an episode count of 10 or more.
- Further adjustments are necessary if the resulting adjustment described above is inconsistent with Michigan or National trends and data.
 - Example 1: If an episode count is between 10 and 20 and the alternate weight would be less than the standard relative weight, but other severity levels are not consistent with this, then apply the next severity level imputing method.
 - Example 2: If the episode count is between 10 and 20, the state may consider using the Alternate Weight Case Mix Factor applied to the National Alternate Weight if the alternate weight is not consistent with other severity levels of the same DRG.
 - All relative weights are subject to reasonableness testing.

Relative Weight Trim Points:

The following trim points are established for the relative weighting system.

- The low day trim point is used to determine whether an episode qualifies for a low day outlier and is established as follows.
 - If the episode count for a DRG is 10 or more, the low day trim point is set to the 3rd percentile of the length of stay for the DRG.
 - If the episode count for a DRG is less than 10, the low day trim point is set to the lesser of the national low day trim point or 3rd percentile of length of stay for the DRG.
 - If the episode count for a DRG is zero, the low day threshold is set to the national low day trim point for the DRG.
- The average length of stay (ALOS) is used to price claims episodes involving a transfer from a hospital and is established as follows.
 - If the episode count for a DRG is 10 or more, set the ALOS to the simple average length of stay for the DRG.
 - If the episode count for a DRG is less than 10, set the ALOS to the lesser of national ALOS or the simple average length of stay for the DRG.
 - If the episode count for a DRG is zero, set the ALOS to the national ALOS.



2.3.A.4. AREA WAGE INDEX

The area wage index described in this section is used to determine adjusted hospital costs as described in the Episode File section. In addition, it is used to adjust the statewide rate to recognize variances in area labor costs.

To calculate each hospital's area wage index, two years of Medicare-audited wage data, as published in the Medicare Inpatient Prospective Payment System (IPPS) Final Rule, are obtained for the most recent available hospital fiscal years. Contract labor costs, as defined by Medicare, are included in determining a hospital's wage costs. Hospitals are grouped by U.S. Census Core Based Statistical Areas (CBSAs) as determined by CMS for the Medicare program. Consistent with CMS, the cost report references are obtained from the Medicare Provider Manual, Worksheet S3, Part 3, Line 6 for wages and hours.

The following calculations are completed:

- Each hospital's wage costs are brought to a common point in time by multiplying the hospital's fiscal year end costs by inflation factors derived from IHS Global Insight and weighting factors.
- For hospitals with cost reporting periods ending other than the end of a quarter, the inflation update for the quarter in which the hospital's fiscal year ends is used.
- The cost reports do not differentiate salaries/hours by unit type.
- The wage adjustor is based on a two-year moving average with the most recent year weighted at 60 percent and the second year weighted at 40 percent.
- If two or more hospitals merge and are operating as a single hospital, salary and wages are computed using the combined cost report data from all hospitals involved in the merger. Salary data is inflated to a common point in time.
- The average wage for each CBSA is calculated with and without hospital reclassifications:
 - a) The average wage for each CBSA without reclassifications is determined. The statewide average wage for all hospitals in the state is calculated. Using these data, CBSA-specific area wage indices are calculated by dividing the average wage for the CBSA by the statewide average wage. This quotient is area wage index A.
 - b) The average wage for each CBSA with reclassifications is determined. Using these data and the statewide average wage for all hospitals in the state, CBSA-specific area wage indices are calculated by dividing the average wage for the CBSA by the statewide average wage. This quotient is area wage index B.
- For hospitals that did not reclassify:
 - If area wage index A is greater than one percent variation from its area wage index B, area wage index A will be used. Otherwise, area wage index B will be used.
- For hospitals that reclassified, area wage index B will be used.
- The state will apply a rural floor whereby no hospital will have an area wage index less than the rural index.



Only the labor share of the statewide rate is adjusted by the area wage index using the following formula:

$$\text{Medical/Surgical Area Wage Index Adjusted Rate} = 0.70 \times \text{Area Wage Index} + 0.30$$

2.3.A.5. COST-TO-CHARGE RATIO

The operating cost-to-charge ratios described in this section are used to determine adjusted hospital costs as described in the Episode File section. In addition, they are used to reimburse hospitals for transplant services, cost outliers and low-day outliers. The operating cost-to-charge ratios are updated annually on October 1 by rolling the data forward by one year.

The most recent two years of cost report data for hospitals are used to calculate hospital-specific operating cost-to-charge ratios. For example, for the one year rate that begins on October 1, 2015, data from cost reports with fiscal years ending between October 1, 2011 and September 30, 2013 are used. Data for the most recent year are weighted at 60 percent while data for the second previous year are weighted at 40 percent. Costs and charges for both FFS and managed care are combined so that a weighted operating cost-to-charge ratio is developed. Cost and charge data are inflated to a common point in time using inflation factors from IHS Global Insight. The cost-to-charge ratio will not exceed 1.0.

If two or more hospitals merge and are operating as a single hospital, a cost-to-charge ratio for the period is computed using the combined cost report data from all hospitals involved in the merger.

The operating cost-to-charge ratios are published on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.3.A.6. SPECIAL CIRCUMSTANCES

Normal reimbursement for a medical/surgical inpatient hospital stay is equal to the applicable statewide rate multiplied by the DRG weight. However, for the following special circumstances, different reimbursement methodologies apply.

High Cost Outliers	<p>For unusually high cost stays, the State will use a special reimbursement methodology.</p> <p>An episode is a high cost outlier when costs (charges X the hospital's operating cost-to-charge ratio) exceed the computed cost threshold. Transplant claims cannot qualify as a high cost outlier.</p> <p>Reimbursement for cost outliers is dependent upon the cost threshold.</p> <p>The cost threshold is the greater of:</p> <ul style="list-style-type: none"> ▪ 2 x Hospital DRG Rate x Relative Weight (twice the regular payment for a transfer paid on a per day basis for episodes getting less than a full DRG); or ▪ \$35,000.
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	<p>Cost outliers are reimbursed according to the following formula:</p> $(\text{Hospital DRG Rate} \times \text{Relative Weight}) + [(\text{Charges} \times \text{Operating Cost-to-Charge Ratio}) - (\text{Cost Threshold})] \times 85 \text{ percent} = \text{Reimbursement for Cost Outlier Claim}$
<p>Low Day Outliers</p>	<p>For services where the length of stay is less than the published low day threshold, reimbursement is charges multiplied by the individual hospital's operating cost-to-charge ratio, not to exceed the full DRG payment. Length of stay is calculated using the From and To dates of service. The specific low day outlier threshold for each DRG is listed on the MDHHS website. (Refer to the Directory Appendix for website information.)</p>
<p>Transfers</p>	<p>Payment to a hospital that receives a patient as a transfer from another inpatient hospital differs depending on whether the patient is discharged or is subsequently transferred again.</p> <ul style="list-style-type: none"> • <u>Payment to the Transferring Hospital</u> <p>Except in the cases where the DRG is defined as a transfer of a patient (for which a full DRG payment is made, plus an outlier payment, if appropriate) the transferring hospital is paid a DRG daily rate for each day of the patient's stay, not to exceed the appropriate full DRG payment, plus an outlier payment, if appropriate.</p> <ul style="list-style-type: none"> • <u>Payment to the Receiving Hospital</u> <p>If the patient is discharged, the receiving hospital is paid the full DRG payment, plus an outlier payment if appropriate.</p> <p>Reimbursement is based on discharge in the following situations. If the patient:</p> <ul style="list-style-type: none"> ➤ Is formally released from the hospital, or ➤ Is transferred to home health services, or ➤ Dies while hospitalized, or ➤ Leaves the hospital against medical advice, or ➤ Is transferred to a long-term care facility. <p>If the patient is transferred again, the hospital is paid as a transferring hospital.</p>
<p>Readmissions</p>	<p>Readmissions within 15 days for a related condition, whether to the same or a different hospital, are considered a part of a single episode for payment purposes.</p> <p>If the readmission is to a different hospital, full payment is made to the second hospital. The first hospital's payment is reduced by the amount paid to the second hospital. The first hospital's payment is never less than zero for the episode.</p> <p>Readmissions for an unrelated condition, whether to the same or a different hospital, are considered separate episodes for payment purposes.</p>



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<p>Transplant Services</p>	<p>Transplant services are paid using the following formula: Hospital Charges x Hospital Operating Cost-to-Charge Ratio = Hospital Payment</p> <p>Transplant services are defined as claims which fall under the following DRGs:</p> <table border="1" data-bbox="565 457 1312 955"> <thead> <tr> <th>DRG</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>001x</td> <td>Liver Transplant and/or Intestinal Transplant</td> </tr> <tr> <td>002x</td> <td>Heart and/or Lung Transplant</td> </tr> <tr> <td>006x</td> <td>Pancreas Transplant</td> </tr> <tr> <td>440x</td> <td>Kidney Transplant</td> </tr> </tbody> </table> <p>Organ acquisition within these DRGs is billed at acquisition cost and is reimbursed at 100% of acquisition cost.</p>	DRG	Description	001x	Liver Transplant and/or Intestinal Transplant	002x	Heart and/or Lung Transplant	006x	Pancreas Transplant	440x	Kidney Transplant
DRG	Description										
001x	Liver Transplant and/or Intestinal Transplant										
002x	Heart and/or Lung Transplant										
006x	Pancreas Transplant										
440x	Kidney Transplant										
<p>Long-Acting Reversible Contraception</p>	<p>Long Acting Reversible Contraceptives (LARCs) provided in the inpatient hospital setting immediately postpartum are excluded from the DRG payment. An additional payment for the LARC device will be made to a hospital when a LARC is provided immediately postpartum. Practitioners will receive payment for their professional services related to the immediate postpartum LARC insertion procedure when billed separately from the professional global obstetric procedure codes and the hospital facility. Costs associated with a LARC device are to be billed separately from the inpatient visit using the Medicaid fee schedule (insertion and device).</p>										
<p>Hospitals Outside Michigan</p>	<p>Medical/surgical hospitals not located in Michigan are reimbursed under the DRG system. The DRG price is the statewide rate multiplied by an area wage index of 1.0. All other reimbursement policies apply.</p> <p>Hospitals that have charges that exceed \$250,000 during a single fiscal year (using the State of Michigan fiscal year – October 1st through September 30th) may be reimbursed the hospital’s inpatient operating cost to charge ratio for those Michigan Medicaid DRGs reimbursed by percentage of charge. The hospital’s chief financial officer must submit, and the MSA must accept, documentation stating the hospital’s Medicaid cost to charge ratio in the state that the hospital is located. Once accepted, the hospital’s actual cost to charge ratio is applied prospectively to those DRGs and claims subject to percentage of charge reimbursement using the Michigan DRG payment system.</p>										
<p>New Hospitals</p>	<p>A new medical/surgical hospital is one for which no Michigan Medicaid program cost or paid claims data exists during the period used to establish hospital rates or one which was not enrolled in the Medicaid program when hospital rates were last established. Hospitals that experience a change of ownership or that are created as the result of a merger are not considered new hospitals.</p>										



The DRG rate for new general hospitals is the statewide rate multiplied by the applicable area wage index.

2.3.B. REIMBURSEMENT FOR LONG TERM ACUTE CARE HOSPITALS (LTACHs) AND FREESTANDING REHABILITATION HOSPITALS/DISTINCT PART REHABILITATION UNITS

Episodes of care for LTACHs and Freestanding Rehabilitation Hospitals/Distinct Part Rehabilitation Units will be reimbursed using a statewide per diem rate.

2.3.B.1. DESCRIPTION OF LTACH AND FREESTANDING REHABILITATION HOSPITALS/DISTINCT PART REHABILITATION UNITS EPISODE FILE

The episode file is comprised of the underlying data used to calculate the statewide per diem rates. The costs associated with episodes from the episode file are standardized as described below. The episode file is comprised of two years of Medicaid and Children's Special Health Care Services FFS paid claims and managed care encounters.

The data is adjusted to:

- Eliminate episodes with any Medicare charges. (For dual Medicare/Medicaid eligible beneficiaries, only claims paid a full Medicaid payment are included.)
- Eliminate episodes without any charges or days.
- Eliminate episodes with a zero dollar Medicaid liability.
- Limit episodes to those from Michigan hospitals (provided that hospital cost report data is available).
- Limit episodes to those with a valid discharge status.

Total charges and days paid are summed by hospital.

The cost for each hospital is calculated by multiplying the charges for the hospital by the operating cost-to-charge ratio for the hospital. (Refer to the Cost-to-Charge section of the Reimbursement for Medical/Surgical Hospitals section of the State Plan for additional information.)

The cost per day by hospital is calculated by dividing the sum of the costs by the number of days for the hospital. To determine a statewide per diem base rate:

- Multiply the result by the applicable inflation factor to bring costs to a common point in time. Costs are inflated through the rate period. For example, for FY 2015 rates, costs are inflated through September 30, 2016. Inflation factors are obtained from IHS Global Insight.
- Recognize area cost differences by dividing the costs for each hospital by an area wage index. (Refer to the Area Wage Index section of the Reimbursement for Medical/Surgical Hospitals section of the State Plan for additional information.)



- Calculate the statewide operating rate (by provider type). A separate operating rate will be calculated for LTACHs and for Freestanding Rehabilitation Hospitals/Distinct Part Rehabilitation Units. This is a weighted mean of all hospitals' individual rates.
- The per diem rate for each provider type is the weighted mean adjusted by the area wage index specific to the hospital.

2.3.B.2. LTACH AND FREESTANDING REHABILITATION HOSPITALS/ DISTINCT PART REHABILITATION UNITS OUTSIDE OF MICHIGAN

LTACHS, freestanding rehabilitation hospitals, and distinct part rehabilitations units not located in Michigan are reimbursed using the per diem rate applicable to their provider type.

2.3.B.3. NEW LTACHS, FREESTANDING REHABILITATION HOSPITALS, AND DISTINCT PART REHABILITATION UNITS

If a hospital at least doubles the number of licensed beds in its distinct part unit and the number of licensed beds in the units increases by at least 20, the entire unit is treated as a new distinct part unit for determining the per diem rate. In order for this provision to apply, the hospital must request, in writing, that the unit is treated as a new unit. The new unit rate will become effective on the date that the number of licensed beds doubles and the increase is at least 20 beds, or the date on which the request is received by MSA, whichever is later.

New LTACHs, freestanding hospitals, and distinct part units are reimbursed using the per diem rate applicable to their provider type.

2.3.C. FREQUENCY OF UPDATES

The State will update area wage index, cost to charge ratio, relative weights, APR-DRG grouper, DRG rates, and per diem rates on an annual basis.

2.3.D. MERGERS

2.3.D.1. GENERAL HOSPITALS

In the event of a merger between two or more hospitals, the DRG rate for the surviving hospital will be computed as follows:

- The statewide rate will be adjusted by applicable area wage index.
- The cost to charge ratios of the hospitals will be combined to create a new cost to charge ratio.



2.3.D.2. LTACHs, FREESTANDING PSYCHIATRIC AND REHABILITATION HOSPITALS/DISTINCT PART PSYCHIATRIC AND REHABILITATION UNITS

In the event of a merger between two or more hospitals, the resulting per diem rate for the surviving hospital will be computed as follows:

- The statewide rate will be adjusted by applicable area wage index.
- The cost to charge ratio of the hospitals will be combined to create a new cost to charge ratio.

2.3.E. HOSPITAL CHANGE OF OWNERSHIP

In accordance with 42 CFR 455.104 and the Provider Ownership and Control Disclosures subsection of the General Information for Providers Chapter of the Medicaid Provider Manual, hospitals are required to disclose ownership information to MDHHS within 35 days of a change of ownership. Failure to notify MDHHS of any change in identification information may result in the loss of Medicaid enrollment, lapse of provider eligibility, or nonpayment of services.



SECTION 3 - SPECIAL INPATIENT SITUATIONS

3.1 MEDICARE/MEDICAID CLAIMS

For patients treated in the inpatient setting with either Medicare Part A coverage or Medicare Part B coverage, no reimbursement is made for capital.

Exception: Where a patient is dually eligible for Medicare/Medicaid and his Medicare Part A benefits have exhausted, Medicaid reimburses the hospital for capital.

Prior to final settlement, hospitals must identify claims eligible to receive capital costs as a result of the patient's Medicare Part A benefits being exhausted. A copy of the Medicaid invoice and the Medicaid Remittance Advice (RA) page showing approval must be provided for these claims. The hospital must also provide a copy of the Medicare Explanation of Benefits (EOB) showing that the patient's Part A benefits have been exhausted. Failure by the hospital to provide this information results in these claims being excluded from its final settlement.

For patients with Medicare Part B coverage and no Medicare Part A coverage, the Medicaid payment amount is determined by subtracting the Medicare Part B payment from the Medicaid inpatient amount that would otherwise be approved (either under DRG or per diem).

For patients with Medicare Part A coverage, the Medicare payment is compared to the Medicaid inpatient amount that would otherwise be approved (either under DRG or per diem).

- If the Medicare amount is greater, no additional payment is made, even though a coinsurance or deductible amount may be due.
- If the Medicaid amount is greater, the difference is paid, up to a maximum of the Medicare coinsurance and deductible amounts due for the claim. If a beneficiary is in a Medicare Advantage Plan, Medicaid's liability never exceeds that of the beneficiary. In addition, if the provider accepts the payment from the Medicare Advantage Plan as payment in full, Medicaid has no further liability.

3.2 SUBACUTE VENTILATOR-DEPENDENT CARE

Payment for services provided to patients in Subacute Ventilator-Dependent Care Units (SVDCU) is made using a negotiated prospective per diem rate that includes capital and direct medical education costs. The per diem rate is based on cost estimates for the upcoming year. The negotiated per diem rate is not to exceed the average outlier per diem rate that would be paid for outlier days between DRG 004X and DRG 005X. The payment rate for patients in subacute ventilator-dependent care units is an all-inclusive facility rate. No additional reimbursement is made for capital or direct medical education costs. These units are not eligible for indigent volume adjustor or indirect medical education adjustor payments.



The provider agrees to maintain separate accounting records for all costs associated with the dedicated ventilator-dependent unit using special procedures and instructions provided by MDHHS.

- Providers must maintain a separate cost center consistent with the requirements of MDHHS for all costs directly associated with the SVDCU, such as salaries, ancillary costs and others. The capital costs and other indirect costs are to be allocated to SVDCU using the method in accordance with Medicaid Long Term Care Cost Reporting requirements.
- SVDCU patient days and discharges must be reported separately under an inpatient cost center identified as SVDCU patient care on the cost report.
- Cost reporting for this separate SVDCU must be consistent for Medicaid and Medicare cost reporting.

3.3 MICHIGAN STATE-OWNED HOSPITALS

Michigan state-owned hospitals are reimbursed for their services using a prospective per diem rate. Each facility, in aggregate, will not receive payments in excess of the costs it incurs providing services to its Medicaid patients. Reimbursement for Michigan state-owned hospitals is subject to Federal upper payment limits.



SECTION 4 - HOSPITAL REIMBURSEMENT BY MEDICAID HEALTH PLANS

4.1 MEDICAID HEALTH PLAN PAYMENTS TO OUT OF NETWORK HOSPITALS

Medicaid Health Plans are to reimburse out of network medical/surgical hospitals at Medicaid FFS DRG hospital prices. MHPs are to reimburse out of network freestanding rehabilitation hospitals and distinct-part rehabilitation units at Medicaid per diem rates. MHPs are to use the DRG Grouper in use by Medicaid for the date of service to process out of network inpatient hospital claims and assign DRGs to determine relative weights, outliers, and average lengths of stay.

The hospital’s Medicaid operating cost to charge ratios in effect for the date of service are to be used in the calculation of low day outliers, cost outliers, and organ transplants. Refer to the Special Circumstances subsection of this Appendix for information about MDHHS reimbursement for Transplant Services.

In addition to the DRG or per diem payment, a separate capital payment must be made for each out of network medical/surgical admission at the per discharge rate. A separate capital payment must also be made for each day a patient receives care in an out of network freestanding rehabilitation hospital and distinct-part rehabilitation unit. Capital payments for acute care and rehabilitation units and for freestanding hospitals will be updated annually.

4.2 TERMS OF SERVICE AND PAYMENT BETWEEN NONCONTRACTING HOSPITALS AND MHPs

To assure that all Medicaid beneficiaries have universal access to medically necessary covered hospital services, MDHHS, in cooperation with Medicaid enrolled hospitals and MHPs, developed a set of mutually identified obligations and a process to assure these obligations are met.

To acknowledge the responsibilities of hospitals and MHPs in noncontracting circumstances, a Hospital Access Agreement and MHP Obligations document were developed. Each Hospital is encouraged to execute the Hospital Access Agreement. Although execution of this Agreement is voluntary on the part of each Hospital, MDHHS expects that substantially all Hospitals will sign and return the Agreement. Signed copies of the Hospital Access Agreement are to be submitted by hospitals to MDHHS. The Hospital Access Agreement is not a contract with a MHP.

Refer to the Medicaid Health Plans Chapter of this manual for additional information about noncontracting hospitals and MHPs.

4.2.A. DEFINITIONS

The definitions of terms used in this section and in the Hospital Access Agreement, MHP Obligations, and Rapid Dispute Resolution Process (RDRP) are as follows:

Authorization or Prior Authorization (PA)	Documented approval by a MHP for the medical services rendered to an enrollee by a hospital based on clinical information provided to the MHP and pursuant to the terms set forth in this chapter.
Beneficiary	An individual who has been determined eligible for Medicaid.



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Certificate of Coverage	Certificate of Coverage means the written document approved by the Department of Insurance and Financial Services (DIFS) which explains the scope of benefits, limitations of coverage, and exclusions governing the enrollee’s health care benefit coverage pursuant to the MHP’s Medicaid Contract with the State of Michigan.
Clean Claims	Clean Claims as defined in PA 187 OF 2000, being MCL 400.111i and OFIR bulletin 2000/09.
Covered Services	All required services for Medicaid enrollees as defined by: <ul style="list-style-type: none"> ▪ Section 400.105 of the Michigan Compiled Laws, ▪ Title XIX of the federal Social Security Act, 42 USC 1395 et. seq., ▪ MDHHS Program Manuals and Bulletins, ▪ The contract between MHPs and the Michigan Department of Technology, Management & Budget for services rendered to enrollees, and ▪ The Certificate of Coverage.
Emergency Medical Condition	Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: <ul style="list-style-type: none"> ▪ Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; ▪ Serious impairment to bodily functions; or ▪ Serious dysfunction of any bodily organ or part.
EMTALA	The Emergency Medical Treatment and Active Labor Act, 42 USC 1395dd that requires a hospital to perform a medical screening examination of any individual presenting in its emergency department (ED) to determine if an emergency medical condition exists and to stabilize the individual’s medical condition.
Enrollee	A Medicaid-eligible beneficiary who is enrolled in a MHP and who is either eligible at the time of service or determined retroactively eligible.
Hospital	The licensed entity that executed the Hospital Access Agreement included below and which has the inpatient capacity that is necessary to provide covered services.
Medicaid Health Plan	A Medicaid managed care plan that provides medical assistance through the delivery of covered services to beneficiaries and that holds a Medicaid Contract with the State of Michigan.
Medicaid Rates	The entire amount payable by MDHHS to hospitals for covered medical services provided to Medicaid beneficiaries who are not enrolled in MHPs. It includes, without limitation, DRG payments, per diem payments for exempt units, outpatient fee screen payments and applicable pass-through payments. Any other available resources, such as Medicare or other insurances, reduce the amount payable.



Noncovered Service	<p>A medical or health care service that is:</p> <ul style="list-style-type: none"> ▪ Not covered by Medicaid, ▪ Not medically necessary; ▪ Not described in a MHP's Certificate of Coverage, ▪ Provided before or after a beneficiary is an enrollee in a MHP, or ▪ A non-emergency service for which the Hospital did not secure PA.
Rapid Dispute Resolution Process	<p>The process implemented by MDHHS to administer and resolve claim disputes according to the terms set forth in the Rapid Dispute Resolution Process (RDRP).</p>

4.2.B. HOSPITAL ACCESS AGREEMENT

The Hospital Access Agreement (HAA) is between MDHHS and the hospital, and applies when a hospital provides services to Medicaid beneficiaries who are enrolled in a MHP with which the hospital does not have a contract. Where a hospital and MHP have a contract, the terms of that contract govern each relationship, and the HAA does not apply. When a hospital and a MHP have a limited services contract, the HAA applies for all covered services outside the scope of the limited services contract. Since the HAA is not a contract between a hospital and MHP, it is expected that health plans will continue to use network-contracted providers where appropriate.

The HAA is based on the following principles:

- It is intended to provide access for all covered services that are available at a hospital for all Medicaid enrolled beneficiaries, and to provide for the payment and billing policies and procedures for those services where the hospital and the enrollee's MHP have not entered into a contract.
- MDHHS, hospitals, and MHPs believe that it is essential to encourage contracting as the preferred relationship between health plans and hospitals, and to preserve the freedom of contract between hospitals and MHPs.
- The hospital will be entitled to payment by a health plan for all covered services provided in accordance with the HAA at Medicaid rates.
- In the event a MHP does not make the payment to a hospital as required under the HAA, MDHHS will deduct the unpaid amount from future health plan capitation payments and make such payment to the hospital in accordance with the HAA.
- MDHHS requires that the contracts between the State and each MHP include a provision that each MHP will comply with the terms of the HAA.

The agreement covers:

- Provision of Covered Services
- Health Plan Payment
- MDHHS Payment



- Authorization Requests - Post Stabilization
- Prior Authorization - Elective Admissions and Services
- Data Coordination
- Quality, Utilization and Risk Management (Q/U/RM)
- Orderly Transfer
- Claims
- Disputed Claims
- Payment
- Enrollee Hold Harmless
- Termination of the Agreement
- Parties to This Agreement
- Governing Law
- Notice of Change

A copy of the Hospital Access Agreement is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

4.3 MHP OBLIGATIONS

The MDHHS contract with each MHP contains an amendment regarding the MHP's obligation to a hospital when the MHP does not have a contract with the hospital to provide services to the MHP's Medicaid beneficiaries and where the hospital has signed a Hospital Access Agreement with MDHHS.

The MHP makes efforts to utilize network-contracted services where appropriate.

The contract amendment specifies MHP requirements for:

- Timely processing of claims
- Authorization requests - post stabilization
- Disputed claims
- Claim payment
- Claims data coordination
- Quality, Utilization and Risk Management (Q/U/RM)
- Orderly transfers
- Dispute Resolution

A copy of the MHP contract and the Health Plan Obligation Amendment are available on the MDHHS website.



4.4 DISPUTED CLAIMS

A Rapid Dispute Resolution Process (RDRP) was developed to provide a method for hospitals and MHPs to resolve disputed claims when the parties cannot reach an agreement. The process is included with the Hospital Access Agreement.



SECTION 5 – CAPITAL

Effective January 1, 2015, MDHHS will reimburse inpatient capital using a hospital-specific prospective rate. A prospective per-discharge amount will be calculated for medical/surgical hospitals, including critical access hospitals and children's hospitals. Freestanding rehabilitation hospitals and distinct part rehabilitation units will be reimbursed a prospective per diem capital rate. Transfer claims will not receive a prospective capital payment.

When calculating the prospective capital rates, data from the second previous state fiscal year will be used. For example, to calculate January 1, 2015 capital rates, data from cost reports with fiscal years that end between October 1, 2012 and September 30, 2013 will be used. Fee-for-Service (FFS) data will be used to calculate capital amounts.

The capital amount for the medical/surgical component of the hospital is established using the following lines (or comparable lines from succeeding cost reports) from the hospital's cost report. The data for routine capital costs is obtained from the CMS 2552-10, Worksheet D, Part I, Title XIX, Column 7, Lines 30-35 and 43. The ancillary capital costs are obtained from the CMS 2552-10, Worksheet D, Part II, Title XIX, Column 5, Lines 50-77 and 90-92. The sum of routine and ancillary cost for FFS is then divided by the medical/surgical FFS discharges for the same period to calculate the hospital-specific prospective per discharge rate for Managed Care Organizations (MCOs) and FFS.

The capital amount for freestanding rehabilitation hospitals or distinct part rehabilitation units is established using the following lines from the hospital's cost report. The data for routine capital costs is obtained from the CMS 2552-10, Worksheet D, Part I, Title XIX, Line 41. The ancillary capital costs are obtained from the CMS 2552-10, Worksheet D, Part II, Title XIX, Column 5, Lines 50-76.99 and 90-92. The sum of the routine and ancillary cost for FFS is then divided by the FFS rehabilitation Medicaid days for the same period to calculate the hospital-specific prospective per diem rate for MCOs and FFS.

Current occupancy limits will remain when the hospital specific prospective capital rates are developed. Capital amounts will be set annually. Capital amounts may be adjusted due to significant changes in capital costs that are not reflected in the cost report utilized to set the rate. Hospitals may request a capital rate adjustment by submitting a written request to the MDHHS Hospital and Clinic Reimbursement Division (HCRD). (Refer to the Directory Appendix for contact information.)

Hospitals may continue to receive capital interim payments, but only if they receive Medicaid interim payments. Otherwise, the hospital will receive its prospective rate when the inpatient claim is adjudicated. If the hospital receives capital interim payments, amounts will be reconciled 15 months after the hospital's fiscal year ends, and again at final settlement 27 months after the hospital's fiscal year ends.

5.1 DISTINCT PART REHABILITATION UNITS AND FREESTANDING REHABILITATION HOSPITALS

For distinct part rehabilitation units and freestanding rehabilitation hospitals, a separate inpatient capital rate will be calculated. The sum of the Medicaid fee-for-service (FFS) and managed care organization (MCO) routine and ancillary costs are divided by the FFS and MCO rehabilitation Medicaid days to calculate the hospital-specific prospective per diem rate.



5.2 MEDICAL/SURGICAL HOSPITALS

For medical/surgical hospitals, a separate inpatient capital rate will be calculated. The sum of the Medicaid FFS and MCO routine and ancillary costs are divided by the medical/surgical FFS and MCO discharges to calculate the hospital-specific prospective per discharge rate.

5.3 LIMITS ON CAPITAL

The limits on capital described in this section apply for fiscal years beginning on and after October 1, 1990.

5.4 NET LICENSED BEDS

Net licensed beds are used to determine net licensed bed days for capital reimbursement and include all beds temporarily delicensed, except for rural banked beds, with rural as defined below. Net licensed bed days are:

$$\text{Total Licensed Bed Days} - \text{Rural Banked Bed Days}$$

A hospital may apply for a reduction in net licensed bed days to subtract bed days unavailable due to construction or renovation. Such a reduction is only available for beds which are taken out of service for construction or renovation for a limited period of time and which are returned to active inpatient service at the end of the construction or renovation project. Documentation of the construction or renovation project is required.

Occupancy is:

$$\text{Total Inpatient Days (Including Nursery Days)} / \text{Net Licensed Bed Days}$$

5.4.A. SOLE COMMUNITY PROVIDER ELIGIBLE HOSPITALS

If the hospital is eligible for sole community provider status (as defined by Medicare standards), the Medicaid share of allowable capital costs is reimbursed in full.

5.4.B. RURAL HOSPITALS

If a hospital is located in a rural area, as defined below, capital reimbursement is limited if occupancy in the hospital is less than 60 percent during the hospital's fiscal year. A hospital is considered a rural hospital if it is located outside a city of 40,000 or more people by a distance of 10 miles or more (U.S. Census Bureau population data is used). For hospitals with occupancy less than 60 percent, the Medicaid reimbursement for capital is:

$$(\text{Occupancy} / 0.6) \times \text{Medicaid Share of Capital}$$

If occupancy is at least 60 percent, the Medicaid reimbursement for capital is 100 percent of the Medicaid share of capital.



5.4.C. OTHER HOSPITALS

If a hospital is not eligible to be a sole community provider and is not located in a rural area, capital reimbursement is limited if occupancy in the hospital is less than 75 percent during the hospital's fiscal year. For hospitals with occupancy less than 75 percent, the Medicaid reimbursement for capital is:

$$(\text{Occupancy}/.75) \times \text{Medicaid Share of Capital}$$

If occupancy is at least 75 percent, the Medicaid reimbursement for capital is 100 percent of the Medicaid share of capital.

5.4.D. HOSPITALS OUTSIDE OF MICHIGAN

Medical/surgical hospitals not located in Michigan receive a per case add-on amount to cover capital cost.

Freestanding rehabilitation hospitals and distinct part rehabilitation units of hospitals not located in Michigan receive a per diem add-on amount to cover capital cost.

The add-on amounts are an estimate of the statewide average paid to hospitals located in Michigan. Capital payments to out-of-state hospitals are not cost settled.



SECTION 6 - MEDICAID INTERIM PAYMENTS

Medicaid Interim Payments (MIPs) are available on a voluntary basis to all inpatient hospitals. MIPs are paid on a monthly schedule (12 payments per year).

For hospitals electing MIP, at the beginning of each hospital's fiscal year, annual program liabilities are set for Title XIX and Title V. Separate amounts are computed for each of a hospital's inpatient units (e.g., acute care and rehabilitation).

6.1 DRG

6.1.A. TITLE XIX GROSS PROGRAM LIABILITY

If DRG-reimbursed, Title XIX calculation of gross program liability is as follows:

- Gross Liability = (Discharge Count x Case Mix Value x DRG) + (Calculated Outlier Amount) + (Capital Rate Per Discharge x Discharge Count).
- Discharges are from the four most recently filed Quarterly Cost Reports, less Outlier Count from MDHHS paid claims files.
- Case mix is a hospital specific value and is drawn from MDHHS paid claims files.
- Gross Liability is reduced by estimated other insurance and patient pay amounts.

6.1.B. TITLE V GROSS PROGRAM LIABILITY

If DRG-reimbursed, Title V calculation of gross program liability is as follows:

- Gross Liability = (Discharge Count x Case Mix Value x DRG) + (Capital Rate Per Discharge x Discharge Count).
- Discharges are from the four most recently filed Quarterly Cost Reports.
- Case mix is a hospital specific value and is drawn from MDHHS paid claims files.
- Gross liability is reduced by estimated other insurance and patient pay amounts.

6.2 PER DIEM

If per diem reimbursed, calculation of gross program liability is as follows:

- Gross Liability = (Days Count x Per Diem) + (Days Count x Capital Rate Per Diem).
- Days are from the four most recently filed Quarterly Cost Reports.
- Gross liability is reduced by estimated other insurance and patient pay amounts.



6.3 LIMITS

For both DRG and per diem reimbursed hospitals/units, the MIP amount is based on a percentage of inpatient charges approved to inpatient charges filed from the prior year. Further, the MIP amount is limited based on application of a charge ceiling.

6.4 RECONCILIATION

An initial MIP reconciliation is done for operating costs only. Fifteen months after a hospital's fiscal year ends, reconciliation is done to compare the amount paid by MDHHS to the claims approved amount for the fiscal year reviewed.

For capital cost settlements for hospitals with fiscal years ending on and after January 1, 2002, filed Medicaid Cost Reports, instead of audited Medicaid Cost Reports, are used to complete a hospital desk review and settlement prior to issuing a Notice of Program Reimbursement. MDHHS does not wait for Medicare to complete its audit of a hospital's cost report before MDHHS does its cost settlement. In order to capture the maximum paid claims data, Medicaid final settlements and corresponding final reconciliations are not calculated earlier than 27 months after the end of a hospital's fiscal year end.

6.5 DATA CORRECTIONS

MIP is an estimate of the amount due a provider in the interim. There is no appeal process. If there is a calculation mistake, the hospital must notify the MDHHS HCRD in writing. (Refer to the Directory Appendix for contact information.)

6.6 MONITORING

Hospitals that wish to receive MIPs must file Quarterly Cost Reports. MDHHS specifies the format and time frames for the filing of these reports. MIP is monitored based on the quarterly reports submitted by the provider. These reports are due 30 calendar days after the end of the quarter. Hospitals may elect to be removed from MIP and receive payments for claims processed weekly. Hospitals removed from MIP are not allowed to reenter the MIP process. If the MIP payment significantly exceeds the amount approved for two consecutive years, the hospital may be removed from MIP. Hospitals under bankruptcy are automatically removed from MIP and are reimbursed for claims processed through CHAMPS.



SECTION 7 – SPECIAL PAYMENTS

7.1 DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

Indigent volume data is taken from each hospital's Medicaid Cost Report and from supplemental forms that each hospital must file with its Medicaid Cost Report. Data from the most recently available filed Medicaid Cost Report are used to calculate a disproportionate share adjustor. New adjustors are calculated and become effective concurrently with annual inflation updates. Separate indigent volume data is collected for and separate adjustors are applied to distinct part psychiatric units and distinct part rehabilitation units.

Indigent volume is measured as the percentage of inpatient indigent charges to a hospital's net hospital charges as reported on the Medicaid Cost Report. Indigent charges are the annual charges for services rendered to patients eligible for payments under Medicaid, CSHCS, MICHild, MOMS, and Healthy Michigan Plan, plus uncompensated care charges. Uncompensated care is limited by Medicare standards and is offset by any recoveries.

No Medicare charges and no Medicaid obligation to cover premiums, copayments, coinsurance and/or deductibles for beneficiaries who are dually eligible for both Medicaid and Medicare are to be included as a Medicaid charge for the purpose of calculating the amount of indigent volume to be reported on any line of a hospital's Indigent Volume worksheet. Also excluded are charges for Medicaid patients who have other insurance coverage and for whom the full payment, except for copayment, coinsurance and/or deductible, comes from the insurance payer.

Uncompensated care, bad debt recovery, and/or Hill-Burton offset may be apportioned using the ratio of total inpatient medical-surgical charges to total charges, the ratio of total distinct part rehabilitation unit charges to total charges, the ratio of total distinct part psychiatric unit charges to total charges, and the total of outpatient charges to total charges.

7.1.A. INDIGENT VOLUME DATA AND DISPROPORTIONATE SHARE HOSPITAL ELIGIBILITY FORM

Each hospital must complete the Indigent Volume (IV) worksheet and the Disproportionate Share Hospital (DSH) Eligibility Status Verification form to be eligible for Disproportionate Share Hospital (DSH) funds.

The Indigent Volume (IV) worksheet is to be completed as part of the hospital's annual Medicaid Cost Report and returned to MDHHS. The Medicaid Cost Report will not be accepted without the IV worksheet.

In order to receive a disproportionate share adjustor other than 1.00, hospitals must also meet at least one of the four criteria on the Disproportionate Share Hospital (DSH) Eligibility Status Verification form.

The Disproportionate Share Hospital (DSH) Eligibility Status Verification form is to be completed annually and is reported separately from the Medicaid Cost Report.



An example of the form follows.

Michigan Department of Health and Human Services
Disproportionate Share Hospital (DSH) Eligibility Status Verification

State Fiscal Year: _____
 Medicare Number: _____
 NPI: _____
 Facility Name: _____

Prepared By: _____
 Phone Number: _____
 Fax Number: _____
 Email Address: _____

To be considered valid, this form must be completed by the person authorized to sign the Medicaid Filed Cost Report.

I certify that the following DSH Eligibility Status applies for the above facility for the state fiscal year as of the date of submission of this form as it was entered on the DSH Eligibility Status Report.

1. At least two (2) obstetricians with staff privileges at this hospital have agreed to provide obstetric services to individuals who are eligible for Medicaid services.
 First Physician Name and NPI: _____
 Second Physician Name and NPI: _____

2. This hospital is located in a rural area (as defined for purposes of section 1886 of the Social Security Act) and at least two (2) physicians with staff privileges at this hospital have agreed to provide obstetric services to individuals who are eligible for Medicaid services.
 First Physician Name and NPI: _____
 Second Physician Name and NPI: _____

3. This hospital serves as inpatients a population predominantly comprised of individuals under 18 years of age.

4. On December 22, 1987, this hospital did not offer obstetric services to the general population, except in emergencies.

5. None of the above apply. The hospital is not eligible for a disproportionate share adjustor.

7.1.B. MEDICAID UTILIZATION RATE

In addition to the minimum requirements specified in the form, each hospital must have a Medicaid utilization rate of at least one percent. Medicaid utilization is measured as:

$$\frac{\text{Medicaid Inpatient Days (Whole Hospital, including Subproviders)}}{\text{Total Hospital Days (Whole Hospital, including Subproviders)}}$$

Days are taken from filed hospital Medicaid Cost Reports for fiscal years ending during the second previous state fiscal year. All charge, cost and payment data must be on an accrual basis for each hospital's cost reporting period ending during the second previous state fiscal year (i.e., DSH payments for state FY 1998 are calculated using data collected in state FY 1996).



7.2 REGULAR DSH PAYMENTS

7.2.A. \$45 MILLION POOL

Medicaid inpatient DSH payments are made annually in a single distribution, based on charges converted to cost, using the hospital's cost to charge ratio. The payment will be made at the end of the state fiscal year.

Each hospital's indigent volume is taken from hospital cost reporting periods ending during the second previous state fiscal year.

Title XIX charges used for computing DSH payments are the sum of Title XIX charges and Title XIX MCO charges from hospital IV worksheets for cost periods ending during the second previous state fiscal year. Data for cost periods of more or less than one year is proportionately adjusted to one year.

Hospital total cost ratios are taken from hospital cost reporting periods ending during the second previous state fiscal year. If a hospital has more than one cost reporting period ending within this range, data from the two periods are added together and a single ratio is computed. If the ratio is greater than 1.00, a ratio of 1.00 is used.

1. DRG Reimbursed Hospitals (\$37,500,000 allocated)

The DSH payments for DRG reimbursed hospitals are split into two pools.

- A. Hospitals with at least 50 percent IV (\$7,300,000). The share of the DSH payment for hospitals with at least 50 percent IV is based on a DSH share computed as follows:

$$\text{Title XIX Charges} \times \text{Operating Ratio} \times (\text{IV} - 0.5)$$

- B. Hospitals with at least 20 percent IV (\$30,200,000). The share of the DSH payment paid to hospitals with at least 20 percent IV is based on the following DSH share amount. This is in addition to the amount from A. above.

$$\text{Title XIX Charges} \times \text{Operating Ratio} \times (\text{IV} - 0.2)$$

2. Per Diem Reimbursed Hospitals and Units (\$7,000,000 allocated)

The share of the DSH payment paid to hospitals with IV of at least 20 percent is based on a DSH share based on the following:

$$\text{Title XIX Charges} \times \text{Operating Ratio} \times (\text{IV} - 0.2)$$



3. Distinct-Part Rehabilitation Units (\$500,000 allocated).

The share of the DSH payment paid to hospitals with IV of at least 20 percent is based on a DSH share of the following:

$$\text{Title XIX Charges} \times \text{Operating Ratio} \times (\text{IV} - 0.2)$$

4. For items 1 through 3 above, the determination of the share of the allocated DSH pool is made using the DSH share of the following:

$$(\text{Hospital's DSH Share} / \Sigma \text{ DSH Shares for the Group}) \times \text{Allocated DSH Pool}$$

5. 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.

7.3 SPECIAL DSH PAYMENTS

7.3.A. GOVERNMENT PROVIDER DSH POOL

A special pool for non-state government-owned or -operated hospitals will be established and renewed annually. The purpose of the pool is to assure funding for costs incurred by public facilities providing inpatient hospital services which serve a disproportionate number of low-income patients with special needs. A historical list of Government Provider pool sizes is maintained on the MDHHS website. (Refer to the Directory Appendix for website information.) Allocations will be determined based upon non-reimbursed costs certified as public expenditures in accordance with 42 CFR 433.51.

To be eligible for the Government Provider DSH Pool, hospitals must:

- Meet minimum federal requirements for Medicaid DSH payments; and
- Be non-state government-owned or -operated.

Medicare 2552 cost reports, supplemented by the Medicaid Cost Reports, will be used to determine each hospital's allowable DSH costs eligible for federal financial participation.

An interim payment and reconciliation process will be employed when making allocations from this pool. Allowable DSH costs will be determined based on information obtained from the cost report periods ending during the second previous state fiscal year. Costs will be obtained from the most recently filed Medicare 2552 cost report and Medicaid Cost Report for that period. These costs will be trended to the current state fiscal year using an inflation factor taken from Health-Care Cost Review published quarterly by Global Insight. Interim payments will then be made.



Interim payments will be reconciled twice. First, an interim reconciliation of the original payments will be conducted based on updated allowable DSH costs. Information needed to reconcile initial payments will be obtained from hospital Medicare 2552 cost reports filed with the fiscal intermediary and Medicaid Cost Report for the applicable reporting period. Second, payments will be adjusted for a final time based on Medicare 2552 cost reports finalized with the fiscal intermediary and Medicaid Cost Report for the applicable reporting period.

Aggregate DSH expenditures will be made in accordance with Section 1923(g)(1)(A) of the Social Security Act. Prior to computing the amount of payment each individual hospital is eligible to receive from this pool, all other DSH and Medicaid payments that the hospital is scheduled to receive will be counted against the hospital's DSH limit.

7.3.B. UNIVERSITY WITH BOTH A COLLEGE OF ALLOPATHIC MEDICINE AND A COLLEGE OF OSTEOPATHIC MEDICINE

A separate pool will be created annually in the following amounts: \$2,772,003 in fiscal year 2005, \$2,764,340 for fiscal years 2006 – 2012, and \$3,500,000 for each subsequent fiscal year. The purpose of the pool is to:

- Assure continued access to medical care for indigents; and
- Increase the efficiency and effectiveness of medical practitioners providing services to Medicaid beneficiaries under managed care.

Only one agreement per year is approved by MDHHS for this purpose. To be eligible for the pool, a hospital must meet the following criteria:

- Meet minimum federal requirements for Medicaid DSH payments; and
- Have in place an approved agreement between itself and a university with both a college of allopathic medicine and a college of osteopathic medicine that specifies all services and activities to be conducted.

This agreement shall not require the hospital to donate money or service to the other party in the agreement.

7.3.C. OUTPATIENT UNCOMPENSATED CARE DSH POOL

A special pool will be created annually for the purpose of reimbursing hospitals for a portion of their uncompensated care. The Outpatient Uncompensated Care DSH Pool will be split into Small and Rural and Large-Urban components. A historical record of the pool amounts can be found on the MDHHS website. (Refer to the Directory Appendix for website information.) Payments from the pool will be made annually.

Funds will be distributed from the Outpatient Uncompensated Care DSH Pool to all qualifying Privately-Owned or -Operated and Non-State Government-Owned or -Operated DSH eligible hospitals in Michigan. DSH eligibility criteria are specified in the Disproportionate Share Hospital Payments, the Indigent Volume worksheet and Disproportionate Share Hospital Eligibility Form, and the Medicaid Utilization Rate



subsections of this chapter. These criteria must be met for a hospital to receive an allocation from any component of the Outpatient Uncompensated Care DSH Pool.

For purposes of distributions from this pool, any DSH hospital located in Michigan with less than 100 acute care beds will be considered a small hospital. Also for purposes of distributions from this pool, any DSH hospital located in a Michigan rural or Micropolitan County will be considered a rural hospital. All hospitals meeting either of these criteria will be eligible to receive a proportional share of the small and rural components of the pool.

For purposes of distributions from this pool, any DSH hospital with 100 or more acute care beds located in an urban Michigan county will be considered a large-urban hospital. Only hospitals meeting both of these criteria will be eligible to receive a proportional share of the large-urban components of the pool. Hospitals meeting only one of these criteria are by definition eligible to receive a proportional share of the small and rural components of the pool. No hospital is eligible to receive allocations from both the small and rural and the large-urban components of the Outpatient Uncompensated Care DSH Pool.

The determination of the number of acute care beds for a hospital will be based on data reported on hospital Medicaid Cost Reports for hospital fiscal years ending during the second previous state fiscal year. Specifically, data reported on Worksheet S-3, Part 1, Column 2, Line 14 (or comparable lines from succeeding Medicaid Cost Reports) will be assessed to determine the number of total hospital beds. The determination will apply to all components of the Outpatient Uncompensated Care DSH Pool regardless of the state fiscal year from which the DSH funds are drawn.

The distribution of funding from the Outpatient Uncompensated Care DSH Pool will be based on each hospital's proportion of outpatient uncompensated care relative to other hospitals in each component of the pool. The process will be repeated for each component of the pool until the entire pool has been distributed. The process to accomplish this is detailed below.

Beginning in FY 2015, \$5,000,000 of the Large-Urban Component of the pool will be distributed to reward and incentivize hospitals providing low cost and high quality Medicaid services. The Medicare Value Based Purchasing (VBP) Adjustment Factor will be obtained annually from the Federal Register. Each hospital's respective payment from the \$5,000,000 pool component will be calculated as follows:

- $(\text{Hospital's Outpatient Uncompensated DSH Hospital Pool Factor}) \times (\text{Hospital's VBP Adjustment Factor}) = (\text{Hospital's Outpatient Uncompensated DSH Value Adjustment Factor})$
- $(\text{Hospital Outpatient Uncompensated DSH Value Adjustment Factor}) / (\sum \text{All Hospital Outpatient Uncompensated DSH Value Adjustment Factors}) \times (\text{Total Pool Amount}) = (\text{Outpatient Uncompensated DSH Value Payment})$



1. A Medicaid outpatient payment to charge ratio will be calculated for each hospital as follows:

$$\frac{(\text{Hospital Title XIX Outpatient FFS Payments})}{(\text{Hospital Title XIX Outpatient FFS Charges})} = (\text{Hospital Title XIX Outpatient Payment to Charge Ratio})$$

2. Net uncompensated outpatient charges will then be computed for each hospital as follows:

$$(\text{Hospital Uncompensated Outpatient Charges}) - (\text{Hospital Uncompensated Outpatient Payments}) = (\text{Net Hospital Uncompensated Outpatient Charges})$$

3. The computed net hospital uncompensated outpatient charges will be standardized by converting them to a Medicaid fee-for-service payment equivalent. This will be done by multiplying the results of Step 1 by the results of Step 2 as follows:

$$(\text{Hospital Title XIX Outpatient Payment to Charge Ratio}) \times (\text{Net Hospital Uncompensated Outpatient Charges}) = (\text{Net Hospital Outpatient Uncompensated Title XIX Equivalent Payments})$$

4. Each hospital's proportion of the pool component being calculated (or hospital pool factor) is determined by dividing their Medicaid fee-for-service payment equivalent by the total of all Medicaid fee-for-service payment equivalents of hospitals in the pool component. This step is expressed as follows:

$$\frac{(\text{Net Hospital Outpatient Uncompensated Title XIX Equivalent Payments})}{(\sum \text{of all Net Hospital Outpatient Uncompensated Title XIX Equivalent Payments})} = (\text{Outpatient Uncompensated DSH Hospital Pool Factor})$$

5. Each hospital's respective pool component payment is determined by multiplying their hospital pool factor from Step 4 by the total pool component amount being calculated as follows:

$$(\text{Outpatient Uncompensated DSH Hospital Pool Factor}) \times (\text{Outpatient Uncompensated DSH Pool Component Amount}) = (\text{Outpatient Uncompensated DSH Hospital Pool Component Payment})$$

Pool component payments calculated for individual hospitals that are in excess of an individual hospital DSH ceiling will be placed back into that component of the pool. These payments will then be reallocated to the remaining hospitals in that component of the pool which have not exceeded the room available under their individual hospital DSH ceiling. The reallocation will be based on the original five step funding formula specified above. Only hospitals with available DSH ceiling capacity will be included in the relevant portions of the formula. This reallocation process will be repeated as many times as necessary to expend all funds in each component of the pool.



7.4 CALCULATION OF DSH CEILING

Hospital data utilized to calculate hospital-specific DSH ceilings includes inpatient and outpatient data. All charge, cost and payment data must be on an accrual basis for each hospital’s cost reporting period ending during the second previous state fiscal year. Data should be separated by subprovider.

1. DSH Ceiling Financial Elements

- Title XIX Charges – Base year Title XIX charges include Title XIX charges for those beneficiaries enrolled in MHPs and beneficiaries dually enrolled in Title V and Title XIX.
- Title XIX Costs – Multiply total base year Title XIX charges times the hospital’s Title XIX cost to charge ratio for the cost reporting period to determine Title XIX Costs. (The cost to charge ratio should be inclusive of capital and medical education costs.)
- Uninsured Charges – Uninsured charges are charges for services provided to beneficiaries who do not have any insurance coverage or for services not covered by the patient’s insurance coverage. (Services covered by Medicare and/or Medicaid are not included as uninsured charges.)
- Uninsured Costs – Multiply total base year uninsured charges times the hospital’s cost to charge ratio to determine uninsured costs. (The cost to charge ratio should be inclusive of capital and medical education costs.)
- Title XIX Payments – Title XIX Payments made by MDHHS or MHPs for services are included in computing the base year Title XIX payments. (Payments must include capital and medical education payments.)
- Uninsured Payments – Uninsured payments are those made by or on behalf of an individual beneficiary for the services included in computing base year uninsured payments.

The DSH ceiling calculation is:

$$\begin{aligned} &\text{Title XIX charges} \times \text{Title XIX cost to charge ratio} = \text{Title XIX costs} \\ &\text{Uninsured charges} \times \text{uninsured cost to charge ratio} = \text{uninsured costs} \\ &\text{Title XIX payments} + \text{uninsured payments} + \text{pool payments} = \text{total payments} \\ &\text{Title XIX costs} + \text{uninsured costs} - \text{total payments} = \text{DSH ceiling} \end{aligned}$$

The following trend factors will be applied to the financial elements used to calculate hospital DSH ceilings only during the Initial DSH Calculation for each year. These trend factors will not be applied during the Interim DSH Settlement calculations.

- Base Year Cost Inflation – Inflation of base year costs (inpatient and outpatient) is computed using the Global Insight index of inflation for the entire hospital. Hospital costs are inflated from the hospital FYE to the current state FYE. Inflation of payments is computed from the hospital’s rate change over time.
- Base Year Utilization Trend – Hospital costs and payments are also adjusted from the state base year to the state current year end by the percentage change in the projected annual average Medicaid enrollment between the two periods.



During the Interim DSH Settlement calculation, an upward historical adjustment to the calculated DSH ceiling will be applied to those hospitals that meet certain requirements. To qualify, a hospital would need to be DSH eligible and have a higher audited ceiling calculation compared to the Interim ceiling calculation for each of the last three years of available DSH audits. An increase based on the difference between the audited ceiling and Interim ceiling from the most recent available year will then be applied to the current Interim DSH ceiling calculation. Hospitals may decline this upward adjustment by reducing their ceiling during the Interim DSH Settlement review period.

7.5 DISPROPORTIONATE SHARE HOSPITAL (DSH) PROCESS

The DSH process is designed to mitigate DSH audit-related recoveries. It is a multiple-step process that allows hospitals to provide input into the DSH calculations, decline DSH funds, and reduce their DSH ceiling. The multiple-step DSH process is as follows.

Step 1: Initial DSH Calculation

MDHHS will calculate hospital-specific DSH ceilings, DSH payment allocations and Medicaid utilization rates as part of its Initial DSH Calculation. Inpatient and outpatient data from the hospital's cost reporting period ending during the second previous state FY will be used for the DSH ceiling, DSH payment and Medicaid utilization rate calculations. The data will be trended to the current FY for DSH ceiling calculation purposes. For example, data from hospital Medicaid Cost Reports with FYs ending between October 1, 2009 and September 30, 2010 will be used to complete the FY 2012 Initial DSH Calculation.

MDHHS will share Initial DSH Calculations with hospitals. Hospitals will be able to decline DSH funds following the Initial DSH Calculation findings. If a hospital declines DSH funds during the Initial DSH Calculation step, the decision is irrevocable and the hospital is not eligible for any DSH funds for that state FY. Hospitals may also request a downward adjustment to their DSH ceiling during the Initial DSH Calculation step. Upon receipt of this feedback from hospitals, each hospital's calculated DSH ceiling will be reduced to the requested amount. No hospital will receive a DSH payment in excess of its initial DSH ceiling.

DSH payments will be applied against a hospital's DSH ceiling in the following order:

1. \$45 Million Pool
2. Outpatient Uncompensated Care DSH Pool
3. University with Both a College of Allopathic Medicine and a College of Osteopathic Medicine Pool (University Pool)
4. Indigent Care Agreements Pool (ICA Pool)
5. Government Provider DSH Pool (GP DSH Pool)

Step 2: Interim DSH Settlement

DSH ceilings, DSH payments and Medicaid utilization rates are recalculated using new Medicaid Cost Report data during the Interim DSH Settlement step to mitigate final DSH audit-related DSH recoveries.



This may result in DSH recoveries for some hospitals during this step. DSH funds will be reallocated in a manner that maintains the pool order outlined in the Initial DSH Calculation step.

As part of the Interim DSH Settlement, MDHHS will recalculate hospital-specific DSH ceilings, DSH payment allocations and Medicaid utilization rates during the year following the applicable DSH year. Inpatient and outpatient data from Medicaid Cost Reports with hospital FYs ending during the previous calendar year will be utilized for ceiling, payment, and Medicaid utilization rate recalculations. The data will not be trended. For example, during 2013, data from hospital cost reports with FYs ending between January 1, 2012 and December 31, 2012 will be used to complete the FY 2012 Interim DSH Settlement calculations.

MDHHS will share Interim DSH Settlement results with hospitals. Hospitals are able to decline DSH funds following the Interim DSH Settlement. If a hospital declines DSH funds during the Interim DSH Settlement step, the decision is irrevocable and the hospital is not eligible for any DSH funds for that state FY. Hospitals may also request a downward adjustment to their DSH ceiling during the Interim DSH Settlement step. Upon receipt of this feedback from hospitals, each hospital's calculated DSH ceiling will be reduced to the requested amount and Interim DSH Settlement payments will be issued.

Funds recovered from the \$45 Million Pool and Outpatient Uncompensated Care DSH Pool are reallocated to other qualifying hospitals within that pool based on the original formula used to allocate funding from the pool. Funds recovered from the ICA Pool will be reallocated to other qualifying hospitals within that pool.

No hospital will receive a DSH payment in excess of its Interim DSH Settlement ceiling.

Step 3: Final DSH Audit-Related DSH Redistribution

If the Final DSH Audit determines that a hospital has been paid in excess of its hospital-specific DSH ceiling, funds will be recovered from hospitals in the following order:

1. Funds from pools allocated exclusively to state government-owned or -operated or non-state government-owned or -operated public hospitals
2. All other DSH pools

MDHHS will recoup all payments that exceed audited hospital-specific DSH ceilings in the order stated above and then apply the following redistribution process. Only funds that exceed the audited hospital-specific DSH ceiling will be recovered and redistributed:

1. Funds recovered from pools allocated exclusively to state government-owned or -operated, or non-state government-owned or -operated public hospitals are reallocated to other like hospitals up to the lesser of the audited hospital-specific ceilings or other federal limits. No hospital is to receive a DSH payment that exceeds its audited hospital-specific DSH ceiling. Unspent DSH funds will be added to the "All Other DSH Pools" described in Step 2 below. The formulas to redistribute these recouped funds are as follows:
 - a. $(\text{Eligible Hospital's Remaining Audited DSH Ceiling Capacity}) / (\sum \text{ of all Eligible Hospitals' Audited Remaining DSH Ceiling Capacity}) = (\text{Hospital Pool Factor})$
 - b. $(\text{Hospital Pool Factor}) \times (\text{Pool Amount}) = \text{Pool Payment}$



2. Funds recovered from the other DSH pools, plus any unspent DSH funds recouped from pools allocated exclusively to state government-owned or -operated, or non-state government-owned or -operated public hospitals, are reallocated to all remaining eligible hospitals proportionately based on their share of remaining audited hospital-specific DSH ceiling capacity adjusted to exclude the DSH payment amounts hospitals received from the ICA, University and GP DSH Pools during the Initial DSH Calculation and Interim DSH Settlement steps. No hospital will receive an allocation in excess of its remaining audited hospital-specific DSH ceiling capacity. The formulas to redistribute these recouped funds are as follows:
 - a.
$$\frac{(\text{Eligible Hospital's Remaining Audited DSH Ceiling Capacity} + \text{ICA DSH Payment Amount} + \text{University DSH Payment Amount} + \text{GP DSH Payment Amount})}{(\sum \text{of all Eligible Hospitals' Audited Remaining DSH Ceiling Capacity} + \text{ICA DSH Payment Amount} + \text{University DSH Payment Amount} + \text{GP DSH Payment Amount})} = (\text{Hospital Pool Factor})$$
 - b.
$$(\text{Hospital Pool Factor}) \times (\text{Pool Amount}) = \text{Pool Payment}$$

Pool payments calculated for individual hospitals that are in excess of a hospital's audited DSH ceiling will be placed back into that pool. These payments will then be reallocated to the remaining hospitals in that component of the pool which have not exceeded their audited hospital-specific DSH ceiling capacity. The reallocation will be based on the funding formula specified above. Only hospitals with available audited DSH ceiling capacity will be included.

In addition, any unspent federal DSH allotment will be distributed using the formula outlined in Step 3: Final DSH Audit-Related DSH Redistribution through a new pool. Funds from this pool will first be allocated to state government-owned or -operated hospitals up to applicable federal DSH limits. Any remaining unspent DSH allotment will be allocated proportionally to all other hospitals based on remaining DSH limit capacity.

7.5.A. DISTRIBUTION OF DSH PAYMENTS FOR MERGED HOSPITALS

When two or more hospitals merge, eligibility for DSH payments after the merger is based on the combined Medicaid Cost Report data of the merged hospitals.

7.6 MEDICAID ACCESS TO CARE INITIATIVE

To ensure continued access for Medicaid patients to high quality hospital care, MDHHS established special funding pools. The pool dollar amounts are renewed annually and posted on the MDHHS website.

To keep payments within the Medicare upper payment limits, separate pools are established for privately owned or operated hospitals and nonstate government-owned or operated hospitals for both inpatient and outpatient hospital services. Only hospitals located within Michigan, enrolled in Medicaid, open, treating, and admitting Medicaid FFS and MHP patients 10 days prior to a scheduled payment are eligible to receive distributions from these pools.



7.6.A. POOL DESCRIPTIONS

7.6.A.1. PRIVATELY-OWNED OR OPERATED INPATIENT HOSPITAL POOL

This inpatient pool is computed based upon the total number of privately owned DRG reimbursed hospitals and distinct part rehabilitation units. Privately owned freestanding rehabilitation hospitals with Medicaid FFS payments also participate in this pool.

Hospitals with Medicaid inpatient FFS payments share proportionately in this pool based on each hospital's total Medicaid FFS inpatient payments divided by the total Medicaid FFS inpatient payments for all privately owned or operated hospitals and units.

7.6.A.2. PRIVATELY-OWNED OR OPERATED OUTPATIENT HOSPITAL POOL

This outpatient pool is computed based upon the total number of privately owned outpatient units of DRG reimbursed hospitals and privately owned outpatient hospital rehabilitation units.

Hospitals with Medicaid outpatient FFS payments share proportionately in this pool based on each hospital's total Medicaid FFS outpatient payments divided by the total Medicaid FFS outpatient payments for all privately-owned or operated hospitals and units.

7.6.A.3. NONSTATE GOVERNMENT-OWNED OR OPERATED INPATIENT HOSPITAL POOL

This inpatient pool is computed based upon the total number of nonstate government-owned DRG reimbursed hospitals and distinct part rehabilitation units. Nonstate government-owned freestanding rehabilitation hospitals with Medicaid FFS payments participate in this pool also.

Hospitals with Medicaid inpatient FFS payments share proportionately in this pool based on each hospital's total Medicaid FFS inpatient payments divided by the total Medicaid FFS inpatient payments for all nonstate government-owned or operated hospitals and units.

7.6.A.4. NONSTATE GOVERNMENT-OWNED OR -OPERATED OUTPATIENT HOSPITAL POOL

This outpatient pool is computed based upon the total number of nonstate government-owned outpatient units of DRG reimbursed hospitals and outpatient hospital rehabilitation units.

Hospitals with Medicaid outpatient FFS payments share proportionately in this pool based on each hospital's total Medicaid FFS outpatient payments divided by the total Medicaid FFS outpatient payments for all nonstate government-owned or operated hospitals and units.



7.6.B. POOL SIZES

A historical list of MACI pool sizes is maintained on the MDHHS website. (Refer to the Directory Appendix for website information.)

7.6.C. DISTRIBUTIONS

The distribution from these pools will supplement hospitals' regular DRG and per diem payments (for rehabilitation units and hospitals) and is not considered part of a hospital's FFS reimbursement. Medicaid payers that normally match MDHHS FFS payments to medical providers are not required to match the distribution payments from these pools as part of their FFS payments.

The MACI pool dollar amounts will be renewed annually. The dollar amounts of the new pools will be based on the calculated gap between the Medicare Upper Payment Limit and Medicaid fee-for-service payments.

7.6.D. PAYMENT SHARE

The inpatient and outpatient hospital files used to distribute MACI payments will include FFS payments made on behalf of both Medicaid and CSHCS eligible beneficiaries.

7.6.D.1. INPATIENT PAID CLAIMS FILE

To determine each hospital's share of a pool, MDHHS will use paid claims for the fiscal year ending two years prior to the current fiscal year. Claims will be restricted to those paid by June 30th of the following year (e.g., paid claims from FY 2004 paid by June 30, 2005 will be used to calculate the FY 2006 MACI payments). The paid claims file will include all FFS payments made through CHAMPS, including DRG and per diem payments, DRG outlier payments, and claims paid based on a percent of charge. Paid claims will include those with other insurance and patient-pay amounts. Inpatient services will include both acute and rehabilitation services provided through distinct part rehabilitation units, freestanding rehabilitation hospitals, and subacute ventilator-dependent care units. Services paid to LTC providers will not be included, with the exception of services paid to subacute ventilator-dependent care units with beds licensed as hospital beds. Revenue from licensed hospital beds utilized at less than an acute or rehabilitation level of care will be excluded from the paid claims file, with the exception of revenue from subacute ventilator-dependent care beds licensed as hospital beds. Payments made outside CHAMPS, such as capital, graduate medical education (GME), and disproportionate share hospital (DSH), will not be included in the paid claims file used to distribute the MACI hospital pools.

7.6.D.2. OUTPATIENT DISTRIBUTION DATA

To determine each hospital's share of a pool, MDHHS will use paid claims for the fiscal year ending two years prior to the current fiscal year. Claims will be restricted to those paid by June 30 of the following fiscal year (e.g., paid claims from FY 2014 will be used to calculate payments in FY 2016 with claims limited to those paid by June 30, 2015). The paid claims file will include all Medicaid FFS payments made for both Medicaid and



dual CSHCS eligible beneficiaries through the CHAMPS System. Outpatient services will include both acute and rehabilitation services. Payments made outside CHAMPS, such as capital, graduate medical education (GME), or disproportionate share hospital (DSH), will not be included in the payments used to distribute the MACI pools.

7.6.E. ALLOCATION OF POOLS

MACI distributions are made prospectively based on historical data. Eligible hospitals will share proportionately from each pool based upon a hospital's total paid claims (inpatient)/Medicaid Cost Report payments (outpatient), divided by the total Medicaid paid claims/MMS payments for all eligible hospitals, times the dollar amount of the individual pool. If a hospital closes or is determined ineligible to receive distributions from a pool, its MACI distribution will be redistributed to the remaining eligible hospitals based on the original distribution formula. In the event the MACI distributions would result in aggregate Medicaid payments exceeding the UPL, the size of the pool(s) will be reduced to bring the aggregate Medicaid payments within the UPL.

7.6.F. LIMITS TO INDIVIDUAL HOSPITALS

Total Medicaid payments are limited by federal regulation to a hospital's charges for inpatient services and by state policy to the lower of charges or costs for outpatient services. These limits apply by hospital fiscal year for FFS reimbursed services. Hospitals may elect to receive less (but not more) than their calculated quarterly MACI payment. The amount by which a hospital elects to reduce its payment will be redistributed to the remaining eligible hospitals based on the original distribution formula until the respective MACI pools are empty. All MACI payments are final. If charge/cost limits are exceeded, the amounts in excess of the limits will be recovered from hospitals at the time of final settlement. Any funds recovered from hospitals at final settlement will not be redistributed.

Prior to the first quarterly MACI payment for each state fiscal year, each hospital will be notified of the amount of its calculated quarterly MACI payments. A hospital electing to reduce a portion of any MACI payment to avoid exceeding charge/cost limits must inform the state of the amount to be reduced by no later than two weeks prior to the scheduled payment date.

7.6.G. PAYMENT SCHEDULE

MACI payments are made within 45 days of the beginning of each quarter. Quarterly payments are made in four equal installments based on the annual amount each hospital is eligible to receive. However, if a hospital elects to reduce a portion of any MACI payment to avoid exceeding charge/cost limits, then that payment is reduced to the amount specified by the hospital.

7.7 SPECIAL PAYMENT ADJUSTMENTS

Effective August 1, 2007 and each subsequent fiscal year, MDHHS is directed to reduce hospital payments in each respective fiscal year. These reductions are pursuant to the budgetary savings included in the MDHHS annual appropriations act. The amount of the reductions and the distribution by



hospital are posted on the MDHHS website. (Refer to the Directory Appendix for website information.) The calculation of the reductions by hospital is described below.

A calculated share of the total annual reductions will be assessed to all hospitals and units operating and enrolled in the Medicaid program on the date the reductions are processed. A hospital's annual reduction will be based on its inpatient hospital paid claims for hospital admissions from October 1 to September 30 of the second previous fiscal year. (The same paid claims file will be used to calculate the hospital MACI payments and the reductions for the fiscal year.) Paid claims include Title V, Title XIX, and Title V/XIX inpatient hospital claims. A hospital's share of the annual reductions is calculated by dividing the total of its paid claims by the total of the paid claims for all affected hospitals times the total amount of funds to be recovered.

Merged hospitals will have their reductions combined. Reductions will be taken from the surviving hospital. Should a hospital or distinct part unit close prior to the end of the fiscal year, its reduction will become part of the hospital's final settlement.

Each hospital's share of the reductions will be made by gross adjustments to the hospital's inpatient provider NPI number. Recoveries will be taken from the hospital's payments until the reductions are complete.

7.8 RURAL ACCESS POOL [CHANGE MADE 10/1/20]

The Rural Access Pool (RAP) is a pool for hospitals that provide Medicaid services to low-income rural residents and will be created and renewed annually. Effective state FY 2021, eligibility for RAP is limited to non-critical access hospitals. (text added per bulletin MSA 20-39) To be eligible for this pool, hospitals must be categorized by CMS as a sole community hospital, or meet both of the following criteria:

- A hospital must have 50 or fewer staffed beds. MDHHS will calculate staffed beds by dividing the total hospital days reported by the hospital on its Medicaid Cost Report with a FY ending between October 1, 2010 and September 30, 2011 by the number of days covered in the Medicaid Cost Report; and
- A hospital must be located in a county with a population of not more than 165,000 and within a city, village, or township with a population of not more than 12,000. The population threshold will be measured against population counts from the 2000 federal decennial census.

Each hospital's allocation from this pool will be calculated as the unreimbursed cost the hospital incurred providing inpatient and outpatient services to Michigan Medicaid beneficiaries during its cost period that ended during the second previous FY. (Example: To calculate the FY 2014 pool, hospital Medicaid Cost Reports with FYs ending between 10/1/2011 and 9/30/2012 will be used.) The following gross Medicaid payments from this Medicaid Cost Report period will be applied against cost to determine unreimbursed costs: operating, capital, graduate medical education (GME), executive order reductions, and Medicaid Access to Care Initiative (MACI). Payments from this pool will be issued quarterly in four equal installments based on the total amount the hospital is eligible to receive.

In the aggregate, MDHHS will reimburse hospitals up to the maximum allowable under the federal upper payment limits for inpatient and outpatient services provided to Medicaid beneficiaries. To keep total Medicaid Fee-For-Service payments to hospitals within the federal upper payment limits, MDHHS will reduce the size of the corresponding FY MACI pool each year by the amount of the RAP.



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Payments made from the RAP will be applied against hospitals' inpatient and outpatient settlement limits. Funds paid in excess of these limits will be recovered during settlement, and the federal share returned to the federal government.



SECTION 8 - GRADUATE MEDICAL EDUCATION

8.1 SERVICE OF TEACHING PHYSICIANS

Medicaid uses the Medicare Principles of Reimbursement to determine Medicaid allowable costs in the hospital setting. The administrative costs associated with teaching physician services as well as payment for direct patient care services provided by an intern, resident, or fellow in a teaching setting and supervised by a teaching physician, are subject to guidelines and conditions developed and published by Medicare.

Teaching institutions and teaching physicians within those institutions must abide by the CMS physician guidelines which explain when services provided in a teaching setting can be billed to Medicaid on a FFS basis or must be reported as allowable medical education costs on the hospital's cost report. The most recent guidelines for when the program may be billed directly are found in 42 CFR §415.

The guidelines require the presence of the teaching physician during the key portion of the performance of a service in which a resident is involved for which payment is sought by the teaching physician (or the hospital on behalf of the physician). The medical record must fully support the physician presence and participation in the service provided. There are exceptions and other considerations that may apply. Consult the full text of the guidelines to be sure you are in compliance for both Medicare and Medicaid.

Medicaid covers preventative medicine services that Medicare does not cover. For Medicaid, preventative medicine evaluation and management services are identified by procedure codes 99381 through 99397. These preventative medicine services may be provided without the presence of the teaching physician as long as all other requirements for the "presence" exception for E/M services furnished in certain primary care centers are met. Follow-up for any abnormal findings during a preventative medicine visit is subject to the teaching physician guidelines for all E/M services.

8.2 DISTRIBUTION OF GME FUNDS

Distribution of graduate medical education funds is calculated annually for three formula pools: the Dental and Podiatry, the GME Funds and the Primary Care. In order to receive funds for GME, a hospital must have operated a nationally accredited medical education program(s) in the fiscal year that data is drawn from the hospital cost reports used to calculate the GME payments. Payments are made only to hospitals that provide requested information by the dates required.

Only intern and resident full time equivalents (FTEs) in approved programs as specified in Federal Regulations (see 42 CFR §413.75-83) are eligible for inclusion in the data used to calculate the distribution of the Dental and Podiatry, the GME Funds and the Primary Care Pools.

- To obtain an average FTE payment for dental and podiatry residents, the GME liability for hospitals operating dental and podiatry residency programs only are summed. Hospital GME liability data is drawn from calendar year 1995 filed hospital cost reports used to calculate GME payments made to hospitals between July 1, 1997 and December 31, 2001. The summed total of these liabilities is divided by the total number of dental and podiatry FTEs as reported by the same hospitals and from the same filed cost reports that the GME liability data is drawn. The product is an average dental and podiatry FTE payment that is made to all hospitals reporting these FTEs.



- Annually, each hospital reporting dental and podiatry FTEs is reimbursed the average dental and podiatry FTE payment, as calculated above, for each dental and podiatry FTE it reports. Data for each hospital’s dental and podiatry FTE count is drawn from the hospital cost report (Worksheet E-4, Title XVIII, Line 10, Column 2). If the cost report is changed, equivalent data is used. Dental and podiatry FTEs are drawn from hospital cost reports for the same state fiscal year that FTEs are drawn to distribute the GME Funds and the Primary Care Pools.
- The dental and podiatry FTE payments made to all hospitals are summed and the total is deducted from the GME Funds Pool before any other distributions are made from this pool.
- Once the dental and podiatry FTE payments have been deducted, the remaining funds in the GME Funds Pool are distributed as described later in this section.
- Each hospital’s dental and podiatry FTE count and the total dollar amount allocated to pay hospitals for dental and podiatry FTEs is updated annually. The average dental and podiatry FTE dollar payment is not. The average dental and podiatry FTE dollar payment is adjusted only when the GME Funds and the Primary Care Pools are adjusted. Any adjustment to the average dental and podiatry FTE dollar payment is proportional to the changes in these two pools.

To distribute funds from the GME Funds and the Primary Care Pools, data is drawn from accepted hospital cost reports for the most recent fiscal year that data is available. For the GME Funds Pool, the unweighted FTE count is used (Worksheet E-4, Title XVIII, Line 6) + (Worksheet E-4, Title XVIII, Line 15.01). For the Primary Care Pool, the weighted FTE count for primary care physicians is used (Worksheet E-4, Title XVIII, Line 8, Column 1) + (Worksheet E-4, Title XVIII, Line 15.00). If the cost report is changed, equivalent data is used.

Both the hospital and its residency programs must be operating during the funding period in order to receive GME funds. Hospitals must notify MDHHS in writing at least 30 days prior to the termination date of any of its residency programs. Funds distributed to ineligible hospitals are subject to recovery.

GME payments to hospitals that merge are combined, provided that the surviving hospital continues to operate all residency programs that the pre-merger hospitals operated. The surviving hospital must notify MDHHS within 30 calendar days after the merger is completed of any reductions or terminations to its residency programs. The GME payments to the surviving hospital are reduced proportionately to the reduction in its GME programs. Overpayments to surviving hospitals based on reductions in GME programs are subject to recovery.

8.3 GME FUNDS POOL

Adjustments made to the amount of the GME Funds Pool due to legislative action or executive order are posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

The dollar amount of this pool is appropriated annually by the legislature. To calculate each eligible hospital’s share of the GME Funds Pool, the following formulas are used:

$$\text{FTEs} \times \text{Case Mix} \times (\text{Hospital's Title V \& Title XIX Days} / \text{Hospital's Total Days}) = \text{Adjusted FTEs}$$

$$\text{Pool Size} \times (\text{Adjusted FTEs} / \Sigma \text{Adjusted FTEs}) = \text{Hospital's Distribution}$$

* GME Funds Pool size: \$52,565,600



8.4 PRIMARY CARE POOL

Adjustments made to the amount of the Primary Care Pool due to legislative action or executive order are posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

The dollar amount of this pool is appropriated annually by the legislature. To calculate each hospital's share of the Primary Care Pool, the following formula is used:

$$\text{FTEs} \times (\text{Hospital's Title V \& Title XIX Outpatient Charges} / \text{Hospital's Total Charges}) = \text{Adjusted FTEs}$$

$$\text{Pool Size} \times (\text{Adjusted FTEs} / \Sigma \text{Adjusted FTEs}) = \text{Hospital's Distribution}$$

* Primary Care Pool size: \$10,322,700

8.5 DEFINITIONS/NOTES

Title V & Title XIX Days	Includes FFS days. Days include those from distinct-part psychiatric and distinct-part rehabilitation units.
Title V & Title XIX Outpatient Charges	Includes FFS outpatient charges. Charges include those from distinct-part psychiatric units.
# of Hospital Eligible Resident FTEs	Number of Hospital Eligible Resident FTEs for the GME Funds and the Primary Care Pools FTE data is drawn from hospital cost reports as indicated above.
Hospital's Non-Traditional Case Mix	The sum of the hospital's payments for all Medicaid admissions divided by the number of Medicaid admissions during the period covered. This figure is then divided by the hospital's price or rate.

8.6 PAYMENT SCHEDULE

Payments from the GME Funds and the Primary Care Pools will be made quarterly in four equal payments. Payments from the Dental and Podiatry Pool will be made once annually.

8.7 GME INNOVATIONS AGREEMENTS

8.7.A. GME INNOVATIONS HOSPITAL PROGRAM

GME Innovations Agreements support innovative GME programs that emphasize the importance of coordinated care, health promotions and psychiatric care in integrated systems. The purpose of this training is to develop the skills and experience necessary to provide psychiatric services utilized by Michigan Medicaid patient groups. Current single state agency agreements with innovative hospital GME programs include:

- Detroit Receiving Hospital for \$8,929,800 annually;
- Hurley Medical Center for \$2,018,078 in FY 2018 and \$4,381,078 in FY 2019 and future years;
- Pine Rest Christian Mental Health Services for \$3,960,000 in FY 17, \$6,336,000 in FY 18, and \$7,603,200 in FY 19 and future years.



MDHHS will approve three agreements statewide each fiscal year. To be eligible for the pool, a hospital must meet the following criteria:

- Be a Michigan Medicaid enrolled provider.
- Have in place an approved agreement between itself, a university psychiatric residency training program, and one or more community mental health services programs to provide accredited psychiatric residency training.
- Provide assurances that all training will take place in Michigan and prepare health care professionals to provide care to populations with the special characteristics of Michigan Medicaid patient groups.

8.7.B. GME INNOVATIONS SPONSORING INSTITUTION PROGRAM

The GME Innovations Sponsoring Institution Program supports limited non-hospital affiliated GME Programs that emphasize the importance of coordinated care, health promotions and psychiatric care in integrated systems. The purpose of this training is to develop the skills and experience necessary to provide psychiatric services utilized by Michigan Medicaid patient groups.

The GME Innovations Sponsoring Institution Program supports limited non-hospital affiliated GME programs that meet the requirements below. This includes sponsoring institutions whose primary purpose is to provide educational programs and/or health care services. A sponsoring institution assumes the financial and academic responsibility for a GME program.

The single state agency will approve one (1) agreement statewide each Fiscal Year (FY). This agreement will be with Authority Health for \$2.8 million for FY 2017 and \$3.1 million for FY 2018 and subsequent years. If GME distributions exceed the expenses incurred by the sponsoring institution in residency training, the size of the agreement will be reduced to bring these elements into alignment. To be eligible for the GME Innovations Program without a hospital partner, an organization must meet the following criteria:

- The organization must possess appropriate accreditation credentials.
- The organization must meet the requirements associated with receiving Medicaid payments.
- The organization must have an approved agreement with a sponsoring institution, a university psychiatric residency training program, and one or more community mental health services programs to provide accredited psychiatric residency training.
- The organization must provide assurances that all training will take place in Michigan and prepare health care professionals to provide care to populations with the special characteristics of Michigan Medicaid patient groups.

8.7.C. GME INNOVATIONS MICHIGAN DOCTORS (MIDOCs) PROGRAM

The GME MIDocs program supports the expansion of residencies and subsequent retention efforts for approved high need specialties in underserved areas of the state where current and future physician shortages undermine the health and well-being of Medicaid beneficiaries. The MIDocs program offers physician training in integrated and



patient-centered care for underserved populations that will further the state's Medicaid quality goals. To be eligible for MIDocs GME funding, the MIDocs participating medical school must enter into an agreement with the state agency specifying the number of MIDocs residents to be supported, the total annual cost of such residencies, any post-residency expenditures to retain physicians in underserved areas of Michigan, and the amount of other sources of funding available for the program, if any. Sponsoring institutions may receive funding from other sources but Medicaid will act as a payer of last resort to only cover costs not reimbursed through other sources. The state agency will pay the MIDocs participating medical school an amount equal to the amount of otherwise unreimbursed costs.

The single state agency will approve four (4) agreements with MIDocs participating medical schools statewide each state fiscal year (SFY), covering residencies for the academic year (July-June (AY)) beginning within the SFY. The agreements will total \$1.52 million in fiscal year 2019, \$10.73 million in fiscal year 2020, \$19.98 million in fiscal year 2021, \$27.75 million in fiscal year 2022, and \$28.5 million in fiscal year 2023.

In addition, the following requirements must be met:

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



SECTION 9 - COST REPORTING REQUIREMENTS

Each hospital, unless specifically exempt, is required to submit a MDHHS Facility Settlement Medicaid Cost Report to the MDHHS HCRD on or before the last day of the fifth month following the close of its cost reporting period. The HCRD grants extensions only when a hospital's operation is adversely affected due to circumstances beyond its control (e.g., staffing turnovers are considered within the control of the hospital, whereas fires and floods would be considered beyond its control). If a hospital fails to submit a completed Medicaid Cost Report via the MDHHS Facility Settlement system on time and has not been granted an extension of the time limit, a notice of delinquency is issued. If the Medicaid Cost Report is not submitted within 30 calendar days from the date of the notice of delinquency, the hospital's payments are terminated until the Medicaid Cost Report is received and accepted by MDHHS in the Facility Settlement system. Payments withheld due to late submission are paid upon acceptance of the Medicaid Cost Report.

The cost report covers a 12-month cost reporting period unless the Medicare and Medicaid Programs have granted prior approval. Approval for filing a cost report for a period other than 12 months may be granted when a hospital changes the end date of its cost reporting period. In such case, the hospital is required to file a Medicaid Cost Report for the period between the end of the original cost reporting period and the beginning of the new cost reporting period.

Hospitals with subacute ventilator dependent care units must obtain MDHHS approval to file Medicaid Cost Reports treating the unit as a subprovider in accordance with the HIM-15 2336, 2336.1, 2336.2, and 2336.3. MDHHS approval must be requested in writing from the HCRD and must be obtained prior to the start of the first hospital fiscal year during which the exemption applies.

Each hospital's Medicaid Cost Report data must include an itemized list of all expenses recorded from the formal and permanent accounting records of the facility. The accrual method of accounting is mandated for all facilities not owned by government. Generally accepted accounting principles must be followed. All of the hospital's accounting and related records, including the general ledger, books of original entry, and statistical data, must be maintained for at least three years after receipt of final settlement (42 CFR §413.20 and Provider Reimbursement Manual §2304; 42 CFR §405.1885). These records must be made available for verification during onsite visits by state or federal audit staff. All Medicaid Cost Reports are retained by MDHHS for at least three years following the date of settlement.

The Medicaid Cost Report must be sent to MDHHS HCRD via the Facility Settlement system. The Medicaid Cost Report must include:

- The CMS 2552 Medicare standardized electronic cost report (ECR) filed in the manner required by MDHHS for MDHHS programs reporting.
- MDHHS specific filed Medicaid Cost Report.
- The hospital's audited Financial Statements.
- Hospitals that participate in the Medicaid FFS 340B program must provide sufficient documentation to confirm the reasonableness of reported charges.

The Medicaid Cost Report is accepted only if all of the following conditions are met:

- All submitted documents are in a usable format.



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- MDHHS can generate a full CMS 2552 cost report from the electronic cost report file. MDHHS uses the KPMG/CompuMax system to generate viewable cost reports.
- Data is provided for all authorized MDHHS units and programs (Medical/Surgical, Rehabilitation, Outpatient, Psychiatric, Clinic, Title V, Title XIX and Healthy Michigan Plan).
- Data meet a set of reasonableness checks, or variances are explained.
- Hospitals that participate in the Medicaid FFS 340B program must provide sufficient documentation to confirm the reasonableness of reported charges.
- Hospitals must maintain an active NPI and accurate specialty enrollment information as described in the General Information for Providers chapter of the Medicaid Provider Manual.



SECTION 10 – AUDITS

The audit and settlement process determines the amount of reimbursement to which an individual hospital is entitled. Cost settlements are made to assure payment of the MDHHS share of reimbursable cost. The audit and settlement process begins with the receipt of the hospital's annual cost report and ends with the electronic issuance of the Notice of Amount of Program Reimbursement that conveys the results of the audit.

10.1 DESK AUDIT

The audit process includes desk audit procedures and audit scope determinations for both MDHHS program(s) audit verification purposes and determination of allowable costs. All cost reports are examined to:

- Verify the completeness and arithmetic accuracy of all schedules in the report;
- Reconcile reported hospital program data with MDHHS approved data; and
- Identify the need for supporting documentation and arrange to receive same.



SECTION 11 – SETTLEMENTS

11.1 INITIAL UPPER PAYMENT LIMIT

In aggregate, MDHHS limits hospital reimbursement to the maximum allowable under the Federal upper payment limits (UPL) for services provided to Medicaid beneficiaries. MDHHS calculates inpatient and outpatient UPLs by benefit plan using CMS 2552 and Medicaid Cost Reports. The UPL calculation is completed at the time MDHHS accepts a hospital's Medicaid Cost Report and recovers amounts in excess of calculated limits.

11.2 HOSPITAL UNDERPAYMENTS AND OVERPAYMENTS

11.2.A. UNDERPAYMENTS TO A HOSPITAL

MDHHS pays a determined amount of an initial settlement due a hospital after notice has been furnished to the hospital. However, MDHHS retains the right to withhold a portion of an initial payment based on individual circumstances.

11.2.B. OVERPAYMENTS TO A HOSPITAL

Once a determination of overpayment has been made, the amount so determined is a debt owed to the State of Michigan and is recovered by MDHHS after notice has been furnished to the hospital.

11.3 FINAL SETTLEMENT(S)

Settlement is based upon processed non-zero dollar MDHHS liability claims for services rendered to MDHHS beneficiaries during the Medicaid Cost Report period and remitted prior to the paid claim report run date. MDHHS calculates the final settlement amount to be reimbursed no earlier than 27 months after the period covered by the Medicaid Cost Report. MDHHS may approve requests for final settlement calculations prior to 27 months in the event of hospital bankruptcy or closure. Upon completion, the final settlement results are transmitted to the hospital via the Facility Settlement system, the Medicare/Medicaid CMS 2552 report and/or the Medicaid Cost Report and will not be amended unless specific cost report changes are approved by MDHHS. Facilities can appeal or request changes to the final settlement up to 30 calendar days from the final settlement completion date noted in the Facility Settlement system.

The total amount paid for inpatient capital is eligible to be settled 27 months after the hospital's fiscal year ends. For testing against the Medicaid upper payment limits, inpatient payments are limited by allowable inpatient charges and outpatient payments are limited by allowable outpatient costs. Total payments for inpatient services are limited to the lesser of operating amount approved (DRG, per diem, and the operating portion of any percent of charge payments), including capital less any limits that apply, or full charges. This limitation is applied separately by program against the aggregate operating payment amounts approved and capital payments. Final reimbursement is limited to the lesser of outpatient payment amounts approved, allowable outpatient charges, or allowable outpatient costs.

For the purpose of the hospital final settlement process only, hospitals that participate in the Medicaid FFS 340B program will have the option to have their 340B drug costs adjusted from actual acquisition cost to a hospital's normal and customary charge. Participation in the 340B final settlement adjustment



process is contingent on the provision of sufficient documentation to confirm the reasonableness of reported charges. This adjustment will not apply to drug reimbursement, and participating providers are required to continue to bill 340B actual acquisition cost and all applicable modifiers. This policy does not impact or require any additional action for providers that do not participate in the Medicaid FFS 340B program. This policy is effective for final settlements with fiscal year ends on and after October 1, 2015, and does not apply to prior settlements or settlements reopened prior to this effective date.

11.4 RESPONSES TO THE FINAL SETTLEMENT

The Facility Settlement system contains a descriptive list of all program data adjustments made to a Medicaid Cost Report by the MDHHS HCRD audit staff. The Notice of Amount of Program Reimbursement is the notice of final determination and is considered the offer of settlement for all reimbursement issues for the cost reporting period under consideration.

The process is initiated by the hospital after the receipt of the Facility Settlement system notification. The MDHHS HCRD concludes the process on the day the Notice of Amount of Program Reimbursement is electronically transmitted to the hospital.

The final settlement result must be accepted or rejected by the hospital within 30 calendar days of the Notice of Amount of Program Reimbursement being electronically transmitted to the hospital.

The hospital may take the following actions:

- **Hospital Accepts the Notice of Amount of Program Reimbursement**

If the hospital accepts the findings contained in the final settlement, an appropriate officer of the hospital must electronically sign the final settlement within the Facility Settlement system. The MDHHS Notice of Amount of Program Reimbursement will be electronically transmitted to the hospital. No further administrative appeal rights will be available for the adjustments contained in the final settlement.

- **Hospital Does Not Respond to the Notice of Amount of Program Reimbursement**

If the hospital does not respond within the 30 calendar day time period, MDHHS shall electronically transmit a Notice of Amount of Program Reimbursement, which is the final determination of an adverse action. No further administrative appeal rights are available.

- **Hospital Rejects the Notice of Amount of Program Reimbursement**

If the hospital rejects any or all of the findings contained in the final settlement within 30 calendar days of the transmit date of the Notice of Amount of Program Reimbursement, then an informal appeal can be requested. An informal appeal process involves the audit staff and the hospital working to resolve differences prior to a formal appeal. The hospital may request a formal appeal hearing through the administrative appeal process.

11.5 REOPENING OF SETTLEMENTS

For all MDHHS final settlement reopenings, MDHHS has adopted and follows all applicable provisions of the Medicare Provider Reimbursement Manual (HIM-15), Part 1, Sections 2931 and 2932, as well as all applicable provisions of 42 CFR Section 405.1885 et. seq.



For all reopenings, there is a three-year statute of limitations that begins on the date of the original MDHHS Notice of Amount of Program Reimbursement. The three-year time period ends on the third anniversary of that date. A separate Facility Settlement system notification regarding settlement recalculation will be required for each provider and each cost year. If MDHHS electronically notifies a provider of its settlement recalculation before the expiration of the three-year period, the three-year requirement will be considered met. After this point, the reopened settlement will be completed in a timely fashion.

A Medicare settlement reopening will not affect the application of the three-year time limit on MDHHS settlement reopenings. Once the final settlement has been calculated and sent to the hospital, the Medicare/Medicaid CMS 2552 report will not be amended without specific CMS 2552 changes being approved by MDHHS.

New laws, regulations, policy directives, or the interpretation of such issued subsequent to a settlement will not serve as basis to reopen a settlement. Additionally, the above cannot be introduced as part of a reopened settlement. The sole exception is when MDHHS is directed to do so by court order.



SECTION 12 - APPEALS

12.1 DATA CORRECTIONS

Once a hospital report (e.g., cost, indigent volume, and/or data) has been reviewed and provisionally accepted by MDHHS, the hospital is notified in writing of MDHHS acceptance of the report. The hospital then has 30 calendar days in which to notify MDHHS of any errors or corrections to the report/data. After the 30-day notification period, the report is deemed accepted by MDHHS and will be used to rebase or update the hospital's pricing components as appropriate.

Only those reports on file and accepted nine months prior to the beginning of a new rate period are used for rebasing.

12.2 PRICE APPEALS

MDHHS considers appeal requests received within 30 calendar days from the date of notice to the hospital advising it of a change in its pricing components. Appeal requests must be submitted in writing to MDHHS. Requests must clearly state the item(s) being appealed, the remedy being sought, and must include all necessary documentation to support the hospital's position. Appeal requests received after 30 calendar days are not accepted. Appeal requests may not be used as a means to delay submission or fail to produce cost reports in the format and within the time frame required. Failure to include all necessary documentation to support the hospital's position may result in a hospital's appeal request being rejected.

Items subject to appeal include:	Items not subject to appeal include:
<ul style="list-style-type: none"> ▪ Interpretations and/or application of program: <ul style="list-style-type: none"> ➢ Policy ➢ Procedures ➢ Formulas ➢ Pertinent laws and regulations (e.g., Code of Federal Regulations, HIM-15, etc.) ▪ Incorrect data and/or paid claims information used in price calculations – excluding data and paid claims information from the hospital's annual cost report previously submitted by it and accepted by MDHHS. 	<ul style="list-style-type: none"> ▪ Data previously submitted by the hospital and accepted by MDHHS. ▪ The establishment and use of DRGs. ▪ The Medicare Principles of Reimbursement (e.g., 42 CFR, HIM-15, etc.) as adopted by MDHHS and used to reimburse providers. ▪ The use of relative weights as part of the DRGs. ▪ Interim payment rates which are in compliance with state and/or federal regulations. ▪ Nonprogram related issues.

Appeal requests must be sent to the Michigan Office of Administrative Hearings and Rules (MOAHR). (Refer to the Directory Appendix for contact information.)

12.3 APPEAL PROCESS [CHANGES MADE 4/1/20]

Upon receipt of an appeal request, a conference is scheduled and conducted by MDHHS staff from MOAHR. During this conference, the MDHHS staff and hospital representatives discuss the issues related to the appeal.



Failure to appear at a scheduled conference without good cause and reasonable advance written or telephone notification to the MDHHS staff person assigned to the appeal is considered an abandonment of the appeal.

After the conference, a final determination notice is sent to the hospital outlining the MDHHS position on the item(s) appealed.

A price appeal decision may include a correction to the data used to set rates. If so, the corrected data is used beginning with the rate period for which the appeal was filed. Data corrections and any resultant price component changes that are accepted through pre-hearing conference or prevail at hearing are made for the current base period only for the hospital filing the appeal. MDHHS may make changes to price components that affect all providers in subsequent rebasing periods.

Hospitals may elect to appeal an adverse action by requesting an administrative hearing as provided in MDHHS Provider Hearing Rules, R 400.3402 through R400.3404. Requests for hearing must be sent to MOAHR. Appeal requests must be made in writing and received within 30 calendar days of the notice of adverse action. If an appeal is not made in a timely manner, the notice of adverse action is final. **(revised 4/1/20)**

12.4 ADMINISTRATIVE HEARINGS

Hearings conducted by MOAHR follow the MDHHS Provider Reviews and Hearings Rules found at R400.3406 through R400.3424.



SECTION 13 - ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAM FOR HOSPITALS

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, authorized incentive payments through Medicare and Medicaid to eligible hospitals as they adopt, implement, and/or upgrade, or demonstrate meaningful use of certified Electronic Health Record (EHR) technology. The hospital incentive program is designed to support hospitals in a period of health information technology transition and instill the use of EHRs in meaningful ways to help improve the quality, safety, and efficiency of patient health care.

The purpose of EHRs and meaningful use is to:

- Improve quality, safety, efficiency, and reduction of health disparities;
- Engage patients and families in their health care;
- Improve care coordination;
- Improve public health; and
- Ensure adequate privacy and security protections for personal health information.

13.1 REGISTRATION AND INTERFACES WITH THE NATIONAL LEVEL REPOSITORY

All hospitals seeking an EHR incentive payment are required to register with the National Level Repository (NLR). The NLR is the federal database which verifies basic provider information prior to notifying State Medicaid programs of a provider's intent to participate in the Medicare and Medicaid EHR Incentive Program. To register with the NLR, all Eligible Hospitals (EHs) must have a National Provider Identifier (NPI) and be enrolled in the CMS Provider Enrollment, Chain, and Ownership System (PECOS). Registration requires an active user account in the National Plan and Provider Enumeration System (NPPES). Note that any revisions to information provided in the NLR must be modified at the NLR level.

MDHHS is notified upon successful registration with the NLR. EHs are directed to the Michigan Medicaid Community Health Automated Medicaid Processing System (CHAMPS) to begin the Michigan Medicaid EHR registration process. The EHR Incentive Program module was created within the CHAMPS system to collect and record EH data. All providers have up to 30 days from MDHHS receipt of the NLR file to submit completed registration information in the CHAMPS EHR module. Failure to do so in the allotted timeframe could require hospitals to re-register at the NLR level. Providers must be an enrolled Michigan Medicaid provider and have an active Payee-Tax Identification on record within SIGMA Vendor Self Service (VSS). EHs are only required to register once for the Medicare and Medicaid EHR Incentive Programs. However, they must successfully demonstrate that they have adopted, implemented and/or upgraded (first participation year for Medicaid) or meaningfully used certified EHR technology each year in order to receive an incentive payment for that year. Additionally, providers seeking the Medicaid incentive must annually re-attest to other program requirements, such as meeting the required patient volume thresholds.

Following EH data collection in the NLR and Medicaid EHR CHAMPS module, EH eligibility determinations are calculated.

Following a successful eligibility determination, EH payments are calculated. A final report is filed with the NLR following a processed EHR incentive payment.



13.2 REQUIREMENTS FOR PARTICIPATION

In order to participate in the Michigan Medicaid EHR Incentive Program, hospitals must be a Medicaid enrolled provider and have a completed Medicaid Quarterly Report, Medicaid Cost Report and CMS 2552 Cost Report on file with MDHHS that correlates with the specified timeframe from which data are pulled. In an effort to have the most complete and accurate information for program calculations, all revisions, amendments, and modifications to data sources used in eligibility and payment calculations must be complete prior to hospital registration in the EHR Incentive Program. Incomplete data sources or data that is under revision are not utilized; therefore, hospital eligibility determinations and payment calculations could be delayed as a result.

Hospitals must review and agree to the attestation requirements outlined in the Michigan Medicaid EHR CHAMPS module. EHs select their EHR status (e.g., Adopt, Implement, and/or Upgrade or Meaningful Use) and provide their EHR certification number. EHs attest that the information they are providing is true, accurate, and complete.

EHs may participate in both the Medicare EHR Incentive Program and the Medicaid EHR Incentive Program. Hospitals must choose only one state from which to register and receive a Medicaid EHR incentive payment.

13.3 ELIGIBLE HOSPITALS DEFINED

Per CMS, eligible hospitals are defined as follows:

- Acute care hospitals (includes critical access hospitals [CAH]) and cancer hospitals meeting the following requirements:
 - A health care facility where the average length of patient stay is 25 days or fewer,
 - CMS Certification Number (CCN) ending between 0001 and 0879 or 1300-1399, and
 - Meet a Medicaid patient volume threshold of at least 10%; **or**
- Children's hospitals (does not include children's wings of larger hospitals) which are separately certified children's hospitals with CCN ending between 3300 and 3399.

Children's hospitals do not have to meet a minimum Medicaid patient volume threshold.

13.4 ELIGIBILITY VERIFICATION

To verify hospital eligibility, data reported on the CMS 2552, Medicaid Quarterly Report, and the MMF are utilized. Eligibility requirements are calculated annually upon registration in the Medicaid EHR Incentive Program. Hospitals should confirm that all necessary data elements are complete and reported for EHR incentive calculation purposes.



13.4.A. AVERAGE LENGTH OF STAY (LOS)

Average LOS is calculated by reviewing the current CMS 2552 Cost Report and Medicaid Cost Report on file with MDHHS. The following calculation is used:

$$\text{Total Inpatient Days} / \text{Total Inpatient Discharges} = \text{Hospital Average LOS}$$

13.4.B. MEDICAID ELIGIBLE PATIENT VOLUME

A hospital’s Medicaid eligible patient volume is calculated using the Medicaid Quarterly Report. Acute care hospitals must annually meet a 10% Medicaid eligible patient volume threshold to participate in the EHR Incentive Program. EH Medicaid eligible patient volumes are verified each year of a hospital’s participation in the EHR Incentive Program. (Children’s hospitals are exempt from the volume threshold requirement.) MDHHS will select the hospital quarter with the highest Medicaid eligible patient volume (90-day continuous period) from the applicable calendar year’s Medicaid Quarterly Report to derive program eligibility. For purposes of measuring Medicaid eligible patient volume, an inpatient hospital day or hospital discharge with a Medicaid-enrolled patient, including those with no Medicaid payment liability, is considered an encounter. One of two calculation methods is utilized to determine Medicaid eligible patient volume. The quarter of the prior calendar year and calculation method that yields greater Medicaid eligible patient volume is utilized to determine hospital eligibility. Patient encounters include both Fee-for-Service (FFS) and Managed Care Organization (MCO) data.

One of the following calculations will be utilized to determine Medicaid Patient Volume:

$$\frac{\text{Total Medicaid Hospital Days}}{\text{Total Hospital Days}} \times 100 = \text{Medicaid Patient Volume}$$

OR

$$\frac{\text{Total Medicaid Hospital Discharges}}{\text{Total Hospital Discharges}} \times 100 = \text{Medicaid Patient Volume}$$

13.5 INCENTIVE PAYMENT CALCULATION

EHR Incentive Program payments are calculated in accordance with the formula outlined in the HITECH under Section 495.310. Payments are made over a total of three years and are paid 50% of the aggregate calculation in the first year, 40% in the second year, and 10% in the third year.



13.5.A. TIMING

EHRs that adopt, implement, and/or upgrade a certified EHR system or are meaningful users can begin receiving incentive payments in any year from 2011 to 2016. The Medicaid EHR Incentive Program operates on a calendar year (CY) reporting period (January 1 through December 31). While the statute defines a payment year in terms of a CY, a hospital does not have to begin receiving incentive payments in CY 2011. However, the last year a hospital can first receive an initial Medicaid incentive program payment is CY 2016.

EHRs are paid up to 100% of the calculated aggregate EHR hospital incentive payment amount over a three-year period. Data utilized to calculate the aggregate EHR hospital incentive amount is derived from filed hospital cost reports (CMS 2552 and Medicaid Cost Report) from the hospital CY that ends during the CY prior to the hospital CY that serves as the first payment year.

All revisions, amendments, and modifications to data sources must be completed prior to a hospital's registration for the EHR Incentive Program. This includes revisions to the filed cost reports (CMS 2552 and Medicaid Cost Report) used to calculate the aggregate EHR incentive amount. Incomplete hospital data sources will result in delays in eligibility determinations and payment calculations.

13.5.B. PAYMENT FORMULA

The aggregate EHR incentive amount is a one-time calculation based upon the sum of a theoretical four-year calculation period where the amount of each year is the product of the following factors:

- the overall EHR amount; and
- the Medicaid Share.

The overall EHR amount is also based upon the sum over a theoretical four-year calculation period where the amount of each year is the product of two factors:

- an Initial Amount; and
- the Transition Factor applicable to each of the four years.

(All data used in the payment calculation is derived from the same 12 month cost report period, other than discharge data used to calculate the annual growth rate.)

Initial Amount and Theoretical Four-Year Calculation Period

The Initial Amount is the sum of a base amount and a discharge-related amount. The base amount is \$2,000,000, and the discharge-related amount provides an additional \$200 for estimated discharges between 1,150 and 23,000. No discharge-related amount is made for discharges prior to the 1,150th discharge or for discharges after the 23,000th discharge.



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For the first calculation year, data on hospital discharges from the hospital fiscal year that ends during the FFY prior to the hospital fiscal year that serves as the first payment year is used as the basis for determining the discharge-related amount. To determine the discharge-related amount for the three subsequent theoretical calculation years, the number of discharges is based on the average annual growth rate for the hospital over the most recent three years of available data. The growth rate is based on a three-year average of total discharges, beginning with the initial calculation year and including data from the three prior years. The annual growth rate is applied to the base year’s discharges to arrive at the three subsequent year discharge amounts. If an EH’s average annual rate of growth is negative over the three-year period, the rate is applied as such.

Transition Factor

For each of the four years of the calculation, a different transition factor applies. The aggregate Medicaid EHR Incentive Payment is calculated once and is then distributed over three actual payment years. The transition factors listed below are used to calculate the aggregate EHR amount but do not indicate that hospital payments will be recalculated on a yearly basis.

Theoretical Calculation Period	Transition Factor
Year 1	1.00
Year 2	0.75
Year 3	0.50
Year 4	0.25

Medicaid Share

The Medicaid Share is the percentage of a hospital’s inpatient, non-charity care days that are attributable to Medicaid inpatients.

The numerator of the Medicaid Share is the sum of:

- The estimated number of Medicaid inpatient-bed-days; and
- The estimated number of Medicaid managed care inpatient-bed-days.

The denominator of the Medicaid Share is the product of:

- The estimated total number of inpatient-bed-days for the eligible hospital during that period; and
- The estimated total number of the eligible hospital’s charges during that period, not including any charges that are attributable to charity care, divided by the estimated total amount of the hospital’s charges during that period.



For the purposes of the EHR incentive payment calculation, charity care is calculated using data from the Medicaid Cost Report Indigent Volume worksheet as follows:

$$(\text{Total Uncompensated Charges} - \text{Third Party Bad Debts} - \text{Uninsured Payments from Charges} - \text{Recoveries for Uninsured Bad Debt}) = \text{Charity Care}$$

The removal of charges attributable to charity care in the formula, in effect, increases the Medicaid Share resulting in higher incentive payments for hospitals that provide a greater proportion of charity care.

Payment Calculation Summary

1. Calculate initial amount	\$2 million base amount + ((discharge bonus)*200) = initial amount \$200 per total discharge between 1,150 and 23,000
2. Calculate four theoretical years	Year 1: 100% of initial amount Year 2: 75% of initial amount (+ or – any change in discharge level based on annual growth rate) Year 3: 50% of initial amount (+ or – any change in discharge level based on annual growth rate) Year 4: 25% of initial amount (+ or – any change in discharge level based on annual growth rate)
3. Sum four theoretical year calculations	Year 1 + Year 2 + Year 3 + Year 4 = Aggregate Hospital EHR Incentive Amount
4. Calculate Medicaid Share	Medicaid inpatient days / (total inpatient days * ((gross revenue – charity) / gross revenue))
5. Multiply Aggregate Hospital EHR Incentive Amount by Medicaid Share	Aggregate Hospital EHR Amount * Medicaid Share = Total Hospital EHR Incentive Amount
6. Paid over three payment years	Payment Year 1 = 50% of Total Hospital EHR Incentive Amount Payment Year 2 = 40% of Total Hospital EHR Incentive Amount Payment Year 3 = 10% of Total Hospital EHR Incentive Amount

13.6 PAYMENT NOTIFICATION AND GROSS ADJUSTMENTS

EH Medicaid Incentive payments are made annually via gross adjustment. EHs cannot receive more than one incentive payment in each State CY.

Following the verification of hospital eligibility, an incentive payment is calculated and the EH is notified of the final amount. EHs have up to 30 days from receiving their payment notice to dispute payment calculations. If no communication is received or the EH agrees with the payment notice, the incentive payment is processed via gross adjustment in the CHAMPS system.



13.7 ADOPT, IMPLEMENT, AND/OR UPGRADE OR MEANINGFUL USE

To receive a first year's incentive payment, EHs must attest to adopting, implementing, and/or upgrading (AIU) a certified EHR system. EHs are required to provide the certification number of their EHR system within the EHR CHAMPS module during registration as part of AIU attestation. Eligible Medicaid hospitals can receive their first year's payment for AIU attestation and not meaningful use, but must meet the meaningful use requirement in all subsequent participation years.

If an EH is eligible for both Medicare and Medicaid EHR Incentive Programs and has achieved meaningful use standards under Medicare, they are recognized as a meaningful user for Medicaid purposes.

In order to continue to receive incentive payments after the first payment year, providers must achieve and maintain a set of meaningful use measures as defined by CMS. Meaningful use employs a three-stage approach, with each stage building on the preceding stage:

- Stage 1 – Data capture and sharing
- Stage 2 – Expand on Stage 1 criteria to encourage the use of health information technology for continuous quality improvement
- Stage 3 – Expand on Stage 2 with a focus on promoting outcomes in quality, safety, and efficiency

To demonstrate Stage 1 of meaningful use, an EH must comply with a set of "core" requirements and a selection of "menu" requirements. MDHHS has adopted the same requirements outlined by CMS without modification.



SECTION 14 – SHORT-STAY HOSPITAL REIMBURSEMENT

The State utilizes a Short Hospital Stay (SHS) rate of reimbursement for certain outpatient and inpatient hospital stays. The SHS encompasses funding for both operating and capital costs. The SHS rate will be identical for inpatient and outpatient services, and will apply to all services billed on the claim. The SHS rate is published on the MDHHS website. (Refer to the Directory Appendix for website information.)

The SHS rate of reimbursement does not modify billing requirements for hospitals. If the patient meets criteria for an inpatient admission, the claim must be submitted as an inpatient claim. Conversely, if the patient does not meet criteria for an inpatient admission, the claim must be submitted as an outpatient claim. In either case, if the criteria for the SHS rate are met, the hospital will receive the same reimbursement for services rendered. The SHS rate only applies to discharges from a facility, and does not apply to transfers, leaving against medical advice (AMA), or other discharge statuses.

The SHS logic will apply to both emergent and elective claims. For purposes of this reimbursement structure, SHSs will be defined using the following criteria.

14.1 DIAGNOSES

In order to qualify for a SHS rate, a claim must include one of the primary diagnosis codes list. This list is maintained on the MDHHS website. (Refer to the Directory Appendix for website information.) The list of eligible codes will be evaluated annually and updated as necessary.

For outpatient dates of service and inpatient dates of discharge on or after July 1, 2015 and before October 1, 2015, ICD-9 diagnosis codes will be used. For outpatient dates of service and inpatient dates of discharge on or after October 1, 2015, ICD-10 diagnosis codes will be used.

14.2 OUTPATIENT HOSPITAL CLAIMS QUALIFICATION

An outpatient hospital claim will qualify for the SHS reimbursement if all of the following criteria are met:

- The primary diagnosis code billed on the outpatient claim is listed on the primary diagnosis codes list referenced above.
- The claim does not include a surgical revenue code (36x) billed on any line of the outpatient claim.
- The claim does not include cardiac catheterization lab revenue code 481.
- The claim includes observation revenue code 762.

14.3 INPATIENT HOSPITAL CLAIMS QUALIFICATION

An inpatient hospital claim will qualify for the SHS reimbursement if all of the following criteria are met:

- The primary diagnosis code billed on the inpatient claim is listed on the primary diagnosis codes list referenced above.
- The claim does not include a surgical revenue code (36x) billed on any line of the inpatient claim.
- The claim has a date of discharge equal to or one day greater than the date of admission.
- The claim does not include cardiac catheterization lab revenue code 481.



14.4 EXCLUSIONS

The SHS logic will not apply to inpatient or outpatient claims with the following conditions:

- Claims where Medicaid is the secondary payer. MDHHS will follow the rules of the primary payer, and MDHHS will be responsible for payment up to co-insurance and/or deductible.
- Hospital discharges with discharge status codes other than 1, 6, 9, 21, 30, 50, or 51.
- Claims for patients who leave the hospital AMA.
- Claims for deceased patients.
- Claims that include primary diagnoses that are not on the diagnosis list referenced above, including claims for births and deliveries, for example.

14.5 SHORT HOSPITAL STAY RATE AND METHODOLOGY

A single SHS rate will be developed for certain outpatient and inpatient hospital stays. This rate will encompass funding for both operating and capital costs, will be identical for inpatient and outpatient services, and will encompass all services billed on the claim.

The rate will be established using Medicaid hospital Fee-for-Service paid claims and managed care encounters that meet the SHS criteria. To calculate the rate, the following process will be employed:

- Aggregate Fee-for-Service operating payments on qualifying claims with dates of service during the second previous fiscal year will be identified.
- Aggregate Fee-for-Service capital payments will be calculated by multiplying the Fee-for-Service inpatient claims count for qualifying claims with dates of service during the second previous fiscal year by the current year statewide capital rate.
- Aggregate managed care operating and capital payments on qualifying encounters with dates of service during the second previous fiscal year will be identified.
- Fee-for-Service and managed care operating and capital payments will be aggregated and divided by the number of claims and encounters that meet the SHS criteria. The resulting quotient will be the SHS rate.

MDHHS will monitor the diagnosis code sets and reimbursement to ensure budget neutrality is maintained or to maintain consistency with future reimbursement changes.



INDEPENDENT DIAGNOSTIC TESTING FACILITIES AND PORTABLE X-RAY SUPPLIERS

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SECTION 1 - INTRODUCTION

1.1 GENERAL INFORMATION

The Michigan Department of Health and Human Services (MDHHS) enrolls and reimburses Independent Diagnostic Testing Facilities (IDTF) and Portable X-ray Suppliers (PXRS) for Medicaid covered diagnostic services. An IDTF or PXRS may provide services in a mobile facility or portable unit and is independent of a physician's office or hospital. Providers and equipment must comply with all federal, state and local regulations applicable to the type of service(s) provided.

MDHHS aligns with Medicare's IDTF and PXRS policies whenever possible. IDTF and PXRS entities must be enrolled with Medicare before requesting to enroll with Michigan Medicaid. (For information on the MDHHS Provider Enrollment process, refer to the General Information for Providers Chapter in this manual).



SECTION 2 - GENERAL INFORMATION FOR IDTF AND PXRS BILLING AND REIMBURSEMENT

Claims for enrolled providers are submitted in the ASC X12N 837 5010 professional format to the MDHHS Community Health Automated Medicaid Processing System (CHAMPS).

- Michigan Medicaid reimbursement for IDTF and PXRS services is based upon the limits and rates associated with MDHHS physician professional services.
- Procedure codes and fee screens for the IDTF or PXRS are available on the MDHHS website and in the Medicaid Code and Rate Reference tool in CHAMPS. (Refer to the Directory Appendix for website information.)
- To bill transportation and set up codes for portable x-rays, an IDTF must qualify and be enrolled as a PXRS.

A referral or an order for a diagnostic test or x-ray is required from the provider treating the patient. Providers arranging or rendering services upon the order of another provider must maintain that order for a period of seven years.

When an enrolled IDTF or PXRS provides the professional component (PC) interpretation from a distant site, the Place of Service (POS) codes assigned by the physician or other provider will be the setting in which the patient received the technical component (TC) of the service.

Michigan policies regarding National Provider Identifier (NPI) Type, Global or Component Billing, and Referring/Ordering and Supervising Providers are available in this manual. Refer to the General Information for Providers, Billing & Reimbursement for Professionals, and Practitioner chapters for complete descriptions on required claim information.



SECTION 3 - INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTF)

An IDTF is approved to provide specific diagnostic tests when performed by licensed, certified personnel (42 CFR 410.33). The IDTF must provide the appropriate amount of physician general supervision based on the number of enrolled locations.

The IDTF may have either a fixed or mobile location and different practice sites. Each practice location and/or mobile unit must be separately enrolled and meet all applicable requirements for the type of diagnostic test performed. A mobile IDTF can provide portable x-ray services if the provider is enrolled with Medicare for this service. To bill transportation and set up codes, the IDTF must also be a qualified and enrolled PXRS.

An IDTF does not provide therapeutic procedures. Test results from an enrolled IDTF are used by the referring provider in the medical management of the beneficiary.



SECTION 4 – PORTABLE X-RAY SUPPLIERS (PXRS)

In compliance with 42 CFR 410.32 (c) (i-ii), PXRS are limited to performing Medicaid covered x-rays of the extremities, pelvis, spine, skull, chest and abdomen. There must be one or more physicians who are responsible for the general supervision of the PXRS as described in 42 CFR 486.102.

An order from the provider treating the patient is required. The order must specify both the reason for the x-ray and the need for portable services.

PXRS claims may include up to four components:

- transportation when x-ray equipment is taken to the location where services are performed,
- set-up of the equipment,
- administration of the x-ray (technical component), and
- interpretation of the x-ray (the professional component).

Appropriate HCPCS and Level II HCPCS modifiers are required. The modifier determines the number of beneficiaries served at a location, and total payment for services is adjusted by the number of patients.

Portable x-rays furnished in a place of residence used as the patient's home require the corresponding POS code. For patients residing in a nursing facility, the transportation, set-up and personnel costs are included in the nursing facility's per diem rate with a PXRS and are not separately reimbursable. For information on the nursing facility coverage of transportation costs, refer to the Nursing Facility Chapter of this manual.



LABORATORY

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SECTION 1 - GENERAL INFORMATION

This chapter applies to Independent Clinical Labs.

Medicaid reimburses laboratories only for those services it is certified by the Clinical Laboratory Improvement Amendments (CLIA) to perform and for those services ordered by physicians (MD or DO), physician assistants (PAs), advanced practice registered nurses (APRNs) [including certified nurse practitioners (NPs), certified clinical nurse specialists (CNSs) and certified nurse midwives (CNMs)], podiatrists (DPMs), or dentists. The ordering practitioner must document the medical necessity of laboratory tests in the beneficiary's medical record, regardless of where the test(s) is performed. Medicaid covers only those medically necessary laboratory tests needed to diagnose a specific condition, illness, or injury. Medicaid does not cover any laboratory tests ordered by a chiropractor.

The ordering practitioner is held responsible if they order excessive or unnecessary laboratory tests, regardless of who actually renders the laboratory services. The ordering practitioner is also held responsible for the medical necessity of every laboratory test that is ordered as part of a custom- or laboratory-designed profile. The ordering practitioner may be subject to corrective action related to these services, including recoupment of funds. The laboratory also may be subject to corrective action, including the recoupment of funds, if it submits a claim for laboratory services not specifically ordered by a practitioner.

Screening or routine laboratory testing, except as specified for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, or by Medicaid policy, is not a benefit. Ordering or rendering of "profiles", "batteries" or "panels" of tests that include tests not necessary for the diagnosis or treatment of the beneficiary's specific condition are considered random screening and are not covered. Multiple laboratory tests carried out as a part of the evaluation of the beneficiary, when the results of the history and physical examination do not suggest the need for the tests, are considered screening and are not covered.

Laboratory services performed by a laboratory or its employees may not be billed to the ordering practitioner.



SECTION 2 - BILLING INFORMATION

When billing Medicaid for services rendered, the date of service (DOS) indicated on the claim must be the date the specimen is collected. Refer to the Billing & Reimbursement for Professionals Chapter of this manual for additional information about billing.

2.1 MEDICAL NECESSITY

The medical record and claims (with applicable attachments) must contain documentation of medical necessity describing the beneficiary's symptoms and other findings that led the practitioner to order the laboratory test(s). An explanation of the laboratory testing method or the results of the diagnostic tests, whether normal or abnormal, is not documentation of medical necessity. For approval of payment, the laboratory procedure(s) must be specific and appropriate to the beneficiary's documented condition and diagnosis.

2.2 PHYSICIAN SELF-REFERRAL

Stark Legislation or Physician Self-Referral Legislation, 42 USC 1395nn, limits certain physician referrals made to entities where the physician has a financial relationship. A physician should make no referrals of laboratory tests to a laboratory in which the physician (or the physician's immediate family members) has a financial relationship unless the referral falls under the "in-office ancillary services" exception.

Michigan Department of Health and Human Services (MDHHS) defines the following terms as they relate to the Physician Self-Referral portion of the Stark Legislation:

2.2.A. PHYSICIAN'S OFFICE LABORATORY

A Physician's Office Laboratory (POL) meets the following parameters:

- A physician or a group practice owns the laboratory.
- The laboratory performs testing only on specimens generated by the physician owner.

The laboratory is subject to the following policies:

- Laboratory claims must be billed using the physician's provider NPI number.
- The laboratory must not accept referrals from physicians outside of the physician's practice or group practice.

2.2.B. DUAL PHYSICIAN'S OFFICE/INDEPENDENT LABORATORY

A dual physician's office/independent laboratory meets the following parameters:

- A physician or a group practice owns the laboratory.
- The laboratory is a physician's office laboratory for those specimens generated by the physician owner.



- The laboratory is an independent laboratory for those specimens that are referred by physicians outside of the physician's practice or group practice.

Dual physician's office/independent laboratories are subject to the following policies:

- Laboratory claims generated by the physician owner must be billed using the physician's provider NPI number.
- Laboratory claims generated by physicians outside of the physician's practice or group practice must be billed using the independent laboratory NPI number.
- The laboratory must not accept referrals from immediate family members.

2.2.C. INDEPENDENT LABORATORY

An independent laboratory meets the following parameters:

- It may be owned by:
 - A physician or a group practice.
 - A non-physician.

The physician-owned independent laboratory is subject to the following policies:

- The laboratory must not accept referrals from the physician owner or his immediate family members.
- Laboratory claims are billed using the independent laboratory NPI number.

The non-physician owned independent laboratory is subject to the following policies:

- The laboratory must not accept referrals from the owner or his immediate family members.
- Laboratory claims are billed using the independent laboratory NPI number.

2.3 CLINICAL LABORATORY IMPROVEMENT AMENDMENTS CERTIFICATION

All providers that submit claims must have Clinical Laboratory Improvement Amendments (CLIA) certification and the CLIA number must be present on the claims. Providers are limited to billing the lab services that they are CLIA-certified to perform. This includes the specialties as listed under their CLIA certificate.

When billing Medicaid for services rendered, providers performing tests that use waived methodologies must enter the QW modifier with the appropriate Current Procedural Terminology (CPT) code to denote the waived test.

Questions regarding CLIA certification should be addressed to the state-licensing agency. (Refer to the Directory Appendix for contact information.)



2.4 PROCEDURE CODES

Laboratories should refer to the current edition of the CPT manual published by the American Medical Association (AMA) for the appropriate procedure code to use when billing Medicaid. The laboratory is also subject to the pathology and laboratory guidelines that provide definitions and/or instructions for specific sections in the manual.

2.5 COMPONENT BILLING

Most pathology procedures are billed together as a total service, and a single charge is made for both professional and technical components. Some pathology procedures are composed of professional and technical components that are billed separately by the facility and the provider. In these instances, the procedure code requires the use of a two-character modifier to accurately identify the service provided. Do not bill for component services when the entire procedure is performed.

Payment for the technical component to the laboratory includes personnel, materials, space, equipment, report of test results, and other items.

The professional component represents the professional services of a pathologist/hematologist. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters. These are limited to certain services as noted on the Practitioner and Medical Clinic Fee Schedule located on the MDHHS website. (Refer to the Directory Appendix for website information.) Payment for this component includes:

- Examination of the beneficiary, when indicated.
- Performance and supervision of the procedure.
- Reading, interpretation, and written report of the findings.
- Consultation with the referring physician.

When the laboratory performs services for hospital inpatients, only the pathologist can bill the professional component (the pathologist's services) directly to Medicaid. The technical component is included in the reimbursement to the hospital for the inpatient services.

2.6 MEDICARE RELATED BILLING

Medicaid reimburses laboratories for the coinsurance and deductible amounts subject to Medicaid's reimbursement limitations on all Medicare-approved claims even if Medicaid does not normally cover the service.

2.7 BILLING FOR SERVICES PERFORMED BY REFERENCE LABORATORIES UNDER ARRANGEMENT WITH ENROLLED HOSPITAL LABORATORIES

Following Medicare guidelines and applicable state and federal laws in situations where an enrolled hospital laboratory must refer a specimen to a reference laboratory, the enrolled laboratory will be allowed to bill Medicaid for the services provided by the reference laboratory under the following conditions:



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- The reference laboratory holds the required Clinical Laboratory Improvement Amendments (CLIA) certification and state licensure, if required, to perform the test;
- The enrolled hospital laboratory and the reference laboratory have a contractual agreement (termed "Under Arrangements" by Medicare) to provide such services, with the hospital laboratory responsible for reimbursing the reference laboratory for the services; and
- If the service requires prior authorization, the enrolled hospital laboratory must request and receive prior authorization approval for the service to be performed by the reference laboratory. The prior authorization number must be included on the claim.

The definitions of reference laboratory and referring laboratory may be found in the Glossary Appendix.



SECTION 3 - REIMBURSEMENT

Reimbursement rates for clinical laboratories, physician's offices, and clinics are established by MDHHS as a fee screen for each procedure. MDHHS uses the Medicare Clinical Laboratory Fee Schedule (MCLFS) prevailing fees as a guideline or reference in determining the maximum fee screens for individual procedures. Services are reimbursed at a maximum rate of 90% of the MCLFS. The Medicaid Clinical Laboratory fee schedule is updated following the January release of the MCLFS. Reimbursement for laboratory services includes the collection of the specimen(s), the analysis, and the lab test results.

Medicaid performs pre- and/or post-payment reviews to monitor laboratory procedures for medical necessity and appropriate practitioner orders. A beneficiary cannot be charged for any covered laboratory procedures, including those that are determined to be non-medically necessary.

Laboratory services provided by outpatient hospitals or ESRD facilities are reimbursed through the Medicaid Outpatient Prospective Payment System (OPPS) and not subject to the reimbursement methodology described in this section.



SECTION 4 - SPECIAL COVERAGE

4.1 CHILDREN'S SPECIAL HEALTH CARE SERVICES COVERAGE

The coverage limits do not apply to beneficiaries with Children's Special Health Care Services (CSHCS) only eligibility.

The coverage limits do apply to beneficiaries with dual Medicaid and CSHCS eligibility if the laboratory procedures are not related to the beneficiary's CSHCS qualifying diagnosis.

4.2 BLOOD HANDLING

The fee for blood handling is usually included in the reimbursement for the blood test. Situations in which the drawing, packaging, and mailing of a blood specimen are the only services provided are rare and include:

- A beneficiary that is referred to a laboratory for the sole purpose of drawing, packaging, and mailing a blood sample to MDHHS for blood lead analysis. The State provides lead-free vacutainers for the analysis. Requests for vacutainers and the samples for analysis should be sent to the MDHHS Bureau of Laboratories – Trace Metals Section. (Refer to the Directory Appendix for contact information.)
- A beneficiary occasionally requires blood tests that are not performed in conjunction with other reimbursable services. Whenever possible, the beneficiary should be sent to the laboratory that is to perform the test(s). If this is not practical (i.e., the laboratory is not a local facility) and the sole purpose of a visit is to draw, package, and mail the sample to a laboratory, the blood-handling fee may be billed by the practitioner. The blood-handling fee is not a benefit when any other service is reimbursable on the same date of service.
- A beneficiary may be referred to a laboratory for the sole purpose of drawing, packaging, and mailing a blood sample to MDHHS for HIV-1 viral load analysis and/or CD4/CD8 enumeration. The State provides specimen containers and mailing kits for the analysis. Requests for supplies and samples for analysis should be sent to the MDHHS Bureau of Laboratories – Trace Metals Section. (Refer to the Directory Appendix for contact information.)

When billing Medicaid for services rendered, blood handling may be billed if the drawing, packaging, and mailing of a blood sample are the only services provided as described above. Procedure Code 36415 (routine venipuncture for collection of specimen[s]) and the U&C charge for the service must be used.



SECTION 5 - PROCEDURE GUIDELINES

5.1 HEMATOLOGY STUDIES

A practitioner's order for a complete blood count (CBC) with white blood cell (WBC) differential includes the red blood cell (RBC) and WBC count, Hgb, Hct, MCH, MCHC, MCV, RBC morphology, platelet estimate, and WBC differential only. If three or more of the component tests are performed on a single blood sample, the code that most closely represents the entire procedure must be reported. If automated instrumentation yields additional test parameters, the results are not reimbursable unless medically necessary and specifically ordered by a practitioner.

Any payment for a differential includes payment for routine cell morphology and platelet estimation.

5.2 MICROBIOLOGY STUDIES

Isolation and presumptive ID procedure codes are meant to cover the usual methods recommended for the culture set up, isolation of suspected pathogens and the presumptive ID of any pathogens.

Definitive culture procedure codes may not be billed in combination with other microbiology codes that duplicate the ID of a microbe. Any reported organisms must be identified as to group, genus and species according to procedures recommended by the American Society for Microbiology (ASM), the College of American Pathologists (CAP) or the Centers for Disease Control and Prevention (CDC).

Anaerobic culture procedure codes should only be reported for methods recommended by the ASM, CAP, CDC or the Virginia Polytechnic Institute (VPI) using special anaerobic media.

Microbiology smear procedure codes are to be reported only for microscopic examination of the original specimen and are not to be reported when inoculum from a culture or subculture is examined as part of the ID of an organism.

Special attention should be given to the antimicrobial susceptibility procedure code definitions when reporting the quantity. Depending on the code, the quantity is determined by the number of agents, number of plates or number of enzymes tested.

5.3 TEST REPORTS

Anatomic Pathology	Cryopreservation (frozen cell storage and thawing) is a covered service for bone marrow transplants only.
Arsenic Testing	This testing is not covered for hair and nail sources.
Calculated Results	The mathematical calculation of two or more results to produce an index or ratio or any other result may not be billed as a separate independent test.



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Complete Procedures and Unbundling	In some instances, a procedure is listed both in its entirety and also with component services specified. If the entire procedure is performed, the code for the entire procedure must be reported. Do not bill for component services when the entire procedure is performed.
Creatinine Blood Tests	Calculate and report the Glomerular Filtration Rate (eGFR) for tests processed for beneficiaries in outpatient settings and for beneficiaries 18 years of age and older. The eGFR test results must report two values on the lab report for beneficiaries: one for African-American and one for non-African-American, or one value if race is available and able to be used in calculating the value.
Evocative/ Suppression Testing	Medicaid does not cover these codes. Report the individual tests.
Panel Tests	Only AMA-approved organ- or disease-oriented panels may be billed. All tests within the panel must be medically necessary. When a complete panel is ordered and performed, a panel code should be billed. When some, but not all the tests identified in a panel are performed, bill as individual tests. If a group of tests overlaps two or more panels, report the panel that incorporates the greater number of tests to fulfil the code definition and report the remaining tests as individual tests.
Specimen Source	The tested entity may be from any source, unless the source is specified in the procedure code description.
Test Results	Reimbursement is made for tests performed using a method that yields quantitative results unless the nomenclature specifies a different method.
Urinalysis	In the event a single urine specimen is tested for the same entity (chemical, element, compound, substance) by more than one method, the procedure code used to denote the entity may be reported only once.

5.4 PATHOLOGY CONSULTATION

Clinical pathology consultation may be billed by a hematologist/pathologist for the review of abnormal laboratory test results, but cannot be billed for routine quality control review. (Refer to the current CPT manual for the guidelines for the provision of this service.)

5.5 GENETIC AND MOLECULAR TESTING

A genetic or molecular test is a specialized diagnostic laboratory test performed to detect changes or variants in genes, chromosomes, proteins, or certain metabolites which may identify increased risks of health problems, help choose treatments, or assess patient responses to treatments.

The following standards of coverage and prior authorization and documentation requirements apply to beneficiaries served by Fee-for-Service Medicaid. For beneficiaries enrolled in a Medicaid Health Plan, the provider must check with the beneficiary’s plan for coverage and prior authorization requirements.



5.5.A. STANDARDS OF COVERAGE

Whenever possible, Michigan Medicaid follows Medicare guidelines. Medicare does not cover a genetic test for a clinically affected individual for purposes of medical research, family planning, disease risk assessment of other family members or when the treatment and surveillance of the beneficiary will not be affected, or in any other circumstance that does not directly affect the diagnosis or treatment of the beneficiary.

Medicaid reimburses medically necessary genetic testing when one of the following apply:

- The test is necessary to establish a molecular diagnosis when a definitive diagnosis remains uncertain and a genetic diagnosis is suspected, and the results will directly impact the treatment or management of the disease.
- A definitive diagnosis has been made through conventional diagnostic testing and the test is necessary to guide treatment or management of the disease, including selection of specific medication and/or medication dose to ensure efficacy and safety.

Genetic testing **is** considered a covered benefit when it is medically necessary to establish a molecular diagnosis and treatment of a genetic disease and all of the following are met:

- The testing must be ordered by a licensed physician (MD or DO), physician assistant, or advanced practice registered nurse (i.e., nurse practitioner, certified nurse midwife) who is an enrolled provider.
- The beneficiary has documented clinical features symptomatic of a condition or disease, or is at risk of inheriting the disease based upon personal history, family history, documentation of a genetic mutation and/or ethnic background.
- A physical examination, history, pedigree analysis, and completion of conventional diagnostic testing must be completed prior to testing.
- If applicable, the testing method is an FDA-approved method for the identification of a specific genetically-linked inheritable disease as evidenced by the following measures:
 - The genotypes to be detected by a genetic test must be shown, by scientifically valid methods, to be associated with the occurrence of the disease;
 - The analytical and clinical validity of the test must be established;
 - The observations must be independently replicated and subject to peer review; and
 - The clinical testing laboratory must be an enrolled provider who is properly certified by CLIA.

The clinical utility of all requested genes and gene variants must be established and documented in the beneficiary's medical record regardless of where the test(s) is performed.

Testing is allowed once during the beneficiary's lifetime per disease for diagnostic purposes. If medically necessary, and on a case-by-case basis, prior authorization may be requested to allow for exceptions to this restriction.



Providers must follow state law (Public Act 368 of 1978, Section 333.17020 Genetic test; informed consent) regarding informed consent for predictive genetic testing. This includes any statutory requirements for pre- or post-testing genetic counseling. There must be made available, upon request, documentation of pre-testing informed consent provided before testing. This documentation must include the limitations of the test, possible outcomes, and methods for communicating and maintaining confidentiality of results.

Genetic testing **is not** considered a covered benefit for:

- Criteria other than those outlined above.
- Testing to confirm a diagnosis or disorder that can be diagnosed by conventional diagnostic methods.
- Testing for conditions or purposes where the test results would not directly influence the management or treatment of the disease or condition (e.g., a disease without known treatment).
- Testing for informational purposes or management of a beneficiary's family member.
- Confirmatory testing for validation of laboratory results.
- Screening for investigational or research purposes.
- Minors under the age of 18 for adult onset conditions that have no preventative or therapeutic treatments.
- Testing that has not been performed in a CLIA-certified laboratory.
- The sole purpose of family planning counseling and infertility services.
- Testing attributable to standing laboratory orders. Testing must be ordered for a specific beneficiary and the medical record and/or order must clearly document the medical necessity of the specific diagnostic test to be performed.

5.5.B. PRIOR AUTHORIZATION REQUIREMENTS AND DOCUMENTATION

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

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

- Indication for the test. Indications should be beneficiary specific and clinical in nature.
- Clinical notes that clearly detail the beneficiary's related signs and symptoms.



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



SECTION 6 - FACILITY SERVICES

6.1 DIALYSIS RELATED LAB SERVICES

Payment for laboratory services related to maintenance dialysis is included in the composite rate regardless of whether the tests are performed in the facility or an independent laboratory. The following tests are considered to be a routine part of maintenance dialysis and may not be billed separately unless it is medically necessary to perform them in excess of the frequencies indicated.

Laboratory tests for Hemodialysis, Peritoneal Dialysis, and Continuous Cycling Peritoneal Dialysis (CCPD) that are included in the composite rate:

Per Treatment:	Weekly:	Monthly:
<ul style="list-style-type: none"> ▪ All hematocrit or hemoglobin tests and clotting time tests 	<ul style="list-style-type: none"> ▪ Prothrombin time for patients on anticoagulant therapy ▪ Serum Creatinine ▪ BUN 	<ul style="list-style-type: none"> ▪ CBC, including platelet count and additional indices ▪ Serum Calcium ▪ Serum Chloride ▪ Serum Potassium ▪ Serum Bicarbonate ▪ Serum Phosphorus ▪ Total Protein ▪ Serum Albumin ▪ Alkaline Phosphatase ▪ SGOT ▪ LDH

Laboratory tests for Continuous Ambulatory Peritoneal Dialysis (CAPD) that are included in the monthly composite rate include:

- | | | |
|------------------------|---------------------|-----------------|
| ▪ Albumin | ▪ CO2 | ▪ LDH |
| ▪ Alkaline Phosphatase | ▪ Creatinine | ▪ Phosphate |
| ▪ AST, SGOT | ▪ Dialysate Protein | ▪ Potassium |
| ▪ BUN | ▪ HCT | ▪ Sodium |
| ▪ Calcium Magnesium | ▪ Hgb | ▪ Total Protein |

Laboratory tests not listed above may be separately billed by the dialysis facility or CLIA-certified lab performing the test.



6.2 ICF/IID FACILITIES

Reimbursement for laboratory services provided to patients in intermediate care facilities for individuals with intellectual disabilities (ICF/IID) is included in the per diem rate paid to the ICF/IID. Laboratories may not bill MDHHS for these services.



LOCAL HEALTH DEPARTMENTS

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SECTION 1 – GENERAL INFORMATION

This chapter applies to all Local Health Departments (LHDs).

1.1 REGULATORY AUTHORITY

A public facility is defined in the following Sections of the Michigan Public Health Code (PA 368 of 1978, as amended):

- Section 333.2413
- Section 333.2415
- Section 333.2421

Local health departments (LHDs) may participate as providers in the Medicaid Program as Public Clinics. Statutory basis for their participation is pursuant to 42 CFR 431.615 (Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees), thereby implementing Section 1902(a)(11) and (22)(C) of the Social Security Act.

A Title V grantee means an agency, institution, or organization that receives federal payments for part or all of the cost of any service program or project authorized by Title V of the Social Security Act, including:

- Children and youth projects;
- Children’s Special Health Care Services (CSHCS);
- Maternal and child health services;
- Maternal and infant care projects; and
- Projects for the dental health of children.

1.2 PROVIDER ENROLLMENT

Michigan Department of Health and Human Services (MDHHS) requires all LHDs to have a Group (Type 2 - Organization) National Provider Identification (NPI) number in order to receive the enhanced LHD reimbursement. For LHDs with multiple locations and multiple rates, an NPI number for each location may be necessary so that the proper reimbursement rate of all encounters can be determined. If the LHD fails to obtain and/or use the correct NPI number, the LHD reimbursement will be determined under fee for service rules. The NPI number must be reported to MDHHS via the on-line CHAMPS Provider Enrollment (PE) subsystem before billing Medicaid services.

Individual providers (doctors, dentists, optometrists, etc.) are required to obtain a Provider (Type 1 - Individual) NPI number and report the number to MDHHS.



SECTION 2 - BENEFITS

Covered services provided by LHDs include preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a public facility that is not part of a hospital but is organized and operated to provide medical care to outpatients.

2.1 COVERED SERVICES

LHDs receive full cost reimbursement for the following services:

- Breast and Cervical Cancer Control Program Services
- Child Health and Primary Care Services
- Communicable Disease Services (e.g., Tuberculosis [TB])
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (including blood lead testing and follow-up services)
- Family Planning Clinic Services
- Hearing and Vision Screening
- Home Health (HH) Care Services
- Immunizations *
- Maternal and Child Health Lab Services
- Maternal Infant Health Program (MIHP) Services
- Prenatal Care Clinic Services
- Sexually Transmitted Disease Services

2.2 ADDITIONAL INFORMATION ON BLOOD LEAD TESTING

2.2.A. INITIAL BLOOD LEAD TESTING

LHDs are not required to obtain a referral or receive PA to obtain a blood lead sample from Medicaid-covered children through six years of age, whether they are enrolled in a MHP or are FFS beneficiaries. To prevent duplication of services, the LHD must make reasonable effort to assure that a blood lead test has not been obtained by the child's primary care provider (PCP).

All blood lead draws must be provided in compliance with Medicaid policy. Refer to the Early and Periodic Screening, Diagnosis and Treatment Chapter for additional information regarding guidelines for age-appropriate blood lead testing intervals.

* An immunization administered for travel to a foreign country is not a covered benefit.



The LHD must instruct the laboratory completing the blood lead analysis to send all blood test results to the child's PCP and health plan, if enrolled in managed care. Should a positive test be found, the LHD must collaborate with the PCP to assure the appropriate follow-up care is provided. The PCP is responsible for any additional blood lead testing.

If a capillary blood specimen is obtained, the LHD may bill MDHHS using procedure code 36416 for both MHP enrolled and FFS beneficiaries.

The LHD may send the sample to the State Laboratory for analysis or to any clinical laboratory that is CLIA-certified to perform blood lead analysis. The information accompanying the sample to the laboratory must include the name of the PCP, if known, and the name of the health plan for those children enrolled in managed care.

The LHD may complete the blood lead analysis if they are CLIA-certified to do so. If the LHD completes the blood lead analysis, procedure code 83655 should be billed. The reimbursement includes payment for the capillary or venipuncture blood lead draw.

2.2.B. BLOOD LEAD POISONING FOLLOW-UP SERVICES

LHDs may provide blood lead poisoning follow-up services which consist of environmental investigations and nursing assessment visits.

LHDs may provide blood lead poisoning follow-up services provided to any Medicaid-covered child, regardless if the child is enrolled with an MHP or is in the FFS program. Authorization for these services is not required by the MHP; however, LHDs must notify the plan of the service(s) provided and provide the plan with a summary of each.

Documentation of the child's blood lead poisoning level that initiated service must be maintained, as well as documentation of all environmental investigations and nursing assessment visits.

2.2.B.1. BLOOD LEAD NURSING ASSESSMENT VISITS

Blood lead nursing assessment visits for children with blood lead levels of 5 mcg/dL or greater are covered under the Children's Special Health Care Services (CSHCS) case management benefit. Beneficiaries are eligible for a maximum of six billing units per year. (Refer to the Children's Special Health Care Services Chapter, Case Management Benefit for more information.)

2.2.B.2. ENVIRONMENTAL INVESTIGATIONS

An environmental investigation of a beneficiary's home or primary residence is covered for the LHD. A beneficiary's home is defined as their legal address. The beneficiary's primary residence is a place other than their legal address where the beneficiary spends a significant amount of time. To be eligible for the service, the beneficiary must be under 21 years of age and have a confirmed elevated blood lead level of 5 mcg/dL or greater.

If more than one child in the home has blood lead poisoning, the LHD must select one child's Medicaid ID number and report a single environmental investigation visit. An



environmental investigation visit can be billed directly to Medicaid FFS regardless if the beneficiary is enrolled in a MHP. Reimbursement is limited to the time and activities provided by certified assessors during the on-site investigation.

Environmental investigations must be performed by assessors certified by the Michigan Department of Health and Human Services (MDHHS) Healthy Homes Program. The home or primary residence to be investigated must meet one of the following criteria:

- The home or primary residence was built before 1978.
- A home or primary residence built after 1978 when identification of other possible sources of lead exposure such as a job, hobby, environmental, home remedies, or cultural practices that use lead are associated with the property in question.

The investigation must follow the Protocol for Environmental Investigations for Children with Elevated Blood Lead Levels and risk assessment activities per the Lead Abatement Act of 1998. The investigation must include testing of appropriate potential sources of paint, house dust, soil, water, and other household risk factors such as pottery and home remedies. Education must be provided regarding known and potential sources of lead poisoning, reduction of future exposures, and suggestions for specialized cleaning techniques.

Risk assessors must prepare a risk assessment report per rule R325.99404 promulgated pursuant to the Lead Abatement Act that includes lead hazard control recommendations and the potential relocation of the child depending upon the severity of the lead hazards found.

Discussion with the family must include agencies that may be able to provide assistance with lead hazard control recommendations provided in the risk assessment report.

An episode includes a venous blood sample indicating the child is at risk according to recommendations by the Centers for Disease Control and Prevention (CDC), and also includes resulting treatment and follow-up services.

When an environmental investigation of the home finds no sources of lead or insufficient evidence to justify the beneficiary's elevated blood lead level, a second site may be investigated (e.g., home of a family member, relative, or other informal child care where a child often visits). When billing for the second site, local health departments must report the TS modifier with the procedure code on the claim. A maximum of two sites may be investigated.

2.2.C. BLOOD LEAD RESOURCE DOCUMENTS

Providers may obtain the Protocol for Environmental Investigations for Children with Elevated Blood Lead Levels, a list of certified risk assessors, applications for training and certification, and education materials from the MDHHS Lead Hazard Remediation Program. (Refer to the Directory Appendix for contact information.)

Refer to the Early and Periodic Screening, Diagnosis and Treatment Chapter for additional information on blood lead.



2.3 ADDITIONAL INFORMATION ON OBJECTIVE HEARING & VISION SCREENING

To be eligible to provide and bill for services, all LHD screening staff must be qualified to administer preschool objective hearing and objective vision screening by the MDHHS Public Health Administration. This service coverage is limited to LHD providers when performed either on-site or in the community setting.

Objective hearing screening and objective vision screening may be performed on eligible Medicaid preschool-aged children from age three through six years of age by qualified LHD staff. LHDs may provide objective hearing and/or vision screening services and accept referrals for screening from physicians and from Head Start agencies. The objective hearing and/or vision screening results must be reported to the child's primary care provider (PCP). If the LHD is unable to report the results to the child's PCP, the LHD must clearly document why this could not be accomplished. Providers are strongly encouraged to share the results with the Head Start agency if that agency was the referral source, and if the provider receives authorization.

2.4 ADMINISTRATIVE SERVICES

Full cost reimbursement is not allowed for Medicaid administrative services and should not be included on the Medicaid Cost Report.

LHDs providing Medicaid administrative services should report costs for these services on their quarterly Financial Status Report in accordance with federal regulation to qualify for Federal matching funds. These reports must be submitted to the MDHHS Bureau of Purchasing, Grants Division/Electronic Grants Section. Questions regarding reimbursement of administrative services should be directed to the MDHHS Bureau of Purchasing, Grants Division/Electronic Grants Section. (Refer to the Directory Appendix for contact information.)

Refer to the Medicaid Outreach Activities section for reporting requirements, and billing and reimbursement information related to outreach activities.

2.5 MEDICAID HEALTH PLAN SERVICES

LHDs must obtain PA from a Medicaid Health Plan (MHP) for any Medicaid covered service provided to a Medicaid beneficiary enrolled in a health plan **except** for the following services:

- Immunizations
- Sexually Transmitted Disease (STD) services
- TB Diagnosis and Treatment
- Family Planning Services
- Blood lead draws for children through six years of age
- Hearing and vision screening

Except for blood lead draws, payment for covered services is based on the terms of the contract between the LHD and health plan if the LHD and a MHP have entered into a contract. In the absence of a contract, payment is based on the Medicaid fee-for-service (FFS) rates in effect on the date of service (DOS). Medicaid encourages contractual relationships between these entities.



LHDs must bill the MHP directly for immunizations provided to beneficiaries enrolled in managed care. Any claims billed to the Community Health Automated Medicaid Processing System (CHAMPS) for MHP members will be denied.

The following out-of-plan services performed by the LHD can be billed directly to Medicaid FFS regardless if the beneficiary is enrolled in a MHP:

- Blood lead draws
- Lead investigations and follow-up services
- Hearing and vision screenings



SECTION 3 – MEDICAID OUTREACH ACTIVITIES

3.1 ALLOWABLE ACTIVITY CATEGORIES

Local Health Departments may perform the following Medicaid outreach activities and receive reimbursement through their Comprehensive Planning, Budgeting and Contracting (CPBC) Grant Agreement with MDHHS.

All outreach activities must be specific to the Medicaid program. In addition, activities that are part of a direct service are not claimable as an administrative service.

3.1.A. MEDICAID OUTREACH AND PUBLIC AWARENESS

Informing Medicaid eligible and potentially Medicaid eligible children and families about the benefits and availability of services provided by Medicaid.

This category of outreach also includes coordinating and presenting information about Medicaid through media resources, health fairs and other community forums.

Examples of activities in this category include, but are not limited to:

- Developing, compiling, and/or distributing materials that inform individuals about the Medicaid program, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, and how and where to obtain benefits.
- Contacting pregnant and parenting women about the availability of Medicaid services, including referral to family planning and well-baby care programs and services.

Examples of activities that are not appropriate for this category include, but are not limited to, Women, Infants, and Children (WIC) and Maternal Infant Health Program (MIHP) staff providing referral information about available health and community services. The State of Michigan mandates that these services be provided as a condition of operating the program.

3.1.B. FACILITATING MEDICAID ELIGIBILITY DETERMINATION

Activities related to assisting potentially Medicaid-eligible individuals in applying for Medicaid benefits.

This includes explaining the Medicaid program to individuals or families, providing a Medicaid application form, assisting an individual in completing a Medicaid application, and/or referring individuals to the local MDHHS office for determination of benefits. Community health workers may act as client advocates when additional assistance is needed to complete the application process. Community health workers can also help clients overcome other barriers such as linguistic, cultural, and cognitive challenges to the application and enrollment process.



Examples of activities in this category include, but are not limited to:

- Verifying an individual's current Medicaid eligibility status for purposes of the Medicaid eligibility process.
- Assisting the individual or family in collecting/gathering required information and documents for the Medicaid application.

Examples of activities that are not appropriate for this category include, but are not limited to:

- Verifying an individual's current Medicaid eligibility status for a direct service or billing of medical appointment.
- Explaining the eligibility process for non-Medicaid programs.

3.1.C. PROGRAM PLANNING, POLICY DEVELOPMENT, AND INTERAGENCY COORDINATION RELATED TO MEDICAL SERVICES

Development of health programs and services targeted to the Medicaid population and collaboration between the LHD and other agencies to ensure the delivery of Medicaid-covered services.

Activities in this category only apply to LHD staff whose position descriptions include program planning, policy development and interagency coordination, and/or those staff specifically appointed to appropriate committees/programs performing required activities. This includes planning and developing procedures to track requests for referrals and coordinating services with the Medicaid Health Plans.

Examples of activities in this category include, but are not limited to:

- Working with other agencies and/or providers that provide medical/dental/mental health services to improve the coordination and delivery of services, to expand access to additional Medicaid populations, increase provider participation, and improve provider relations.
- Enhancing, improving, or streamlining health care service delivery systems in the community.
- Representing the LHD on a committee or task force that is intended to improve access to Medicaid programs and services.

Examples of activities that are **not appropriate** for this category include, but are not limited to:

- Developing procedures for tracking families' requests for assistance with non-Medicaid services and the providers of such services.
- Creating a collaborative of health professionals to provide consultation and advice on the delivery of health care services to the non-Medicaid population.



3.1.D. REFERRAL, COORDINATION AND MONITORING OF MEDICAID SERVICES

Making referrals for, coordinating access to, and/or monitoring the delivery of Medicaid services. Working with Medicaid providers to improve the coordination and delivery of clinical health care services, expand access to specific Medicaid populations, and improve collaboration around early identification of medical/dental problems.

Examples of activities in this category include, but are not limited to:

- Making referrals for and/or scheduling appropriate Medicaid-covered services for Medicaid-enrolled individuals.
- Developing referral sources for the LHD, such as a list or brochure of the physicians, dentists or Health Maintenance Organizations (HMOs) in the area who accept Medicaid patients for evaluation or treatment, or a list of other health agencies providing Medicaid services.
- Monitoring or coordinating the completion of the prescribed services, the termination of services, and the referral of the individual to other Medicaid services as necessary.

Examples of activities that are **not appropriate** for this category include, but are not limited to:

- Conducting quality assurance reviews when MDHHS requires the reviews as a condition of operating the program.
- Making referrals for, and coordinating access to, non-Medicaid services, such as child care, employment, job training, food assistance, and housing.
- Activities that are an integral part of or an extension of a direct medical service.

3.1.E. MEDICAID-SPECIFIC TRAINING ON OUTREACH ELIGIBILITY AND SERVICES

Outreach activities that focus on coordinating, conducting, or participating in training and seminars for staff and/or contractors regarding the Medicaid program and available services, the benefits of the program, and how to assist families in accessing Medicaid services.

These include trainings that enhance early identification, screening, and referral of children and adolescents for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. This category also includes development and presentation of training modules regarding Medicaid eligibility and benefits to LHD staff.

Examples of activities in this category include, but are not limited to:

- Participating in or coordinating training that improves the delivery of Medicaid services.
- Attending or participating in a Medicaid Outreach inservice or webinar.
- Developing, participating in, or presenting training that addresses the clinical importance of pediatric or other clinical standards for preventive care offered through the Medicaid program.



Examples of activities that are **not appropriate** for this category include, but are not limited to:

- Participating in or coordinating training that improves the delivery of general LHD services.
- The time spent determining if a specific task can be considered Medicaid outreach.

3.1.F. ARRANGING FOR MEDICAID-RELATED TRANSPORTATION

Assisting an individual in obtaining transportation for Medicaid-related services. NOTE: This does **not** include activities that contribute to the actual billing of transportation as a medical service.

Examples of activities in this category include, but are not limited to:

- Scheduling or arranging transportation to and from Medicaid-covered services for a Medicaid-enrolled individual.
- Assisting or arranging for transportation for the parent/guardian of a Medicaid-enrolled individual in support of the referral and evaluation activities.

Examples of activities that are **not appropriate** for this category include, but are not limited to:

- Transporting or accompanying a Medicaid-enrolled individual to a medical appointment.
- Assisting an individual in obtaining transportation for non-Medicaid services.

3.1.G. ARRANGING FOR OR PROVIDING MEDICAID-RELATED TRANSLATION SERVICES

Arranging for or providing translation services related to a Medicaid-covered service when translation services are not included and/or paid for as part of a direct medical assistance service.

Examples of activities in this category include, but are not limited to:

- Arranging for or providing translation services (oral or signing services) to assist an individual with completing a Medicaid application.
- Arranging translation services that assist an individual in understanding the Medicaid services available.

Examples of activities that are **not appropriate** for this category include, but are not limited to:

- Developing translation materials that assist individuals in accessing and understanding non-Medicaid programs and services.
- Arranging for or providing translation services (oral or signing services) that assist the individual in accessing non-Medicaid services.



- Providing translation services to assist a Medicaid-enrolled individual in communicating as part of a direct medical service.

3.2 DOCUMENTATION AND REPORTING REQUIREMENTS

Documentation maintained in support of administrative claims must be sufficiently detailed to allow determination of whether the activities were necessary for the proper and efficient administration of the Medicaid State Plan. The LHD is responsible for all claiming determinations.

LHDs that bill for Medicaid Outreach Activities are expected to provide a quarterly summary report of Medicaid outreach activities. Guidelines and reporting requirements are described in the Comprehensive Agreement.

3.3 BILLING AND REIMBURSEMENT

3.3.A. GRANT AGREEMENT

The CPBC Grant Agreement includes the Medicaid Outreach Activities provision. This provision is part of the standard CPBC Grant Agreement language.

Each fiscal year, MDHHS will identify Medicaid outreach priorities. LHDs that bill for Medicaid outreach activities must focus, at a minimum, on one of the identified outreach priorities.

3.3.B. BILLING

The LHDs bill for these outreach activities on a quarterly basis in a single column on a Financial Status Report (FSR). The column should be titled Medicaid Outreach Activities. The FSR is part of the LHDs quarterly CPBC FSR submission to MDHHS. MDHHS aggregates all of the quarterly amounts billed for LHD Medicaid outreach activities and submits a claim for the federal portion of the costs. MDHHS reimburses the LHDs after MDHHS receives the reimbursement of the federal claim.

These Medicaid Outreach Activities are claimed at the 50% administrative match rate.

Full cost reimbursement is not allowed for Medicaid administrative services and should not be included on the Medicaid Cost Report.

3.3.C. COST ALLOCATION PLANS

MDHHS requires LHDs to certify that their existing cost allocation plan is in compliance with OMB Title 2 CFR Part 200 and that the plan identifies Medicaid outreach activities as a specific element of the plan. The certification is accepted by MDHHS as documentation to continue this administrative claiming. Each cost allocation plan is subject to MDHHS review for compliance with OMB Title 2 CFR Part 200.



3.3.D. CERTIFICATIONS

The LHD Cost Allocation Plan certifications are kept on file and should be submitted to the MDHHS Bureau of Purchasing, Grants Division/Electronic Grants Section. (Refer to the Directory Appendix for contact information.)

New certifications are required if a modification occurs in the LHD's cost allocation plan that impacts the Medicaid Outreach Activities element or upon a Department review that results in a finding of non-compliance. If neither of these conditions exist, the certification remains valid in subsequent fiscal years.



SECTION 4 – ENCOUNTERS

Encounters are counted and reported by LHDs on the Michigan Medicaid Local Health Department (LHD) Cost Report in order to receive full cost reimbursement. The reported encounters include the health department's total facility encounters, minus dental encounters and, as a subset of total encounters, the total Medicaid encounters at the LHD clinic.

In order to determine a rate per encounter, the total costs of facility services are divided by the total encounters, resulting in a rate per encounter. The rate per encounter is multiplied by the number of Medicaid encounters to determine the total Medicaid costs to be reimbursed.

4.1 DEFINITION OF ENCOUNTER

An encounter is a face-to-face contact between a patient and the provider of health care services who exercises independent judgment in the provision of health care services. For a health service to be defined as an encounter, the health service must be recorded in the patient's record.

The following examples help to understand and define an encounter:

- To meet the encounter criterion for independent judgment, the provider must be practicing within the scope of practice defined in the Michigan Public Health Code. The provider must be acting independently and not be assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history or drawing a blood sample is not credited with a separate encounter.
- Services such as drawing blood, collecting urine specimens, performing laboratory tests, taking x-rays, filling and/or dispensing prescriptions, in and of themselves, do not constitute encounters. However, these procedures may accompany professional services performed by medical or other health providers which do constitute encounters.
- A provider may be credited with no more than one encounter with a given patient during a single day, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. For example, when a patient sees a physician for flu symptoms early in the day and then later the same day sees the same physician for a broken leg, then visits may be classified as two encounters.

The encounter criteria are not met in the following circumstances:

- When a provider participates in a community meeting or group session that is not designed to provide health services.
- When the only service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program.



- The following services are not classified as encounters:
 - Allergy injection(s)
 - Collecting urine specimens
 - Dispensing prescriptions
 - Drawing a blood sample
 - Filling out insurance forms, etc.
 - Performing laboratory tests
 - Refilling prescriptions
 - Taking a history
 - Taking vital signs
 - Taking x-rays

4.2 MEDICARE/MEDICAID ENCOUNTERS

Services for Medicare and Medicaid dual beneficiaries are eligible for full cost reimbursement, and these encounters are considered Medicaid encounters.

4.3 OTHER INSURANCE ENCOUNTERS

Medicaid services provided to beneficiaries with other commercial health insurance carriers are eligible for full cost, and the encounters are considered Medicaid encounters. Medicaid requires beneficiaries' other insurance resources and their network providers to be utilized for all services covered under the private coverage before billing Medicaid. Even if the other insurance payment for a specific service exceeds the amount Medicaid would pay, providers must still bill the procedure code and enter the other insurance payment on the claim. The claim showing other insurance reimbursement or zero payment must be processed through the claim system in order to be counted as a Medicaid encounter. (Refer to the Billing & Reimbursement for Professionals and the Coordination of Benefits Chapters of this manual for additional information.)



SECTION 5 – PUBLIC DENTAL CLINIC ENHANCED REIMBURSEMENT RATE

5.1 GENERAL INFORMATION

Public Dental Clinics are paid at the average commercial rate for Medicaid dental services. Qualifying providers include any Public Dental Clinic as identified in one of the following sections of the Michigan Public Health Code (PA 368 of 1978 as amended): 333.2413, 333.2415, or 333.2421.

5.2 RATE DETERMINATION

The average commercial rate is determined by MDHHS staff through information supplied by the commercial dental insurers and paid to providers eligible for this supplemental payment. If this information is not available from the commercial carriers, MDHHS may determine the rate from other sources.

5.3 PAYMENT METHODOLOGY

Public dental clinics submit claims and receive payment based on MDHHS fee-for-service (FFS) rates throughout the year. MDHHS identifies services and payments from Medicaid paid claims records at the end of the public dental clinic's fiscal year. An annual settlement calculation is performed to determine the difference between the Medicaid fee screen payments and the average commercial rate.

This calculation and a notice are sent to the public dental clinic indicating the amount of local share that must be received from the public dental clinic. The local share must be received prior to the submission of the federal claim. The local share is sent from the public dental clinic to MDHHS via the Intergovernmental Transfer process. After receipt of the local share, MDHHS will process a payment to the public dental clinic for the entire amount of difference between the FFS payments and the average commercial rate. The settlements are performed each public dental clinic and for each fiscal year ending after March 31, 2005.

MDHHS may pay interim payments for the estimated difference between Medicaid FFS payments and the average commercial rate. Interim payments will be reconciled at the time of annual settlement.

Settlements do not apply to services for which primary reimbursement is the responsibility of the Dental Health Plan (DHP) through the *Healthy Kids Dental* contract or any other third party payer.

The enhanced reimbursement rate process is in place of the cost-settlement process for dental encounters.



SECTION 6 – COST REPORTING REQUIREMENTS

6.1 FULL COST METHODOLOGY

The term full cost reimbursement, as used in this chapter, means the cost of providing Medicaid services as determined by information provided on the Michigan Medicaid Cost Report for LHDs. Full cost is derived from the amounts the LHD receives from Medicaid Fee-for-Service and Medicaid Health Plan payments, other third party insurers, quarterly payments from MDHHS, and initial and final settlements. A combination of local and state general funds provides the basis for full cost reimbursement and is used for claiming federal financial participation. MDHHS will reimburse the LHD for its services, other than dental services, at reasonable and allowable actual incurred costs according to 42 CFR § 431.615(c)(4).

To receive full cost reimbursement, qualified providers must supply the MDHHS Hospital and Clinic Reimbursement Division (HCRD) with a Michigan Medicaid cost report.

6.2 COST SETTLEMENTS

Cost settlements are performed annually to ensure that the payments were made at reasonable and allowable full cost. As necessitated by the cost settlement process, any financial adjustments are made with the LHD. Settlements are performed for each LHD for each fiscal year.

6.3 REASONABLE AND ALLOWABLE COSTS

Reasonable and allowable costs are determined using the applicable Medicare cost reimbursement principles detailed in 42 CFR, Part 413.

6.4 FILING COST REPORTS

LHDs must file a Michigan Medicaid cost report with the MDHHS HCRD annually. The authorized individual must sign the cost report and related Medicaid supplemental documents. The LHD cost report is due five months after the end of the normal fiscal period.

- A 30-day extension of the due date may, for good cause, be granted if a written request is received by the HCRD prior to the expiration of the original five months.
- The LHD cost report may be filed for more or less than an annual period only when necessitated by facilities terminating their agreement with MDHHS, by a change in ownership, or by a change in fiscal period.

Improperly completed or incomplete filings are returned to the LHD for proper completion and must be resubmitted to MDHHS within 30 days of receipt of the cost report.

If the required cost report and supplemental documents are not submitted within the required time limit (including approved extensions), no cost settlement for full cost reimbursement occurs for that fiscal period. By not submitting a cost report, it is understood that the LHDs are withdrawing from the full cost program. This action remains in effect until proper submission of all the required documents in a subsequent fiscal period.



If LHDs do not file a cost report, any interim payments are recovered for the year in which the LHD did not participate in the full cost reimbursement program.

6.5 AMENDING COST REPORTS

LHDs may amend a cost report by requesting the amendment in writing and submitting a revised cost report to the MDHHS HCRD. The revised cost report must be submitted no later than one year from the original filing date. The letter must explain why the cost report requires revision, and how it was changed.

6.6 ACCOUNTING AND RECORD KEEPING

Each LHD operating a clinic in the State of Michigan and seeking payment under the LHD provisions must complete LHD cost reports.

Medicaid supplemental documents must be filed using the modified accrual method of accounting. These documents must be forwarded to MDHHS Bureau of Purchasing, Grants Division/Electronic Grants Section. (Refer to the Directory Appendix for contact information.)

The LHD must maintain, for a period of not less than seven years from the end of the fiscal year of the LHD cost report, financial and clinical records for the period covered by the cost report which are accurate and in sufficient detail to substantiate the cost data reported. If there are unresolved issues at the end of this seven-year period, the records must be maintained until these issues are resolved. Expenses reported as reasonable costs must be adequately documented in the financial records of the LHD or they are disallowed.

The MDHHS HCRD maintains each required LHD cost report and supplemental documents submitted by the provider for seven years following the date of submission of the report. In the event there are unresolved issues at the end of this seven-year period, the cost report is maintained until such issues are resolved.

Financial and clinical records of the LHD must be available for review by authorized personnel of MDHHS, the Health Care Fraud Division of the Michigan Department of Attorney General, or the U.S. Department of Health & Human Services (HHS) in conformity with the provisions of the Social Security Act.



SECTION 7 – INTERIM PAYMENTS, SETTLEMENTS AND APPEALS

7.1 SETTLEMENT(S) OF LOCAL HEALTH DEPARTMENTS

An initial settlement is calculated annually from the cost of providing Medicaid covered services to Medicaid beneficiaries enrolled in the FFS program and MHPs. Calculations are determined from the filed Medicaid LHD cost report.

FFS encounters are verified for the cost settlement from the MDHHS paid claims data. Encounters for MHP or private HMO enrollees are recorded in the cost report. An initial settlement generally is completed within three months of the receipt of a complete and acceptable cost report. MDHHS retains the right to withhold a portion of an initial payment based on individual circumstances.

Final settlements for LHDs generally are completed within one year of the fiscal year end using updated Medicaid data for the period covered by the LHD cost report. This allows sufficient time for all claims to clear the MDHHS payment system. Medicaid data is updated using MDHHS approved claims payment data, all other payments for Medicaid services, and Medicaid visits.

Settlements with amounts due to the LHD are paid with a payment voucher. Settlements showing an overpayment to the LHDs must be repaid to the State of Michigan as noted in the settlement letter.

7.2 AUDIT ADJUSTMENT REPORT

An Audit Adjustment Report showing adjustments to the filed cost report is sent with the final settlement. If the LHD accepts the findings contained in the Audit Adjustment Report, an appropriate officer of the LHD signs the report and mails the report to the MDHHS HCRD. (Refer to the Directory Appendix for contact information.)

7.3 MEDICAID PROVIDER APPEALS

Medicaid providers have the right to appeal any adverse action taken by MDHHS unless that adverse action resulted from an action over which MDHHS had no control (e.g., Medicare termination, license revocation). Appeals must be submitted in writing and mailed to the Michigan Office of Administrative Hearings and Rules (MOAHR). (Refer to the Directory Appendix for contact information.)

The appeals process is outlined in the MDHHS Medicaid Provider Reviews and Hearings rules, Michigan Administrative Code R400.3402 through R400.3425, amended. Any questions regarding the appeal process should be directed to MOAHR.



MATERNAL INFANT HEALTH PROGRAM

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SECTION 1 - GENERAL INFORMATION

This chapter applies to certified Maternal Infant Health Program (MIHP) providers servicing Medicaid and Maternity Outpatient Medical Services (MOMS) beneficiaries. The purpose of MIHP is to reduce infant mortality and morbidity. This is an objective of both the State of Michigan and the federal government who fund this program. The goal of the MIHP is to promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development.

Accordingly, MIHP services are intended to help pregnant Medicaid beneficiaries who are most likely to experience serious psychosocial or nutritional issues. Services are intended to supplement regular prenatal/infant care and to assist the following providers in managing the beneficiary's health and well-being:

- Physicians (MD, DO)
- Certified Nurse Midwives
- Pediatric Nurse Practitioners
- Family Nurse Practitioners
- Medicaid Health Plans
- Physician Assistants

This chapter is designed to work with the Maternal Infant Health Program Operations Guide, developed and maintained by the MDHHS Division of Family & Community Health. The Guide is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

1.1 PROGRAM SERVICES

MIHP services are preventive health services provided by an agency that is certified by the Michigan Department of Health and Human Services (MDHHS). MIHP services are provided by a licensed social worker and a licensed registered nurse. Licensed social workers and licensed registered nurses who are certified as an Internationally Board Certified Lactation Consultant (IBCLC) may provide services. An infant mental health specialist with an Infant Mental Health endorsement may be included. A registered dietitian may also provide services with a physician order. All physician orders for MIHP services must be in compliance with state and federal laws prohibiting self-referral. All physician orders for MIHP services must be in compliance with state and federal laws prohibiting self-referral.

Program services include social work, nursing services (including health education and nutrition education), breast feeding support, nutritional counseling, and beneficiary advocacy services. MIHP services include:

- Psychosocial and nutritional assessment
- Plan of care development
- Professional intervention services



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- Maternal and infant health and nutrition education
- Arranging transportation as needed for health care, substance abuse treatment, support services, and/or pregnancy-related appointments
- Referral to community services (e.g., mental health, substance abuse)
- Coordination with other medical care providers and Medicaid Health Plans (MHPs)
- Family Planning education and referral
- Coordinating or providing childbirth or parenting education classes

1.2 STAFF CREDENTIALS

MIHP staff consists of registered nurses and licensed social workers with the following qualifications:

Nurses	<p>All nurses must possess:</p> <ul style="list-style-type: none"> ▪ current Michigan licensure as a registered nurse by the Michigan Department of Licensing and Regulatory Affairs; and ▪ at least one year of experience providing community health, pediatric or maternal/infant nursing services.
Social Workers	<p>All social workers must possess:</p> <ul style="list-style-type: none"> ▪ current Michigan licensure as a licensed social worker by the Michigan Department of Licensing and Regulatory Affairs; and ▪ at least one year of experience providing Social Work services to families.

Other professionals who may provide services must have the following qualifications:

Infant Mental Health Specialist	<ul style="list-style-type: none"> ▪ Current Michigan licensure as a psychologist, master social worker, or professional counselor by the Michigan Department of Licensing and Regulatory Affairs; ▪ Infant Mental Health Endorsement by the Michigan Association for Infant Mental Health (MI-AIMH), demonstrating competency at the Infant Mental Health Specialist level; and ▪ At least one year of experience in an infant health program.
Internationally Board Certified Lactation Consultant (IBCLC)	<p>All IBCLCs must possess:</p> <ul style="list-style-type: none"> ▪ current Michigan licensure as a registered nurse or licensed social worker by the Michigan Department of Licensing and Regulatory Affairs; and ▪ credentialing by the International Board of Lactation Consultant Examiners (IBCLE) and a valid and current IBCLC certification.



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Registered Dietitian	<ul style="list-style-type: none"> ▪ A Master's Degree in Public Health with emphasis in nutrition or a Master's Degree in human nutrition; or ▪ a Bachelor's Degree and registration as a dietitian (RD); or ▪ a Bachelor's Degree and RD-eligible with examination pending in six months or less; and ▪ at least one year of experience providing community health, pediatric, and/or maternal/infant nutrition services. <p>A physician order is needed before the dietitian may provide services.</p>
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A physician order must be obtained before a registered dietitian may visit with the beneficiary. The physician order must be included in the beneficiary record. If community resources are available, such as a hospital dietitian, the MIHP may coordinate with the physician to refer the beneficiary to the hospital dietitian. The MIHP may also coordinate nutrition services with the MHP. When nutrition counseling is needed, the documentation must indicate how services were provided. All physician orders for MIHP services must be in compliance with state and federal laws prohibiting self-referral.

1.3 ELIGIBILITY

Maternal Services	Pregnant Medicaid beneficiaries qualify for MIHP services at any time during the pregnancy. After delivery, a new maternal MIHP case cannot be opened. For purposes of closing a case, services may be provided for up to 60 days after the pregnancy ends or the end of the month in which the 60th day falls.
Infant Services	MIHP services for an infant begin after the infant's birth and hospital discharge. Infant services are exclusively for the benefit of the infant on Medicaid, primarily by working with the infant's family. It is expected that a minimum 90% of Infant Risk Identifier visits and 80% of professional visits will be provided in the home.
Both Maternal and Infant Services	An infant case and a maternal case can both be open at the same time in some incidences. If the MIHP is seeing an infant and the mother becomes pregnant, a maternal risk identifier assessment visit can be completed and billed as such. After this initial risk identifier assessment visit is completed, all subsequent professional visits for that family should be blended visits and billed under one Medicaid ID. The program is based on the family dyad, and both the infant and parent are to be assessed at each visit and billed as "blended visits" under either the parent's or the infant's Medicaid ID.

1.4 MEDICAID HEALTH PLANS (MHP)

MIHP services provided to individuals enrolled in a MHP are administered by the MHP in adherence to the program components as outlined in this chapter. All MIHP services provided to MHP enrollees are coordinated and reimbursed by the MHPs.



1.4.A. CONTRACTUAL AGREEMENTS

MIHP providers must establish and maintain provider contractual agreements with the MHPs in their service area to receive payment for in-network services provided to MHP enrollees unless the MHP indicates otherwise. MIHP providers are encouraged to contract with the MHPs in their service area.

1.4.B. CARE COORDINATION AGREEMENTS

MIHP providers are encouraged to establish Care Coordination Agreements (CCAs) with all MHPs in their service area. MIHP providers and MHPs must also establish and maintain a CCA for in-network and out-of-network services. The intent of the CCA is to explicitly describe the services to be coordinated and essential aspects of collaboration between the MHP and the MIHP provider. (Refer to the Forms Appendix for an example of a Care Coordination Agreement.)

1.4.C. FREEDOM OF CHOICE

MIHP services are voluntary and participants must be allowed the freedom of choice of MIHP providers, including the opportunity to: select an in-network provider; maintain a current service relationship which extends services to the infant by the same provider who rendered maternal services; change providers within the MHP network of providers; or decline services.

1.4.D. REFERRAL TO AN MIHP

Within one month of when the MHP determines a pregnant or infant enrollee is eligible for MIHP services, the MHP must refer the enrollee to an MIHP provider. MHPs are not required to refer enrollees to an MIHP provider if the enrollee is already participating in an MDHHS approved equivalent evidence-based home visiting program that provides pregnancy-related or infant support services. This may be evidenced by enrollee self-attestation. MHPs may be required to present MDHHS evidence of MIHP referral and care coordination, evidence of participation in an equivalent evidence-based home visiting program, or refusal of MIHP services upon request.

1.4.E. PRIOR AUTHORIZATION OF SERVICES

MHPs may not require prior authorization for the Initial Risk Assessment visit, professional visits, drug-exposed infant visits, MIHP lactation support visits, childbirth education classes, or parenting education classes when provided within the criteria and limits established in policy. MIHP services in excess of limits established in policy may be subject to MHP prior authorization requirements.



1.4.F. OUT-OF-NETWORK MIHP SERVICES

It is incumbent upon MIHP providers to check eligibility and MHP enrollment at every visit. Relationships established during previous pregnancies with out-of-network MIHP providers are not required to be covered by the MHP. Non-contracted MIHP providers, including those who have a current MIHP relationship with a pregnant woman or infant, are required to contact the enrollee's MHP to discuss operational details before providing out-of-network services.



SECTION 2 - PROGRAM COMPONENTS

The assessment visit is the initial visit with the beneficiary. It is conducted in person with the beneficiary and either a registered nurse or licensed social worker. The assessment visit should be billed using the appropriate place of service code.

The Risk Identifier is a mandatory tool utilized during the assessment visit. The Risk Identifier assures all appropriate services are identified prior to initiation of professional visits, child birth education, parenting education or transportation services. If a Risk Identifier indicates a need for MIHP services, an appropriate Plan of Care (POC) must be developed that clearly outlines the beneficiary's problems/needs, objectives/outcomes, and the intervention(s) to address the problem(s). The Risk Identifier and the POC must be completed and the Risk Identifier entered into the MIHP database before further MIHP services are initiated.

If the Risk Identifier does not indicate the need for MIHP services or when, after completion of the Risk Identifier the beneficiary refuses services, then the POC is not developed and the Discharge Summary is completed accordingly. No follow-up services should be provided; however, the beneficiary should receive the informational packet. (Refer to the Maternal Infant Health Program Operations Guide for additional information.)

2.1 MATERNAL RISK IDENTIFIER

The Maternal Risk Identifier covers multiple domains, including basic care, drug and alcohol use, smoking, shelter, depression, transportation needs, intent to breast feed, and support systems. The Maternal Risk Identifier can be found in the Maternal Infant Health Program Operations Guide. It must be completed for each pregnant woman to determine the services needed through the MIHP. Either the licensed social worker or the registered nurse must work face-to-face with the beneficiary to complete the form. MIHP services will be provided based on the beneficiary's responses to the various questions on the Maternal Risk Identifier. The Maternal Risk Identifier must be completed to assure all appropriate services are identified. Reimbursement for the Maternal Risk Identifier is limited to one Maternal Risk Identifier for each eligible Medicaid beneficiary for each pregnancy.

The Maternal Risk Identifier results must be entered into the MIHP database. (Refer to the Maternal Infant Health Program Operations Guide for additional information.) The MIHP database will score each risk as high, medium, low, or no risk. Based on the risks identified and professional observation, the registered nurse and the licensed social worker, working together, must write a plan of care to determine appropriate interventions. The initial assessment visit and up to nine professional visits per woman per pregnancy are billable. The MIHP provider must respond to all referrals promptly to identify the beneficiary's needs. Documentation must indicate attempts to visit or contact the pregnant woman within 14 calendar days after the referral is received.

MIHP serves the maternal/infant dyad. When infant services are initiated, an Infant Risk Identifier must be completed.

2.2 INFANT RISK IDENTIFIER

The Infant Risk Identifier, as found in the Maternal Infant Health Program Operations Guide, must be completed for each infant entering the MIHP to determine the services needed. Either the licensed social worker or the registered nurse must work face-to-face with the beneficiary and primary caregiver to



complete the form. The Infant Risk Identifier is made up of many domains, including health and safety, feeding and nutrition, family support, child care, and general growth and development. MIHP services will be provided based on the responses to the various questions on the Infant Risk Identifier.

The MIHP provider must respond to all referrals promptly to identify the beneficiary's needs. Documentation must indicate attempts to visit or contact the beneficiary within a maximum of seven calendar days for the infant. For referrals received prior to the infant's discharge from the inpatient setting, the Risk Identifier should be conducted within two (2) business days following the hospital discharge. If the MIHP provider is unable to visit the beneficiary within the stated time frame, documentation must clearly support all attempts to contact or visit the infant beneficiary.

When infant services are initiated, an Infant Risk Identifier may be billed as a separate visit from a maternal postpartum professional visit when these services are performed on the same date of service. Documentation must substantiate why it was necessary to perform both visits on the same date of service. Servicing the maternal/infant dyad, all subsequent visits for that family should be "blended visits" and billed as "blended visits" under either the mother's or the infant's Medicaid ID.

The Infant Risk Identifier must be entered into the MIHP database. The system will score each risk as high, medium, low, or no risk. Based on the risks identified and professional observation, the registered nurse and the licensed social worker, working together, must write a plan of care for each beneficiary.

The initial assessment visit and up to nine professional visits per infant/family are billable. An additional nine infant visits may be provided when requested in writing by the medical care provider. All visits beyond the original nine visits must have a written physician order. The reason for and purpose of additional visits must be well documented in the medical record.

2.3 MULTIPLE BIRTHS

In cases of multiple births, each infant should have a separate risk identifier visit completed. This also applies to infants in foster care where there are two infants in the same home. These separate risk identifier visits can be billed separately under each individual infant Medicaid identification number. Subsequent professional visits should be billed under each infant ID if the infants are from different families, such as with foster care families. If the infants are siblings, the visits should be "blended visits" and billed under one Medicaid ID only. The risk identifier visit and up to nine professional visits can be made to the family. A physician order is needed if more than nine infant visits are needed per family.

2.4 PSYCHOSOCIAL AND NUTRITIONAL ASSESSMENT-RISK IDENTIFIER

The MIHP consists of many interventions in multiple domains designed to educate and inform the beneficiary, both as a pregnant woman and as the parent of an infant. Domains include basic care, physical abuse, substance abuse, social behavior and health history. The Risk Identifiers are designed to determine if there is high, medium, low, or no risk for each domain. Based on the Risk Identifier and professional observation, the MIHP provider will determine interventions specific to each beneficiary. Refer to the Maternal Infant Health Program Operations Guide for more information and interventions related to the domains.

If the Risk Identifier does not indicate the need for MIHP services, then no follow-up services should be provided; however, the beneficiary should receive the informational packet. (Refer to the Maternal Infant Health Program Operations Guide for additional information.) If a need is indicated, an appropriate POC



must be developed that clearly outlines the beneficiary's problems/needs, objectives/outcomes, and the intervention(s) to address the problem(s). If a MIHP prenatal case subsequently becomes an MIHP infant case, the Infant Risk Identifier must be completed to determine eligibility for the infant before professional visits are made.

The beneficiary must be assessed (Risk Identifier completed) for the need for transportation assistance, childbirth/parenting education classes, health education, breast feeding support, and family planning services. The completion of the Risk Identifier must precede any professional or IBCLC visits. The Risk Identifier must be completed by the licensed registered nurse or the licensed social worker.

2.5 PLAN OF CARE

The registered nurse and the licensed social worker, working together, must develop a comprehensive POC to provide identified services to the beneficiary and/or referrals to community agencies. The POC must indicate the specific domains at risk, the specific objectives, specific intervention(s) to be implemented, and the number of visits that are required for actualizing the plan. The POC must be updated whenever a significant change occurs. Documentation must support the changes made. The MIHP provider must determine how best to involve the registered nurse and the licensed social worker in implementing the POC based on the needs identified.

The POC must identify if a beneficiary would benefit from a visit with a registered dietitian based on the needs identified. If the services of a registered dietitian are needed, the necessary physician order must be obtained. The beneficiary may be referred to their MHP or local hospital for nutritional counseling.

The beneficiary's exit from the program is expected to occur when the objectives of the POC are complete, or when the MIHP provider determines that continued interventions are no longer needed.

2.6 CARE COORDINATOR

A specific registered nurse or licensed social worker will be identified as the care coordinator assigned to monitor and coordinate all MIHP care, referrals, and follow-up services for the beneficiary. The care coordinator must assure the family is appropriately followed and referred for needed services. The name of the care coordinator must be documented in the beneficiary's record. The care coordinator must refer all beneficiaries to the Women, Infants and Children (WIC) Program if they are not receiving WIC.

For the infant, MIHP providers are encouraged to participate in local Children's Protective Services (CPS) Interdisciplinary Team meetings, Part C/Early On Interagency Coordinating Council meetings, and in similar efforts to coordinate the infant's care. This assures the use of and coordination with other community resources to avoid duplication of services, identify gaps, and to assure ongoing support when the MIHP case is closed. When appropriate, MIHP referrals to CPS must be made. Appropriate family planning education and referrals must be made and documented.

2.7 PROFESSIONAL VISITS

A professional visit is a face-to-face encounter with a beneficiary conducted by a licensed professional (i.e., licensed social worker, registered nurse, or infant mental health specialist) for the specific purpose of implementing the beneficiary's plan of care. A registered dietitian may conduct a visit when ordered by a physician.



The professional visit is a one-on-one visit that must be scheduled to accommodate the beneficiary's situation and be appropriate to the beneficiary's level of understanding. Visits lasting less than 30 minutes or provided in a group setting are not billable.

Medicaid reimbursement for a professional visit includes related care coordination activities. MIHP providers are eligible for Medicaid reimbursement for one professional visit per beneficiary on the same date of service, regardless of the place of service. When beneficiary needs arise, the MIHP provider must coordinate all necessary MIHP related services with the appropriate community agencies. Visits beyond the established limit cannot be billed to the beneficiary or Medicaid.

All professional visit records must include the place of service, time the visit began and ended, risk factors discussed, and actions taken. Coordination of agency and community services and arranging transportation for the beneficiary are part of each professional visit. The MIHP provider must assure the beneficiary has been referred to the WIC program.

Family planning options must be discussed throughout the course of care, giving the woman time to consider her options.

The MIHP must provide directly or arrange bilingual services and/or services for the visually impaired and/or hearing impaired when needed so all beneficiaries may fully participate in the MIHP.

MDHHS does not reimburse for missed visits/appointments. A beneficiary may not be billed for a missed visit/appointment.

2.8 DRUG-EXPOSED INFANT

A drug-exposed infant is an infant born with the presence of an illegal drug(s) and/or alcohol in his circulatory system, or who is living in an environment where substance abuse and/or alcohol is a danger or is suspected. Due to the complex nature of these cases, additional visits may be required. A separate drug-exposed procedure code is assigned for additional visits. The beneficiary's record must contain documentation to support the use of the drug-exposed procedure code.

The initial assessment and up to nine professional visits for a drug-exposed infant are billable by the MIHP. An additional nine infant visits may be provided when requested in writing by the medical care provider. In these cases, the reason for and purpose of additional visits must be well documented in the beneficiary record.

The maximum of 36 professional visits and the initial assessment visit may be reimbursed for a drug-exposed infant. The provider must use the professional visit code for the first 18 visits; the drug-exposed procedure code may then be billed for up to an additional 18 visits. Refer to the MDHHS website for additional code information. (Refer to the Directory Appendix for website information.)

2.9 PLACE OF SERVICE

Reimbursement for professional visits is based on the place of service. A clinic/office visit and a home visit pay different amounts; therefore, the place of service must be documented in each professional visit note.



Typically, all visits are performed at the beneficiary's home or at the MIHP provider's office. On rare occasions when a visit cannot be completed in the beneficiary's home or in the provider's office, the provider may work with the beneficiary to identify a mutually agreeable site to conduct a visit. These types of visits are referenced as visits occurring in the community setting.

For a community visit to be reimbursable, the beneficiary record must clearly identify the reason(s) why the beneficiary could not be seen in her home or in the MIHP office setting. This documentation must be completed for each visit occurring in the community setting. Visits occurring in buildings contiguous with the provider's office, in the provider's satellite office, or rooms arranged or rented for the purpose of seeing beneficiaries are considered to be in an office setting rather than in a community setting. Visits should never be conducted in the MIHP provider's home.

2.9.A. MATERNAL SERVICES

- Professional visits may be provided in a clinic/office setting or in the beneficiary's home/place of residence, including homeless shelter, or at a mutually agreed upon community location.
- Professional visits may not be provided in the inpatient hospital setting.
- Efforts must be made to visit the beneficiary in the home. MDHHS requires one visit be made to the beneficiary's home during the prenatal period to better understand the beneficiary's background.
- A second home visit must be made after the birth of the infant to observe bonding, infant care and nutrition, and discuss family planning. An MIHP provider may complete and bill an infant risk identifier visit separate from a maternal postpartum professional visit. A maternal postpartum professional visit may be made on the same date of service as the infant risk identifier visit. Providers must document why both visits need to be done on the same date of service. The maternal visit must be a minimum of 30 minutes and be reflected in the professional note. After the risk identifier assessment visit has been completed, all subsequent professional visits should be blended visits.

2.9.B. INFANT SERVICES

- MIHP is a home-visiting program.
- The initial assessment visit, when the Infant Risk Identifier is completed, must be completed in the beneficiary's home at least 90% of the time.
- On average, 80% of all professional interventions must be done in the beneficiary's home.
- If a home visit is not feasible, services may be provided any place other than an inpatient hospital setting.
- The infant and primary caregiver must be present at all visits.

2.10 TRANSPORTATION

Transportation services are available to help MIHP-enrolled pregnant and infant beneficiaries access their health care and pregnancy-related appointments and for a mother to visit her hospitalized infant. Pregnancy-related appointments include those for oral health services, WIC services, behavioral or



substance use disorder treatment services, and childbirth and parenting education classes. Through the completion of the Risk Identifier, the MIHP provider must assess each MIHP beneficiary's need for transportation services.

Beneficiaries in the Nurse Family Partnership (NFP) do not need a Risk Identifier completed to receive transportation services. Transportation is the only MIHP service available to NFP beneficiaries.

2.10.A. TRANSPORTATION FOR MIHP MEDICAID HEALTH PLAN ENROLLEES

MHPs are responsible for providing transportation for pregnancy-related appointments for MHP enrolled MIHP and NFP participants. MIHPs are subject to the MHP's internal processes for the coordination of transportation services for MHP enrollees.

2.10.B. TRANSPORTATION FOR MIHP FEE FOR SERVICE BENEFICIARIES

The MIHP may provide transportation to MIHP Fee-for-Service (FFS) beneficiaries for medical/health care services and pregnancy related appointments when no other means of transportation are available, including transportation from the local MDHHS office. Transportation services provided to the pregnant beneficiary should be billed utilizing the Medicaid ID number of the pregnant woman, and transportation services provided for infant services should be billed utilizing the infant's Medicaid ID number.

Reimbursement for transportation services provided to Medicaid FFS beneficiaries is made according to the allowable amount established by MDHHS and aligns with rates established for Non-Emergency Medical Transportation (NEMT) services. Refer to the MDHHS Non-Emergency Transportation Database located on the MDHHS website. (Refer to the Directory Appendix for website information.)

MDHHS reimburses the MIHP provider an administrative fee equal to six percent of the cost of transportation provided to MIHP FFS beneficiaries. When billing, the six percent fee should be calculated and included in the amount charged, not to exceed the maximum amount allowed. The MIHP provider must determine the most appropriate and cost effective method of transportation. MDHHS reimburses transportation costs at the lesser of actual cost or the maximum/upper limit for:

- Bus
- Mileage (personal, including beneficiary, relative or friend).
- Taxi

If other methods of transportation are not available or appropriate, the MIHP provider may make arrangements with local cab companies to provide taxi service for MIHP beneficiaries. Since this is a more expensive service, MDHHS reimburses a maximum of 20 trips per beneficiary through the MIHP.

The MIHP provider must maintain documentation of transportation for each beneficiary for each trip billed. The record must specify:

- The name and address of the beneficiary;



- The date of service (DOS);
- The trip's starting point and destination (address, city);
- The purpose of the trip;
- The number of tokens or miles required for the trip;
- The amount that the beneficiary or transportation vendor was reimbursed;
- The provider identification information for the individual or business providing transportation; and
- Verification of transportation provider enrollment in CHAMPS.

The MIHP provider must ensure the beneficiary kept the appointments for which transportation tokens or funds were provided. Medicaid does not pay for transportation not provided.

The MIHP provider may give transportation tokens or funds to the pregnant woman or to the caregiver of the infant. In situations where funds are provided, it is recommended that the pregnant woman or the caregiver sign a receipt and that the receipt be retained in the case records. The MIHP may also contract for transportation services. Transportation services should be billed for each date of service it was provided. MDHHS contracts with a transportation brokerage company to arrange and provide NEMT for beneficiaries residing in Wayne, Oakland and Macomb counties. Transportation may be provided when the beneficiary qualifies for service and has no other means of transportation. (Refer to the Directory Appendix for contractor contact information.)

2.11 CHILDBIRTH EDUCATION

Childbirth education is a series of group classes intended to help:

- Understand the changes in the body during pregnancy;
- Understand the delivery process, including information regarding pre-term labor;
- Understand the postpartum period;
- Care for the infant (classes may include information on developing positive parenting skills);
- Interact with other pregnant women; and
- Build a support network.

First-time mothers must be encouraged to complete the course.

The medical care provider or the MIHP provider may make a referral for childbirth education classes. MIHP providers may provide this service directly or have a contract with a local hospital's outpatient clinic. An outpatient hospital clinic that provides this service may bill Medicaid directly for FFS beneficiaries. The contract must indicate which provider is to bill and receive payment. These services are provided to a group in a classroom situation.



MIHP childbirth education includes, but is not limited to, the following topics:

- Pregnancy,
- Labor and delivery,
- Infant care and feeding,
- Postpartum care, and
- Family planning.

In unusual circumstances (e.g., beneficiary entered prenatal care late or is homebound due to a medical condition), childbirth education may be provided in the beneficiary's home as a separately billable service. Case records must document the need for one-on-one childbirth education and where services were provided. (Refer to the Education Reimbursement subsection of this chapter for additional billing information.)

2.12 PARENTING EDUCATION

Parenting education is intended to develop positive parenting skills and attitudes, provide interaction with other parents, and possibly build a support network. Parenting education may be billed once per infant or, in the case of multiple births, once per family.

The infant's medical care provider or the MIHP provider may make a referral for parenting education classes. The services may be provided by the MIHP provider or by contract with an outpatient hospital or community-based organization. The contract must indicate which provider is to bill and receive payment. These services are provided to a group in a classroom situation.

Parenting education classes should include, but are not limited to,:

- General feeding recommendations throughout the first year of life,
- Normal and abnormal patterns of elimination,
- Common signs and symptoms of infant illness,
- Common childhood injuries and how to care for them,
- Normal range of sleep, rest, activity and crying patterns,
- General hygiene needs of infants,
- Normal developmental milestones of infants throughout the first year,
- Basic emotional needs,
- Basic protection from toxic and/or hazardous waste,
- Basic immunizations and health maintenance, and
- General day-to-day living with children.

(Refer to the Education Reimbursement subsection of this chapter for additional billing information.)



2.13 LACTATION SUPPORT AND COUNSELING SERVICES

Medicaid will reimburse for evidence-based lactation support services provided to post-partum women in the outpatient setting up to and through 60 days post-delivery when services are provided by a qualified licensed MIHP registered nurse or licensed social worker in possession of a valid and current IBCLC certification. A maximum of two visits per pregnancy will be reimbursed for either a single or multiple gestation pregnancy. One visit is reimbursable per date of service.

Before initiating MIHP IBCLC services, the initial assessment visit, appropriate Risk Identifier (infant or maternal), and Plan of Care (infant or maternal) must be completed and the Risk Identifier entered into the MIHP database.

Although MIHP serves the mother-infant dyad, a distinction is made between maternal and infant services for billing purposes. IBCLC services are considered a component of pregnancy related services. Claims for IBCLC services are to be submitted utilizing the mother's Medicaid beneficiary identification number. Documentation must include the need for maternal lactation support, a begin time and end time of services provided, and a comprehensive description of the professional interventions provided.

For all IBCLC rendered services, a copy of the current, valid IBCLC certification is to be maintained by the MIHP organization in accordance with the record keeping requirements of the Medicaid program.

Refer to the Billing & Reimbursement for Professionals Chapter of this manual for additional billing information. Refer to the Practitioner Chapter of this manual for additional information related to the service component requirements.

2.14 TRANSFER OF CARE/RECORDS

During the course of care, the beneficiary may require services from a different provider due to a move to another area or otherwise request a change of MIHP providers. When an MIHP provider is aware of a planned change in provider, information about the MIHP provider at the new location should be provided to the beneficiary. The referring provider must consult with the new provider about the case and transfer necessary information or records in compliance with the privacy and security requirements of Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations. A copy of the completed Risk Identifier, POC, and visit notes must be shared with the new provider. Close coordination between providers should avoid duplication of services. A release of information from the beneficiary is necessary.

2.15 IMMUNIZATIONS

Immunization status must be discussed throughout the course of care. Providers must determine the status of the MIHP beneficiary's (i.e., mother and/or child) immunizations. The parent(s) should be encouraged to obtain immunizations and be assisted with appointments and transportation as needed. Before closing an MIHP case, the provider must have assessed immunization status, provided immunization education, and documented accordingly in the case record.

2.16 SPECIAL ARRANGEMENTS FOR CHILD PROTECTIVE SERVICES

Because of the serious nature of MIHP cases, some beneficiaries need the assistance of the MDHHS Children's Protective Services (CPS) program. The MIHP provider must work cooperatively and continuously with the local CPS office. Contact persons for MIHP and CPS must be identified. Referral



protocol and a working relationship must be developed and maintained. MIHP is a valuable resource for the CPS program. The MIHP provider must seek CPS assistance in a timely manner. MIHP and CPS work concurrently on at least some referred cases. CPS is not to be viewed as a resource of last resort for the agency to call when all else fails.

The Michigan Child Protection Law (Act No. 238, Public Acts of 1975) requires health care professionals and others to report cases of suspected child abuse/neglect to CPS. When and how the MIHP provider must refer can best be determined by discussions with the local CPS agency. MIHP activity does not replace the need for required CPS referrals.

2.17 COMMUNICATIONS WITH THE MEDICAL CARE PROVIDER

When an MIHP case is opened, the MIHP provider must notify the medical care provider within 14 calendar days. When an MIHP case is opened for a pregnant woman with no medical care provider, the MIHP must assist the woman in finding a medical care provider.

The MIHP provider must keep the medical care provider informed of services provided as directed by the medical care provider or when a significant change occurs. The initial assessment visit is the first visit when the Risk Identifier is completed. The communication identifying risks must be sent to the medical care provider within 14 calendar days after the initial assessment visit is completed. The discharge summary, including the services provided, outcomes, current status, and ongoing needs of the beneficiary, must be completed and forwarded to the medical care provider when the MIHP case is closed.

2.18 AUTHORIZATION FOR PROGRAM EXCEPTIONS

In limited situations, when beneficiary needs surpass outlined MIHP program parameters, MIHP consultants may recommend additional visits for MIHP services, as required, in the following circumstances:

- Initiation of services for a child over 12 months of age;
- Continuation of services beyond 18 months of age; and
- Professional observation indicating that a beneficiary will benefit from MIHP services after being assessed with no risks using the appropriate program assessment tool (Risk Identifier).

MIHP providers seeking program exceptions for all beneficiaries must submit documentation to their assigned MIHP consultant that supports any identified risks and how the beneficiary may benefit from services. As a reminder, program screening tools and educational materials utilized by the MIHP are designed for maternal and infant use only.

MIHP consultants will be responsible for direct authorization of program exceptions for FFS beneficiaries. For beneficiaries enrolled in MHPs, the MIHP consultants will recommend exception visits to the MHPs. MHPs will be responsible for the review and processing of the prior authorization request for the services in accordance with their utilization management processes. All approved written authorizations are to be kept in the beneficiary's MIHP provider file and must be available upon request. Additionally, as applicable, the MIHP provider is required to note any granted authorizations in the program approved communication tool for a beneficiary enrolled in a Medicaid Health Plan.



SECTION 3 – REIMBURSEMENT

To receive reimbursement for services, the MIHP billing National Provider Identifier (NPI) must be a facility, agency, or organization. A MIHP specialty must be indicated when enrolling as a MIHP provider through CHAMPS. The MIHP provider must bill only the procedure codes listed in the MDHHS Maternal Infant Health Program Database located on the MDHHS website. (Refer to the Directory Appendix for website information.)

All services provided by MIHP providers to MHP enrollees should be billed directly to the MHP. All services provided by MIHP providers to Fee-for-Service beneficiaries should be billed directly to MDHHS. MIHP services are a Medicaid only benefit. MIHP providers are not required to secure other insurance adjudication response(s) for claims for MIHP services prior to billing Medicaid FFS or MHPs, as the parameters of other carriers would never cover MIHP services. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for additional billing information.)

The Risk Identifier is required to be completed and entered into the MIHP database before the service is billed. (Refer to the Maternal Infant Health Program Operations Guide for additional information.) MIHP providers receive separate reimbursement for each Risk Identifier form completed and entered into the MIHP database even if it is determined the beneficiary does not need MIHP services. The Risk Identifier is billed and reimbursed based on place of service. As with all Medicaid services, documentation must support the services billed and paid.

Reimbursement is limited to one Maternal Risk Identifier per pregnant woman during her pregnancy and one Infant Risk Identifier per infant. Due to factors such as premature termination of a pregnancy or a subsequent pregnancy in the same year, an MIHP provider may do a Risk Identifier on a pregnant woman and receive reimbursement twice in the same year. In such instances, the provider must indicate "second pregnancy" in the remarks section of the claim when billing for the service.

Reimbursement for a professional visit is based on the place of service. The place of service must be documented in each professional visit note and billed accordingly. Medicaid reimbursement for a professional visit includes related care coordination and monitoring of activities.

Services scheduled but not provided to the beneficiary are not billable. This includes all MIHP services. The beneficiary must not be billed for visits provided beyond the established limit.

3.1 EDUCATION REIMBURSEMENT

Reimbursement for MIHP childbirth education classes and/or parenting education classes are for the complete course, regardless of the number of classes needed to complete the course. At a minimum, the course outline found in the Maternal Infant Health Program Operations Guide must be covered. Additional items may be added at the discretion of the provider. The pregnant woman or caregiver must attend at least one-half of the classes or cover at least one-half of the curriculum for the service to be billed. Dates of attendance must be documented in the beneficiary's record. If the class is offered in the community, but not all items on the outline are covered, the missed items should be covered during a professional visit and not billed separately as education.

- MIHP childbirth education may be billed one time per beneficiary per pregnancy.
- MIHP parenting education may be billed one time per infant. In the case of twins or other multiple births, parenting education may be billed only once for the family.



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If the MIHP provider refers the beneficiary to a local hospital to provide the classes, the hospital must bill the appropriate MHP to receive payment. If the MIHP provider contracts with an outpatient hospital or community based organization for childbirth education, the contract must indicate which provider is to bill and receive payment. If the classes are available at no charge to the public from a community-based organization, the MIHP cannot bill the Medicaid Fee-for-Service program or the beneficiary for the service.



SECTION 4 - FORMS

MIHP providers must use standardized forms developed by MDHHS. Copies of the forms are located in the Maternal Infant Health Program Operations Guide and/or on the MDHHS website. (Refer to the Directory Appendix for website information.) At a minimum, the data elements included in these forms must be maintained. If additional data elements are needed, it is suggested the agency develop a separate form to accommodate their needs, to be used in addition to the state forms. The goal is to have standardized forms statewide.



SECTION 5 - OPERATIONS AND CERTIFICATION

MDHHS certifies MIHP providers. To become an MIHP provider, the criteria in the Michigan Medicaid Provider Manual and the Maternal Infant Health Program Operations Guide must be met. Provider participation criteria includes, but is not limited to, required staffing and the capacity to provide services, including outreach, and weekend and after-hours coverage. MIHP providers must follow all policies and procedures in the Michigan Medicaid Provider Manual in addition to the Maternal Infant Health Program Operations Guide.

5.1 CRITERIA

Providers must meet the following participation criteria.

- The provider must meet program requirements to qualify for enrollment in Medicaid.
- In cases where services are provided through a contract with another agency, the contract or letter of agreement must be on file for review by MDHHS. It must specify the time period of the agreement, the names of the individuals providing services, and where the billing responsibility lies.
- The provider's physical facilities for seeing beneficiaries must be comfortable, safe, clean, and meet legal requirements.
- The provider must have experience in the delivery of services to the target population and demonstrate understanding of the concept and delivery of maternal and infant services.
- The provider must demonstrate linkages to relevant services and health care organizations in the area to be served.
- The organization must demonstrate a capacity to conduct outreach activities to the target population and to medical providers in the geographic area to be served.

5.2 STAFFING

Required staff for the MIHP is comprised of licensed registered nurses and licensed social workers. Optional staff may include a registered dietitian, infant mental health specialist, or an IBCLC. All staff must meet the qualifications as stated in the Staff Credentials subsection of this chapter.

5.3 OPERATIONS AND CERTIFICATION REQUIREMENTS

Providers must demonstrate their ability to validate the need for, and delivery of, MIHP services appropriate to each beneficiary's individual need. The MIHP must:

- Deliver services appropriate to the beneficiary's level of understanding.
- Schedule services to accommodate the beneficiary's situation.
- Complete appropriate Risk Identifier by a licensed social worker or a registered nurse.
- Develop the plan of care by a licensed social worker and a registered nurse (jointly).
- Complete the Risk Identifier based on a home visit as required for the infant and, if possible, for the pregnant woman.



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- Demonstrate a system for handling beneficiary grievances.
- Provide for weekend and after-hours emergencies.
- Provide directly or arrange for bilingual services, and services for the visually impaired and/or hearing impaired, as indicated.
- Maintain all physician orders in the medical record.
- Coordinate agency and community services for the beneficiary.
- Arrange transportation services when appropriate.
- Respond to referrals promptly to identify the beneficiary's needs (within a maximum of 7 calendar days for the infant and 14 calendar days for the pregnant woman).
- Respond to referrals received prior to the infant's discharge from the inpatient setting within two business days of hospital discharge.
- Notify the medical care provider of the beneficiary's enrollment within 14 days.
- Document and report disposition of the referral (i.e., initiation of services, inability to locate, or refusal of services) to the referring source.
- Provide ongoing communication with the beneficiary's medical care provider.
- Provide, directly, the services of at least a registered nurse or licensed social worker. Infant mental health specialist and/or registered dietitian services may be provided through a subcontractor or services may be accessed in other ways.
- Not bill for services provided by community resources.
- Provide services in a clinic, an office, a home setting and/or community setting, as appropriate.
- Maintain a current list of local Public Health programs such as WIC Nutrition, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Community Mental Health (CMH), Children's Special Health Care Services (CSHCS), and other agencies that may have appropriate services to offer the beneficiary, and agree to work cooperatively with these agencies.
- Have written protocols that comply with the reporting requirements mandated by the Michigan Child Protection Law (Act No. 238, Public Acts of 1975). Include protocols on coordination with the CPS unit of the local MDHHS office that specify how the MIHP provider will make CPS referrals, initiate follow-up contacts with CPS, and participate in local CPS multidisciplinary team meetings involving infants served by the MIHP.
- Maintain an adequate and confidential beneficiary records system, including services provided under a subcontractor. (HIPAA standards must be met.)
- Have written internal protocols to include all aspects of the program.
- Be actively linked to or a member of the Great Start Collaborative. When providing infant services, in addition to the Great Start Collaborative, providers must also be actively linked to or be a member of the local Part C/Early On Interagency Coordinating Council.
- Report all new MHP enrollees to the appropriate MHP on a monthly basis or as agreed to in the Care Coordination Agreement.
- Follow all procedures as written in the Maternal Infant Health Program Operations Guide.



- Follow all Medicaid policies as published in the Michigan Medicaid Provider Manual, Medical Services Administration Bulletins, and the Maternal Infant Health Program Operations Guide.

5.4 ISSUANCE OF CERTIFICATION

Based upon satisfactory application, MDHHS provides a provisional MIHP certification. After an agency is provisionally certified and providing services, MDHHS conducts a provider site visit. The site visit must occur within six months of the provisional certification. The site visit is to observe how the program is being implemented and to assist in resolving any problems experienced in the implementation of the program. Based upon the site visit, MDHHS grants the agency either a six-month certification, a three-year certification, or discontinues certification. MDHHS makes a formal certification visit every three years, with informal site visits at more frequent intervals.

If at any time after receiving certification the provider becomes deficient in any of the qualifying criteria, including staffing, the provider must notify the MDHHS Division of Family & Community Health immediately. (Refer to the Directory Appendix for contact information.) MDHHS then determines whether the agency may continue providing services given the deficiency(ies). The MDHHS decision is based on the evaluation of many factors, including the number of deficiencies, the specific deficiency(ies) involved, the availability of other providers in the area, impact on caseload, etc.

If at any time the MIHP provider fails to meet the program policies or certification requirements, Medicaid reimbursement can be jeopardized. The MIHP provider is subject to audit by Medicaid and if any discrepancy(ies) is found, appropriate follow-up action may be taken, such as recoupment of payments, holding reimbursement on claims, or termination of Medicaid enrollment. If a negative action is imposed, the MIHP provider is given an opportunity for appeal.

Agencies wishing to become a MIHP provider may contact the MDHHS Division of Family & Community Health. (Refer to the Directory Appendix for contact information.)



MATERNITY OUTPATIENT MEDICAL SERVICES PROGRAM

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SECTION 1 – GENERAL

The Maternity Outpatient Medical Services (MOMS) program covers outpatient pregnancy-related services for the unborn child of an undocumented pregnant woman during the prenatal and postpartum period as well as inpatient delivery-related services. MOMS will also cover family planning services for the mother during the postpartum period.

1.1 ELIGIBILITY DETERMINATION

Women who are pregnant and meet the following criteria may apply for MOMS coverage:

- Income at or below 195 percent of the Federal Poverty Level.
- Covered by the Medicaid Emergency Services Only (ESO) program.

Women who are incarcerated in any institution where residents are precluded from using their Medicaid coverage are not eligible for this program.

1.2 PERIOD OF COVERAGE

The MOMS enrollment period is from the date of application, once eligibility is determined, through 60 days after the pregnancy ends. The maximum period of retroactive eligibility for MOMS is 90 days from date of application.

1.3 VERIFYING ELIGIBILITY

MOMS enrollees are given a Guarantee of Payment for Pregnancy Related Services (DCH-1164) letter. The letter is intended to assure providers that MDHHS will reimburse for pregnancy-related services provided to the beneficiary. The letter includes information on eligibility, covered services, billing instructions, etc. (A sample of the letter is included in the Forms Appendix.)

Once a woman is determined eligible for the MOMS program, a MOMS Eligibility Letter is issued. The letter contains the beneficiary's identification (ID) number.

MOMS beneficiaries are identified in the eligibility response with the Benefit Plan ID of MOMS. (Refer to the Beneficiary Eligibility chapter for additional information.)



SECTION 2 – SERVICES

2.1 COVERED SERVICES

The following services are covered consistent with current MOMS policy:

- Prenatal period services, including:
 - Prenatal care and pregnancy-related care
 - Condoms (covered in the prenatal period for sexually transmitted infection [STI] prevention)
 - Pharmaceuticals and prescription vitamins
 - Laboratory services
 - Radiology and ultrasound
 - Maternal Infant Health Program (MIHP) - for prenatal services only
 - Childbirth education
 - Outpatient hospital care
- Labor and delivery services (including all professional and inpatient hospital services) are covered.
- Postpartum care is limited to medically necessary ambulatory postpartum services.
- Family planning services, including:
 - Office visits for family planning related services, including preventive evaluation and management office visits and other outpatient visits for family planning services.
 - Contraceptives, including oral contraceptives and injectables.
 - Contraceptive supplies and devices for voluntarily preventing or delaying pregnancy.
 - Diagnostic evaluation and pharmaceuticals related to contraceptive management or the initial treatment of sexually transmitted infections.
 - Sterilizations completed in accordance with current Medicaid policy.
 - Counseling for family planning services, including sterilization, as a part of the family planning visit.

2.2 NONCOVERED SERVICES

Postpartum outpatient lactation support and counseling services provided by an IBCLC are not covered. MIHP coverage is limited to the prenatal period only.



2.3 PRIOR AUTHORIZATION

If a service does not meet the definition of the pregnancy-related services noted above or if the service normally requires prior authorization (PA) by the Medicaid program, a PA request must be submitted to MDHHS. Requests of authorization of pharmaceuticals must be made to the MDHHS Pharmacy Benefits Manager (PBM). (Refer to the Directory Appendix for contact information.)



SECTION 3 – BILLING & REIMBURSEMENT

Billing and coordination of benefits policies and procedures, as well as reimbursement rates, parallel Medicaid. (Refer to the Billing & Reimbursement and the Coordination of Benefits Chapters of this manual for additional information.)

3.1 SUBMITTING MEDICAL CLAIMS

Providers should not bill Medicaid without a valid MOMS ID number. MOMS claims should be held until the beneficiary's MOMS ID number can be obtained from the eligibility response, the MOMS Eligibility Letter, or the beneficiary's **mihealth** card. (Refer to the Beneficiary Eligibility Chapter for additional information.) The "M" or "I" number that may appear in the upper right-hand corner of the Guarantee of Payment for Pregnancy Related Services (DCH-1164) letter cannot be used to identify MOMS beneficiaries on claims submitted to MDHHS.

If a provider is unable to obtain the MOMS ID number in a reasonable period of time, a copy of the DCH-1164 may be faxed to the MDHHS Customer Services Division and a beneficiary ID number requested. (Refer to the Directory Appendix for contact information.) The name and phone number of a contact person should be included with the fax request. MDHHS then provides the beneficiary's ID number to the requester.

Providers must use the appropriate Z30 International Classification of Diseases (ICD) diagnosis code as the primary diagnosis on claims for family planning services.

3.2 SUBMITTING PHARMACY CLAIMS

Pharmacy services provided to MOMS beneficiaries must be billed to the MDHHS Pharmacy Benefits Manager (PBM). (Refer to the Directory Appendix for contact information.) Pharmacies have the option of billing the PBM in one of two ways:

- Hold the claim until the beneficiary ID number is available in the eligibility response and then bill via the PBM's online system; or
- Submit a claim, along with a copy of the DCH-1164, to the PBM per the instructions in the PBM manual.

Family planning supplies not furnished by the practitioner as part of the medical services must be prescribed by a Medicaid enrolled practitioner and dispensed by a pharmacy. Exceptions include condoms and similar supplies that do not require a prescription.

3.3 REMITTANCE ADVICE

MOMS claim adjudication information is included in the weekly Remittance Advice (RA), merged alphabetically with Medicaid and other MDHHS-administered programs. (Refer to the Billing & Reimbursement Chapters for additional information.)



MEDICAID HEALTH PLANS (MHPs)

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SECTION 1 – GENERAL INFORMATION

The Michigan Department of Health and Human Services (MDHHS) 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 Technology, Management & 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 MDHHS website. (Refer to the Directory Appendix 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 this 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 Clinical Nurse Specialist services
- Certified nurse-midwife services
- Certified pediatric and family nurse practitioner services
- Childbirth and parenting classes
- Chiropractic services
- 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
- 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) for up to 45 days
- Maternal Infant Health Program (MIHP)
- Medically necessary transportation for enrollees without other transportation options
- Medically necessary weight reduction services
- Mental health care
- Out-of-state services authorized by the MHP
- Outreach for included services, especially pregnancy-related and well-child care
- Pharmacy services
- Podiatry services
- Practitioner services (such as those provided by physicians, optometrists, or oral-maxillofacial surgeons)
- Prosthetics and orthotics
- Therapies (speech, language, physical, occupational)
- Tobacco cessation treatments, including pharmaceutical and behavior support
- Transplant services
- Transportation for medically necessary covered services
- Treatment for sexually transmitted disease (STD)
- Vision services
- Well child/EPSTD for individuals under age 21

The covered services provided to Healthy Michigan Plan enrollees under the contract include all those listed above and the following additional services:

- Additional preventive services required under the Patient Protection and Affordable Care Act as outlined by MDHHS
- Habilitative services
- Dental services
- Hearing aids for persons 21 and over

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



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- Certain dental services (Refer to the Dental chapter of this manual for additional information.)
- MDHHS also maintains a list of specific Medicaid program-covered physician-administered drugs and biological products that are not covered by MHPs. This list of physician-administered drugs and biological products, carved out from MHP coverage, will be reimbursed as a Fee-for-Service (FFS) benefit for all beneficiaries in FFS and for those enrolled in an MHP. (Refer to the Physician-Administered Drugs and Biological Products Not Covered by Medicaid Health Plans subsection of the Practitioner chapter of this manual for additional information. Refer to the Directory Appendix for website information for the physician-administered drugs and biological products list.)
- Home and Community Based Waiver program services
- Inpatient hospital psychiatric services (MHPs are not responsible for the physician cost related to providing a 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
- Private Duty Nursing services
- Services provided to persons with developmental disabilities and billed through the Community Mental Health Services Program (CMHSP)
- 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
- Beneficiaries diagnosed with inborn errors of metabolism that have been authorized for and use metabolic formulas (B4157 and B4162) will receive all of their Medicaid services through the Medicaid Fee-For-Service Program.
- Services provided to an individual with Medicaid who resides in a State Veterans' Home.
- Pediatric Outpatient Intensive Feeding Program services



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;
- Elective cosmetic surgery; and
- Services for treatment of infertility.



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 MDHHS 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 INFANT HEALTH PROGRAM (MIHP)

Effective for dates of service on or after January 1, 2017, MIHP services provided to individuals enrolled in an MHP are administered by the MHP as outlined in the Maternal Infant Health Program Chapter of this manual. All MIHP services provided to MHP enrollees are coordinated and reimbursed by the MHPs. Only MDHHS certified providers may deliver MIHP services to MHP enrollees.



To maintain fidelity of the program and to facilitate compliance with the reporting requirements of Public Act 291 of 2012, it is the expectation that MIHP providers and MHPs will adhere to program components, including but not limited to: MDHHS program certification, the required professional qualifications of staff, and the use of MDHHS MIHP forms. MHPs must establish and maintain a Care Coordination Agreement (CCA) with MIHP providers for both in-network and out-of-network services.

Within one month of when the MHP determines a pregnant or infant enrollee is eligible for MIHP services, the MHP must refer the enrollee to an MIHP provider. MHPs are not required to refer enrollees to an MIHP provider if the enrollee is already participating in an MDHHS approved equivalent evidence-based home visiting program that provides pregnancy-related or infant support services.

MHPs work cooperatively with the local MDHHS office to maintain a referral protocol for those enrollees who need the assistance of MDHHS Children's Protective Services. MIHP providers must work with the MHP and MDHHS Children's Protective Services to ensure appropriate care for MHP enrollees. (Refer to the Maternal Infant Health Program Chapter of this manual for additional information.)

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;
- Tuberculosis services; and
- Certain MIHP services (refer to the Maternal Infant Health Program Chapter for additional information).

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 MDHHS, 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 MDHHS website. (Refer to the Directory Appendix 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.

2.6.C. POST-STABILIZATION AUTHORIZATION DETERMINATIONS

Non-contracted hospitals are required to obtain a patient post-stabilization authorization determination from the beneficiary's MHP prior to any treatment and after stabilization. A post-stabilization authorization determination refers to the process in which inpatient hospital admission or admission to observation status is authorized by the MHP after the beneficiary has been stabilized. (Note: This applies only to MHP beneficiaries who are not dually Medicare and Medicaid eligible. MHPs may not utilize prior authorization (PA) requirements for hospital services for dual Medicare and Medicaid eligible beneficiaries enrolled in an MHP and Medicare fee-for-service.)

Hospitals are required to make and document all post-stabilization authorization requests by telephone call to the beneficiary's MHP prior to providing any treatment after stabilization. Hospitals must provide the MHP with all requested, necessary and current information, including the clinical status upon initial presentation, the clinical status after stabilization, and the initial treatment plan. This information must be provided in accordance with the Emergency Medical Treatment & Active Labor Act (EMTALA). The MHP is required to respond to post-stabilization requests within one hour of receipt of the telephone call and may not require hospitals to make additional phone calls if the initial phone call included all necessary and current clinical information. If the MHP does not respond within one hour, authorization for inpatient admission, payment and additional services is automatic.

Within one hour of the phone call in which the hospital provides the required clinical information noted above, the MHP must make an authorization decision which specifies the service authorized. The decision must be based on the information presented by the hospital at the time of the request rather than a list of pre-determined diagnoses that automatically authorize the patient for admission to observation status and not admission to the inpatient hospital. The MHP may not indicate that observation or admission will be authorized depending upon the clinical outcomes, and the MHP may not subsequently reverse an authorization decision based upon the clinical outcomes or length of time the patient remains in inpatient status. If the hospital and MHP are unable to reach agreement on an authorization decision at the time of the request, the hospital and the MHP must arrange a discussion between physicians in order to resolve the dispute.



The MHP contract requires MHPs to provide twenty-four (24) hour, seven (7) days-a-week availability for post-stabilization authorization requests. Hospitals may not wait until the next business day after stabilization to call for authorization. If the hospital does not call for authorization after stabilization prior to providing additional services, the MHP may review the clinical record at the time of request for authorization or payment to determine if inpatient hospital admission or admission to observation status was clinically appropriate.

2.7 MENTAL HEALTH

MHPs are required to provide behavioral health services 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, MHPs must coordinate with the appropriate PIHP/CMHSP to ensure that medically necessary mental health services are provided. The Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter provides coverage policies for PIHPs/CMHSPs.

2.8 CHILD AND ADOLESCENT HEALTH CENTERS AND PROGRAMS (CAHCP)

2.8.A. REQUIREMENTS

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.

2.8.B. OUTREACH SERVICES

MHPs contract with CAHCPs to provide outreach services to school-aged children on behalf of the respective plans. The following represent categories of outreach activities that CAHCPs must provide under the contracts:

- Medicaid outreach and public awareness
- Facilitating Medicaid eligibility determination
- Program planning, policy development, and interagency coordination related to Medicaid services



- Referral, coordination, and monitoring of Medicaid services
- Medicaid-specific training on outreach eligibility and services

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 MDHHS. (Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of this manual for information on substance abuse services provided through PIHPs/CMHSPs.)

2.9.A. INPATIENT

FFS covers an inpatient hospitalization designed for the purpose of detoxification in an inpatient setting. The primary diagnosis on the claim must document that the hospitalization was for the sole purpose of providing an inpatient setting for detoxification. Inpatient detoxification is only allowed under Medicaid policy under limited conditions described in the Acute Inpatient Medical Detoxification subsection of the Hospital Chapter of this manual.

MHPs cover inpatient hospitalization if the beneficiary is hospitalized for medical complications due to substance abuse. In these cases, the primary diagnosis will reflect the medical problem for which the beneficiary was admitted; substance abuse may be a secondary diagnosis. The existence of substance abuse as a secondary diagnosis does not render the admission payable by FFS under the inpatient acute detoxification exception; the MHP is responsible for the claim.

2.9.B. EMERGENCY SERVICES

If the beneficiary is subsequently admitted to an inpatient facility, the emergency services are covered as part of the DRG payment.

If the beneficiary is not admitted, payment for screening and stabilization is covered by the MHP. Hospitals must comply with authorization requirements for services beyond screening and stabilization.

If the beneficiary is not admitted and the services provided in the emergency room (beyond screening and stabilization) are for the sole purpose of treating the substance abuse, e.g., conducting an intake interview for substance abuse treatment, the regional PIHP is responsible for those services. The PIHP is not responsible for the screening and stabilization or other medical treatment provided in the emergency room even if a beneficiary's substance abuse is the underlying cause of the medical problem.

2.9.C. CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS

For beneficiaries eligible for mental health services under the MHP contract, MHPs may not deny mental health treatment due to the existence of a co-occurring substance use disorder. MHPs must provide the medically necessary mental health services whether the substance abuse diagnosis is the beneficiary's primary diagnosis or a secondary diagnosis.



While MHPs are not required to provide substance abuse treatment, the MHP should direct the plan's mental health providers to identify potential substance abuse issues. If a substance abuse issue is identified, the MHP must provide the medically necessary mental health treatment and coordinate with the appropriate Pre-Paid Inpatient Health Plan (PIHP) regarding the member's substance abuse treatment. MHPs must provide medically necessary mental health services without consideration of the member's decision to seek, or not seek, substance abuse services or on the success or failure of substance abuse treatment.

MHPs must educate providers regarding screening and referral for substance abuse issues. A document that lists the MHP and PIHP available in each county to facilitate coordination among the PIHP and MHP, as well as a listing of available telephone numbers, is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

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.

2.11 HOSPITAL 15-DAY READMISSIONS

MDHHS developed a set of readmission guidelines for hospitals and Medicaid Health Plans to utilize in determining whether a 15-day readmission should be treated as a separate admission or a combined admission for payment purposes. The guidelines and suggested discharge documentation elements provide clarification of the policy specified in this manual. The guidelines do not replace or revise the 15-day readmission policy detailed in the Hospital Chapter.

Accurate and complete documentation and discharge planning is vital to successfully implementing the readmission grid which enables the hospital and MHP to agree on whether a readmission should be separate or combined for payment purposes. The guidelines are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

Hospitals and MHPs are encouraged to work together to develop discharge documentation and planning processes that are mutually agreeable. If a hospital system utilizes discharge documentation and planning processes that provide all necessary information, MHPs should not require the hospital system to replace the existing processes with a specific documentation template developed by the MHP.

Alternatively, if a hospital system's discharge documentation and planning processes do not provide all necessary information, the hospital system should revise their existing documentation processes to include the necessary information. If the hospital system does not have a discharge documentation and planning process, the MHP and hospital should work together to develop mutually agreeable documentation processes.



SECTION 3 – CLAIMS, COPAYMENTS AND REIMBURSEMENT

MHP claim completion requirements must be consistent with MDHHS claim completion requirements as detailed in the Billing and Reimbursement chapters of this 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

Beneficiaries enrolled in an MHP may have different copayment requirements through the MHP than through FFS. The MHP copayment amount must be less than or equal to the Medicaid FFS copayment amount for the same service. Beneficiaries excluded from Medicaid FFS copayments are also excluded from MHP copayment requirements. A list of current copayments is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

3.3 PAYMENT RESPONSIBILITY WHEN ENROLLMENT STATUS CHANGES

MHPs should refer providers to the Billing and Reimbursement chapters of this 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.



SECTION 4 - MEDICAID HEALTH PLAN RATES

4.1 GENERAL INFORMATION

Federal regulations (42 CFR 438.6) require rates paid by the State of Michigan to MHPs to be actuarially sound. The State of Michigan contracts with a certified actuary to develop actuarially sound rates for the MHPs. Rates are not included in the MHPs competitive bid process and, therefore, the MHPs are not required to certify rates as actuarially sound. Under this methodology, the State's Actuary establishes a rate range for each rate cell covered under the Comprehensive Health Care Program. As mandated by the federal requirement, the State's Actuary certifies these rates are actuarially sound. There is no federal requirement that rates be actuarially sound for a particular MHP.

Actuarially sound rates for MHPs are capitation rates that meet the following requirements:

- Developed in accordance with generally accepted actuarial principles and practices.
- Appropriate for the populations included and services covered under the State's contract with the MHPs.
- Certified as meeting all requirements for actuarial soundness by actuaries who meet the qualification standards established by the American Academy of Actuaries and who follow the practice standards established by the Actuarial Standards Board.

4.2 RATE CATEGORIES

In order to establish actuarially sound rates, MDHHS establishes separate rate cells based on the following classifications:

- Aid program category
- Age
- Gender
- Region
- Maternity case rate

For enrollees in the Blind and Disabled program category, Michigan utilizes the Chronic Illness and Disability Payment System (CDPS) to adjust the MHP capitation rates. Under CDPS, diagnosis coding (as reported on claim and encounter transactions) is used to compute a score for each individual. Individuals with inadequate eligibility history are excluded from these calculations. For qualifying individuals, these scores are aggregated into an average case-mix value for each contractor based on its enrolled population. The regional rate for the Blind and Disabled program category is multiplied by the average case mix value to produce a unique case mix adjusted rate for each MHP. The aggregate impact is budget or rate neutral. MDHHS fully re-bases the risk adjustment system annually.



4.3 DATA METHODOLOGY

MDHHS has a generally consistent approach to the rate development and certification methodology. The approach incorporates the factors recommended by the American Academy of Actuaries, including the following criteria:

- Base utilization and cost data are derived from the population covered under the MHP contract to the extent that adequate accurate information on this population is available to the State's Actuary at the time of rate development and certification.
- Base utilization and cost data are derived from the population comparable to the population covered under the MHP contract.
- Base utilization and cost data are derived from the set of covered services under the MHP contract.
- Adjustments may be made to smooth data and account for factors such as incomplete data.
- Assumptions may be made related to medical trend inflation, MHP administration, and projected utilization.
- Rate cells are specific to the enrolled population.
- Assumptions may be made related to payment mechanism, utilization, and cost appropriate for individuals with chronic illness, disability, risk adjustment or other appropriate cost-neutral methods.
- Assumptions are based on the State Actuary's professional judgment regarding the appropriateness of adjustments to the base year data.

4.4 DATA SOURCES

The annual rate development methodology for the establishment of actuarially sound rates utilizes some or all of the following data sources:

- Fee for service (FFS) data for individuals eligible for Medicaid.
- FFS data for the 12 months preceding the individual's enrollment into the MHP.
- Aggregate MHP financial and/or encounter data.
- MHP annual financial filings reported to the Department of Insurance and Financial Services (DIFS) up to 36 months preceding the date that the proposed rates were established by MDHHS.
- Other data available to MDHHS that is for the covered population and which is identified in the report produced by MDHHS.

MDHHS utilizes the data source deemed most appropriate by the State's Actuary dependent upon data availability and data accuracy.



4.5 PUBLIC REVIEW OF DATA METHODOLOGY

MDHHS shall produce for public review a report that includes the proposed MHP rates, documentation of the rate development, and actuarial certification prior to formal submission to the federal government. As recommended by the American Academy of Actuaries, the report shall include a description of the relevant data, sources of data, material assumptions, and methodology by which the rates were developed.



SECTION 5 – MEDICAID HEALTH PLAN PROVIDER ENROLLMENT

MHPs are prohibited from making payments to all typical network and out-of-network Michigan providers who appear on a claim and are not enrolled in CHAMPS. Typical providers are professional health care providers who provide health care services to beneficiaries. Typical providers must meet education and state licensure requirements and have assigned National Provider Identifiers (NPIs). Examples of typical provider types include, but are not limited to, physicians, physician assistants, certified nurse practitioners, dentists and chiropractors.

A list of currently allowed typical provider enrollment information is available on the MDHHS Provider Enrollment website. Providers not included on the allowed list are not required to enroll. The Provider Enrollment website is updated periodically. Any updates to the MDHHS Provider Allowed Enrollment lists will be subject to provider enrollment requirements. (Refer to the Directory Appendix for website information.)

MDHHS does not prohibit payment to out-of-state, out-of-network pharmacies and providers who provide Medicaid beneficiaries with emergency medical services. Payment for out-of-state, out-of-network medical services are subject to Medicaid policy and applicable health policies and procedures. (Refer to the Out-of-Network Services subsection of this chapter for additional information.)

Refer to the General Information for Providers Chapter, Provider Enrollment section of this manual for additional provider enrollment information.



MEDICAL SUPPLIER

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SECTION 1 – PROGRAM OVERVIEW [CHANGE MADE 4/1/20]

This chapter applies to Medical Suppliers/Durable Medical Equipment and Orthotists/Prosthetists.

(text deleted per bulletin MSA 19-37)

The primary objective of the Medicaid Program is to ensure that medically necessary services are made available to those who would not otherwise have the financial resources to purchase them.

The primary objective of the Children's Special Health Care Services (CSHCS) Program is to ensure that CSHCS beneficiaries receive medically necessary services that relate to the CSHCS qualifying diagnosis.

This chapter describes policy coverage for the Medicaid Fee-for-Service (FFS) population and the CSHCS population. Throughout the chapter, use of the terms Medicaid and Michigan Department of Health and Human Services (MDHHS) includes both the Medicaid and CSHCS Programs unless otherwise noted.

Medicaid covers the least costly alternative that meets the beneficiary's medical need for medical supplies, durable medical equipment or orthotics/prosthetics.

Below are common terms used throughout this chapter:

<p>Medical Supplies</p>	<p>Health care related items that are required to address an individual’s illness, injury or disability; are consumable, disposable or have a limited life expectancy, cannot withstand repeated use, and are suitable for use in any non-institutional* setting in which normal life activities take place. Examples are: hypodermic syringes/needles, ostomy supplies, and dressings necessary for the medical management of the beneficiary. Medical supplies are items covered that:</p> <ul style="list-style-type: none"> ▪ Treat a medical condition. ▪ Prevent unnecessary hospitalization or institutionalization. ▪ Support Durable Medical Equipment (DME) used by the beneficiary.
<p>Durable Medical Equipment (DME)</p>	<p>Equipment that can withstand repeated use, is reusable or removable, is suitable for use in any non-institutional* setting in which normal life activities take place, is primarily and customarily used to serve a medical purpose, and is generally not useful to an individual in the absence of illness, injury or disability. Examples are: hospital beds, wheelchairs, and ventilators. DME is a benefit for beneficiaries when:</p> <ul style="list-style-type: none"> ▪ It is medically and functionally necessary to meet the needs of the beneficiary. ▪ It may prevent frequent hospitalization or institutionalization. ▪ It is life sustaining.
<p>Mobility Related Activities of Daily Living (MRADL)</p>	<p>Daily activities (e.g., grooming, dressing, toileting, etc.) the beneficiary is able to perform with the aid of mobility equipment.</p>



Orthotics	<p>Orthotics assist in correcting or strengthening a congenital or acquired physical anomaly or malfunctioning portion of the body. Orthotics are a benefit to:</p> <ul style="list-style-type: none"> ▪ Improve and/or restore the beneficiary's functional level. ▪ Prevent or reduce contractures. ▪ Facilitate healing or prevent further injury.
Prosthetics	<p>Prosthetics artificially replace a portion of the body to prevent or correct a physical anomaly or malfunctioning portion of the body. Prosthetics are a benefit to:</p> <ul style="list-style-type: none"> ▪ Improve and/or restore the beneficiary's functional level. ▪ Enable a beneficiary to ambulate or transfer.

*MDHHS considers an institution to be a nursing facility, hospital or intermediate care facility for individuals with intellectual disabilities.

Durable medical equipment, medical supplies and orthotics must be registered with the Food and Drug Administration, except for custom-fabricated items. (Refer to the Standard Equipment and Custom-Fabricated Seating and the Noncustom versus Custom-Fabricated subsections for additional information.)

1.1 PROVIDER TYPES

Services provided must be appropriate for the specified provider types according to the CHAMPS Provider Enrollment (PE) on-line application. The provider types and the services they may provide are as follows:

Orthotist and Prosthetist	<ul style="list-style-type: none"> ▪ Prefabricated, custom-fitted and custom-fabricated orthoses and prostheses ▪ Medical supplies related to orthotics and prosthetics (e.g., stump socks, etc.) ▪ Shoes
Medical Supplier	<ul style="list-style-type: none"> ▪ Durable medical equipment (including oxygen) ▪ Medical supplies ▪ Prefabricated and specific custom-fitted orthoses (custom-fitting may only include simple or minor intervention) ▪ Shoes
Shoe Store	<ul style="list-style-type: none"> ▪ Shoes, selected shoe inserts and additions

1.1.A. PROVIDER ENROLLMENT [SUBSECTION ADDED 4/1/20]

Providers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) must be enrolled as a Medicare provider effective September 30, 2009. Each DMEPOS provider must enter their Medicare Provider Transaction Access Number (PTAN) in the CHAMPS Provider Enrollment subsystem. (Refer to the General Information for Providers chapter for provider enrollment policy that applies to all providers.)

To be eligible to enroll as a Medicaid DMEPOS provider, applicants must be compliant with policy indicated in the General Information for Providers chapter and all of the following:



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- The provider must be compliant with all federal and state licensing, certification and regulatory requirements.
- The provider must have a national provider identifier (NPI) for each location and may not allow another entity to use that billing NPI (separate enrollment is required for each location serving Medicaid beneficiaries).
- The provider must be accredited (separate accreditation per location) by one of the Centers for Medicare & Medicaid Services (CMS) approved accreditation organizations (AOs) and must indicate the specific DMEPOS items approved under that accreditation for that location (CMS-determined pharmaceutical exemptions apply).
- The provider must permit MDHHS to conduct on-site inspections to evaluate the provider's compliance with State and Federal DMEPOS standards.
- The provider must have a primary business telephone listed under the business name in a local directory or a toll-free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during business hours is prohibited.
- The provider must fill orders from its own inventory or contract with other companies for the purchase of items necessary to fill orders. The provider may not contract with any entity that is excluded from Medicare, Medicaid or any other federally funded program. Provider use of distributors or contracted supply companies is acceptable if the provider follows Medicare DMEPOS standards and Medicaid policy regarding delivery, record keeping and education on the use of the item(s).
- The provider must accept beneficiary returns of substandard, defective or unsuitable items.
- The provider must notify the beneficiary of warranty coverage, honor all warranties under applicable State law, and repair or replace free of charge Medicaid-covered items under that warranty.
- The provider must provide maintenance, replacement or repair at no charge to the beneficiary or Medicaid, either directly or through a service contract with another company, during the Medicaid rental period.
- The provider is responsible for delivery, set-up and education on the use of the DMEPOS item(s) and must maintain proof of delivery and education in the beneficiary file. The delivery ticket must include the beneficiary's (or beneficiary guardian/appointee's) signature and date as confirmation of receipt. Provider use of courier or shipping services is acceptable if the DMEPOS provider follows current policy requirements for delivery, record keeping and education on the use of the item(s).
- The provider must answer beneficiary questions, respond to complaints, and maintain documentation of such contact(s) in the beneficiary file.
- The provider must have a complaint resolution protocol to address beneficiary complaints. Records of complaints must be maintained at the physical location. The complaint record must include the name, address, telephone number and Medicaid ID number of the beneficiary, complaint summary, and actions taken to resolve the complaint.



- All provider locations, whether owned or subcontracted, must meet the Medicare DMEPOS Supplier Standards (including, but not limited to, surety bond and liability insurance requirements) and Medicare quality standards.
- The provider must display on-site all licensing, certifications and accreditations, as applicable (out-of-state and borderland providers must be licensed and/or certified by the appropriate standard-setting authority in the state they are practicing).
- To be considered “in-state,” the provider must have a physical storefront located within Michigan (or within the borderland areas of adjoining states). The location must be accessible to the public (including handicap accessible), be open for business for no less than 30 hours a week, be staffed during business hours, and maintain a visible sign with posted hours of business. Occupational therapists, physical therapists, and orthotic and prosthetic providers of custom orthotics and prosthetics are exempt from the 30 hour per week business rule but must comply with the accessibility and signage portions of the rule. (Out-of-state providers should refer to the Out of State/Beyond Borderland Providers subsection in the General Information for Providers Chapter for additional information.)
- The location must contain space for and have beneficiary records on site. For electronic health records, it is preferred that electronic health record systems be contained on the Certified Health IT Product List (CHPL) as published and maintained by the Office of the National Coordinator for Health Information Technology (ONC). Records must be made available upon MDHHS request.
- The location must display equipment/supplies provided and have inventory on site (custom-made items are exempt).
- The provider may not share space with other Medicare or Medicaid healthcare entities except for the following:
 - The provider is also enrolled as a pharmacy and owned by the same entity; or
 - The provider is hospital-owned and located within the hospital or a hospital-owned clinic.

NOTE: Separately identified physical space (e.g., clearly identified suites) within the same building is not considered “sharing space” if each space/location is recognized by the United States Postal Service (USPS) as a separate physical address.

Michigan Medicaid does not enroll warehouses or distribution centers as the function of these entities is to ship/store products and are not considered a storefront. **(text added per bulletin MSA 19-37)**

1.2 MDHHS MEDICAL SUPPLIER/DME/PROSTHETICS AND ORTHOTICS DATABASE

For specifics regarding the Healthcare Common Procedure Coding System (HCPCS) codes used to denote covered services, refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter or the Medicaid Code and Rate Reference tool for more information. (Refer to the Directory Appendix for website information.) Information includes the HCPCS codes, short description, designated modifiers, quantity limits, prior authorization (PA) indicator, fee screens, ICD diagnosis codes, and whether the item may be billed by a medical supplier if the beneficiary resides in a



nursing facility. If there is no established procedure code that adequately describes the item, use the appropriate Not Otherwise Classified (NOC) HCPCS procedure code.

1.2.A. HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) CODES

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirement, as defined by the Code of Federal Regulations (CFR) under 45 CFR 162.10002 for standardized coding systems, established HCPCS level II codes as the standardized coding system for describing and identifying health care equipment and supplies in health care transactions that are not identified by HCPCS level I or Current Procedural Terminology (CPT) codes.

HCPCS is a system for identifying items and services. It is not a system for making coverage or payment determinations, and the existence of a code does not determine coverage or non-coverage of an item or service. Decisions regarding the addition, deletion, or revision of HCPCS codes are made independent of the process for determination of coverage and payment.

National permanent codes are maintained by the Centers for Medicare & Medicaid Services (CMS) HCPCS Workgroup. The Workgroup is responsible for making decisions about additions, revisions, and deletions to the permanent national alpha-numeric codes. The permanent national codes serve the function of providing a standardized coding system that is managed jointly by private and public insurers.

National codes also include miscellaneous/not otherwise classified (NOC) codes. These codes are used when a medical supplier submits a bill or request for an item or service where there is no existing national code that adequately describes the item or service. Before using a miscellaneous/NOC code, the medical supplier should check with the Medicare Pricing, Data Analysis and Coding (PDAC) contractor to determine whether there is a specific code that should be used. (Refer to the Directory Appendix for contact and website information.)

When submitting a bill or request, medical suppliers are required to use HCPCS codes to identify items. The descriptor assigned to a code represents the definition of the item/service that can be billed using that code. MDHHS reserves the right to determine and apply correct HCPCS codes used for the purpose of reimbursement.

1.3 FACE-TO-FACE (F2F) VISIT REQUIREMENTS

Section 6407 of the Patient Protection and Affordable Care Act (ACA) of 2010 and Section 504 of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) of 2015 require a face-to-face (F2F) visit with a physician or non-physician practitioner (NPP) prior to the initial written order for specific durable medical equipment and medical supplies. The Centers for Medicare & Medicaid Services maintains the list of specified items that require a face-to-face visit. The Durable Medical Equipment Face-to-Face List is posted on the MDHHS website. (Refer to the Directory Appendix for provider-specific webpage information.)



1.3.A. F2F VISIT

Prior to the initial written order and delivery of selected durable medical equipment and medical supplies (some accessories), the beneficiary must have a face-to-face visit with a physician or NPP within six months prior to the initial written order. The visit must be related to the primary condition that supports the medical need for the equipment or supply. Telemedicine visits (refer to the Practitioner Chapter) qualify as face-to-face visits. A new face-to-face visit is required for the following:

- Initial order for rental/purchase;
- New prescription/order,
- Replacement of the base equipment;
- When there is a change in the prescription/order of the item;
- When there is a change in the supplier of the item and the new supplier is unable to obtain a copy of the original order and documentation from the original supplier; and
- When there is change in state or federal law, policies or regulations.

1.3.B. PRACTITIONERS WHO MAY PERFORM THE FACE-TO-FACE VISIT

The face-to-face evaluation may be provided by a physician (MD or DO) or any of the following NPPs:

- Physician Assistant (PA)
- Certified Nurse Practitioner (NP)
- Certified Clinical Nurse Specialist (CNS)

Although the PA, NP or CNS may conduct the face-to-face visit, they may not write prescriptions/orders for the specified equipment or medical supplies, and the physician must certify that the face-to-face occurred.

1.3.C. PHYSICIAN CERTIFICATION OF THE FACE-TO-FACE VISIT

The ordering physician must certify that a face-to-face visit occurred within six months prior to the written order whether he/she performed the visit or another treating or attending physician or NPP performed the visit. The physician must document the date of the face-to-face visit and specify the name of the practitioner who performed the evaluation, document the clinical findings that support the need for the item(s), and confirm the primary reason for the visit that relates to the need for the item(s).

A treating or attending physician (e.g., inpatient hospital physician) may conduct the face-to-face visit and order the item(s) if all criteria of the face-to-face rules are met. If the treating or attending physician performs the face-to-face evaluation but does not write the initial order; he/she must communicate the details of the visit to the ordering physician.



Documentation of the face-to-face visit may be indicated on the prescription/order, the certificate of medical necessity (CMN), or other medical record. A copy of the face-to-face visit must be kept in the beneficiary's file and the original sent to the durable medical equipment (DME) supplier. Upon receipt, the DME supplier must date stamp the face-to-face documentation and maintain the documentation in the beneficiary file. The face-to-face documentation must be available upon MDHHS request. For items requiring a prior authorization, the documentation of the face-to-face visit must accompany other required documentation with the prior authorization request.

1.3.D. FACE-TO-FACE PRESCRIPTIONS/ORDERS

DME and medical supplies that require a face-to-face visit may only be ordered by a physician regardless of State licensing rules that may allow NPPs to write orders.

MDHHS recommends the ordering physician include the face-to-face visit information on the written order or CMN; however, it is acceptable for this information to be indicated on other medical documentation (e.g. discharge summary). If the ordering physician chooses to document the face-to-face visit on the order, he/she must include the date of the visit, the name of the physician or NPP that performed the evaluation, and document the visit was related to the primary condition that supports the need for the item(s).

The face-to-face visit requirement applies to initial orders and not to supply refills, equipment repairs, the servicing of equipment, or to accessories (except for those accessories indicated on the CMS list). The ordering physician must assess the continued need for the medical supply or equipment on an annual basis. For refills of supplies, the ordering physician must indicate "renewal" on the order.

1.3.E. BILLING FACE-TO-FACE ITEMS

For items requiring a face-to-face visit, the KX modifier must be appended to the HCPCS code on the claim. The KX modifier indicates that policy requirements have been met and that documentation is on file and available upon request. Adding the KX modifier on the claim if the face-to-face documentation has not been received and/or is not in the beneficiary file is incorrect billing and could result in post-payment recovery of funds or provider audit.

1.3.F. HOME HEALTH AGENCIES PROVIDING DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES

The ACA requires home health agencies (HHAs) to provide medically necessary durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) either directly or through arrangement with DME providers when providing home health nursing or aide services.

Except for items identified in the Home Health chapter as routine medical supplies, and those items listed on the Home Health database as separately reimbursed to HHAs, HHAs choosing to provide DMEPOS must enroll with Medicaid as DME providers. HHAs must comply with all federal and state DMEPOS provider rules, policies, and regulations.



(Refer to the General Information for Providers chapter and the Home Health chapter for additional information.)

1.4 PLACE OF SERVICE

Medicaid covers medical supplies, durable medical equipment (DME), orthotics, and prosthetics for use in any non-institutional setting in which normal life activities take place except for skilled nursing facilities, nursing facilities, or intermediate care facilities for individuals with intellectual disabilities.

For residents in a skilled nursing or nursing facility, most medical supplies and/or DME are considered as part of the facility's per diem rate. Wheelchair requests for the primary purpose of meeting resident nursing care needs that are the responsibility of the nursing facility are not covered. Wheelchairs for social or recreational purposes are the responsibility of the nursing facility. The Nursing Facility Chapter further describes coverage policy in the nursing facility. The following items are exempt from the per diem rate and must be billed by the medical supplier:

- Air-fluidized beds
- Bariatric beds
- Custom-fabricated seating systems may be covered outside of the nursing facility per diem rate when a standard item will not meet the medical and functional needs of the user and standards of coverage are met.
- Gaseous oxygen and equipment if required by the beneficiary for frequent or prolonged use (eight or more hours of use on a daily basis)
- Orthotics and Prosthetics
- Parenteral nutrition, including all supplies, equipment, and solutions
- Powered air flotation bed (low air loss therapy)
- Selected surgical dressings
- Shoes and Additional Components

To determine the acceptable place of service (POS) codes allowed for billing purposes, refer to the Billing & Reimbursement for Professionals Chapter of this manual.

In an outpatient facility, all equipment and services required for treatment during an emergency room or clinic visit are included in the reimbursement to the hospital (e.g., cervical collar, air cast).

In an inpatient hospital setting, services provided as part of the hospital care and treatment would be part of the DRG payment to the hospital (e.g., cervical collar or cast). Services provided to be used after discharge and delivered to the hospital to facilitate discharge may be reimbursed to the medical supplier (e.g., oxygen, walker, wheelchair).

MDHHS does not separately reimburse DMEPOS providers for services related to the beneficiary's terminal illness when the beneficiary is enrolled in a hospice program. All DMEPOS services related to the beneficiary's terminal illness are either arranged for (via contract agreement) and reimbursed by, or provided by, the hospice program. Refer to the Hospice chapter for additional information about hospice services.



1.5 AGE FACTORS

Coverage of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) may differ based on the beneficiary's age. When age factors exist, the DMEPOS provider can submit a prior authorization request for consideration of coverage beyond the policy standards of coverage. For specifics of HCPCS codes and age parameters, refer to the Coverage Conditions and Requirements section and the Healthcare Common Procedure Coding System (HCPCS) Codes subsection of this chapter and to the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)

1.6 MEDICAL NECESSITY

Medicaid covers medically necessary durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) for beneficiaries of all ages. DMEPOS are covered if they are the least costly alternative that meets the beneficiary's medical/functional need and meet the Standards of Coverage stated in the Coverage Conditions and Requirements Section of this chapter.

The medical record must contain sufficient documentation of the beneficiary's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement. The information should include the beneficiary's diagnosis, medical condition, and other pertinent information including, but not limited to, duration of the condition, clinical course, prognosis, nature and extent of functional limitations, other therapeutic interventions and results, and past experience with related items. Neither a physician, clinical nurse specialist (CNS), nurse practitioner (NP) or physician assistant (PA) order nor a certificate of medical necessity by itself provides sufficient documentation of medical necessity, even though it is signed by the treating/ordering physician, CNS NP or PA. Information in the medical record must support the item's medical necessity and substantiate that the medical device needed is the most appropriate economic alternative that meets MDHHS standards of coverage.

Medical equipment may be determined to be medically necessary when all of the following apply:

- The service/device meets applicable federal and state laws, rules, regulations, and MDHHS promulgated policies.
- It is medically appropriate and necessary to treat a specific medical diagnosis, medical condition, or functional need, and is an integral part of the nursing facility daily plan of care or is required for the community residential setting.
- The safety and effectiveness of the product for age-appropriate treatment has been substantiated by current evidence-based national, state and peer-review medical guidelines.
- The function of the service/device:
 - meets accepted medical standards, practices and guidelines related to:
 - type,
 - frequency, and
 - duration of treatment; and
 - is within scope of current medical practice.
- It is inappropriate to use a nonmedical item.



- It is the most cost effective treatment available.
- The service/device is ordered by the treating physician, NP or PA (for CSHCS beneficiaries, the order must be from the pediatric subspecialist) and clinical documentation from the medical record supports the medical necessity for the request (as described above) and substantiates the practitioner's order.
- The service/device meets the standards of coverage published by MDHHS.
- It meets the definition of Durable Medical Equipment (DME) as defined in the Program Overview section of this chapter.
- Its use meets FDA and manufacturer indications.

MDHHS does not cover the service when Medicare determines that the service is not medically necessary.

Medicaid will not authorize coverage of items because the item(s) is the most recent advancement in technology when the beneficiary's current equipment can meet the beneficiary's basic medical/functional needs.

Medicaid does not cover equipment and supplies that are considered investigational, experimental or have unproven medical indications for treatment.

Refer to the Prior Authorization subsection of this chapter for medical need of an item beyond the MDHHS Standards of Coverage.

NOTE: Federal EPSDT regulations require coverage of medically necessary treatment for children under 21 years of age, including medically necessary habilitative services. Refer to the Early and Periodic Screening, Diagnosis and Treatment Chapter for additional information.

The Healthy Michigan Plan (HMP) covers habilitative services for all ages. Refer to the Healthy Michigan Plan Chapter for additional information.

1.6.A. PRESCRIPTION REQUIREMENTS

A prescription must contain all of the following:

- Beneficiary's name;
- Beneficiary's date of birth (DOB);
- Beneficiary ID number or Social Security Number (SSN) (if known);
- Prescribing physician's, NP's or PA's name, address, and telephone number;
- Prescribing physician's, NP's or PA's signature (a stamped or co-signature will not be accepted);
- The date the prescription was written;
- The specific item prescribed;
- The amount and length of time that the service is needed; and
- Start date of order if different from the physician's, NP's or PA's signature date.



The prescription must meet the following timeframes:

- For medical supplies, refills may be allowed up to one year from the original physician's signature date on the prescription.
- For oxygen, ventilators, and other long-term use, up to one year from the original physician signature date.
- For purchase of DME, the original physician signature date must be within the last 180 days.
- For orthotics and prosthetics, the original physician signature date for an initial service must be within the last 60 days. For replacement of an orthosis or prosthesis, the physician signature date must be within the last 180 days.

A new prescription will be required when there is a change in the beneficiary's condition causing a change in the item or the frequency of its use.

The provider may complete a detailed description of the item with applicable HCPCS procedure codes, but the treating physician must review this description and personally sign and date the order to indicate agreement. The provider may not change or modify a prescription, certificate of medical necessity (CMN), or any other physician or healthcare practitioner's signed documentation.

For beneficiaries eligible for CSHCS coverage only, the following additional requirements apply:

- The prescription must be related to the CSHCS qualifying diagnosis. (Providers must verify this information by referring to the beneficiary's eligibility letter received from CSHCS.)
- A physician subspecialist must sign the prescription if it is stated as required by the CSHCS Program in the Coverage Conditions and Requirements Section of this chapter.

MDHHS reserves the right to request additional documentation from a specialist for any beneficiary and related service on a case-by-case basis if necessary to determine coverage of the service.

Note: Refer to the Face-to-Face (F2F) Visit Requirements subsection for timelines, additional documentation requirements, and ordering/prescribing/evaluation requirements.

1.6.B. AUTOMATIC REFILLS

Automatically issuing refills of medical supplies to beneficiaries results in unnecessary expenditures and/or unused products.

The standard physician order for medical supplies is written for monthly refills. The beneficiary or his/her representative must verify that the refill is necessary and confirm any changes/modifications at the time the monthly refill is ordered.



Automatic refills of medical supplies without receiving prior customer approval or a request for a refill is considered program abuse. Subsequent refills should not be confirmed or issued any earlier than five to seven days prior to the end of the last monthly order.

For audit purposes, provider records should document this contact for products shipped to the beneficiary's home.

1.6.C. DOCUMENTATION

The Coverage Conditions and Requirements Section of this chapter specifies the documentation requirements for individual service areas. Additional information other than what is required on the prescription may be required. To provide this information, Medicaid accepts a certificate of medical necessity (CMNs will be mandatory for electronic PA), a letter or a copy of applicable medical record. The prescribing physician must sign all documentation and the documentation (if a letter or applicable medical records) must state the beneficiary's name, DOB and ID number (if known) or SSN (if known).

1.6.D. CERTIFICATE OF MEDICAL NECESSITY REQUIREMENTS

A CMN must contain all of the following:

- Beneficiary's name and address;
- Beneficiary's date of birth (DOB);
- Beneficiary ID number (if initiated by the provider) or SSN;
- Prescribing physician's signature, date of signature, telephone number;
- The suppliers' name and address;
- The expected start date of the service (if different from the prescription date);
- A complete description of the item;
- The amount and length of time the item is needed;
- Beneficiary's diagnosis; and
- The medical necessity of the item.

For specifics, refer to the Coverage Conditions and Requirements section and the Face-to-Face (F2F) Visit Requirements subsection of this chapter.

MDHHS will accept a CMN initiated by a medical supplier, orthotist or prosthetist. However, only the beneficiary identifier fields and the areas detailing the description of the item with applicable HCPCS procedure codes are to be completed by the provider. The physician must complete the CMN by writing the medical reason or necessity for the specific item being requested. A medical supplier, orthotist, or prosthetist may not alter or write the medical reason or necessity for the item requested.



Additional documentation (including the CMN) must be current and within the timeframe stated in the Coverage Conditions and Requirements Section of this chapter, under Documentation for each item.

1.7 DOCUMENTATION IN BENEFICIARY FILE

The medical supplier must maintain clean, reproducible copies of all required documentation for the specific medical device, including the physician's order, the MSA-1656 (and Addendum A and/or Addendum B, as applicable), the MSA-1653-B, and the MSA-1653-D in the beneficiary's file for seven years. For audit purposes, the supplier's records or beneficiary's medical record must contain the prescription and required documentation that substantiates the medical necessity of the item supplied. In addition to the prescription and any applicable documentation required, the provider must maintain on file:

- Equipment use logs or other provider required documentation as stated in the Coverage Conditions and Requirements Section of this chapter under Documentation for the item.
- For items purchased, proof of purchase (e.g., delivery slips, sales slips, vouchers).
- For items rented, set-up slips and pick-up slips with signature of beneficiary or legal representative, and maintenance records.
- For items shipped directly to the beneficiary, the date of delivery must be maintained in the records with delivery slip. It is the provider's responsibility to replace a service for which the beneficiary states was not received without additional cost to MDHHS or the beneficiary.
- Proof of education and instruction to beneficiary and/or caregiver regarding the proper usage of equipment and/or supplies when applicable (e.g., delivery slip signed by beneficiary).
- Documentation of the face-to-face visit (if applicable).

1.8 PRIOR AUTHORIZATION

Prior authorization (PA) is required for certain items before the item is provided to the beneficiary or, in the case of custom-fabricated DME or prosthetic/orthotic appliances, before the item is ordered. To determine if a specific service requires PA, refer to the Coverage Conditions and Requirements Section of this chapter and the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)

PA will be required in the following situations:

- Services that exceed quantity/frequency limits or established fee screens.
- Medical need for an item beyond the MDHHS Standards of Coverage.
- Use of a Not Otherwise Classified (NOC) code.
- More costly service for which a less costly alternative may exist.
- Procedures indicating PA is required as noted in the Medicaid Code and Rate Reference tool.



Prior authorization coverage determinations are based on the evaluation of the documentation received and all of the following:

- The beneficiary's benefit plan scope and coverages (e.g., Emergency Services Only);
- Food and Drug Administration (FDA) and manufacturer product intended usage(s);
- Healthcare Common Procedure Coding System (HCPCS) Level II code definitions as deemed by the American Medical Association; and
- The safety and effectiveness of the product for age-appropriate treatment as substantiated by current evidence-based national, state and peer-review medical guidelines.

MDHHS reserves the right to a final determination of whether the practitioner's submitted medical documentation sufficiently demonstrates the medical necessity for the services requested.

Beneficiaries may request a fair hearing in accordance with 42 CFR Part 431 Subpart E for any MDHHS coverage denials. (Refer to the General Information for Providers chapter for additional information.)

1.8.A. PRIOR AUTHORIZATION FORM

Requests for PA must be submitted on the Special Services Prior Approval-Request/Authorization form (MSA-1653-B) or, for mobility and custom seating items, submit the Complex Seating and Mobility Device Prior Approval-Request/Authorization form (MSA-1653-D). (Refer to the Forms Appendix for a copy of the PA form and completion instructions.) In addition, the medical documentation specific to each type of device requested must accompany the form. The information on the PA request form must be:

- Typed – All information must be clearly typed in the designated boxes of the form.
- Complete – The provider must use the specific HCPCS code and the code description. A NOC code may not be used unless the use of a NOC code for the item has been approved by the PDAC. The brand, model, product or part number must be stated on MSA-1653-B or MSA-1653-D with the appropriate HCPCS code and description. The prescription and medical documentation must be submitted with the request. (Refer to the Coverage Conditions and Requirements section of this chapter for additional information regarding standards of coverage and payment rule requirements.)

PA request forms and attached documentation may be mailed or faxed to the MDHHS Program Review Division. (Refer to Directory Appendix for contact information.)

Instructions for the electronic submission of PA requests and the HIPAA 278 transaction code set are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

1.8.B. EVALUATION AND MEDICAL JUSTIFICATION FOR COMPLEX SEATING SYSTEMS AND MOBILITY DEVICES FORM

The Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices form (MSA-1656) provides a standard assessment tool for a licensed medical professional to use when performing assessments for wheelchairs, seating systems, and



pediatric standing systems. The form is required for all ages and covered settings. (Refer to the Forms Appendix for a copy of the form and form completion instructions.)

The MSA-1656 serves as a baseline evaluation for the beneficiary and is a clinical assessment that also includes an assessment of current technology options available to meet the beneficiary's medical and functional goals. The evaluation process assists the evaluator in determining the most appropriate level of equipment that will aid the beneficiary in completing mobility related activities of daily living (MRADL). Once problems and goals are determined, the process includes a patient simulation trial using comparable loaner or demonstration technology. The patient simulation is performed jointly by the clinician and a qualified assistive technology practitioner.

The initial MSA-1656 is retained on file by MDHHS. A new MSA-1656 is not required for additions or revisions to a seating system or mobility item unless there is a change in the beneficiary's functional status.

- Addendum A: Mobility/Seating – This form must be completed and submitted with MSA-1656 and MSA-1653-D when requesting complex seating, a manual wheelchair with accessory add-ons, power wheelchairs, scooters, and power accessories. The evaluator must complete only the sections that apply to the requested equipment and accessories.
- Addendum B: Strollers, Gait Trainers, Standers, Car Seats, and Children's Positioning Chairs – This form must be completed and submitted with MSA-1656 and MSA-1653-D when requesting these items. The evaluator must complete only the sections that apply to the requested equipment and accessories.

Form completion instructions describe the responsibilities of the treating physician, the physical and occupational therapist, the medical supplier, and the nursing facility staff (when appropriate).

The MSA-1656 must be submitted within 90 days of the date the evaluation was completed. Completion/submission of the MSA-1656 without supporting documentation from the medical record is not acceptable. The use of medical supplier-created mobility forms or "canned" documentation statements are not acceptable and may not be used as a substitute for information from the medical record or for completion of required MDHHS forms.

The outpatient therapy provider or the nursing facility may bill for the mobility and seating assessment performed by the licensed medical professional using HCPCS code 97542.

1.8.C. EMERGENCY PRIOR AUTHORIZATION

A provider may contact MDHHS to obtain a verbal PA when the prescribing physician has indicated that it is medically necessary to provide the service within a 24-hour time period.

To obtain a verbal PA, the provider may call the Program Review Division or fax a request. (Refer to the Directory Appendix for contact information. Refer to the Forms Appendix for copies of forms MSA-1653-B and MSA-1653-D and completion instructions.)



If an emergency service is required during nonworking hours (i.e., after 4:00 p.m., weekends, and State of Michigan holidays), the provider must contact the Program Review Division on the next available working day.

The following steps must still be completed before an actual PA number is issued for billing purposes:

- Submission of the PA request to MDHHS within 30 days of the verbal authorization. (Refer to the Forms Appendix for copies of forms MSA-1653-B and MSA-1653-D and completion instructions.)
- Submission of the supporting documentation (e.g., prescription and CMN, physician letter, or applicable medical record).

The PA number will not be given for billing MDHHS and the provider will not be reimbursed if:

- The beneficiary was not eligible when the service was provided.
- A completed PA request (MSA-1653-B) is not received within 30 days of the verbal authorization.
- Required prescription and documentation is not received.
- The prescription and/or documentation are not signed within 30 days of the effective date.
- The prescription and/or documentation are not received within 30 days of the date of service (DOS).
- The medical need for the service is different than what was verbally given and does not fall within the Standards of Coverage.

Verbal authorization does not guarantee payment or eligibility.

1.8.D. RETROACTIVE PRIOR AUTHORIZATION

Services provided before PA is requested will not be covered unless the beneficiary was not eligible on the DOS and the eligibility was made retroactive. If the MDHHS record does not show that retroactive eligibility was provided, then the request for retroactive PA will be denied.

1.8.E. BENEFICIARY ELIGIBILITY

Approval of a service on MSA-1653-B or MSA-1653-D confirms that the service is authorized for the beneficiary. The approval does not guarantee that the beneficiary is eligible for Medicaid. If the beneficiary is not eligible on the DOS or is enrolled in a Medicaid Health Plan (MHP) and the provider orders or delivers the service, MDHHS will not reimburse the provider. To assure payment, the provider must verify eligibility prior



to ordering or delivering the service. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.)

When equipment is prior authorized (if required) and ordered but not delivered before the loss of eligibility, MDHHS will pay for the service if the product is delivered within 30 days after the loss of eligibility.

1.8.F. CHANGES IN ENROLLMENT (FFS/MHP)

When beneficiaries change enrollment status (e.g., from managed care to FFS or FFS to managed care), the following applies:

- When custom-fabricated equipment (prosthetic or orthotic) is ordered for a beneficiary during a hospital stay but not delivered until discharge and enrollment changes, the payment must be made by the party responsible for the hospital stay.
- When a custom-fabricated, -fit, or -modified service is prior authorized and ordered by the provider before a change of enrollment, the party that authorized the service is responsible for payment. This responsibility only applies if the service is delivered within 30 days of the change of eligibility.

This policy does not apply to prefabricated, mass-produced, or ready-made items that can be used by a person other than for whom it is ordered. It also excludes rental items, all expendable/disposable medical supplies, or any item that does not require a length of time (days or weeks) to special order for a specific person.

1.8.G. REIMBURSEMENT AMOUNTS

Most items have established fee screens that are published in the MDHHS Medical Supplier/DME/Prosthetics and Orthotics Fee Schedule. The approved reimbursement amount of the fees for NOC codes and all codes without established fee screens will be indicated on the authorized PA request. For items that do not have established fee screens or are custom fabricated, refer to the Medicaid Code and Rate Reference tool for payment rules. (Refer to the Directory Appendix for website information.) The provider must provide a manufacturer's invoice that states the acquisition cost for the service on the PA request form. Manufacturer quotes or dealer list prices are not accepted as documentation of cost. Modified manufacturer invoices will not be accepted. If the manufacturer's actual invoice is not included, medical review will assign a penny screen to the code until the actual invoice is received. If the provider is requesting reimbursement for labor, the specific time must be stated on the request form. MDHHS reserves the right to set a dollar limit on how much MDHHS will reimburse for a NOC code or any manually priced procedure code for a specific range of products.

Medicaid payment rates may not exceed those paid by Medicare. MDHHS will adjust its Medicaid fee schedule when Medicare rate changes result in noncompliance with this requirement. The changes will be reflected on the MDHHS Medical Supplier/DME/Prosthetics and Orthotics Fee Schedule and in the Medicaid Code and Rate Reference tool. No notice will be issued directly to providers.



1.8.H. BILLING AUTHORIZED SERVICES

After an authorization is issued, the information (e.g., PA number, procedure code, modifier, and quantity) that was approved on the authorization must match the information on the invoice. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for complete billing instructions.)

1.8.I. HOSPITAL DISCHARGE WAIVER SERVICES

Hospital Discharge Waiver Services are DME items rented for the beneficiary in which the PA requirement is waived for up to the first three months after hospital discharge. If the beneficiary still requires these items after three months from hospital discharge, the PA requirement would still apply.

These items are as follows: HCPCS codes E0163, E0165, E0181, E0255, E0256, E0260, E0292, E0293, E0565, E0619, E0910, and E0940

1.9 DURABLE MEDICAL EQUIPMENT

1.9.A. STANDARD EQUIPMENT AND CUSTOM-FABRICATED SEATING

Standard equipment and custom-fabricated seating must be medically necessary and meet the medical and/or functional needs of the beneficiary.

- Standard equipment and accessories are products ordered from manufacturer stock. Measuring and custom-fitting a medical device to a beneficiary or custom-assembling a medical device to fit a beneficiary's needs using manufactured stock pieces is not considered to be custom-fabricated.
- Custom-fabricated seating is made from clinically derived, rectified castings, tracings, and other images (such as x-rays) of the beneficiary's body part.

It also includes computer-aided design/computer-aided manufacturing (CAD/CAM) technology used for the seating system. Computer-aided design/manufacturing must be performed by an experienced clinician along with a Certified Rehabilitation Technology Supplier (CRTS) or Assistive Technology Professional (ATP) who has completed the training course offered by the manufacturer. The outcome should be created jointly by the clinician and the CRTS/ATP. The cost for performing these activities is included in the Medicaid payment rate for the custom-fabricated seating system.

MDHHS will only consider coverage of custom-fabricated seating when a standard item will not meet the medical or functional needs of the beneficiary. All custom-fabricated equipment requires prior authorization. Once the custom-fabricated equipment is purchased, it becomes the property of the beneficiary. To be covered as custom-fabricated, the item must meet the MDHHS definition of custom-fabricated. A manufacturer's use of the term custom-fabricated for an item that does not meet the MDHHS definition will not be reimbursed as custom-fabricated. MDHHS reserves the right to determine and apply HCPCS codes used for the purpose of reimbursement.



1.9.B. PAYMENT RULES: RENTAL AND/OR PURCHASE

Generally, equipment will be purchased when a beneficiary requires the equipment for an extended period of time. For prior authorized services, the PA consultant may change the authorization request from a rental to a purchase or a purchase to a rental based on the documentation submitted. If DME items are purchased, the provider must indicate whether the DME item provided is new or used, as appropriate. The provider should refer to the Payment Rules described in the Coverage Conditions and Requirements Section of this chapter for MDHHS policy on specific services.

<p>Purchase (New or Used) - Items may be purchased if they are inexpensive accessories for other DME equipment or the equipment itself will be used for an extended period of time.</p>	<p>To be reimbursed for new equipment, the provider must:</p> <ul style="list-style-type: none"> ▪ Adhere to all aspects of the manufacturer's warranty, including all routine servicing; ▪ Deliver, set-up and install the equipment in the home, if applicable; ▪ Instruct the beneficiary or caregiver in the use and general care of the item; and ▪ Complete all adjustments and/or modifications needed to make the item functional. <p>To be reimbursed for used equipment, the provider must:</p> <ul style="list-style-type: none"> ▪ Ensure that the used equipment is fully serviced and in good operating condition; ▪ Include all routine servicing for the equipment into the purchase price of the item for a minimum of one year; ▪ Instruct the beneficiary or caregiver in the use and general care of the item; and ▪ Not allow the cost of its maintenance to exceed the cost of new equipment.
<p>Rental - The rental payment includes routine servicing and all necessary repairs or replacements to make the rented item functional.</p>	<p>Rental Only – Items that require regular and ongoing servicing/maintenance would be rented for the duration indicated by the physician's order. Examples are oxygen, apnea monitors, and volume ventilators.</p> <p>Capped Rental – Items rented until purchase price is reached. For Medicaid, items may be rented for a maximum period of 10 months. If the provider has been reimbursed for 10 months of rental, the item is considered purchased. (If used equipment is issued to the beneficiary, the usual and customary charge reported to Medicaid must accurately reflect that the item is used.)</p> <p>Converting Rental to Purchase – The majority of DME items can be rented as a capped rental for up to a maximum of 10 months. If the purchase of an item is requested after an initial rental period has occurred, the provider must subtract the amount already paid for the rental item from the total purchase price.</p>



1.9.C. REPAIRS AND REPLACEMENT PARTS

Repairs and the replacement of component parts for DME owned by the beneficiary are reimbursable if MDHHS purchased the item. If MDHHS did not purchase the original item, it must be medically necessary, meet the Standards of Coverage detailed in this chapter, and include the required supporting documentation.

For purchased items, all conditions of the warranty must be followed prior to requesting any repairs or replacement parts. Routine periodic servicing, such as cleaning, testing, regulating, and checking of equipment, is also included in the cost of the equipment. If equipment is found to be defective or not operating properly, it must be removed from service and cannot be placed into use again until it is brought up to manufacturer's operating standards and specifications. It is the responsibility of the provider to supply loaner equipment while the beneficiary-owned item is being serviced at no charge to MDHHS. For audit purposes, all suppliers must maintain protocols and records defining how the maintenance of equipment is to be achieved.

MDHHS will consider reimbursement for a replacement when it is more costly to repair than replace. When submitting a PA request for a replacement, the provider must provide a statement regarding the cost to repair the service versus replacement.

Repairs and the replacement of component parts for DME do not apply to an item that is currently being reimbursed by MDHHS as a rental.

Modifiers to be used when requesting replacements/repairs are as follows:

Modifier	Description
RA	Replacement of a DME, orthotic or prosthetic item
RB	Replacement of a part of a DME, orthotic or prosthetic item furnished as part of a repair

Repair of DME involving the replacement of a component part includes the cost of the part and the labor associated with its removal, replacement and finishing. For repairs to wheelchairs, refer to the Wheelchair Repair/Labor Guide posted on the MDHHS website, and to the Prior Authorization for Purchase, Rentals, Repairs, and/or Replacement of Mobility Devices subsection of this chapter. The RB modifier is required.

For a repair in which no specific HCPCS code is appropriate, report HCPCS code K0739 (for the labor charge) and HCPCS code E1399 (for the replacement part). For wheelchairs, HCPCS code K0108 is to be used in place of HCPCS code E1399. The RB modifier is reported for the replacement part of the DME furnished as part of the repair. PA is required. The provider must provide a manufacturer's invoice that states the acquisition cost for the service with the PA request form. If the provider is requesting reimbursement for labor, the specific time must be stated on the request form.



The replacement of a DME item will be considered when a significant change in the patient's condition has occurred or the cost of the equipment repair is greater than replacement. If the DME item cannot be restored to a serviceable condition and there has been no change in the medical condition of the beneficiary, MDHHS will consider replacement if the existing equipment meets coverage criteria or was purchased by the program. In these cases, a current prescription will meet documentation requirements for the equipment. If there has been a change in the medical condition that would reflect a change in equipment need, then all documentation requirements in the Coverage Conditions and Requirements Section of this chapter apply. Replacement of DME for youth will be evaluated on an individual basis due to the expected growth pattern.

The RA modifier should be reported with the appropriate HCPCS code of the DME to be replaced and should be reported when replacing a DME item with an identical or nearly identical item.

MDHHS will not replace an item due to damage to the item as a result of misuse or abuse by the beneficiary or the caregiver. If damage to an item is the result of theft or car accident, attempts should be made to collect the full or partial payment from the third party's insurance company, if applicable. A copy of the police or fire report must be submitted with the PA request form.

The provider may not provide or substitute a service of lesser quality or provide a different brand or type than what was authorized through prior authorization.

The provider may not add additional component HCPCS codes or bill for a more complex code (e.g., custom versus prefabricated) to increase the amount of reimbursement. The provider may not bill for a HCPCS code describing a custom-fabricated service in lieu of the availability of a code to cover a prefabricated item.

1.9.D. USED EQUIPMENT

Definition	Used durable medical equipment is defined as non-customized equipment previously purchased or rented by one or more users, or equipment utilized as floor models, demonstration equipment or loaner equipment prior to current purchase or rental.
Standards of Coverage	<p>Used equipment may be covered when all of the following are met:</p> <ul style="list-style-type: none"> ▪ The provider determines the item to be the least costly alternative that meets the beneficiary's medical/functional needs; and ▪ The equipment and components are non-customized items; and ▪ The equipment is not intended or labeled as a single user item; and ▪ The equipment is in good working condition and comparable to new equipment quality standards; and ▪ The equipment has been sanitized, repaired and reconditioned between each user. <p>Prior to the provision of used equipment, the beneficiary/parent/legal guardian must be given a choice to accept or refuse used equipment. If the beneficiary chooses to not accept the used equipment, the provider must provide new equipment following the standards of coverage and payment rules indicated in policy.</p>



	<p>MDHHS suggests that used equipment be identified by affixing a tag to the item with the equipment age and make/model/serial number or other identifying information.</p> <p>Providers offering used equipment are responsible to clean, repair and recondition used items between users to assure the equipment is safe and in good working condition. The provider must remove used items from service when such items no longer meet quality standards.</p>
<p>Documentation</p>	<p>In addition to documentation requirements listed in the this chapter, documentation for used equipment must include:</p> <ul style="list-style-type: none"> ▪ Equipment service log <ul style="list-style-type: none"> ➤ Confirmation that the equipment has been fully serviced and is in good working condition; ➤ Repair(s) and sanitization dates, with signature(s) of person(s) performing these functions; ➤ Age of item (if known); ➤ Serial number/make/model (or other identifying information); and ➤ Warranty information. <p>The above information must be incorporated into the beneficiary’s file upon rental/purchase of the item.</p> <ul style="list-style-type: none"> ▪ Beneficiary file <ul style="list-style-type: none"> ➤ Signed and dated agreement from the beneficiary/parent/legal guardian stating he/she understands the equipment is used; ➤ Indication that a manufacturer’s owner’s manual was provided to the beneficiary; and ➤ Provider attestation that the used equipment is durable enough to meet Medicaid minimum frequency limits for replacement equipment. <p>Documentation must be available upon MDHHS request.</p> <p>Refer to the specific policy standards of coverage and documentation requirements listed in this chapter.</p>
<p>PA Requirements</p>	<p>Prior authorization is not required for used equipment if PA is not required for a new item with the same HCPCS code assignment.</p> <p>PA is required for coverage beyond the standards of coverage, repair/replacement rules, and frequency limits indicated for the specified equipment.</p>



Payment Rules	<p>Used equipment may be purchased or rented (up to specified rental periods listed in policy).</p> <p>Repairs/reconditioning/sanitizing and labor costs are included in the initial purchase and rental period per each beneficiary.</p> <p>All warranties must be exhausted prior to requesting prior authorization for repair or replacement of the equipment per beneficiary.</p> <p>MDHHS has identified specific items that must have either the NU or UE modifier appended to the HCPCS code when requesting PA or submitting a claim. Failure to append the correct modifier(s) may result in denied claims or inaccurate payment.</p> <ul style="list-style-type: none"> ▪ NU - New Equipment ▪ UE - Used Equipment <p>Refer to the Medical Supplier database and/or the Medicaid Code and Rate Reference tool for HCPCS codes requiring the NU or UE modifier.</p>
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1.10 PROSTHETICS AND ORTHOTICS

For custom-fabricated prosthetics and orthotics (P&O), MDHHS reserves the right to request a recommendation from an appropriate physician subspecialist, physical therapist (PT) or occupational therapist (OT) evaluation when necessary to determine the functional and/or medical need for the item requested.

1.10.A. NONCUSTOM VERSUS CUSTOM-FABRICATED [CHANGE MADE 4/1/20]

Noncustom orthotics are prefabricated, available off the shelf for use, require basic measurements, and could include simple or minor custom fitting if necessary. Any delivery or service charges, fitting and preparatory procedures are considered part of the total purchase charge. Custom-fabricated P&O require measurements, fitting, casting or recasting, or molding to allow the appliance to meet the specific functional needs of the beneficiary. It may involve the incorporation of some prefabricated components. Adding prefabricated components to a prefabricated item is not considered custom-fabricated. Selection of the procedure code should be based on the service provided. Custom codes should not be used for prefabricated services.

All orthotist and prosthetist providers must have facility accreditation through any of the CMS-approved AOs (revised per bulletin MSA 19-37) in order to furnish and bill for custom-fabricated P&O appliances. Providers must maintain their (text deleted per bulletin MSA 19-37) accreditation and be able to provide proof upon request. Orthotic and prosthetic providers must only bill specific prefabricated and custom-fitted orthotics that may include simple or minor intervention.

Medicaid will consider coverage of these services when provided by other types of practitioners in which the service is within their scope of current medical practice.



1.10.B. HCPCS MODIFIERS - LEFT AND RIGHT SIDE OF THE BODY

The LT or RT modifier must be reported for orthoses and prostheses to designate either the left or right side of the body, if applicable. The frequency limits are based on the individual item being replaced. If the same code is used bilaterally on the same date of service, the modifiers LT and RT must be entered on the same line of the claim listing the appropriate combined quantities. To determine whether a procedure code requires the LT or RT modifier, refer to the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)

The provider may not provide or substitute a service of lesser quality or provide a different brand or type than what was authorized through prior authorization.

The provider may not add additional component HCPCS codes or bill for a more complex code (e.g., custom versus prefabricated) to increase the amount of reimbursement. The provider may not bill for a HCPCS code describing a custom-fabricated service in lieu of the availability of a code to cover a prefabricated item.

1.10.C. ADJUSTMENTS, REPLACEMENTS AND REPAIRS

Adjustments related to the delivery of orthoses are considered as part of the purchase price and are not separately reimbursable up to 90 days following placement. Providers are still responsible for the replacement, modification, and adjustment of any orthotic or prosthetic item that they placed but was not fitted properly. It is expected that the provider will adjust the device if possible before billing the program for modifications or replacements when there is unexpected growth spurt, substantial weight loss or gain, or post surgery.

Replacement of a component part of an orthosis includes the cost of the part and the labor associated with its removal, replacement and finishing.

For a repair in which no specific HCPCS code is appropriate, bill for the actual time it takes to repair or adjust the device and for the minor materials used. Report the labor charge by using HCPCS code L4205 (for orthoses) or HCPCS code L7520 (for prostheses). For minor materials used in repairing the item, report HCPCS code L4210 (for orthoses) or HCPCS code L7510 (for prostheses). MDHHS will cover the acquisition cost of material, not the provider's charge.

1.11 NONCOVERED ITEMS

Items that are not covered by Medicaid include, but are not limited to:

- Adaptive equipment (e.g., rocker knife, swivel spoon, etc.)
- Air conditioner
- Air purifier
- Custom seating for secondary and/or transport chairs



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- Devices used for play, pre-mobility development, or exercise are not considered pediatric mobility devices for the purpose of reimbursement and are not covered (e.g., jet mobile, ready racer, creepster crawler)
- Enteral formula to accommodate psychological or behavioral conditions, food preferences, allergies, loss of appetite, or noncompliance with a specialized diet
- Environmental Control Units
- Equipment not used or not used properly by the beneficiary
- Equipment for social or recreational purposes
- Exam tables/massage tables
- Exercise equipment (e.g., tricycles, exercise bikes, weights, mat/mat tables, etc.)
- Generators
- Hand/body wash
- Heating pads
- Home modifications
- Hot tubs
- House/room humidifier
- Ice packs
- Items for a beneficiary who is non-compliant with a physician's plan of care (or) items ordered for the purpose of solving problems related to noncompliance (e.g., insulin pump)
- Items used solely for the purpose of restraining the beneficiary for behavioral or other reasons
- Lift chairs, reclining chairs, vibrating chairs
- More than one pair of shoes on the same date of service
- New equipment when current equipment can be modified to accommodate growth
- Nutritional puddings/bars
- Over-the-counter shoe inserts
- Padded footplates
- Peri-wash
- Portable oxygen, when oxygen is ordered to be used at night only
- Power tilt-in-space or reclining wheelchairs for a long-term care resident because there is limited staffing
- Pressure gradient garments for maternity-related edema
- Prosthetic appliances for a beneficiary with a potential functional level of K0
- Regular or dietetic foods (e.g., Slimfast, Carnation instant breakfast, etc.)
- Room dehumidifiers
- School Items (e.g., computers, writing aids, book holder, mouse emulator, etc.)



- Second units for school use
- Second wheelchair for beneficiary preference or convenience
- Sensory Devices (e.g., games, toys, etc.)
- Sports drinks/juices
- Stair lifts
- Standard infant/toddler formula
- Therapy modalities (bolsters, physio-rolls, therapy balls, jett mobile)
- Toothettes
- Transcutaneous Nerve Stimulator when prescribed for headaches, visceral abdominal pain, pelvic pain, or temporal mandibular joint (TMJ) pain
- UV lighting for Seasonal Affective Disorder
- Vacu-brush toothbrushes
- Weight loss or "light" products
- Wheelchair lifts or ramps for home or vehicle (all types)
- Wheelchair accessories (e.g., horns, lights, bags, special colors, etc.)
- Wigs for hair loss

For specific procedure codes that are not covered, refer to the Coverage Conditions and Requirements Section of this chapter or the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information.

1.12 CHARGING THE BENEFICIARY

The provider may not charge the beneficiary for failure to provide sufficient documentation to support coverage or failure to obtain PA. The provider may charge the beneficiary if the beneficiary waives his right to PA. The provider must maintain on file a document that demonstrates that the beneficiary knew and understood that the waiver of PA would result in the beneficiary's responsibility for payment. In addition, the provider may not charge the beneficiary any copayments (unless permitted by Medicaid) or charges above the Medicaid allowable amount.

1.13 UNIFORM REPORTING OF SERVICES

MDHHS follows the American Medical Association's manual and guidelines for Current Procedural Terminology (CPT) numeric codes, and the Healthcare Common Procedure Coding System (HCPCS). In conjunction with the CPT/HCPCS coding systems to describe services rendered, MDHHS utilizes the Medicaid National Correct Coding Initiative (NCCI) coding policies and edits as developed by the Centers for Medicare & Medicaid Services (CMS) to promote national correct coding methodologies.



SECTION 2 – COVERAGE CONDITIONS AND REQUIREMENTS

2.1 APNEA MONITOR

Definition	An apnea monitor measures both heart rate and respirations and meets all of the Equipment Control Regulatory Industry (ECRI) Standards for home monitors.
Standards of Coverage	<p>A Newborn Infant Following Hospital Discharge – Units are covered for a newborn infant up to three months following hospital discharge if one of the following diagnoses or medical conditions applies:</p> <ul style="list-style-type: none"> ▪ Apnea of newborn ▪ Apnea of prematurity ▪ Apparent life threatening event (ALTE) ▪ Sibling of Sudden Infant Death Syndrome (SIDS) ▪ Bronchopulmonary Dysplasia <p>A Sibling of Sudden Infant Death Syndrome (SIDS) Following Hospital Discharge –</p> <ul style="list-style-type: none"> ▪ Units are covered for up to one month past the age of the sibling who died from SIDS; or ▪ Up to three months past the age of the sibling who died if the child was a twin of the beneficiary being monitored. <p>An Acute Respiratory Illness - Short-term coverage of a unit (up to two months) is a benefit when the beneficiary has a respiratory illness/diagnosis such as Pertussis, Respiratory Syncytial Virus (RSV), or Pneumonia.</p> <p>As a Diagnostic Tool - Short-term coverage of a unit (up to three months) used as a diagnostic tool is a benefit if the infant is under three months of age at set-up, and the parent and/or guardian reports suspected events.</p> <p>Beneficiaries with Tracheostomy – Units are generally not covered for beneficiaries who have a tracheostomy. Units may be considered for coverage only if, after careful evaluation of current treatment plan and equipment already in the home, the beneficiary's medical needs are still not met. Documentation explaining the medical need must be submitted with a detailed plan of management.</p> <p>Beneficiaries who are Ventilator Dependent - Units are considered to be included in the ventilator reimbursement to function as a backup alarm for the ventilator low-pressure alarm.</p>



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<p>Noncovered Conditions</p>	<p>Units are not covered for the following diagnoses/medical conditions unless documentation justifies medical necessity and usage meets the established Standards of Coverage above:</p> <ul style="list-style-type: none"> ▪ Chromosomal abnormalities ▪ Congenital heart defects with or without arrhythmias ▪ Cerebral palsy ▪ Asymptomatic prematurity ▪ Developmental delay/intellectual disability ▪ Seizure disorder ▪ Hydrocephaly with or without Arnold-Chiari Syndrome ▪ Irreversible terminal conditions ▪ Distant family history of SIDS (other than immediate sibling)
<p>Documentation</p>	<p>The documentation must be less than 30 days old and include all of the following:</p> <ul style="list-style-type: none"> ▪ A statement from an appropriate subspecialist trained in the treatment of apnea (i.e., apnea clinic, neonatologist, pediatric intensivist, pediatric pulmonologist, or neurologist) medically substantiating the continued need for the unit. ▪ Download interpretation of the monitor data documenting continued apnea or bradycardia events. ▪ For a sibling of SIDS, the age of the sibling at death.
<p>PA Requirements</p>	<p>PA is not required for any of the following if the Standards of Coverage are met:</p> <ul style="list-style-type: none"> ▪ Up to three months usage for newborn infants following a hospital discharge. ▪ Up to three months usage for siblings of SIDS following a hospital discharge. ▪ Used up to two months due to a respiratory illness (e.g., Pertussis, Respiratory Syncytial Virus (RSV), or Pneumonia). ▪ Used up to three months as a diagnostic tool for the following diagnoses or medical conditions: <ul style="list-style-type: none"> ➢ Apnea of newborn ➢ Apnea of prematurity ➢ Apparent life threatening event (ALTE) ➢ Sibling of Sudden Infant Death Syndrome (SIDS) ➢ Bronchopulmonary Dysplasia <p>PA is required for the following:</p> <ul style="list-style-type: none"> ▪ Continuation of the monitor beyond the initial two or three months. ▪ Other diagnoses/medical conditions or applications not indicated in the Standards of Coverage.



Payment Rules	<p>An Apnea Monitor is considered a rental only item and includes all of the following:</p> <ul style="list-style-type: none"> ▪ All accessories needed to use the unit (e.g., electrodes, lead wires, belts, cables, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. ▪ Periodic downloading/interpretation of recorded data.
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2.2 BI-LEVEL POSITIVE AIRWAY PRESSURE DEVICE

Definition	<p>The bi-level positive airway pressure (BIPAP) device delivers a noninvasive positive air pressure into the upper airway to assist spontaneous respiratory efforts. The device has two pressure levels (one for breathing in and one for breathing out).</p>
Standards of Coverage	<p>A BIPAP device without the backup rate feature may be covered for the following conditions for up to four months:</p> <ul style="list-style-type: none"> ▪ For Obstructive Sleep Apnea (OSA), if the sleep study (polysomnogram) performed in an accredited Sleep Center or Sleep Laboratory documents the following: <ul style="list-style-type: none"> ➢ Continuous airway pressure of 13-15 cm water does not adequately control/eliminate obstructive/hypopneic events; or ➢ The beneficiary cannot tolerate continuous positive airway pressures of greater than or equal to 12 cm water, in addition to evidence that the sleep lab has worked with the beneficiary to try different application devices, ramp times, relaxation techniques, etc. ▪ For respiratory failure if there are lab values (i.e., arterial blood gas [ABG], venous blood gas [VBG] or capillary blood gas) indicating respiratory failure and follow-up lab values documenting improvement with the use of a BIPAP. ▪ For a diagnosis/medical condition for which a CPAP is inappropriate for use (e.g., cardiomyopathy, cor pulmonale, primary pulmonary hypertension, left ventricular hypertrophy, etc.). <p>A BIPAP device with the backup rate feature may be covered if the beneficiary requires the backup feature due to insufficient spontaneous respiratory efforts (e.g., inadequate negative respiratory force due to central apnea, neuromuscular diseases such as muscular dystrophy, etc.).</p>
Documentation	<p>Documentation must be less than 90 days old and include:</p> <ul style="list-style-type: none"> ▪ Diagnosis related to the need for BIPAP. ▪ BIPAP settings and number of hours per day used. ▪ Other medical conditions ruling out the appropriate use of a CPAP if present (e.g., cardiomegaly, left ventricular hypertrophy, primary pulmonary hypertension, etc.). ▪ For diagnosis of OSA, results of a sleep study (polysomnogram) including CPAP/BIPAP titration. ▪ For diagnosis of respiratory failure, test results substantiating the condition (e.g., ABG, VBG, or capillary blood gas) as well as test results showing improvement on BIPAP.



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	<ul style="list-style-type: none"> Negative inspiratory force measurement, if appropriate. <p>For continued coverage beyond the initial four months, the following additional information must be provided:</p> <ul style="list-style-type: none"> Medical statement indicating beneficiary is stable and the BIPAP device settings are adequate. Documentation of beneficiary compliance through the review of equipment use logs.
PA Requirements	PA is required for all BIPAP requests.
Payment Rules	<p>BIPAP units are considered a capped rental item and are inclusive of all of the following:</p> <ul style="list-style-type: none"> All accessories needed to use the unit (e.g., tubing, application devices, chinstrap, headgear, etc.). Education on the proper use and care of the equipment. Routine servicing and all necessary repairs or replacements to make the unit functional.

2.3 BLOOD PRESSURE MONITORING [RE-NUMBERED 4/1/20]

Definition	Blood pressure monitoring includes manual and automatic blood pressure units.
Standards of Coverage	<p>A manual blood pressure unit may be covered for a beneficiary under the age of 21 when:</p> <ul style="list-style-type: none"> Daily titration of medications is required for renal disease. A cardiovascular condition is present that affects blood pressure (e.g., congenital heart disease). A brain lesion or cancer tumor is present that affects blood pressure. A medication regimen is present that affects blood pressure.
	<p>Coverage for beneficiaries age 21 and over with uncontrolled blood pressures when one of the following is present:</p> <ul style="list-style-type: none"> Fluctuation in blood pressure as a result of renal disease. Medications are titrated based on daily blood pressure readings.
	<p>An automatic blood pressure monitor is covered when:</p> <ul style="list-style-type: none"> Standards of coverage for a manual unit have been met. Beneficiary is age 11 or over. Economic alternatives (such as a manual blood pressure unit) have either been tried or ruled out prior to requesting authorization of an automatic blood pressure monitor.



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Documentation	The documentation must be less than 30 days old and include: <ul style="list-style-type: none"> ▪ Diagnosis/medical condition pertaining to the need for the blood pressure monitor. ▪ Complete physician's treatment plan, including current blood pressure medications, frequency of checks, and specific patient protocol in case of an abnormal reading. ▪ The medical reason a manual blood pressure unit cannot be used (for beneficiaries over the age of ten years). ▪ Prescription from a pediatric nephrologist when daily titration of medications is required for renal disease (required for coverage under CSHCS).
PA Requirements	PA is required for all blood pressure units.
Payment Rules	A blood pressure monitor is considered a purchase only item.

2.4 BREAST PUMPS [RE-NUMBERED 4/1/20]

Medicaid covers hospital-grade electric, personal use double electric, and manual breast pumps.

2.4.A. HOSPITAL-GRADE ELECTRIC BREAST PUMP [RE-NUMBERED 4/1/20]

Definition	A hospital grade electric breast pump is heavy duty, piston-operated, and is capable of being used frequently on a daily basis.
Standards of Coverage	<p>A hospital grade electric breast pump may only be covered for a beneficiary with a Neonatal Intensive Care Unit (NICU) infant, up to three months of age, when one of the following applies:</p> <ul style="list-style-type: none"> ▪ The infant has a severe feeding problem secondary to cleft lip and/or palate. ▪ The infant has a severe feeding problem due to oral motor dysfunction, secondary to prematurity. ▪ The infant is hospitalized resulting in a physical separation of the mother and infant. ▪ The infant or mother is hospitalized, resulting in a physical separation of the mother and infant; and all of the following applies: <ul style="list-style-type: none"> ➢ The pump has an adjustable suction pressure at the breast shield during use between 30 mm Hg and 250 mm Hg (suction just at the low or high end is not acceptable); ➢ The pump has a mechanism to prevent suction beyond 250 mm Hg to prevent nipple trauma; ➢ The pump has an adjustable/varying pumping speed no less than 30 cycles per minute and capable of reaching up to a maximum of 60 cycles per minute; ➢ The pump must be able to operate on a 110-volt household current and be UL listed; ➢ The pump must not weigh over 12 pounds; and ➢ The pump is registered and cleared with the FDA. <p>For continued coverage beyond the initial three months, additional documentation must be provided.</p>



<p>Documentation</p>	<p>Documentation must be less than 30 days old and include:</p> <ul style="list-style-type: none"> ▪ Diagnosis/medical condition of the infant relating to the need for a breast pump. ▪ Infant's age (gestational age, if premature). ▪ Mother's discharge date. ▪ Anticipated duration of need. ▪ An order signed by the treating physician or non-physician practitioner. ▪ The International Classification of Diseases (ICD) diagnosis code(s) related to birth or pregnancy. ▪ Documentation of mother's intent to breastfeed. <p>Documentation must be kept in the beneficiary's file and made available upon request.</p>
<p>PA Requirements</p>	<p>PA is not required when the Standards of Coverage are met.</p> <p>PA is required for coverage beyond three months.</p>
<p>Payment Rules</p>	<p>A breast pump is considered a rental only item and is inclusive of the following:</p> <ul style="list-style-type: none"> ▪ All related accessories necessary to use the equipment. (To obtain additional reimbursement for the initial breast pump kit, report the "KH" modifier with HCPCS code E0604 for the first month of rental only.) ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. <p>The rental pump may be billed using the infant's Medicaid ID number if the need for the hospital grade pump meets the standards of coverage and the mother loses Medicaid eligibility.</p> <p>Rental of the hospital-grade electric breast pump will not be made if a personal use double electric breast pump or a manual breast pump was purchased for the beneficiary within the Standards of Coverage frequency limitations.</p>

2.4.B. PERSONAL USE DOUBLE ELECTRIC BREAST PUMP [RE-NUMBERED 4/1/20]

<p>Definition</p>	<p>A personal use double electric breast pump is defined as a double electric (AC and/or DC) pump, intended for a single user, capable of being used frequently on a daily basis.</p>
<p>Standards of Coverage</p>	<p>A personal use double electric breast pump may be covered once per five years for a beneficiary when all of the following criteria are met:</p> <ul style="list-style-type: none"> ▪ The mother expresses the desire to breastfeed; ▪ The pump has been registered and cleared by the FDA; ▪ The pump has a minimum of a one-year manufacturer's warranty; ▪ The pump has an adjustable suction pressure at the breast shield during use between 30 mm Hg and 250 mm Hg (suction just at the low or high end is not acceptable);



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	<ul style="list-style-type: none"> ▪ The pump has a mechanism to prevent suction beyond 250 mm Hg to prevent nipple trauma; ▪ The pump has an adjustable/varying pumping speed no less than 30 cycles per minute and capable of reaching up to a maximum of 60 cycles per minute; ▪ The pump must be able to operate on a 110-volt household current and be UL listed; ▪ The pump must not weigh over 12 pounds; and ▪ The pump collection bottle must be bisphenol-A (BPA) and DHEP-free.
Documentation	<p>Must be less than 30 days old and include all of the following:</p> <ul style="list-style-type: none"> ▪ An order signed by the treating physician or non-physician practitioner. ▪ The International Classification of Diseases (ICD) diagnosis code(s) related to birth or pregnancy. ▪ Infant’s age (gestational age, if premature). ▪ Mother’s hospital discharge date or infant’s hospital discharge date. ▪ Documentation of mother’s intent to breastfeed. <p>Documentation must be kept in the beneficiary’s file and made available upon request.</p>
PA Requirements	<p>PA is not required when the Standards of Coverage are met. PA is required for circumstances beyond the Standards of Coverage and Payment Rules.</p>
Payment Rules	<p>All personal use double electric breast pumps are purchase only. Payment includes:</p> <ul style="list-style-type: none"> ▪ Education for the proper use, care of the equipment, and storage of breast milk. ▪ Supplies necessary for operation of the pump (pump, adapter/charger, breast shields, bottles, lids, tubing, locking ring, connectors, valves, filters and membranes). <p>The pump may be billed using the infant’s Medicaid ID number if the need for the pump meets the Standards of Coverage and the mother loses Medicaid eligibility. Medicaid will not purchase a personal use double electric breast pump during the rental period of a hospital-grade electric breast pump or if a manual breast pump was purchased within the Standards of Coverage frequency limitations.</p> <p>Replacement parts are covered after the manufacturer’s warranty has expired for included parts. Refer to the Medical Supplier database and the Medicaid Code and Rate Reference tool for covered replacement parts, code descriptions, coverage limitations and reimbursement.</p>

2.4.C. MANUAL BREAST PUMP [RE-NUMBERED 4/1/20]

Definition	<p>A manual breast pump typically consists of a single breast shield, a collection device, and a hand-controlled lever to create suction and express milk. Manual breast pumps are intended for a single user.</p>
Standards of Coverage	<p>A manual breast pump may be covered once per birth. For a beneficiary who has had a multiple birth delivery, only one pump is covered. Coverage of a manual breast pump may be provided when all of the following criteria have been met:</p> <ul style="list-style-type: none"> ▪ The mother expresses the desire to breastfeed.



	<ul style="list-style-type: none"> ▪ The pump has been registered with the FDA. ▪ The pump has a minimum of a one year manufacturer’s warranty. ▪ The pump has a mechanism to prevent suction beyond 250 mm Hg to prevent nipple trauma. ▪ The pump collection bottle must be bisphenol-A (BPA) and DHEP-free.
Documentation	<p>Documentation must be less than 30 days old and include all of the following:</p> <ul style="list-style-type: none"> ▪ An order signed by the treating physician or non-physician practitioner. ▪ The International Classification of Diseases (ICD) diagnosis code(s) related to birth or pregnancy. ▪ Infant’s age (gestational age, if premature). ▪ Mother’s hospital discharge date or infant’s hospital discharge date. ▪ Documentation of mother’s intent to breastfeed. <p>Documentation must be kept in the beneficiary’s file and made available upon request.</p>
PA Requirements	<p>PA is not required when the Standards of Coverage are met. PA is required for circumstances beyond the Standards of Coverage and Payment Rules.</p>
Payment Rules	<p>All manual breast pumps are purchase only. Purchase includes:</p> <ul style="list-style-type: none"> ▪ Education for the proper use, care of the equipment, and storage of breast milk. ▪ Supplies necessary for the operation of the pump (pump, breast shields, bottles, lids, tubing, locking ring, connectors, valves, filters and membranes). <p>The pump may be billed using the infant’s Medicaid ID number if the need for the pump meets the Standards of Coverage and the mother loses Medicaid eligibility. Medicaid will not purchase a manual breast pump during the rental period of a hospital-grade electric breast pump or if a personal use double electric breast pump was purchased within the Standards of Coverage frequency limitations.</p> <p>Replacement parts are covered after the manufacturer’s warranty has expired for included parts. Refer to the Medical Supplier database and the Medicaid Code and Rate Reference tool for covered replacement parts, code descriptions, coverage limitations and reimbursement.</p>

2.4.D. NON-COVERED BREASTFEEDING ITEMS [RE-NUMBERED 4/1/20]

Non-covered breastfeeding items:

- Personal use single electric breast pumps
- Breastfeeding pillows
- Breastfeeding comfort items and clothing
- Accessories not necessary for the operation of the breast pump

2.5 CANES AND CRUTCHES [RE-NUMBERED 4/1/20]

Definition	Canes or crutches include, but are not limited to, adjustable or fixed canes, quad or three prong canes, forearm crutches and underarm crutches.
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Standards of Coverage	<p>Canes or crutches are covered if:</p> <ul style="list-style-type: none"> ▪ The diagnosis/medical condition results in instability in ambulation or inability to ambulate. ▪ The beneficiary requires the stability of a cane or crutch to ambulate.
Documentation	<p>Documentation must be less than 180 days old and include the following:</p> <ul style="list-style-type: none"> ▪ Diagnosis/medical condition related to instability or inability to ambulate. ▪ Type of item requested. ▪ Medical reason for replacement (when appropriate).
PA Requirements	<p>PA is not required when Standards of Coverage are met.</p> <p>PA is required when:</p> <ul style="list-style-type: none"> ▪ The beneficiary is over the age of 21, and replacement is required within five years. ▪ The beneficiary is under the age of 21, and replacement is required within one year. <p>For replacement of pads, handgrips or tips, the provider may call for a verbal authorization. The provider must provide acquisition cost supported by a manufacturer's invoice. A prescription is not required if the program has covered the cane and/or crutch. The original prescription for the item must be kept on file.</p>
Payment Rules	<p>Canes and crutches are considered purchase only items.</p>

2.6 CHILDREN'S PRODUCTS [RE-NUMBERED 4/1/20]

Definition	<p>Children's products that may be considered for coverage include, but are not limited to, equipment that is used in the home or vehicle by children under age 21 for the purposes of positioning, safety during activities of daily living, or assisted mobility. Examples of these items include: bath supports, specialized car seats, corner chairs, dynamic standers, feeder seats, gait trainers, pediatric walkers, positioning commodes, side lyers, standers, and toileting supports.</p>
Standards of Coverage	<p>Children's products are covered if one or more of the following applies:</p> <ul style="list-style-type: none"> ▪ Beneficiary is unable to independently maintain a seated position. ▪ Beneficiary cannot stand and/or ambulate without the aid of an assistive device. ▪ Beneficiary has physical anomalies that require support to allow a functional position or prevent further disability.
Documentation	<p>Documentation must be less than 180 days old and include all of the following:</p> <ul style="list-style-type: none"> ▪ Diagnosis appropriate for the equipment requested. ▪ Any adaptive or assistive devices currently used in the home. ▪ Reason economic alternatives cannot be used, if applicable. ▪ Statement of functional need from an appropriate pediatric subspecialist, occupational or physical therapist.
PA Requirements	<p>PA is required for all requests.</p>



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Payment Rules	All children's products are considered purchase only items.
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2.7 COMMODES [RE-NUMBERED 4/1/20]

Definition	A commode is a chair with an enclosed pan or pail that may be stationary or mobile, with fixed or removable arms, a seat lift, and footrest.
Standards of Coverage	A standard commode may be covered if the beneficiary is unable to safely use home toileting facilities, is confined to a single room, or is confined to one level of the home in which no toileting facilities are available.
	A heavy-duty commode may be covered for a beneficiary weighing 300 pounds or greater and the beneficiary is unable to safely use home toileting facilities, is confined to a single room, or is confined to one level of the home in which no toileting facilities are available.
	A shower commode chair may be covered if required to enable the beneficiary to shower independently or with assistance in the home setting and there are no cost effective alternatives.
Documentation	Documentation must be less than 180 days old and include: <ul style="list-style-type: none"> ▪ Diagnosis appropriate for the equipment requested. ▪ Functional limitations requiring the equipment. ▪ Weight (if a heavy-duty commode is required). ▪ Discharge date from hospital, if applicable.
PA Requirements	PA is not required for any of the following if the Standards of Coverage are met: <ul style="list-style-type: none"> ▪ Up to Three Months Following Hospital Discharge - rental of a stationary commode chair with fixed arms (or) stationary commode chair with detachable arms for a diagnosis not already removed from PA. ▪ Purchase or rental of a stationary, mobile, extra wide, or heavy duty commode chair with fixed or detachable arms for the following diagnoses: <ul style="list-style-type: none"> ➤ Amyotrophic Lateral Sclerosis ➤ Multiple Sclerosis ➤ Cerebral Palsy, Unspecified ➤ Congenital and Progressive Hereditary Muscular Dystrophy ➤ Fracture of Vertebral Column With Spinal Cord Injury (cervical and dorsal) ▪ Replacement of pail or pan for use with commode chair.
	PA is required for the following: <ul style="list-style-type: none"> ▪ Medical need beyond the Standards of Coverage. ▪ Commodes with footrests and/or seat mechanisms. ▪ Continued coverage after the three-month rental following hospital discharge for a diagnosis not removed from PA. ▪ Replacement is required within five years if the beneficiary is over 21. ▪ Replacement is required within two years if the beneficiary is under 21.



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Payment Rules	<p>A commode may be considered a capped rental or purchase item. Reimbursement for all commodes includes pail/pan and accessories (except footrest).</p> <p>If unit is billed as a capped rental, the rental payment would be inclusive of the following:</p> <ul style="list-style-type: none"> ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacement to make the unit functional.
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2.8 COMPRESSOR (LARGE VOLUME) [RE-NUMBERED 4/1/20]

Definition	A compressor is an electrical device that provides humidity to a tracheostomy and is capable of continuous operation.
Standards of Coverage	A compressor is covered to provide humidity for a tracheostomy.
Documentation	<p>Documentation must be less than 90 days old and include all of the following:</p> <ul style="list-style-type: none"> ▪ Diagnosis/medical condition related to the need for the equipment. ▪ Specific unit requested.
PA Requirements	<p>PA is not required for rental of a large volume compressor if the Standards of Coverage are met and documentation details one of the following diagnoses:</p> <ul style="list-style-type: none"> ▪ Artificial Opening Status – Tracheostomy ▪ Attention to Artificial Openings – Tracheostomy <p>PA is required for:</p> <ul style="list-style-type: none"> ▪ Purchase of a large volume compressor (if not rented for 10 months). ▪ Medical need beyond the Standards of Coverage. ▪ Replacement within five years.
Payment Rules	<p>A unit may be considered a capped rental item or purchased item. If unit is billed as a capped rental, the rental payment would be inclusive of the following:</p> <ul style="list-style-type: none"> ▪ All accessories needed to use the equipment. ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.9 CONTINUOUS POSITIVE AIRWAY PRESSURE DEVICE [RE-NUMBERED 4/1/20]

Definition	The continuous positive airway pressure (CPAP) device delivers a noninvasive positive air pressure into the upper airway to assist spontaneous respiratory efforts.
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<p>Standards of Coverage</p>	<p>A CPAP device may be covered for Obstructive Sleep Apnea (OSA) if a sleep study (polysomnogram) performed in an accredited Sleep Center or Sleep Laboratory documents the following:</p> <ul style="list-style-type: none"> ▪ Apnea-Hypopnea Index (AHI) documents a minimum of 15 events per hour, or ▪ AHI documents 5 to 14 events per hour with related symptoms such as: <ul style="list-style-type: none"> ➤ Excessive daytime sleepiness, impaired cognition, mood disorders; and/or ➤ Hypertension, ischemic heart disease, or history of stroke, or morbid obesity. <p>For beneficiaries under the age of 21 only, tracheomalacia, tracheostomy complications or other anomalies of larynx, trachea, and bronchus may be covered when a particular CPAP setting improved and maintained airway patency and oxygenation.</p>
<p>Documentation</p>	<p>Documentation must be less than 90 days old and include:</p> <ul style="list-style-type: none"> ▪ Diagnosis and/or medical condition related to the need for the CPAP device. ▪ A copy of the sleep study (polysomnogram) for a diagnosis of OSA. The recorded sleep study must contain at least two hours of recorded sleep and the AHI must be calculated using actual recorded hours of sleep. ▪ For continued coverage beyond the initial four months, documentation must substantiate that the beneficiary has been compliant with the use of the CPAP and the device continues to be effective in treating the condition. If a unit log is maintained, the information must be submitted. ▪ Prescription from an appropriate pediatric subspecialist is required for coverage under the CSHCS Program.
<p>PA Requirements</p>	<p>PA is not required if the Standards of Coverage are met and:</p> <ul style="list-style-type: none"> ▪ The beneficiary is over the age of 21 and has one of the following diagnoses: <ul style="list-style-type: none"> ➤ Obstructive Sleep Apnea (Adults) ➤ Tracheostomy Complications ➤ Tracheomalacia ➤ Other Anomalies of Larynx, Trachea, and Bronchus ➤ Insomnia with Sleep Apnea ➤ Hypersomnia with Sleep Apnea ➤ Other and Unspecified Sleep Apnea ▪ For unobstructive sleep apnea, use diagnosis description of other and unspecified sleep apnea. ▪ The beneficiary is under the age of 21, has one of the above diagnoses, and the device is prescribed by the appropriate pediatric subspecialist. <p>PA is required for:</p> <ul style="list-style-type: none"> ▪ Medical need beyond the Standards of Coverage. ▪ Replacement within five years. <p>PA is given for the initial four months and then for the final six months.</p>



Payment Rules	<p>A CPAP device is considered a capped rental item and is inclusive of the following:</p> <ul style="list-style-type: none"> ▪ All accessories needed to use the unit (e.g., tubing, application devices, filters, chinstrap, headgear, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. <p>After the first 10 months of use, necessary repairs and/or replacements of accessories are separately reimbursable. (Replacement parts for the full CPAP mask should be considered prior to replacement of the entire mask.)</p>
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2.10 DIABETIC EQUIPMENT AND RELATED SUPPLIES [RE-NUMBERED 4/1/20]

2.10.A. BLOOD GLUCOSE MONITORING EQUIPMENT AND SUPPLIES [RE-NUMBERED 4/1/20]

Definition	<p>Blood glucose monitoring supplies and equipment are defined as those items necessary to monitor blood glucose levels. The equipment and supplies include, but are not limited to, blood glucose monitors, testing strips, lancets, and calibrator solution/chips.</p>
Standards of Coverage	<p>A home blood glucose monitor and related supplies are covered when a beneficiary has been diagnosed with diabetes and it is medically necessary to monitor fluctuations of blood glucose levels on a daily basis. Diabetes includes:</p> <ul style="list-style-type: none"> ▪ Gestational diabetes ▪ Insulin-treated diabetes ▪ Non-insulin treated diabetes <p>Diabetes medications (i.e., metformin, Januvia, etc.) do not qualify as insulin treatment.</p> <p>Quantity limits for lancets, blood glucose test strips/reagent test strips, and urine test/reagent strips/tablets are based upon insulin-treated or non-insulin-treated diabetes. Refer to the Medicaid Code and Rate Reference tool in CHAMPS for quantity and frequency information. (Refer to the Directory Appendix for website information.)</p>
Documentation	<p>Documentation must be less than 90 days old and include all of the following:</p> <ul style="list-style-type: none"> ▪ Diagnosis/condition related to the need for the blood glucose monitoring. ▪ Items to be dispensed. ▪ Quantity of items to be dispensed for 30 days usage. ▪ Frequency of testing. ▪ For beneficiaries under 21, treatment plan for treating abnormal blood glucose levels (if pediatric endocrinologist did not order the monitor/supplies). ▪ For CSHCS beneficiaries, a prescription from a Pediatric Endocrinologist is required. <p>For beneficiaries 21 years of age and older with medical need to test blood glucose more frequently than established quantity limits, the physician must indicate the medical need and duration ("PRN" or "as needed" is not sufficient documentation to support medical need) for the additional quantities.</p>



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PA Requirements	<p>PA is not required when the Standards of Coverage are met and the beneficiary has one of following diagnoses:</p> <ul style="list-style-type: none"> ▪ Diabetes Mellitus Without Mention of Complications ▪ Diabetes with Ketoacidosis ▪ Diabetes with Hyperosmolarity ▪ Diabetes with Other Coma ▪ Diabetes with Renal Manifestations ▪ Diabetes with Ophthalmic Manifestations ▪ Diabetes with Neurological Manifestations ▪ Diabetes with Peripheral Circulatory Disorders ▪ Diabetes with Other Specified Manifestations ▪ Diabetes with Unspecified Complications ▪ Diabetes Mellitus Complicating Pregnancy ▪ Abnormal Glucose Tolerance (Gestational Diabetes Only) <p>In addition to the above, PA will not be required if physician documentation substantiates the medical need for an adult (insulin or non-insulin treated) to test more frequently than standardized MDHHS limits. For such circumstances, the provider must append the KX modifier to the A4253 and to the A4259 on the claim. (Refer to the Medicaid Code and Rate Reference tool for quantity limits when using modifier KX with lancets and test strips.)</p>
	<p>PA is required for:</p> <ul style="list-style-type: none"> ▪ Home blood glucose monitors with special features such as voice synthesis. ▪ Medical need not within the Standards of Coverage if it exceeds quantity limits and/or a diagnosis that has not been removed from PA. ▪ Replacement within three years.
Payment Rules	<p>All items (including the monitor) are considered purchase only items.</p> <p>To report date of service (DOS) for blood glucose test or reagent strips, lancets, and normal, low and high calibrator solution, use a span date in the "From" and "To" fields, not to exceed 90 days.</p>

2.10.B. CONTINUOUS GLUCOSE MONITORING EQUIPMENT AND SUPPLIES [RE-NUMBERED 4/1/20]

Definition	<p>Continuous glucose monitoring systems (CGMS) are devices that measure glucose levels taken from interstitial fluid continually throughout the day and night, providing real-time data to the beneficiary or physician. The CGMS is comprised of three parts:</p> <ol style="list-style-type: none"> 1) A disposable sensor (attaches to the skin and inserts a tiny wire into the subcutaneous tissue to measure glucose levels), 2) The transmitter (attaches to the sensor and sends the data to a wireless receiver/monitor), and 3) A receiver/monitor (records and stores the data and alerts the beneficiary when glucose levels are too high or too low).
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Standards of Coverage

A personal use CGMS and supplies are covered for persons with Type I diabetes when all the following are met:

- The beneficiary is under the care of one of the following:
 - An endocrinologist; or
 - A physician or non-physician practitioner (nurse practitioner, physician assistant or clinical nurse specialist) who is managing the beneficiary's diabetes. (The provider must provide documentation that the beneficiary completed a Medicaid-covered diabetes self-management education [DSME] training within one year prior to the written order);
- The beneficiary has Type I diabetes requiring the administering of insulin three or more times per day or is currently using an insulin pump, and at least one of the following:
 - Is unable to consistently and reliably identify hypoglycemic events (e.g., hypoglycemic unawareness);
 - A recent history of hospitalization or emergency room visits for seizures or other conditions attributed to a hypoglycemic event;
 - Coexistent morbidity that poses an unusual challenge with concomitant hypoglycemia (e.g., uncontrolled epilepsy);
 - The presence of microvascular complication (e.g., vasculopathy, retinopathy); or
 - Ketoacidosis or uncontrolled glucose.

At least one of the above conditions must be documented (e.g., hypoglycemic unawareness).

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



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<p>Documentation</p>	<p>Documentation must be less than 90 days old and include all the following:</p> <ul style="list-style-type: none"> ▪ A written order by the treating physician/non-physician practitioner; ▪ Diagnosis related to the need for the CGMS; ▪ Length of need; ▪ Number of finger-stick tests beneficiary performs per day; ▪ Frequency of insulin administered per day or if the beneficiary is using an insulin pump; ▪ Records of hypoglycemic events, HbA1c levels, uncontrolled ketoacidosis, hypoglycemic events, coexistent morbidity having occurred with hypoglycemia or the presence of a microvascular complication(s), as applicable; ▪ Current treatment plan and beneficiary’s compliance with the plan; and ▪ Documentation of beneficiary completion of a Medicaid-covered certified DSME training program (if provider other than an endocrinologist is treating the beneficiary’s diabetes). The DSME training program must have been completed within one year prior to the written order for the CGMS and include education on the use of CGMS (refer to the Hospital Chapter in this manual for additional information). <p>The initial order must be written for six months. If the beneficiary continues to be compliant with use of the CGMS and treatment plan, the practitioner may write an order for an additional six months. After the first year, an order(s) for replacement sensors, transmitters and receivers (following frequency rules) may be written for a 12-month period.</p> <p>Note: Children’s Special Health Care Services (CSHCS) beneficiaries require a prescription from a pediatric endocrinologist.</p>
<p>PA Requirements</p>	<p>Prior authorization is not required for infants and toddlers (age 5 and under*) if standards of coverage and documentation requirements are met. Prior authorization is required for all other ages and conditions.</p> <p>*It is assumed that hypoglycemic unawareness is common within this age group.</p>
<p>External Insulin Pump Combined with CGMSs</p>	<p>An external insulin pump combined with a CGMS is covered when the external insulin pump and the CGMS policy standards of coverage are met. To be considered for coverage, the device must be approved by the Food and Drug Administration (FDA) as a combined insulin pump/CGMS.</p>
<p>Non-Covered</p>	<p>Smart devices (e.g., smart phones, iPads, tablets, personal computers) used with a CGMS are not classified as durable medical equipment and are not covered by Medicaid.</p>



Payment Rules	<p>The sensor, transmitter and receiver are purchase-only items, except for K0554 (may be purchased, rented or used item).</p> <p>The following HCPCS codes are included in the allowance for K0553 and may not be billed separately: A4233, A4234, A4236, A4244, A4245, A4246, A4247, A4250, A4253, A4255, A4256, A4257, A4258, A4259, E0607, E2100 and E2101.</p> <p>The product warranty must be expired prior to replacement of the transmitter and/or receiver.</p> <p>Providers must use the most appropriate HCPCS code for each brand/make/model of CGMS by reviewing the Food and Drug Administration (FDA) product approvals and the Pricing, Data Analysis and Coding (PDAC) contractor website for coding assignment. Upcoding a product to receive higher reimbursement is incorrect billing and could result in post-payment recovery of funds or provider audit.</p> <p>Refer to the Medicaid Code and Rate Reference tool for HCPCS code coverage parameters.</p>
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2.10.C. EXTERNAL INFUSION (INSULIN) PUMP AND SUPPLIES [RE-NUMBERED 4/1/20]

Definition	Insulin pumps deliver a constant and continuous infusion of insulin, driven by mechanical force, into the subcutaneous space via a needle or soft cannula.
Standards of Coverage	<p>Insulin pumps are covered when other methods to control blood glucose levels have been ineffective and one of the following applies:</p> <ul style="list-style-type: none"> ▪ Blood glucose levels demonstrate poor glycemic control despite monitoring at least four times per day and multiple daily insulin injections with a persistently elevated glycosylated hemoglobin level greater than seven percent. ▪ There is a history of severe glycemic excursions, brittle diabetes, hypoglycemic/hyperglycemic reaction, nocturnal hypoglycemia, any extreme insulin sensitivity, and/or very low insulin requirements. ▪ There is evidence of the "dawn" phenomenon where fasting blood glucose level often exceeds 200 mg/dl.
Documentation	<p>Documentation must be less than 90 days old and include:</p> <ul style="list-style-type: none"> ▪ Diagnosis/medical condition pertaining to the need for the pump. ▪ Lab values of blood glucose levels. ▪ Medical history documenting the need for the pump. ▪ Any medical complications experienced by the beneficiary related to the need for blood glucose monitoring. <p>CSHCS requires a prescription from an appropriate pediatric subspecialist.</p>



PA Requirements	<p>PA is not required if the Standards of Coverage are met, and:</p> <ul style="list-style-type: none"> ▪ The beneficiary is over the age of 16 and has one of the diagnoses indicated below: <ul style="list-style-type: none"> ➤ Diabetes Mellitus without Complication ➤ Diabetes with Ketoacidosis ➤ Diabetes with Hyperosmolarity ➤ Diabetes with Other Coma ➤ Diabetes with Renal Manifestations ➤ Diabetes with Ophthalmic Manifestations ➤ Diabetes with Neurological Manifestations ➤ Diabetes with Peripheral Circulatory Disorders ➤ Diabetes with Other Specified Manifestations ➤ Diabetes with Unspecified Complication ➤ Diabetes Mellitus Complicating Pregnancy ▪ The beneficiary is under the age of 16, has one of the diagnoses above, and the pump is ordered by a pediatric endocrinologist.
	<p>PA is required for the following:</p> <ul style="list-style-type: none"> ▪ Medical need beyond the Standards of Coverage. ▪ Diagnoses/conditions other than those listed above. ▪ Replacement of pump within five years.
Payment Rules	<p>Insulin pumps are considered a purchase only item.</p> <p>The purchase payment is inclusive and includes all of the following:</p> <ul style="list-style-type: none"> ▪ A 30-day trial period at no cost to Medicaid or the beneficiary prior to purchase of device. ▪ Comprehensive care coordination, including a plan for follow-up monitoring by the physician after installation of the pump.

2.11 DIABETIC SHOES AND INSERTS

Definition	Diabetic shoes, inserts and related modifications include, but are not limited to, depth inlay shoes, multi-density inserts, roller or rocker bottoms, wedges, metatarsal bar, and offset heel.
Standards of Coverage	<p>Diabetic shoes, inserts, and/or modifications may be covered for individuals who have, due to complications with diabetes mellitus, one of the following conditions:</p> <ul style="list-style-type: none"> ▪ History of previous foot ulcerations or pre-ulcerative calluses. ▪ Established peripheral neuropathy or sensory impairment. ▪ Peripheral Vascular Disease with an ankle brachial index at rest of 0.5 or less following exercise.



	<ul style="list-style-type: none"> Loss of a toe or portion of the foot due to amputation arising from diabetes. <p>A custom-molded diabetic shoe is covered only if the depth shoe cannot accommodate a foot anomaly.</p> <p>Inserts are covered if the beneficiary requires a depth shoe or custom-molded diabetic shoe. For a depth shoe, three inserts would be separately reimbursable in addition to the noncustomized one included with the shoe. For a custom-molded shoe, two inserts would be separately reimbursable. Modifications to a custom-molded or depth shoe may be covered rather than an additional insert.</p>
Documentation	<p>Documentation must be less than 30 days old and include all of the following:</p> <ul style="list-style-type: none"> Diagnosis/medical condition related to the service requested. Medical reasons for specific shoe type and/or modification.
PA Requirements	<p>PA is not required for the following inserts if the Standards of Coverage are met:</p> <ul style="list-style-type: none"> Multiple density insert, direct formed, molded to foot with external heat source. Multiple density insert, direct formed, compression molded to patient's foot without external heat source. Multiple density insert, custom fabricated and custom-molded from model of patient's foot. Depth inlay shoes. Modifications if an additional insert is not provided. <p>PA is required for:</p> <ul style="list-style-type: none"> Medical need beyond the Standards of Coverage. Replacement within one year. Quantity beyond established limits. Custom-fabricated shoes and other inserts not included above.
Payment Rules	<p>All items are considered purchase only.</p>

2.12 ENCLOSED BED SYSTEMS

Definition	<p>An Enclosed Bed System includes the mattress, bed frame, and enclosure as one unit.</p>
Standards of Coverage	<p>An Enclosed Bed System may be covered if the following applies:</p> <ul style="list-style-type: none"> There is a diagnosis/medical condition (e.g., seizure activity) which could result in injury in a standard bed, crib, or hospital bed; and There are no economic alternatives to adequately meet the beneficiary's needs.



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Documentation	<p>The documentation must be less than six months old and include:</p> <ul style="list-style-type: none"> ▪ Diagnosis/medical condition requiring use of the bed and any special features (if applicable). ▪ Safety issues resulting from the medical condition and related to the need for an Enclosed Bed System. ▪ Other products or safety methods already tried without success (e.g., bumper pads/rails). ▪ Type of bed requested. ▪ Type of special features requested, if applicable.
Noncovered Conditions	Enclosed Bed Systems are not covered when the purpose is to restrain the beneficiary due to behavioral conditions, caregiver need or convenience, etc.
PA Requirements	PA is required for all Enclosed Bed Systems.
Payment Rules	<p>The Enclosed Bed System is considered a purchase only item.</p> <p>For Youth Beds, refer to the Hospital Beds subsection of this chapter.</p>

2.13 ENTERAL NUTRITION

Enteral nutrition is nutrition administered by tube or orally into the gastrointestinal tract. Enteral nutrition is classified into categories that possess similar characteristics. Categories for enteral nutrition are listed by HCPCS codes on the MDHHS Medical Supplier/DME/Prosthetics and Orthotics Fee Schedule on the MDHHS website. For the appropriate HCPCS code, products are listed on the enteral nutrition product classification list on the website for the Medicare Pricing, Data Analysis and Coding (PDAC) contractor. If the formula is not listed in the covered HCPCS codes, the provider must contact the PDAC contractor for a coding determination. (Refer to the Directory Appendix for website and contact information.)



2.13.A. ENTERAL NUTRITION (ADMINISTERED ORALLY)

<p>Standards of Coverage</p>	<p>Enteral nutrition (administered orally) may be covered for beneficiaries under the age of 21 when:</p> <ul style="list-style-type: none"> ▪ A chronic medical condition exists resulting in nutritional deficiencies, and a three-month trial is required to prevent gastric tube placement; or ▪ Supplementation to regular diet or meal replacement is required, and the beneficiary's weight-to-height ratio has fallen below the fifth percentile on standard growth grids; or ▪ Physician documentation details low percentage increase in growth pattern or trend directly related to the nutritional intake and associated diagnosis/medical condition. <p>For CSHCS coverage, a nutritionist or appropriate pediatric subspecialist must indicate that long-term enteral supplementation is required to eliminate serious impact on growth and development.</p> <p>For Healthcare Common Procedure Coding System (HCPCS) code B4162, the beneficiary must have a specified inherited disease of metabolism identified by the International Classification of Diseases (ICD).</p> <p>For beneficiaries age 21 and over:</p> <ul style="list-style-type: none"> ▪ The beneficiary must have a medical condition that requires the unique composition of the formula nutrients that the beneficiary is unable to obtain from food; or ▪ The nutritional composition of the formula represents an integral part of treatment of the specified diagnosis/medical condition; or ▪ The beneficiary has experienced significant weight loss. <p>For Healthcare Common Procedure Coding System (HCPCS) code B4157, the beneficiary must have a specified inherited disease of metabolism identified by the International Classification of Diseases (ICD).</p>
<p>Documentation</p>	<p>Documentation must be less than 30 days old and include:</p> <ul style="list-style-type: none"> ▪ Specific diagnosis/medical condition related to the beneficiary's inability to take or eat food. ▪ Duration of need. ▪ Amount of calories needed per day. ▪ Current height and weight, as well as change over time. (For beneficiaries under 21, weight-to-height ratio.) ▪ Specific prescription identifying levels of individual nutrient(s) that is required in increased or restricted amounts. ▪ List of economic alternatives that have been tried. <p>For continued use beyond 3-6 months, the CSHCS Program requires a report from a nutritionist or appropriate pediatric subspecialist.</p>



PA Requirements	PA is required for all enteral formula for oral administration.					
	The following HCPCS codes require authorization via a telephone authorization process:					
	B4034	B4035	B4036	B4081	B4082	B4083
	B4087	B4088	B4100	B4102	B4105	B4149
	B4150	B4152	B4153	B4154	B4155	B4157
	B4158	B4159	B4160	B4161	B4162	B9002
	B9998	E0776				
Refer to the Directory Appendix for Telephone Prior Authorization Contractor information.						

2.13.B. ENTERAL NUTRITION (ADMINISTERED BY TUBE)

Standards of Coverage	Enteral formula are covered when the diagnosis/medical condition requires placement of a gastric tube and nutrition is administered by syringe, gravity, or pump.																													
Documentation	Documentation must be less than 30 days old and include: <ul style="list-style-type: none"> Specific diagnosis/medical condition requiring tube feeding. Duration of treatment. Amount needed per day. If a pump is required, the medical reason why syringe or gravity method could not be used. 																													
PA Requirements	PA is not required for standard formula for enteral tube feedings provided up to the program's established quantity limits per month. (Applies only to specific enteral formula and related supplies and equipment. Refer to the Medicaid Code and Rate Reference tool for additional information.)																													
	PA is required for the following: <ul style="list-style-type: none"> All specialized enteral formula requests for tube feedings. Over-quantity requests for standard formula enteral tube feedings. Medical need beyond Standards of Coverage. 																													
	The following HCPCS codes require authorization via a telephone authorization process:																													
	<table border="1"> <tr> <td>B4034</td> <td>B4035</td> <td>B4036</td> <td>B4081</td> <td>B4082</td> <td>B4083</td> </tr> <tr> <td>B4087</td> <td>B4088</td> <td>B4100</td> <td>B4102</td> <td>B4105</td> <td>B4149</td> </tr> <tr> <td>B4150</td> <td>B4152</td> <td>B4153</td> <td>B4154</td> <td>B4155</td> <td>B4157</td> </tr> <tr> <td>B4158</td> <td>B4159</td> <td>B4160</td> <td>B4161</td> <td>B4162</td> <td>B9002</td> </tr> <tr> <td>B9998</td> <td>E0776</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>	B4034	B4035	B4036	B4081	B4082	B4083	B4087	B4088	B4100	B4102	B4105	B4149	B4150	B4152	B4153	B4154	B4155	B4157	B4158	B4159	B4160	B4161	B4162	B9002	B9998	E0776			
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B4158	B4159	B4160	B4161	B4162	B9002																									
B9998	E0776																													
Refer to the Directory Appendix for Telephone Prior Authorization Contractor information.																														



2.13.C. ENTERAL NUTRITION PAYMENT RULES

When billing for enteral formula (administered orally or by tube), the appropriate formula HCPCS code should be billed on a monthly basis with total calories used (divided by 100) as the unit amount. (To calculate the appropriate number of caloric units, combine total calories of all cans to be used and divide by 100.) Medicaid will reimburse for a maximum quantity of up to 900 units for any combination of approved formula.

Providers should refer to the following chart for additional assistance:

Formula	100 calories = 1 unit (u)	6 (8 oz) cans a day	1 month = 30 days	6 months = 180 days	\$5.00 cost/8 oz liquid or packet or can
Standard @ 250 calories/8 oz	250 cals/100 = 2.5 units	2.5 u x 6 = 15 units a day	15 u x 30 = 450 units a month	15 u x 180 = 2700 units for 6 months	\$5.00 ÷ 2.5 u = \$2.00 per unit
Caloric Dense @ 355 calories/8 oz	355 cals/100 = 3.55 units	3.55 u x 6 = 21 units a day	21 u x 30 = 630 units a month	21 u x 180 = 3780 units for 6 months	\$5.00 ÷ 3.55 u = \$1.41 per unit
Powder, 1 package = 150 calories	150 cals/ 100 = 1.5 units	1.5 u x 6 = 9 units a day	9 u x 30 = 270 units a month	9 u x 180 = 1620 units for 6 months	\$5.00 ÷ 1.5 u = \$3.33 per unit
Powder, 1# can = 112 oz when mixed @ 20 calories/oz* = 2240 calories for the entire can (*can vary with physician orders)	2240 cals/100 = 22.4 units		6 cans per month = 22.4 u x 6 = 134 units a month	134 u x 6 months = 804 units for 6 months	\$5.00 ÷ 22.4 u = \$0.30 per unit

The necessary equipment and supply code for enteral tube feedings should be billed up to specified quantity limits. Feeding bags, anchoring devices, syringes, drain sponges, cotton tip applicators, tape, adaptors, and connectors used in conjunction with a gastrostomy or enterostomy tube are included in the supply kit codes and should not be billed separately.

Dietary formula for oral feedings may be obtained from either a medical supplier or a pharmacy.

Dietary formula for tube feedings are covered only through the medical supplier.

2.14 HIGH FREQUENCY CHEST WALL OSCILLATION DEVICE

Definition	A high frequency chest wall oscillation (HFCWO) system is an airway clearance device consisting of an inflatable vest connected by two tubes to a small air-pulse generator that is easy to transport. The air-pulse generator rapidly inflates and deflates the vest, gently compressing and releasing the chest wall to create mini-coughs that dislodge mucus from the bronchial walls, increase mobilization, and facilitates it along toward central airways.
Standards of Coverage	A HFCWO system may be covered up to four months if both of the following apply: <ul style="list-style-type: none"> ▪ Diagnosis of Cystic Fibrosis, and ▪ All other treatment modalities have not been effective.



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Documentation	Documentation must be less than 180 days old and include: <ul style="list-style-type: none">▪ Diagnosis pertaining to the need for this unit.▪ Severity of condition (e.g., frequency of hospitalizations, pulmonary function tests, etc.).▪ Current treatment modalities and others already tried.▪ Plan of care by the attending Cystic Fibrosis (CF) Center specialist substantiating need for the device is required under the CSHCS Program.▪ For continuation beyond the initial four months, the following information must be provided:<ul style="list-style-type: none">➢ Documentation of client compliance through the review of equipment use logs; and➢ Medical statement from a CF Center Specialist substantiating the continued effectiveness of the vest is required under the CSHCS program.
PA Requirements	PA is required for all requests.
Payment Rules	The HFCWO system chest compression generator system is considered a capped rental item and is inclusive of the following: <ul style="list-style-type: none">▪ All accessories necessary to use the equipment except for the vest itself. This may be separately reimbursed during the initial rental period.▪ Education on the proper use and care of the equipment.▪ Routine servicing and all necessary repairs and replacements to make the equipment functional.



2.15 HOME INTRAVENOUS INFUSION THERAPY

Definition	Intravenous infusion therapy, administered in the home, is medicine injected directly into a vein.
Standards of Coverage	<p>Coverage of home infusion therapy, its expected course, and duration of treatment is based on the plan of care prescribed by the physician. Only the days involving active infusion will be considered for payment. The medical supplier facilitating the administration of home infusion therapy must:</p> <ul style="list-style-type: none"> ▪ Be accredited through The Joint Commission or other appropriate accrediting body. ▪ Maintain logs detailing proper equipment maintenance consistent with manufacturer's requirements. ▪ Provide education and training to the beneficiary or caregiver related to proper care techniques. ▪ Provide comprehensive care coordination involving the pharmacist, nurses, physician or any other infusion therapy professional.
Documentation	<p>Documentation must be less than 30 days old and include the following:</p> <ul style="list-style-type: none"> ▪ Diagnosis appropriate for specified therapy ▪ Dosage, frequency, route and duration of medication(s) being infused <p>Documentation for antibiotic, antiviral and/or antifungal therapies must include at least one of the following tests results to support the diagnosis:</p> <ul style="list-style-type: none"> ▪ Positive culture from appropriate site (e.g., a blood culture for diagnosis of sepsis, wound culture for diagnosis osteomyelitis, etc.) ▪ Bone scan showing osteomyelitis ▪ X-ray showing osteomyelitis or abscess ECHO/ultrasound showing endocarditis ▪ Vegetations or abscess ▪ CT or MRI scan showing osteomyelitis or abscess ▪ Minimum of three of the following: <ul style="list-style-type: none"> ➢ Fever of 101° F or more, pain, warmth, redness, edema in affected area ➢ Elevated C-reactive protein ➢ Elevated white blood cell count ➢ Elevated erythrocyte sedimentation rate (ESR) ➢ A trial course of oral antibiotic therapy with no improvement or worsening of symptoms ▪ For the diagnoses of cellulitis, pneumonia, urinary tract infection, and otitis media, documentation must indicate a failure of oral antibiotic therapy, unless a culture shows bacteria that is not sensitive to oral antibiotic medications available. This does not apply to cystic fibrosis pneumonia; PA is not needed with a positive sputum culture or a history of positive sputum cultures.



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	Documentation for electrolyte replacement therapy (condition unrelated to hydration status) must include a copy of the appropriate abnormal laboratory level (e.g., low potassium level for diagnosis hypokalemia, etc.).
	Documentation for steroid therapy must indicate exacerbation of multiple sclerosis or diagnosis related to transplant rejections.
	Documentation for chemotherapy and pain management therapy must include a cancer diagnosis and a copy of the treatment protocol to which the beneficiary has been assigned.
	Documentation for hydration therapy for hyperemesis gravidarum must include laboratory results indicating current dehydration level, estimated delivery date, and must address a trial of anti-emetics.
	Documentation for gammaglobulin therapy must include abnormal IGG, IGM, IGA or IGE levels prior to the beneficiary receiving an IVIG. If beneficiary has been receiving IVIG infusion therapy in an outpatient or physician office setting, these laboratory tests may not be current.
	Documentation for iron overload therapy must indicate a diagnosis of Sickle Cell Anemia and support the need for the requested therapy.
	Documentation for factor products must indicate a clotting disorder diagnosis and support the need for requested therapy.
	Documentation for anti-emetic infusion must indicate a diagnosis of cancer or hyperemesis gravidarum and include a trial of oral anti-emetics.
	The provider must keep verification of equipment maintenance on file that includes: <ul style="list-style-type: none"> ▪ Name of the manufacturer. ▪ Dates the equipment was checked for proper use, care and function according to the manufacturer's requirements.
PA Requirements	PA is not required for specific HCPCS "S" codes if all of the following apply: <ul style="list-style-type: none"> ▪ Standards of Coverage are met ▪ Beneficiary is age five or older (for factor products, beneficiaries of all ages) ▪ Medical need for the therapy is related to one of the diagnoses/conditions that do not require PA. (For details regarding covered HCPCS "S" codes, PA requirements and related ICD diagnosis exception code ranges, and quantity limits, refer to the Medicaid Code and Rate Reference tool.



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PA is required for the following:

- Medical need beyond the Standards of Coverage.
- The beneficiary is under the age of five.
- Infusion days exceed the established Medicaid limits.

When PA is required, the following HCPCS codes are authorized via a telephone authorization process:

S5498	S5501	S5502	S5520
S5521	S9326	S9327	S9330
S9331	S9338	S9345	S9346
S9348	S9351	S9355	S9374
S9375	S9376	S9377	S9379
S9490	S9497	S9500	S9501
S9502	S9503	S9504	S9537

Refer to the Directory Appendix for Telephone Prior Authorization Contractor information.



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Payment Rules	<p>Reimbursement for the HCPCS "S" codes related to home intravenous infusion therapy is calculated on a per diem basis as defined by the code descriptions.</p> <p>Costs included within the per diem rate:</p> <ul style="list-style-type: none">▪ All infusion related supplies and equipment, such as the infusion pump, needles, syringes, gauze, sterile tubing, catheters, etc. (For pump-related infusion, the per diem rate payment includes routine servicing and all necessary repairs or replacements to make the rented DME functional.)▪ The compounding of medications compliant with standards of pharmaceutical practice, including a medication profile set-up with recommendations of dosage or medication changes if needed.▪ Patient educational activities related to receiving home infusion therapy and the coordination of care with physicians, nurses and other caregivers. <p>Costs not associated with the per diem rate:</p> <ul style="list-style-type: none">▪ Medications (drugs) must be billed as pharmacy services.▪ Nursing visits are covered through a Home Health Agency.▪ PICC and Midline insertion procedures and associated supplies may be billed separately. <p>HCPCS "S" codes must be reported as a daily rate by reporting the total number of days used as units unless otherwise noted. Routine catheter care is included within the daily rate for the active infusion. For interim maintenance of an infusion line not currently in use, report the appropriate catheter care code and bill as a daily rate by reporting the total number of days used as units. For catheter maintenance of an implanted port, bill the appropriate HCPCS code with modifier "22". Details regarding the type and frequency of catheter maintenance completed must be reported in the Remarks area of the claim.</p> <p>If multiple drugs are being administered concurrently for the same therapy, report modifier "SH" for two drugs or "SJ" for three or more drugs. If multiple therapies are needed, more than one therapy code may be reported.</p> <p>For chemotherapy and pain management, the specific HCPCS code will designate either continuous or intermittent administration. If the therapy is provided without interruption for 24 hours or more, report the continuous therapy code. For less than 24 hours of therapy, use the intermittent code.</p> <p>For antibiotic, antiviral, or antifungal therapy, report the code that best describes the frequency of administration. Only one therapy code of this series may be reported on the same date of service. If multiple drugs are administered, report modifier "SH" or "SJ".</p> <p>With the administration of Medicare Part D drug(s) to dual eligibles (Medicaid/Medicare), report the appropriate HCPCS "S" code for medical supplies and/or equipment (e.g., IV poles, tubing) associated with home intravenous infusion therapy. For dual eligibles residing in a nursing facility, the equipment and supplies are part of the facility's per diem rate.</p>
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2.16 HOME UTERINE ACTIVITY MONITOR

Definition	A home uterine activity monitor (HUAM) is used to record the frequency of uterine contractions for the purpose of predicting pre-term delivery. The monitor is worn on a belt and records the uterine contractions that are transmitted across modem lines to a central monitoring office that contacts the physician's office for interpretation.
Standards of Coverage	<p>A HUAM may be covered for up to 90 days in the home setting for a beneficiary at high risk for pre-term delivery during the 24th through the 36th gestational week, and one of the following medical conditions applies:</p> <ul style="list-style-type: none"> ▪ Pre-term labor on tocolytics. ▪ History of pre-term labor or delivery in previous pregnancies. ▪ Incompetent cervix (cerclage).
Documentation	<p>Documentation must be less than 90 days old and include:</p> <ul style="list-style-type: none"> ▪ Diagnosis and/or medical condition pertaining to the need for the monitor. ▪ Expected date of birth. ▪ Last day of the 36th week of gestation. ▪ Involvement with a regional perinatal center.
PA Requirements	<p>PA is required for all monitors.</p> <p>HCPCS code S9001 requires authorization via a telephone prior authorization process. (Refer to the Directory Appendix for Telephone Prior Authorization Contractor information.)</p>
Payment Rules	<p>A HUAM is a rental only item and is inclusive of the following:</p> <ul style="list-style-type: none"> ▪ The monitor and other related supplies required to use the equipment properly. ▪ Education on proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. ▪ Periodic downloading and interpretation of the data. ▪ Perinatal nursing services related to oversight of the use of the monitor. <p>To provide a HUAM, the medical supplier must complete the CHAMPS Provider Enrollment (PE) on-line application process, selecting a subspecialty of Home Uterine Monitor. (Refer to the Directory Appendix for CHAMPS PE information.)</p>



2.17 HOSPITAL BEDS

Definition	A hospital bed has a special construction, consisting of a frame and an innerspring mattress, with a head and/or leg elevation adjustment mechanism for the purpose of repositioning.
Standards of Coverage	<p>A standard hospital bed may be covered if:</p> <ul style="list-style-type: none"> ▪ The diagnosis/medical condition requires a specific elevation or positioning of the body not possible with a standard bed (elevation of 30 degrees or greater). ▪ The body requires positioning in a hospital bed to alleviate pain. <p>For other beds, the above Standards of Coverage must be met, and one of the following applies:</p> <ul style="list-style-type: none"> ▪ Variable height hospital bed may be covered if different heights are medically necessary for assisting beneficiary transfers from the chair, wheelchair or standing position. ▪ Heavy-duty extra-wide hospital bed may be covered if a beneficiary weighs more than 350 pounds but does not exceed 600 pounds. ▪ Extra heavy-duty bed may be covered if a beneficiary weighs more than 600 pounds. ▪ A fully electric hospital bed may be covered when frequent and/or immediate changes in body position are required and there is no caregiver. ▪ A Youth bed may be covered if the beneficiary is under the age of 21 and the bed is required to have crib style side rails. <p>Hospital Bed Accessories</p> <ul style="list-style-type: none"> ▪ The trapeze bar may be covered when required by the beneficiary to assist with transfers or frequent changes in body position. ▪ Side rails are covered when required for safety. ▪ A replacement innerspring mattress or foam rubber mattress may be covered for replacement when the beneficiary owns the bed.
Noncovered Condition	Youth beds are not covered for the sole purpose of age appropriateness.
Documentation	<p>Documentation must be less than 90 days old and include the following:</p> <ul style="list-style-type: none"> ▪ Diagnosis/medical condition related to the service requested. ▪ Medical and/or functional reasons for the specific type of hospital bed and/or accessory. ▪ Any alternatives tried or ruled out.



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PA Requirements	<p>PA is not required if the Standards of Coverage are met and the following applies:</p> <ul style="list-style-type: none"> ▪ For fixed height, variable height, semi-electric beds, side rail, and trapeze for one of the following diagnoses/medical conditions: <ul style="list-style-type: none"> ➤ Multiple Sclerosis ➤ Infantile Cerebral Palsy ➤ Congenital or Hereditary Progressive Muscular Dystrophy ➤ Fracture of the Cervical or Dorsal Areas (open or closed) ▪ Procedure codes E0255, E0256, E0260, E0292, E0293, E0910, E0940 up to three months for hospital discharge when required for diagnoses not removed from PA.
	<p>PA is required for:</p> <ul style="list-style-type: none"> ▪ Medical need beyond the Standards of Coverage. ▪ Full electric beds or any other hospital beds and/or accessories requiring PA as specified in the Medicaid Code and Rate Reference tool. ▪ Replacement of a fixed height, variable height, or semi-electric bed and/or accessory within five years.
Payment Rules	<p>A bed may be a capped rental or purchase item.</p> <p>If unit is billed as a capped rental, the rental payment would be inclusive of the following:</p> <ul style="list-style-type: none"> ▪ All accessories needed to use the equipment except for trapezes, side rails, and mattresses where appropriate. ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.18 INCONTINENT SUPPLIES

Definition	<p>Incontinent supplies are items used to assist individuals with the inability to control excretory functions.</p> <p>The type of coverage for incontinent supplies may be dependent on the success or failure of a bowel/bladder training program. A bowel/bladder training program is defined as instruction offered to the beneficiary to facilitate:</p> <ul style="list-style-type: none"> ▪ Independent care of bodily functions through proper toilet training. ▪ Appropriate self-catheter care to decrease risk of urinary infections and/or avoid bladder distention. ▪ Proper techniques related to routine bowel evacuation.
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<p>Standards of Coverage (Not Applicable to CSHCS Only Beneficiaries)</p>	<p>Diapers, incontinent pants, liners, and belted/unbelted undergarments without sides are covered for individuals age three or older if both of the following applies:</p> <ul style="list-style-type: none"> ▪ A medical condition resulting in incontinence and there is no response to a bowel/bladder training program. ▪ The medical condition being treated results in incontinence, and beneficiary would not benefit from or has failed a bowel/bladder training program.
	<p>Pull-on Briefs are primarily considered a short-term transitional product for beneficiaries with a medical condition causing incontinence of bowel and/or bladder.</p> <p><u>Pull-on brief coverage for ages 3 through 20:</u></p> <p>Pull-on briefs are covered when there is the presence of a medical condition causing bowel/bladder incontinence and one of the following applies:</p> <ul style="list-style-type: none"> ▪ For short term use: The beneficiary is actively participating in a bowel/bladder training plan and is demonstrating consistent measurable progress in the plan (i.e., consistent reduction in the amount of pull-on briefs used, successful completion of the bowel/bladder training in three years or less, etc.); or ▪ For long term use: The beneficiary has a permanent medical condition (such as Muscular Dystrophy, Spina Bifida, etc.) that will prevent the beneficiary from ever achieving bowel and bladder continence; however, the beneficiary has the cognitive and physical ability to care for his/her toileting needs independently or with minimal assistance. <p>Bowel/Bladder Training Plan</p> <p>A bowel/bladder training plan must be designed and implemented within the school and home environments in order to achieve optimum success.</p> <p>Initial Nursing Assessment and Reassessment</p> <p>The use of pull-on briefs requires an initial nursing assessment and reassessment every six months thereafter or a time determined by the Michigan Department of Health and Human Services (MDHHS). Reassessments must detail measurable progress the beneficiary has made in the training plan since the last assessment. Long-term use requires an initial nursing assessment and reassessment every 24 months thereafter or a time determined by MDHHS. Documentation of the initial nursing assessment and reassessment(s) must be kept in the beneficiary file.</p> <p>If the beneficiary no longer has a medical condition causing bowel/bladder incontinence and he/she has not achieved continence within three years of the start of the bowel/bladder training program, the pull-on briefs will no longer be a covered benefit.</p> <p><u>Pull-on brief coverage for ages 21 and older:</u></p> <p>Pull-on briefs are covered when there is the presence of a medical condition causing bowel/bladder incontinence and the beneficiary is able to care for his/her toileting needs independently or with minimal assistance from a caregiver and one of the following applies:</p> <ul style="list-style-type: none"> ▪ For short term use: The beneficiary has a temporary medical condition (including recent discharge from a nursing home or hospital) causing bowel/bladder incontinence; or



	<ul style="list-style-type: none"> ▪ For long term use: The beneficiary has a permanent medical condition (such as Muscular Dystrophy, Spina Bifida, etc.) that will prevent the beneficiary from ever achieving bowel and bladder continence. <p>Initial Nursing Assessment and Reassessment</p> <p>The use of pull-on briefs requires an initial nursing assessment. Reassessment is required whenever there is a prior authorization request for a change in quantity or a medical condition resulting in continued need beyond established policy timelines. Recent discharge from a nursing home or hospital is considered a qualifying condition for short-term use of pull-on briefs. Beneficiaries with medical conditions which result in permanent incontinence or who have product needs over established policy quantities must be re-assessed every 12 months or a time determined by MDHHS. Documentation of the initial nursing assessment and reassessment(s) must be kept in the beneficiary file.</p> <p>Pull-on briefs are not covered for the following:</p> <ul style="list-style-type: none"> ▪ Beneficiaries under 3 years of age. ▪ A medical condition causing incontinence of bowel/bladder is not present. ▪ For children who have an occasional bowel or bladder accident. ▪ Night time incontinence of bowel or bladder. <p>Incontinent wipes are covered when necessary to maintain cleanliness outside of the home.</p> <p>Disposable underpads are covered for beneficiaries of all ages with a medical condition resulting in incontinence.</p>
<p>Standards of Coverage (Applicable to All Programs)</p>	<p>Intermittent catheters are covered when catheterization is required due to severe bladder dysfunction. Hydrophilic-coated intermittent catheters are considered for individuals that have Mitrofanoff stomas, partial stricture or small, tortuous urethras.</p> <p>Intermittent catheters with insertion supplies are covered for beneficiaries who have a chronic urinary dysfunction for which sterile technique is clinically required.</p>
<p>Documentation</p>	<p>Documentation must be less than 30 days old, kept in the beneficiary file, and include the following:</p> <ul style="list-style-type: none"> ▪ Diagnosis of condition causing incontinence (primary and secondary diagnosis). ▪ Item to be dispensed. ▪ Duration of need. ▪ Quantity of item and anticipated frequency the item requires replacement. <p>In addition to the above documentation requirements, pull-on briefs require the following:</p> <ul style="list-style-type: none"> ▪ An initial nursing assessment for all ages, regardless of whether the pull-on briefs will be used short or long term. ▪ A six-month reassessment is required for under 21 years of age or a time determined by MDHHS.



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	<ul style="list-style-type: none"> If the beneficiary has a medical condition that results in permanent incontinence, reassessment is required annually or a time determined by MDHHS. For under age 21 and attending school, a copy of the teacher's continence report or a letter from the school detailing the bowel/bladder plan. The reassessment must have a copy of the teacher's plan or school letter detailing any changes to the plan and progress made since the last assessment.
PA Requirements	<p>PA is required for:</p> <ul style="list-style-type: none"> Hydrophilic type urinary catheters. usage over the established quantities.
	<p>PA is not required for all other incontinent items unless usage exceeds established quantity limitations.</p>
Payment Rules	<p>Volume Purchase Agreement - Through a competitive bid process, the State of Michigan has contracted with a volume purchase contractor for selected incontinent supplies for beneficiaries enrolled in Medicaid FFS and CSHCS.</p> <p>Beneficiaries Exempt from the MDHHS Volume Purchase Contract - Based on dual eligibility, specific beneficiaries may be exempt from obtaining services from the MDHHS Volume Purchase Contractor as described below:</p> <ul style="list-style-type: none"> Beneficiaries dually enrolled in Medicaid and Medicare are not required to obtain Medicare-covered incontinence items from the contractor but may choose to if preferred. Beneficiaries enrolled in a MHP will receive coverage of these products through the medical supplier contracted by the health plan. This medical supplier could be the Contractor if negotiated by the MHP. Beneficiaries enrolled in either a commercial FFS plan or HMO if its coverage includes incontinence supplies are expected to follow the primary payer's rules first. If these products are not covered by the plan, the beneficiary must obtain these items through the MDHHS Volume Purchase Contractor.
Services Covered Through the Contract	<p>The following list details the selected incontinent supply items that must be obtained from the MDHHS Volume Purchase Contractor for Medicaid and CSHCS Programs. Beneficiaries dually eligible for Medicaid and Medicare are required to obtain the contracted incontinent items (designated with an X) from the MDHHS Volume Purchase Contractor.</p>

HCPCS Code	Nomenclature	CSHCS Coverage	Mandatory for Medicaid/Medicare
A4310	Insert Tray w/o Bag/Cath	X	
A4311	Catheter w/o Bag 2-Way Latex	X	
A4312	Cath w/o Bag 2-Way Silicone	X	
A4314	Cath w/Drainage 2-Way Latex	X	
A4315	Cath w/Drainage 2-Way Silicone	X	



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HCPSC Code	Nomenclature	CSHCS Coverage	Mandatory for Medicaid/Medicare
A4320	Irrigation Tray	X	
A4322	Irrigation Syringe	X	
A4326	Male External Catheter	X	
A4328	Female Urinary Collection Pouch	X	
A4330	Perianal Fecal Collection Pouch	X	
A4331	Extension Drainage Tubing	X	
A4333	Urinary Cath Anchor Device	X	
A4334	Urinary Cath Leg Strap	X	
*A4335	Incontinence Supply	X	
A4338	Indwelling Catheter Latex	X	
A4340	Indwelling Catheter, Specialty Type	X	
A4344	Cath Indw Foley 2-Way Silicone	X	
A4349	Disposable Male External Cat	X	
A4351	Straight Tip Urine Catheter	X	
A4352	Coude Tip Urinary Catheter	X	
A4353	Intermittent Catheter w/insertion supplies	X	
A4354	Insertion Tray w/Drainage Bag w/o Cath	X	
A4357	Bedside Drainage Bag	X	
A4358	Urinary Leg Bag or Abdomen Bag	X	
**A4520	Incontinence Garment Any Type		X
A5112	Urinary Leg Bag; Latex	X	
T4521	Adult Size Brief/Diaper SM		X
T4522	Adult Size Brief/Diaper MED		X
T4523	Adult Size Brief/Diaper LG		X
T4524	Adult Size Brief/Diaper XL		X
T4525	Adult Size Pull-On SM		X



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HCPCS Code	Nomenclature	CSHCS Coverage	Mandatory for Medicaid/Medicare
T4526	Adult Size Pull-On MED		X
T4527	Adult Sized Pull-On LG		X
T4528	Adult Size Pull-On XL		X
T4529	Ped Size Brief/Diaper SM/MED		X
T4530	Ped Size Brief/Diaper LG		X
T4531	Ped Size Pull-On SM/MED		X
T4532	Ped Size Pull-On LG		X
T4533	Youth Size Brief/Diaper		X
T4534	Youth Size Pull-On		X
T4535	Disposable Liner/Shield/Pad		X
T4536	Reusable Pull-On Any Size		X
T4541	Large Disposable Underpad		X
T4542	Small Disposable Underpad		X
T4543	Bariatric Disposable Incontinent Brief/Diaper		X
T4544	Adult disposable incontinence product, protective underwear/pull-on, above extra large		X
S5199	Personal Care Item, NOS (Incontinent Wipe)		X
<p>* Use HCPCS code A4335 only to report belted/unbelted undergarments w/o sides. PA is not required up to the established quantity limit of 150 per month.</p> <p>** Use HCPCS code A4520 only for moisture resistant reusable incontinence pants.</p>			
<p>Quantity Limitations Based on Combination of Items Used</p>		<p>Diapers and Pull-on Briefs - For a beneficiary using both diapers and pull-on briefs, the combined total quantity of these items cannot exceed 300 per month. (The maximum amount of pull-on briefs is 150 per month even if the beneficiary is not using diapers.)</p> <p>Diapers of Different Sizes - For a beneficiary using a combination of different sized diapers, the total quantity must not exceed 300 per month.</p>	



2.19 LIFTS (HYDRAULIC AND ELECTRIC)

Definition	Lifts include, but are not limited to, hydraulic and electric, and accessories include slings and/or seats.
Standards of Coverage	<p>A standard hydraulic lift may be covered when the beneficiary requires assistance in transfers, provision of the lift will allow the beneficiary to be transferred safely, and one of the two conditions stated below are met:</p> <ul style="list-style-type: none"> ▪ The beneficiary requires a one-person assist but the weight or size of the beneficiary prohibits safe transfers or could cause harm to the caregiver. ▪ The beneficiary requires a two-person assist and there are not two caregivers in the home. <p>An electric lift may be covered when the above Standards of Coverage are met and the hydraulic lift cannot be used safely or when the beneficiary's medical condition results in increased tone (e.g., spasticity).</p>
Documentation	<p>Documentation must be less than 90 days old and include the following:</p> <ul style="list-style-type: none"> ▪ Diagnosis/condition requiring use of the lift. ▪ Functional level of assistance required to complete activities of daily living (ADLs). ▪ Type of transfer required. ▪ Weight and height of the beneficiary. ▪ Type of lift requested. ▪ An occupational or physical therapy evaluation and recommendation. ▪ Number of caregivers in the home and number of hours during the 24-hour period that each caregiver is present.
PA Requirements	<p>PA is not required if Standards of Coverage are met for:</p> <ul style="list-style-type: none"> ▪ Hydraulic lifts ▪ Replacement slings or seats <p>PA is required for:</p> <ul style="list-style-type: none"> ▪ Electric lifts ▪ Replacement within ten years
Payment Rules	<p>A lift may be a capped rental or purchase item.</p> <p>If unit is billed as a capped rental, the rental payment would be inclusive of the following:</p> <ul style="list-style-type: none"> ▪ All accessories needed to use the equipment. ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.



2.20 MECHANICAL IN-EXSUFFLATION DEVICE

Definition	A mechanical in-exsufflation device is a portable electric device that utilizes a blower and a valve to alternately apply a positive and then a rapid negative pressure to an individual's airway to assist the person to cough more effectively.
Standards of Coverage	<p>A mechanical in-exsufflation device may be covered for up to four months if the following applies:</p> <ul style="list-style-type: none"> ▪ Diagnosis of respiratory failure due to neuromuscular deficits. ▪ Beneficiary is unable to cough or clear secretions effectively due to reduced peak expiratory force. ▪ Other treatment modalities have not been effective (e.g., inhalers, PEP mask therapy, or flutter devices). <p>For coverage beyond four months, continued use of a mechanical in-exsufflation device may be covered when there is continued effectiveness.</p>
Documentation	<p>Documentation must be less than 180 days old and include the following:</p> <ul style="list-style-type: none"> ▪ Diagnosis/medical condition related to the service requested. ▪ Current treatment modalities and any others already tried. ▪ Documentation of beneficiary's ability to use. ▪ Plan of care from a pulmonologist substantiating need for this device is required under the CSHCS program. ▪ For coverage beyond the first four months, medical statement substantiating continued effectiveness.
PA Requirements	PA is required for all requests.
Payment Rules	<p>A mechanical in-exsufflation device is a capped rental item and is inclusive of the following:</p> <ul style="list-style-type: none"> ▪ All accessories needed to use the unit (e.g., circuits, filters etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.21 NEBULIZER

Definition	A nebulizer is a powered device that allows a medication to be changed from a liquid to a mist so it may be effectively inhaled into the lungs. Types of nebulizers include, but are not limited to, standard and ultrasonic.
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<p>Standards of Coverage</p>	<p>A standard nebulizer device may be covered if:</p> <ul style="list-style-type: none"> ▪ The beneficiary has a diagnosis related to an obstructive airway disease (e.g., asthma, bronchopulmonary dysplasia, chronic obstructive pulmonary disease [COPD], etc.). ▪ The physician has already considered use of a metered dose inhaler and it was insufficient to meet the needs of the beneficiary. <p>An ultrasonic nebulizer is covered when a standard nebulizer is ineffective.</p>
<p>Documentation</p>	<p>Documentation must be less than 90 days old and include the following:</p> <ul style="list-style-type: none"> ▪ Diagnosis/condition requiring use of the nebulizer. ▪ Medications prescribed. ▪ Frequency of administration. ▪ Medical reason economic alternatives are ineffective. ▪ For an ultrasonic nebulizer, pulmonary function testing done after use of a standard nebulizer and after use of an ultrasonic nebulizer showing the ultrasonic is more efficacious.
<p>PA Requirements</p>	<p>PA is not required if Standards of Coverage are met for standard nebulizer and associated accessories up to established quantity limits.</p> <p>PA is required for:</p> <ul style="list-style-type: none"> ▪ Ultrasonic nebulizer. ▪ Replacement of standard nebulizer within five years. ▪ When the Standards of Coverage are not met.
<p>Payment Rules</p>	<p>A nebulizer is considered either a capped rental or purchase item. Accessories are separately reimbursable.</p> <p>If the unit is billed as a capped rental, the rental payment would be inclusive of the following:</p> <ul style="list-style-type: none"> ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.

2.22 NEGATIVE PRESSURE WOUND THERAPY (PUMP AND ACCESSORIES)

<p>Definition</p>	<p>Negative pressure wound therapy (NPWT) utilizes a sub-atmospheric (negative) pressure technique to reduce edema, increase localized blood flow and granulation tissue formation, and remove exudates from the wound. The NPWT pump must be able to apply pressure intermittently or continuously in a range from 25 - 125 mm HG and accommodate multiple wounds.</p>
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<p>Standards of Coverage</p>	<p>Negative pressure wound therapy is covered for short-term therapy (7 to 14 days) if one of the following conditions applies and failure of several less expensive treatment modalities has occurred:</p> <ul style="list-style-type: none"> ▪ Stage III or IV pressure ulcer(s) - <ul style="list-style-type: none"> ➢ Beneficiary has been part of a comprehensive ulcer management program (e.g., appropriately turned and positioned, appropriately managed for either moisture or incontinence, received adequate nutritional support, etc.) for at least the last 30 days. ➢ Beneficiary has used either a Group 2 or 3 Support Surface for at least the last 30 days. ▪ Diabetic Ulcers - Beneficiary has been on a comprehensive diabetic management program. ▪ Venous stasis ulcers - <ul style="list-style-type: none"> ➢ Compression bandages have been applied consistently. ➢ Mobility and leg elevation have been encouraged. ▪ Dehisced incisions or traumatic wounds - Wound care clinical protocols have been ineffective.
<p>Documentation</p>	<p>All documentation, except wound measurements, must be less than 30 days old. Documentation of wound measurements must be less than seven days old and include the following:</p> <ul style="list-style-type: none"> ▪ Evaluation, care and wound measurements by a licensed medical professional. ▪ All previous dressings tried. ▪ Debridement of necrotic tissue, if applicable. ▪ Evaluation and provision of adequate nutritional status. ▪ Appropriate turning/repositioning schedule. ▪ Incontinence management, if applicable. ▪ Appropriate pressure reduction addressed if wound is pressure related.
<p>Continued Coverage</p>	<p>For continued coverage beyond the initial 7 to 14 days, documentation must be submitted detailing updated wound measurements and substantiate continued effectiveness.</p>
<p>PA Requirements</p>	<p>PA is required for all requests.</p> <p>HCPCS codes A6550, A7000 and E2402 require authorization via a telephone prior authorization process. (Refer to the Directory Appendix for Telephone Prior Authorization Contractor information.)</p>
<p>Payment Rules</p>	<p>A negative pressure wound therapy pump is a rental only service. Payment for the pump is considered as a daily rental rate by reporting total number of days used as units.</p> <p>The canister and dressing set are considered purchase items and may be separately reimbursed from the pump code.</p>



2.23 ORTHOPEDIC FOOTWEAR

Definition	Orthopedic footwear may include, but are not limited to, orthopedic shoes, surgical boots, removable inserts, Thomas heels, and lifts.
Standards of Coverage	<p>Orthopedic shoes and inserts may be covered if any of the following applies:</p> <ul style="list-style-type: none"> ▪ Required to accommodate a leg length discrepancy of ¼ inch or greater or a size discrepancy between both feet of one size or greater. ▪ Required to accommodate needs related to a partial foot prosthesis, clubfoot, or plantar fasciitis. ▪ Required to accommodate a brace (extra depth only are covered). <p>Surgical Boots or Shoes may be covered to facilitate healing following foot surgery, trauma or a fracture.</p>
Noncovered Items	<p>Shoes and inserts are noncovered for the conditions of:</p> <ul style="list-style-type: none"> ▪ Pes Planus or Talipes Planus (flat foot) ▪ Adductus metatarsus ▪ Calcaneus Valgus ▪ Hallux Valgus <p>Standard shoes are also noncovered.</p>
Documentation	<p>Documentation must be less than 60 days old and include the following:</p> <ul style="list-style-type: none"> ▪ Diagnosis/medical condition related to the service requested. ▪ Medical reasons for specific shoe type and/or modification. ▪ Functional need of the beneficiary. ▪ Reason for replacement, such as growth or medical change. <p>CSHCS requires a prescription from an appropriate pediatric subspecialist.</p>



PA Requirements	<p>PA is not required for the following items if the Standards of Coverage are met:</p> <ul style="list-style-type: none"> ▪ Surgical boots or shoes. ▪ Shoe modifications, such as lifts, heel wedges, or metatarsal bar wedges up to established quantity limits. ▪ Orthopedic shoe to accommodate a brace. ▪ Orthopedic shoes and inserts when the following medical conditions are present: <ul style="list-style-type: none"> ➤ Plantar Fascial Fibromatosis ➤ Unequal Leg Length (Acquired) ➤ Talipes Equinovarus (Clubfoot) ➤ Longitudinal Deficiency of Lower Limb, Not Elsewhere Classified ➤ Unilateral, without Mention of Complication (Partial Foot Amputation) ➤ Unilateral, Complicated (Partial Foot Amputation) ➤ Bilateral, without Mention of Complication (Partial Foot Amputation) ➤ Bilateral, Complicated (Partial Foot Amputation)
	<p>PA is required for:</p> <ul style="list-style-type: none"> ▪ All other medical conditions related to the need for orthopedic shoes and inserts not listed above. ▪ All orthopedic shoes and inserts if established quantity limits are exceeded. ▪ Medical need beyond the Standards of Care. ▪ Beneficiaries under the age of 21, replacement within six months. ▪ Beneficiaries over the age of 21, replacement within one year.
Payment Rules	<p>These are purchase only items.</p>

2.24 ORTHOTICS (CERVICAL)

Definition	<p>Cervical orthotics include, but are not limited to, cervical collars and cranial helmets.</p>
Standards of Coverage	<p>Cervical collars may be covered to facilitate healing and/or restrict mobility for the following indications:</p> <ul style="list-style-type: none"> ▪ Pre- and post-surgery ▪ Pre- and post-cervical fusion ▪ Cervical trauma ▪ Post fractures



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	<p>Cervical helmets may be covered to prevent head injury for beneficiaries with medical conditions affecting balance that predisposes them to fall.</p> <p>For the medical condition of plagiocephaly, a custom fabricated cranial remolding orthosis is covered and must include the following:</p> <ul style="list-style-type: none"> ▪ Proper measurements including topography, casting, etc. ▪ The use of a FDA registered helmet. ▪ All necessary follow-up visits, including fitting and adjustments, for 18 months after placement.
<p>Documentation</p>	<p>Documentation must be less than 60 days old and include the following:</p> <ul style="list-style-type: none"> ▪ Diagnosis/medical condition related to the service requested. ▪ Medical reasons for appliance requested. ▪ Functional needs of the beneficiary. ▪ Reason for replacement, such as growth or medical change. ▪ Prescription from an appropriate pediatric subspecialist is required under the CSHCS program. <p>For repairs, a copy of the physician's prescription at the time of original placement and itemization of materials used to repair appliance or rationale for related labor costs must be documented.</p>
<p>PA Requirements</p>	<p>PA is not required when the Standards of Coverage are met for:</p> <ul style="list-style-type: none"> ▪ Cervical collars. ▪ Nonmolded cranial helmets. ▪ Molded cranial helmets for a beneficiary under the age of one year with diagnosis of plagiocephaly when prescribed by an appropriate pediatric subspecialist. ▪ Repairs as follows: <ul style="list-style-type: none"> ➢ The total repair cost equals one hour of labor or less ➢ The cost of minor parts equals \$50 or less <p>PA is required for:</p> <ul style="list-style-type: none"> ▪ Custom molded cranial helmets for conditions other than plagiocephaly. ▪ Replacement of a cranial nonmolded helmet or cervical collar within one year. ▪ Repair costs exceed the maximum limits as stated above.
<p>Payment Rules</p>	<p>These are covered as purchase only items.</p>

2.25 ORTHOTICS (LOWER EXTREMITY)

<p>Definition</p>	<p>Lower extremity orthotics includes, but is not limited to, hip, below knee, above knee, knee, ankle, and foot orthoses, etc.</p>
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Standards of Coverage	<p>Lower extremity orthotics (including night splints), regardless of diagnosis, are covered for the following manifestations:</p> <ul style="list-style-type: none">▪ To promote healing and/or proper alignment/positioning following injury, procedure (e.g. serial casting), or surgery of the lower extremity.▪ To support lower extremities due to muscle weakness or abnormal muscle tone (e.g. high/low fluctuating tone) of permanent or long-standing duration (six months or longer).▪ To support, correct or improve:<ul style="list-style-type: none">➢ Biomechanical alignment (e.g. pronation, supination, varus or valgus).➢ Static or dynamic contractures.➢ Congenital or acquired deformities of the lower extremities.
Documentation	<p>Documentation must be less than 60 days old and include the following:</p> <ul style="list-style-type: none">▪ Diagnosis/medical condition related to the service requested.▪ Medical reasons for appliance requested including current functional level.▪ A physical therapy evaluation may be required on a case-by-case basis when PA is required.▪ Reason for replacement, such as growth or medical change.▪ Prescription from an appropriate pediatric subspecialist is required under the CSHCS program.▪ Medical justification for each additional component required. <p>For repairs, a new prescription is not required if the original orthotic was covered by MDHHS. A copy of the original prescription for the orthotic and itemization of materials used to repair appliance and rationale for related labor costs must be documented.</p>



<p>PA Requirements</p>	<p>PA is not required for the following if the Standards of Coverage are met:</p> <ul style="list-style-type: none"> ▪ Fracture orthosis for fractures. ▪ Hip orthosis for Legg Perthes. ▪ Prefabricated knee appliances. ▪ Custom-fabricated knee orthosis for Old Disruption of Anterior Cruciate Ligament. ▪ Prefabricated ankle foot orthosis (AFO) and knee ankle foot orthosis (KAFO). ▪ Custom-fabricated plastic AFOs if up to four additional components with the base code as indicated in the Medicaid Code and Rate Reference tool (add-ons include double action joints, t-strap or malleolar pad, varus/valgus modification and soft interface). ▪ Custom-fabricated metal AFOs if up to six additional components with the base code as indicated in the Medicaid Code and Rate Reference tool (add-ons include double action joints, noncorrosive finish, t-strap or malleolar pad, extended steel shank, long tongue stirrup and growth extensions). Shoes are not considered an add-on and would be considered in addition to the other items. ▪ Custom-fabricated plastic KAFOs if up to eight additional components with the base code as indicated in the Medicaid Code and Rate Reference tool (add-ons include double action joints, t-strap or malleolus pad, drop lock, varus/valgus modification, noncorrosive finish, knee cap, soft interface and growth extensions). ▪ Custom-fabricated metal KAFOs if up to eight additional components with the base code as indicated in the Medicaid Code and Rate Reference tool (add-ons include double action joints, t-strap or malleolus pad, drop lock, growth extensions, noncorrosive finish, knee cap, extended steel shank and long tongue stirrup). Shoes are not considered an add-on and would be considered in addition the other items. <p>If other add-on items not listed above or a greater number of components are medically necessary, PA is required for the entire appliance. Additional components are not covered simply to add reimbursement value to the appliance.</p> <p>For repairs, up to two episodes per year, as follows:</p> <ul style="list-style-type: none"> ▪ The total repair cost equals one hour of labor or less. ▪ The cost of minor parts equals \$50 or less. <p>PA is required for:</p> <ul style="list-style-type: none"> ▪ Custom fabricated knee orthoses for all other diagnoses/medical conditions. ▪ Hip Knee Ankle Foot Orthosis (HKAFO) for all other diagnoses/medical conditions. ▪ Fracture orthosis for all other diagnoses/medical conditions. ▪ Other base codes or additional codes indicated as requiring PA in the Medicaid Code and Rate Reference tool. ▪ Repair costs exceed the maximum limits as stated above. ▪ Replacement within six months for a beneficiary under the age of 21, from the original service date. ▪ Replacement within two years for a beneficiary over the age of 21, from the original service date.
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Payment Rules	These are covered as purchase only items.
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2.26 ORTHOTICS (SPINAL)

Definition	Spinal orthotics include, but are not limited to, cervical, thoracic, lumbar, sacral, spinal, thoracic mid belt lumbar sacral, and sacroiliac orthotics.
Standards of Coverage	<p>Spinal orthotics are covered to:</p> <ul style="list-style-type: none"> ▪ Facilitate healing following a spinal injury. ▪ Arrest or correct the curvature of the spine or spondylolisthesis greater than grade 1. ▪ Support weak spinal muscles due to atrophy and/or a deformed spine. ▪ Facilitate healing following spinal surgery.
Documentation	<p>Documentation must be less than 60 days old and include the following:</p> <ul style="list-style-type: none"> ▪ Diagnosis/medical condition related to the service requested. ▪ Medical reasons for appliance. ▪ Functional needs of the beneficiary. ▪ Reason for replacement, such as growth or medical change. ▪ Prescription from an appropriate pediatric subspecialist is required under the CSHCS program. <p>For repairs, a new prescription is not required if the original orthotic was covered by MDHHS. A copy of the original prescription for the orthotic, itemization of materials used to repair the appliance, and rationale for related labor costs must be documented.</p>



<p>PA Requirements</p>	<p>PA is not required for the following if the Standards of Coverage are met:</p> <ul style="list-style-type: none"> ▪ Prefabricated thoracic-lumbar-sacral orthosis (TLSO) ▪ Prefabricated lumbar sacral orthosis (LSO) ▪ Prefabricated sacroiliac supports ▪ Cervical-Thoracic-Lumbar -Sacral Orthosis (CTLSO) for the treatment of curvature of the spine ▪ Custom-fabricated TLSOs, LSOs, and sacroiliac supports for the base code and up to three additional components indicated in the Medicaid Code and Rate Reference tool and with one of the following diagnoses: <ul style="list-style-type: none"> ➢ Neurofibromatosis, Type 1 ➢ Scoliosis (and Kyphoscoliosis), Idiopathic ➢ Progressive Infantile Idiopathic Scoliosis ➢ Curvature of Spine (Scoliosis) ** ➢ Certain Congenital Musculoskeletal Deformities of the Spine ➢ Spondylolisthesis <p>**Curvature of the spine (scoliosis) must be listed in conjunction with the other conditions of Charcot-Marie-Tooth Disease or Neurofibromatosis to not require PA.</p> ▪ For repairs, up to two episodes per year, as follows: <ul style="list-style-type: none"> ➢ The total repair cost equals one hour of labor or less. ➢ The cost of minor parts equals \$50 or less.
<p>Payment Rules</p>	<p>PA is required for:</p> <ul style="list-style-type: none"> ▪ Diagnoses/medical conditions not removed from PA. ▪ Repair costs exceed the maximum limits as stated above. ▪ Replacement within one year, for a beneficiary under the age of 21, from the original service date. ▪ Replacement within two years, for a beneficiary over the age of 21, from the original service date. <p>These are covered as purchase only items.</p>



2.27 ORTHOTICS (UPPER EXTREMITY)

Definition	Upper extremity orthotics include, but are not limited to, shoulder, elbow, wrist, and hand orthotics.
Standards of Coverage	<p>Upper extremity orthoses are covered:</p> <ul style="list-style-type: none"> ▪ Following an acute cerebral vascular accident. ▪ To support weak muscles due to a neuromuscular condition. ▪ Facilitate healing immediately following surgery. ▪ Improve function due to a congenital paralytic syndrome (e.g., Muscular Dystrophy).
Documentation	<p>Documentation must be less than 60 days old and include the following:</p> <ul style="list-style-type: none"> ▪ Diagnosis/medical condition related to the service requested. ▪ Medical reasons for appliance requested. ▪ Functional needs of the beneficiary. ▪ Reason for replacement such as growth or medical change. ▪ Prescription from an appropriate pediatric subspecialist is required under the CSHCS program. <p>For repairs, a new prescription is not required if the original orthotic was covered by MDHHS. A copy of the original prescription for the orthotic and itemization of materials used to repair appliance and rationale for related labor costs must be documented.</p>
PA Requirements	<p>PA is not required for the following if the Standards of Coverage are met:</p> <ul style="list-style-type: none"> ▪ Prefabricated shoulder orthosis (SO), elbow orthosis (EO) and shoulder-elbow-wrist-hand orthosis (SEWHO). ▪ Custom fabricated SOs, EOs and SEWHOs if the base code and up to two additional components are needed. ▪ Prefabricated upper extremity fracture orthosis if the treatment is related to a fracture related condition. ▪ Custom fabricated upper extremity fracture orthosis if the base code and up to two additional components are needed. ▪ Prefabricated wrist-hand-finger orthosis (WHFO) and hand-finger orthosis (HFO). ▪ For repairs as follows: <ul style="list-style-type: none"> ➤ The total repair cost equals one hour of labor or less. ➤ The cost of minor parts equals \$50 or less.



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	<p>PA is required for:</p> <ul style="list-style-type: none"> ▪ Custom fabricated WHFOs and HFOs. ▪ Repair costs that exceed the maximum limits as stated above. ▪ Replacement within one year, for a beneficiary under the age of 21, from the original service date. ▪ Replacement within two years, for a beneficiary over the age of 21, from the original service date.
Payment Rules	These are covered as purchase only items.

2.28 OSTEOGENESIS STIMULATORS

Definition	<p>An Osteogenesis Stimulator is a device that provides electrical or ultrasonic signal stimulation to augment bone repair. Osteogenesis stimulators include:</p> <ul style="list-style-type: none"> ▪ Noninvasive electrical stimulator characterized by an external power source which is attached to a coil or electrodes placed on the skin or on a cast or brace over a fracture or fusion site; or ▪ Noninvasive electrical multi-level spinal stimulator which involves three or more vertebrae (e.g., L3-L5, L4-S1, etc.); or ▪ Noninvasive low intensity ultrasound stimulator which produces pulsed ultrasonic signals rather than electricity to stimulate bone repair by applying the signal to the skin surface at the fracture site. <p>A long bone is limited to the clavicle, humerus, radius, ulna, femur, tibia, fibula, metacarpal, or metatarsal.</p> <p>The FDA classifies osteogenesis stimulators as Class III devices.</p>
Standards of Coverage	<p>A noninvasive, nonspinal electrical or low intensity ultrasonic osteogenesis stimulator may be covered when other treatment methods have been ineffective and when one of the following applies:</p> <ul style="list-style-type: none"> ▪ There is a nonunion of a long bone fracture with radiographic evidence which indicates that the fracture healing has ceased for three or more months prior to starting treatment with the osteogenesis stimulator. ▪ There is a nonunion of a nondisplaced scaphoid fracture. ▪ If there is failed fusion of a joint, other than in the spine, where a minimum of nine months has elapsed since the surgery. ▪ Congenital Pseudoarthrosis not due to lack of skeletal maturity. ▪ The fracture gap is ≤ 1 cm. ▪ A nonunion of a long bone fracture as described by the appropriate ICD code. <p>Treatment using the above stimulators may not be provided concurrently.</p>



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	<p>A spinal electrical osteogenesis stimulator may be covered when other treatment methods have been ineffective and when one of the following applies:</p> <ul style="list-style-type: none"> ▪ There is a failed spinal fusion where a minimum of nine months has elapsed since the last surgery. ▪ Following multi-level (three or more vertebrae) spinal fusion surgery without instrumentation. ▪ Clinical indication in cervical spine fusions with instrumentation (reviewed on case by case basis). ▪ Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same level(s). How long ago was the failure? ▪ May also be indicated as an adjunct to high-risk fusion; cases that meet one or more of the following criteria: <ul style="list-style-type: none"> ➢ Smoking (cessation attempts) ➢ Diabetes ➢ Metabolic disease where bone healing is likely to be compromised ➢ Grade III or greater spondylolisthesis <p>Treatment using the above stimulator may not be provided concurrently with nonspinal osteogenesis stimulators.</p>				
<p>Covered Conditions</p>	<p>The current International Classification of Diseases (ICD) code related to the type and location of the fracture must be reported by the physician on the prescription/order and in the medical documentation.</p> <table border="1" data-bbox="506 1155 1425 1690"> <tr> <td data-bbox="506 1155 776 1459"> <p>Long Bone Fractures</p> </td> <td data-bbox="776 1155 1425 1459"> <ul style="list-style-type: none"> • Clavicle • Humerus • Radius* and ulna • Femur • Fracture of other and unspecified parts of femur • Tibia* and fibula • Metacarpal bones (hands) • One or more tarsal and metatarsal* bones </td> </tr> <tr> <td data-bbox="506 1459 776 1690"> <p>Other Fractures</p> </td> <td data-bbox="776 1459 1425 1690"> <ul style="list-style-type: none"> • Ankle • Closed navicular (scaphoid*) of wrist • Malunion of fracture • Nonunion of fracture • Acquired spondylolisthesis • Congenital spondylolisthesis </td> </tr> </table> <p>*Coverage of fresh fractures is limited to tibia, radius, scaphoid, and fifth metatarsal.</p>	<p>Long Bone Fractures</p>	<ul style="list-style-type: none"> • Clavicle • Humerus • Radius* and ulna • Femur • Fracture of other and unspecified parts of femur • Tibia* and fibula • Metacarpal bones (hands) • One or more tarsal and metatarsal* bones 	<p>Other Fractures</p>	<ul style="list-style-type: none"> • Ankle • Closed navicular (scaphoid*) of wrist • Malunion of fracture • Nonunion of fracture • Acquired spondylolisthesis • Congenital spondylolisthesis
<p>Long Bone Fractures</p>	<ul style="list-style-type: none"> • Clavicle • Humerus • Radius* and ulna • Femur • Fracture of other and unspecified parts of femur • Tibia* and fibula • Metacarpal bones (hands) • One or more tarsal and metatarsal* bones 				
<p>Other Fractures</p>	<ul style="list-style-type: none"> • Ankle • Closed navicular (scaphoid*) of wrist • Malunion of fracture • Nonunion of fracture • Acquired spondylolisthesis • Congenital spondylolisthesis 				



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<p>Non-Covered Conditions</p>	<p>Medicaid does not cover the use of a bone growth stimulator for any of the following indications as it is considered experimental, investigational, or unproven (not all inclusive):</p> <ul style="list-style-type: none"> ▪ Fresh fractures (other than when using ultrasound bone stimulation for the tibia or radius) ▪ Toe fractures ▪ Sesamoid fractures ▪ Avulsion fractures ▪ Osteochondral lesions ▪ Stress fractures ▪ Displaced fractures with malalignment ▪ Synovial pseudoarthrosis ▪ Fractures related to malignancy ▪ The bone gap is either > 1 cm or > one-half the diameter of the bone ▪ Primary surgeries with current internal fixation techniques (i.e., pedical screw fixation and variants) ▪ Lack of skeletal maturity (refer to congenital pseudoarthrosis)
<p>Documentation</p>	<p>Documentation must be less than 90 days old and include all of the following:</p> <ul style="list-style-type: none"> ▪ Diagnosis/medical condition related to the need for the device. ▪ Alternative treatment methods tried and results. ▪ For a diagnosis of fracture nonunion, reports of sequential x-ray results for a period of no less than 90 days and office records, including previous treatments and operative procedures (if any). ▪ For a spinal fusion procedure, pertinent office and/or hospital records as well as a legible, complete description of indications for electrical stimulation. A copy of the operative report(s) may be required. ▪ Other modalities still to be used (include type and location).
<p>PA Requirements</p>	<p>PA is required and approved for three months at a time for up to a maximum of ten months.</p> <p>For consideration of rental beyond the initial three months, a new MSA-1653-B must be submitted, along with physician documentation establishing medical reason(s) for continued need.</p>
<p>Payment Rules</p>	<p>Osteogenesis stimulators are considered a capped rental item and are inclusive of the following:</p> <ul style="list-style-type: none"> ▪ All accessories needed to use the unit (e.g., electrodes, wires, cables, coupling gel, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional based on manufacturer warranty.



	<p><u>After purchase:</u></p> <p>Accessories needed to use the device, or the replacement of the stimulator, require prior authorization. The manufacturer’s warranty must be exhausted prior to requesting a replacement osteogenesis stimulator.</p>
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2.29 OSTOMY SUPPLIES

Definition	Ostomy supplies are those products necessary to maintain and care for a temporary or permanent stoma and include, but are not limited to, belts, barriers, adhesive remover, filters and pouches.
Standards of Coverage	<p>Standard wear ostomy products are changed daily and are covered for specified quantities when the beneficiary has an ostomy.</p> <p>Extended wear ostomy products may be covered when change is not required on a daily basis. The quantities must match manufacturers' recommendations for use.</p>
Documentation	<p>Documentation must be less than 90 days old and include the following:</p> <ul style="list-style-type: none"> ▪ Diagnosis/medical condition. ▪ Appliance required. ▪ Quantity of item. ▪ Frequency of change. ▪ Type and location of ostomy. ▪ Condition of the skin surface surrounding the stoma.
PA Requirements	PA is not required for ostomy supplies up to established quantity limits.
	PA is required for quantities above established program limits.
Payment Rules	These are purchase only items.

2.30 OXYGEN, OXYGEN EQUIPMENT AND ACCESSORIES [CHANGES MADE 4/1/20]

Definition	Oxygen therapy includes, but is not limited to, stationary compressed systems, portable gaseous systems, stationary liquid systems, portable liquid systems, and concentrators.
Standards of Coverage	<p>Stationary oxygen equipment and accessories may be covered in the home setting for either short-term (less than six months) or long-term (six months or greater) use.</p> <p>For beneficiaries under age 21, oxygen therapy may be covered when oxygen is required during a variety of activities (e.g., sleeping, feeding, resting) and there is an oxygen saturation rate of 93 percent or below or PO2 level of 65 mm HG or below.</p>



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	<p>For beneficiaries age 21 and older, when the beneficiary requires oxygen for continuous use (test taken while the beneficiary is at rest, breathing room air), nocturnal use (test taken while sleeping), or exercise use (test taken during exercise) and the oxygen saturation rate is 88 percent or below or the PO2 level is 55 mm HG or below.</p> <p>Once the Standards of Coverage are met, the type of equipment covered is determined by the following:</p> <ul style="list-style-type: none"> ▪ Medical diagnosis and/or condition related to the need for oxygen. ▪ Activity level. ▪ Amount of liter flow needed. <p>The three main types of oxygen systems are:</p> <ul style="list-style-type: none"> ▪ Compressed Oxygen System – Used primarily for intermittent use or low liter flow requirements (less than one liter per minute). A portable unit may be authorized if activities cannot be accomplished by the use of a stationary unit alone. ▪ Concentrators - Used for higher liter flows, usually one liter or more. A portable compressed oxygen unit may be authorized if activities cannot be accomplished by the use of a concentrator alone. ▪ Liquid Oxygen System - Used for high liter flow requirements. Liter flow must be ordered at more than four liters per minute. In cases where liquid oxygen is inappropriate, a compressed gas or concentrator system could be covered if criteria for that unit are met.
<p>Documentation</p>	<p>Documentation must be less than 30 days old and include the following:</p> <ul style="list-style-type: none"> ▪ Diagnosis/medical condition appropriate for the need of oxygen. ▪ Required liter flow (e.g., two liters per minute). An order for "Oxygen PRN" or "Oxygen as Needed" does not meet this requirement. ▪ Hours used per day (e.g., eight hours a day). For intermittent use (less than eight hours per day), indicate activity or time of day. An order for "Oxygen PRN" or "Oxygen as Needed" does not meet this requirement. ▪ Duration of need (e.g., three months, six months or lifetime). ▪ Delivery system to be used (e.g., concentrator, compressed gas, liquid). ▪ Current PO2 or oxygen saturation level while on room air. (revised per bulletin MSA 19-30) ▪ For liquid oxygen, total number of pounds required per month. ▪ A prescription from a pediatric pulmonologist, a neonatologist, a pediatrician intensivist, and/or pediatric cardiologist is required under the CSHCS program. <p>(text deleted per bulletin MSA 19-30)</p>



Equipment Maintenance - Verification of the proper use, care and function (e.g., verification that the equipment delivers the proper percentage of liter flow) must be performed according to the manufacturer's requirements.

The following information must also be maintained in the patient's file:

- The name of the manufacturer.
- The manufacturer's requirements for verification of proper use, care and function of the equipment.
- The date that each equipment verification was performed.

Six-Month Recertification - After the initial prescription for home oxygen therapy, a six-month follow-up certificate of medical necessity (CMN) must be obtained. At this time, a new pO₂ or oxygen saturation test with the beneficiary on room air must be obtained and indicated on the CMN, along with the date of the test, to substantiate continued need for treatment.

Annual Recertification - Following the first year of oxygen treatment, a new CMN and prescription are required annually. An updated lab test is not required unless there is a change in the level of oxygen usage or type of delivery system required. The most recent pO₂ or oxygen saturation level and the date of the test must be documented on each annual CMN. **(text added per bulletin MSA 19-30)**



<p>PA Requirements</p>	<p>PA is not required for gaseous stationary, concentrators, and portable oxygen systems if the Standards of Coverage are met and the beneficiary has one of the following diagnoses descriptions:</p> <ul style="list-style-type: none"> ▪ Bronchiectasis ▪ Bronchopulmonary Disease ▪ Chronic Airway Obstruction ▪ Chronic Bronchitis ▪ Chronic Pulmonary Heart Disease ▪ Coccidioidomycosis ▪ Congenital Central Alveolar Hypoventilation Syndrome ▪ Congenital Heart Disease ▪ Heart Failure ▪ Idiopathic Sleep Related Nonobstructive Alveolar Hypoventilation ▪ Malignant Neoplasm of Trachea, Bronchus, and Lung ▪ Muscular Dystrophies and other Myopathies ▪ Myoneural Disorders ▪ Other Alveolar and Parietoalveolar Pneumonopathy ▪ Other and Unspecified Disorders of Metabolism (Cystic Fibrosis) ▪ Other Diseases of Blood and Blood -Forming Organs (Secondary Polycythemia, Familial Polycythemia) ▪ Other Emphysema ▪ Pneumoconioses and other Lung Diseases due to External Agents ▪ Postinflammatory Pulmonary Fibrosis ▪ Primary Central Sleep Apnea ▪ Pulmonary Eosenophilia ▪ Pulmonary Tuberculosis ▪ Secondary Malignant Neoplasm of Respiratory and Digestive Systems ▪ Sleep Related Hypoventilation Hypoxemia in Conditions Classified Elsewhere ▪ Tracheomalacia ▪ PA is not required for gaseous stationary or concentrators for the condition of obstructive sleep apnea (adult) (pediatric). <p>PA is required for:</p> <ul style="list-style-type: none"> ▪ Oxygen required for short-term use only. ▪ Liquid oxygen systems. ▪ Liquid oxygen contents only. ▪ Medical need for long-term oxygen use does not meet Standards of Coverage.
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Payment Rules	<p>All oxygen equipment is a rental only and is inclusive of the following:</p> <ul style="list-style-type: none"> ▪ All necessary accessories (e.g., regulator, tubing, mask or cannula, contents base, etc.). Stationary gaseous or liquid oxygen contents are separately payable only when the patient owns the equipment and the coverage criteria has been met. ▪ The rental payment includes routine servicing and all necessary repairs or replacements to make the rented DME functional. The equipment should be checked according to manufacturer's specifications.
	<p>Combination of Equipment Covered:</p> <ul style="list-style-type: none"> ▪ Only one delivery method is covered per month (i.e., gaseous, gaseous/concentrator or liquid). ▪ A portable compressed gaseous system or liquid system will only be provided in addition to an existing stationary system, unless oxygen is needed for ambulation only. ▪ A backup cylinder is considered part of the inclusive reimbursement for the oxygen system.
	<p>Nursing Facility Residents:</p> <ul style="list-style-type: none"> ▪ For a nursing facility resident, the DME provider may bill for oxygen gas, equipment, and supplies only when used for prolonged daily use. Intermittent or infrequent use of these items is included in the nursing facility per-diem rate. Based on this site of service, the monthly rental payment issued to the DME provider for the oxygen concentrator will be reduced compared to the payment for equipment used in the home. ▪ For a County Medical Care Facility or Hospital Long Term Care Unit, the DME provider cannot bill for oxygen gas, equipment and supplies for any resident. <p>NOTE: The rental of a concentrator is billable by a Medical Supplier.</p> <p>Frequent or prolonged use is defined as:</p> <ul style="list-style-type: none"> ▪ Long-term daily basis. ▪ At least eight hours duration or more per day.

2.31 PARENTERAL NUTRITION

Definition	Parenteral nutrition is the provision of nutrition intravenously.
Standards of Coverage	<p>Parenteral nutrition may be covered when:</p> <ul style="list-style-type: none"> ▪ There is an impairment or disease of the gastrointestinal tract that impairs the ability of nutrients to be digested and absorbed. ▪ Post-surgical nonabsorption from a recent massive small bowel resection leaving less than five feet of small bowel remaining beyond the ligament of Treitz or short bowel syndrome with severity that involves a net gastrointestinal fluid and electrolyte malabsorption in which the enteral losses exceed 50 percent of oral/enteral intake.
Documentation	<p>Documentation must be less than 30 days old and include the following:</p> <ul style="list-style-type: none"> ▪ Specific diagnosis related to the beneficiary's inability to take or eat regular food.



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	<ul style="list-style-type: none"> ▪ Amount of nutrients needed per day. ▪ Duration of treatment. ▪ Current height, weight, and recent weight loss. ▪ Identification of levels of individual nutrient(s) that are required in increased or restricted amounts. 										
PA Requirements	<p>PA is not required for parenteral equipment, supplies, and solutions when the Standards of Coverage have been met and one of the following diagnoses exists:</p> <ul style="list-style-type: none"> ▪ Noninfectious Enteritis of the Small Intestine ▪ Noninfectious Enteritis of the Large Intestine ▪ Unspecified Intestinal Obstruction ▪ Fistula of Intestine, Excluding Rectum and Anus ▪ Acute Pancreatitis ▪ Chronic Pancreatitis ▪ Cyst and Pseudocys of Pancreas ▪ Other and Unspecified Post-Surgical NonAbsorption <p>When PA is required, the following HCPCS codes are authorized via a telephone authorization process:</p> <table border="1" style="width: 100%; text-align: center;"> <tr> <td>B4185</td> <td>B4189</td> <td>B4193</td> <td>B4197</td> <td>B4199</td> </tr> <tr> <td>B4220</td> <td>B4224</td> <td>B9004</td> <td>B9006</td> <td>B9999</td> </tr> </table> <p>Refer to the Directory Appendix for Telephone Prior Authorization Contractor information.</p>	B4185	B4189	B4193	B4197	B4199	B4220	B4224	B9004	B9006	B9999
B4185	B4189	B4193	B4197	B4199							
B4220	B4224	B9004	B9006	B9999							
Payment Rules	<p>Parenteral nutrition must be billed as a daily rate by reporting total number of days used as units. The parenteral lipids, the parenteral pre-mix solution, the infusion pump, supply kit, and the administration kit may be billed in combination with each other. If reporting parenteral lipids without one of the parenteral pre-mix solutions, only the pump code is separately reimbursable. The administration kit includes all items necessary for the administration of the solution (e.g., the extension sets, pump cassettes, clamps, containers, and connectors). The supply kit includes all necessary medical supplies such as dressings, tape, alcohol wipes, filters, syringes, needles, and injection caps.</p> <p>For Medicaid beneficiaries residing in a nursing facility, the parenteral solution, equipment and supplies may be billed by the medical supplier.</p>										

2.32 PEAK FLOW METER

Definition	A peak flow meter is a small device used to measure the airflow out of the lungs.
Standards of Coverage	A peak flow meter may be covered if the beneficiary has a diagnosis related to an obstructive airway disease (e.g., asthma, COPD).



Documentation	Documentation must be less than 90 days old and include the following: <ul style="list-style-type: none"> ▪ Diagnosis/condition related to the need for the meter. ▪ Frequency of use.
PA Requirements	PA is not required if the Standards of Coverage have been met.
	PA is required when: <ul style="list-style-type: none"> ▪ Medical need is beyond Standards of Coverage. ▪ Replacement is required within one year.
Payment Rules	This is a purchase only item.

2.33 PHOTOTHERAPY (BILIRUBIN) LIGHT WITH PHOTOMETER

Definition	A phototherapy light with photometer is an ultraviolet light source used to reduce bilirubin levels.
Standards of Coverage	A phototherapy light may be covered if: <ul style="list-style-type: none"> ▪ The beneficiary is being treated for the diagnosis of neonatal jaundice. ▪ The treatment is limited to seven consecutive days and occurs during the first 30 days of life.
Documentation	Documentation must be less than 24 hours old and include: <ul style="list-style-type: none"> ▪ Diagnosis/condition related to the need for the device. ▪ Duration of need.
PA Requirements	PA is not required if the Standards of Coverage are met and there is one of the following diagnoses: <ul style="list-style-type: none"> ▪ Optic Papillitis ▪ Hemolytic Disease due to Other and Unspecified Isoimmunization ▪ Perinatal Jaundice from Other Excessive Hemolysis ▪ Neonatal Jaundice Associated with Pre-term Delivery ▪ Neonatal Jaundice due to Delayed Conjugation from Other Cases ▪ Unspecified Fetal and Neonatal Jaundice ▪ Kernicterus not due to Isoimmunization
	PA is required for: <ul style="list-style-type: none"> ▪ Diagnosis/medical condition other than those listed above. ▪ Medical need is beyond the Standards of Coverage.



Payment Rules	<p>A phototherapy light with photometer is a rental only item, and is inclusive of the following:</p> <ul style="list-style-type: none"> ▪ All accessories needed to use the unit (e.g., ultraviolet light source, a fiberoptic system with fiberoptic blanket if needed, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.
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2.34 PNEUMATIC COMPRESSORS AND APPLIANCES (LYMPHEDEMA PUMP)

Definition	<p>Pneumatic compressors and appliances may be either nonsegmented or segmented, with or without calibrated gradient pressure. An integral part of treatment, along with the pneumatic compression device, is leg or arm elevation and the use of custom fabricated gradient pressure stockings or sleeves, compression bandaging, etc.</p>
Standards of Coverage	<p>A pneumatic compression device may be covered only as a treatment of last resort (e.g., other less intensive treatment has not been effective).</p> <p>A nonsegmented device or segmented device without manual control of the pressure in each chamber may be covered for up to 90 days for any of the following:</p> <ul style="list-style-type: none"> ▪ Radical surgical procedures with removal of regional groups of lymph nodes (e.g., radical mastectomy) ▪ Post-radiation fibrosis ▪ Metastasis of malignant tumors to regional lymph nodes with lymphatic obstruction ▪ Scarring of lymphatic channels if: <ul style="list-style-type: none"> ➢ There is significant ulceration of the lower extremity(ies); and ➢ The beneficiary has received repeated, standard treatments from a physician using such methods as a compression bandage system or its equivalent. ▪ Treatment of chronic venous insufficiency with edema and/or venous ulcers ▪ Milroy's Disease ▪ Congenital anomalies ▪ Refractory lymphedema related to venous insufficiency complicated by recurrent cellulitis (scarring of the lymphatic channels) <p>A segmented device with calibrated gradient pressure may be covered when there is a painful focal lesion (e.g., significant sensitive skin scar or contracture) of the extremity that requires a reduction in pressure over the affected segment.</p>
Documentation	<p>The documentation must be less than 30 days old and include the following:</p> <ul style="list-style-type: none"> ▪ Diagnosis/condition appropriate for the equipment requested ▪ Location and size of the painful focal lesion(s) which necessitates the use of the device, if applicable ▪ Length of time each lesion has been continuously present ▪ Plan of treatment, including the frequency and duration of each treatment episode, and anticipated prognosis



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	<ul style="list-style-type: none"> Type of unit to be used, the necessary pressure in each chamber, and why the specific features of the equipment are needed Description of other treatments that have been tried
Continued Use After the Initial 90 Days	<p>For continued coverage beyond the initial 90 days, the following additional information must be provided:</p> <ul style="list-style-type: none"> Bilateral limb measurements before and after the approved treatment Results of the treatment provided
PA Requirements	PA is required for all requests.
Payment Rules	<p>A unit may be a capped rental or purchase item. If unit is billed as a capped rental, the rental payment would be inclusive of the following:</p> <ul style="list-style-type: none"> All accessories needed to use the equipment Education on the proper use and care of the equipment Routine servicing and all necessary repairs or replacements to make the unit functional

2.35 PRESSURE GRADIENT PRODUCTS

Definition	Pressure gradient products include, but are not limited to, sleeves, wrist gauntlets, vests, legs, etc.
Standards of Coverage	<p>Pressure gradient products may be covered to reduce edema, promote circulation, reduce scarring or reduce retention of fluid in the extremities due to the following conditions:</p> <ul style="list-style-type: none"> Lymphedema Chronic venous insufficiency Thrombophlebitis Burns <p>Up to two garments may be covered when the items must be worn for 24 hours.</p> <p>Gradient compression stockings are custom-fabricated or custom-measured support and are covered when ordered by a physician to treat one of the above conditions and deliver at least 18 mm HG or greater compression. For custom burn garments, refer to HCPCS codes A6501- A6512.</p> <p>Surgical stockings, such as heavy elastic or anti-embolism stockings, are covered when ordered by a physician as a short-term treatment (up to three months) after a surgical event (e.g., prevent blood clots for non-ambulatory individuals after hospital discharge). If required for treatment during an inpatient hospital stay or outpatient hospital visit, the service will not be reimbursed to the medical supplier.</p>
Documentation	<p>Documentation must be less than 60 days old and include the following:</p> <ul style="list-style-type: none"> Diagnosis of condition being treated Item to be dispensed Number of hours to be worn Location and number of extremities involved



PA Requirements	PA is not required for ready-made pressure gradient products up to established quantity limits.
	PA is required for: <ul style="list-style-type: none"> ▪ All custom-measured products and special features such as a zipper, enclosed toe, open pubis, etc. ▪ Replacement within three months
Payment Rules	All pressure gradient products are considered a purchase only item.

2.36 PROSTHETICS (LOWER EXTREMITIES)

Definition	Lower extremity prosthetics include, but are not limited to, partial foot, below knee, above knee, hip and hemi-pelvectomy prostheses.
Standards of Coverage	A lower extremity prosthesis may be covered to restore mobility for a beneficiary who demonstrates the ability to transfer and/or ambulate, and the beneficiary's potential functional level is between the ranges of K1 through K4.
Documentation	Documentation must be less than 60 days old and include the following: <ul style="list-style-type: none"> ▪ Diagnosis/medical condition related to the service requested. ▪ Current functional "K" level. ▪ An occupational or physical therapy evaluation may be required on a case-by-case basis when PA is required.
PA Requirements	<p>Below Knee Prosthesis</p> <ul style="list-style-type: none"> ▪ Preparatory prosthesis - PA is not required for a BK preparatory prosthesis when the Standards of Coverage are met and it consists of a base procedure code (e.g., L5510, L5520, or L5530) and the following add-ons: <ul style="list-style-type: none"> ➤ one test socket ➤ insert ➤ suspension system (e.g., L5666 or L5670) ➤ total contact ➤ distal cushion <p>The SACH foot is included with the BK preparatory base code. If any prosthetic foot other than a SACH foot is placed on a preparatory prosthesis, it will require prior authorization and must be transferred to the definitive prosthesis.</p>



	<ul style="list-style-type: none">▪ Definitive Exoskeletal BK prosthesis – PA is not required for a BK definitive exoskeletal prosthesis when the Standards of Coverage are met and it consists of a base procedure code (e.g., L5100, L5105, L5050) and the following add-ons:<ul style="list-style-type: none">➤ up to two test sockets➤ socket material➤ total contact➤ distal cushion➤ foot➤ suspension locking system➤ insert➤ gel liner▪ Definitive Endoskeletal BK Prosthesis - PA is not required for a BK definitive endoskeletal prosthesis when the Standards of Coverage are met and it consists of a base procedure code (e.g., L5301) and the following add-ons:<ul style="list-style-type: none">➤ up to two test sockets➤ socket material➤ total contact➤ distal cushion➤ foot➤ suspension locking system➤ insert➤ gel liner➤ cover <p>Socks and sheaths are not considered as add-ons and would be considered in addition to the other add-on items for either the preparatory or definitive prosthesis.</p>
	<p>Above Knee Prosthesis</p> <p>PA is not required for:</p> <ul style="list-style-type: none">▪ an above knee preparatory prosthesis when the Standards of Coverage are met and it consists of a base code and the following add-ons: one test socket, foot, knee, socket design and/or suspension system. Socks and sheaths are not considered as add-ons and would be considered in addition to the other items.▪ an exoskeletal above knee definitive prosthesis when the Standards of Coverage are met and it consists of a base code and the following add-ons: up to two test sockets, foot, knee, insert, socket material, socket design, and/or suspension system. Socks and sheaths are not considered as add-ons and would be considered in addition to the other items.



	<ul style="list-style-type: none"> an endoskeletal above knee definitive prosthesis when the Standards of Coverage are met and it consists of a base code and the following add-ons: up to two test sockets, foot, insert, socket material, socket design, and/or suspension system. Socks and sheaths are not considered as add-ons and would be considered in addition to the other others. <p>Refer to the Medicaid Code and Rate Reference tool for the specific codes removed from PA.</p> <p>For repairs, up to two episodes per year, as follows:</p> <ul style="list-style-type: none"> The total repair cost equals one hour of labor or less. The cost of minor parts equals \$50 or less.
	<p>PA is required for either a below knee or above knee prosthesis when:</p> <ul style="list-style-type: none"> The standards of coverage are not met. Any component part of the prosthesis requires PA. The beneficiary is over the age of 21 and replacement is required within five years. The beneficiary is under the age of 21 and replacement is required within two years.
Payment Rules	These are purchase only items.

2.37 PULSE OXIMETER

Definition	A pulse oximeter is a noninvasive device that measures arterial oxygen saturation levels and pulse rate. The device consists of a sensor attached to the patient's finger or ear lobe that is linked to a processing unit that delivers a read-out.
Standards of Coverage	<p>Pulse oximeter may be covered:</p> <ul style="list-style-type: none"> For beneficiaries 21 or over as a diagnostic tool for short-term rental (one month) if ordered for oxygen or ventilator weaning in the home. For beneficiaries under 21: <ul style="list-style-type: none"> As a diagnostic tool for short-term rental (one month) when there are suspected desaturations during sleep, stress, or feeding. Up to six months with a diagnosis requiring oxygen use. Up to six months for beneficiaries with a tracheostomy.
Documentation	<p>Documentation must be less than 90 days old and include the following:</p> <ul style="list-style-type: none"> Diagnosis/medical condition related to the need for the unit. Treatment plan addressing what is to be done for abnormal readings. Current oxygen orders, if applicable. For coverage beyond the initial six-month period, an evaluation by an appropriate pediatric subspecialist (e.g., pediatric pulmonologist, pediatric cardiologist, neurologist, ENT, or pediatric internist) is required under the CSHCS program.



PA Requirements	<p>PA is not required when the Standards of Coverage are met, the beneficiary is under 21, and has one of the following diagnoses:</p> <ul style="list-style-type: none"> ▪ Tracheostomy (Artificial Opening Status) ▪ Tracheostomy (Attention to Artificial Openings)
	<p>PA is required:</p> <ul style="list-style-type: none"> ▪ For all beneficiaries over the age of 21. ▪ When the Standards of Coverage are not met.
Payment Rules	<p>A pulse oximeter is a capped rental item and is inclusive of the following:</p> <ul style="list-style-type: none"> ▪ All accessories needed to use the unit (e.g., nondisposable infant or adult oximeter probes, cables, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. ▪ Periodic downloading of recorded data. <p>If needed for continuous use beyond the 10 months of rental, the item is considered purchased and necessary repairs and/or replacements of accessories are separately reimbursable if not covered under the manufacturer warranty. Replacement of one non-disposable probe annually is separately reimbursable without prior authorization.</p>

2.38 SPEECH GENERATING DEVICES

Definition	<p>Speech generating devices (SGD) are defined as durable medical equipment (electric or nonelectric) that provide an individual with a severe speech impairment, who is unable to communicate using natural means (e.g., spoken, written, gestures, sign language), the ability to meet his or her daily communication needs.</p> <p>Other terms used interchangeably with SGD include augmentative and alternative communication (AAC) device or augmentative communication device (ACD).</p>
Standards of Coverage	<p>To be considered for coverage, documentation must substantiate medical need for beneficiaries whose needs cannot be met using natural communication methods and demonstrate the comprehension and physical skills necessary to communicate using the requested device. An SGD will be considered medically necessary when supporting documentation demonstrates all of the following:</p> <ul style="list-style-type: none"> ▪ The prognosis for developing and using oral speech as a primary method of communication is considered guarded; ▪ The requested SGD is an integral part of the communication plan of care; and ▪ The beneficiary will be able to use the device in all environments he/she frequents (e.g., home, school, job, etc.). <p>Software intended for augmentative communication purposes may be considered upon review of documentation supporting medical necessity. If the beneficiary intends to download augmentative communication software onto his/her personal laptop, computer, or iPad, it is the responsibility of the beneficiary and/or his/her legal guardian to check with the vendor of the personal device for licensing, compatibility, repair, warranty and proprietary information.</p>



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<p>Standards of Coverage – Eye Control</p>	<p>An eye control is a type of mechanism that helps the beneficiary access the SGD. The eye control may or may not be integrated within the speech generating device. Eye control mechanisms will be covered when all of the following apply:</p> <ul style="list-style-type: none"> ▪ All other methods to operate the SGD have been evaluated and ruled out and the eye control is the most appropriate method that provides a functional level of communication (speed, accuracy, etc.); ▪ Documentation specifies medical, functional and physical necessity that supports the need for the eye control; and ▪ The evaluation(s) has documented evidence of the beneficiary’s ability to physically activate the system and demonstrate meaningful use of the device with minimal assistance from others.
<p>Non-covered</p>	<p>The following are non-covered:</p> <ul style="list-style-type: none"> ▪ Items that do not meet the definition of durable medical equipment and are not dedicated speech devices. ▪ Software to play games, create spreadsheets or documents or is not specific to augmentative communication. ▪ Environmental control units. ▪ More than one SGD per beneficiary. ▪ Registering the device. ▪ Extended warranties. ▪ SGDs used solely for education, vocational or recreational purposes. It is expected that the beneficiary will be able to use the device in all environments he/she frequents (e.g., home, school, job, etc.). ▪ Replacements based on manufacturer recommended replacement schedules. ▪ SGD requests for devices that do not match the beneficiary’s current and reasonably foreseeable communication abilities and needs. ▪ Separate billing for interfaces, cables, adapters or interconnects and switches (with the exception of accessing switches) necessary to interface with the SGD. ▪ Requests for replacement due to new technology when the beneficiary’s current SGD continues to meet his/her medical and functional needs. ▪ Items that are not defined by the American Medical Association, the Food and Drug Administration, and the Pricing, Data Analysis, and Coding (PDAC) contractor as medical devices or dedicated durable medical equipment (e.g., personal tablets, computers, iPads, iPhones, etc.).



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<p>Evaluation Components</p>	<p>A speech-language pathologist, in conjunction with other disciplines such as occupational therapists, physical therapists, psychologists, and seating specialists as needed, must provide a thorough and systematic evaluation of the beneficiary's receptive and expressive communication abilities.</p> <p>Ancillary professionals must possess proper credentials (certification, license and registration, etc.) as appropriate.</p> <p>SGD vendors (manufacturers, distributors) may not submit assessment information or justification for any requested SGD.</p> <p>An objective evaluation (using objective functional baseline measures and/or standardized testing) of the beneficiary's receptive and expressive communication abilities by a speech-language pathologist (SLP), in conjunction with other applicable disciplines (e.g., occupational therapist, physical therapist, psychologists, and seating specialists, etc.) as needed, has been performed and the SLP has documented the following:</p> <ul style="list-style-type: none"> ▪ The beneficiary's functional ability to use the device throughout their daily activities. ▪ The consideration of alternative access and positioning devices, as appropriate. ▪ The device is appropriate to the beneficiary's current comprehension, abilities and skills. ▪ The beneficiary demonstrates the cognitive, physical, visual and hearing skills necessary to communicate using the requested device. ▪ The SGD is the least costly device that meets the beneficiary's basic communication needs (in the home and in their community). Include in the evaluation supporting documentation substantiating the requested device as the least costly alternative that meets the beneficiary's current functional needs. ▪ Assessment of the beneficiary on more than one device, by more than one manufacturer, and documenting why the requested device is more appropriate than the other device(s). Include the following in the evaluation: <ul style="list-style-type: none"> ➤ Device(s) evaluated; ➤ The beneficiary's performance on each device evaluated; ➤ The device requested (brand, make/model and type); and ➤ Reasons why other evaluated devices did not meet the beneficiary's needs. ▪ A trial period using the requested device must be provided for initial device authorization requests. The trial period must be a least one month in length (the SLP may submit a prior authorization request for up to three months). The SLP must document a description of the trial period with the requested device, including length of trial, settings, outcome, and additional training needs identified.
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Documentation	<p>Documentation must be within 180 days and include:</p> <ul style="list-style-type: none">▪ the physician's order with the diagnosis directly related to the beneficiary's communication deficit. The order must be based on the SLP's evaluation of the beneficiary's communication abilities and medical needs.▪ the date of onset, progress made and a comprehensive summary of the beneficiary's communication goals. (Refer to criteria outlined in the Therapy Services Chapter, Speech-Language Therapy subsection.)▪ the assessment by a physical therapist (PT) or occupational therapist (OT) to address functional mobility and postural control.▪ the SLP's documentation of hearing and vision status.▪ a copy, if available, of the hearing (audiologist) or vision (ophthalmologist or optometrist) test if the beneficiary has had a hearing or vision test within the past 12 months.▪ a plan of care (POC) identifying other disciplines involved in the care and goals for therapy and training. For beneficiaries under the age of 21 attending school, the POC must include other disciplines and parents/legal guardian as appropriate (i.e., OT, PT, psychologist, school therapist, etc.).▪ specifications for the SGD. (Refer to the Therapy Services Chapter).▪ necessary therapy and training to allow the beneficiary to meet functional needs.▪ the speech and language evaluation results. <p>All SGD evaluation documentation must be submitted following the established criteria stated within the Evaluations and Follow-up for Speech Generating Devices/Voice Prostheses subsection of the Therapy Services Chapter.</p> <p>Documentation for modifications/upgrades must describe the changes in the beneficiary's physical, medical, cognitive, vision or hearing status that necessitates the need for the requested modifications/upgrades for the system or parts.</p> <p>A video of the beneficiary using the SGD and/or eye control is a useful tool in establishing the beneficiary's ability to use either item, but is not required. The SLP may submit a video with the prior authorization request if all of the following are met:</p> <ul style="list-style-type: none">▪ The beneficiary or beneficiary's legal guardian has dated and signed an authorization for the video documentation as additional documentation of the beneficiary's ability to use the device;▪ The video is current (within the past 12 months); and▪ The provider encrypts the video prior to sending it in with the prior authorization request (following HIPAA compliance regulations).
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<p>PA Requirements</p>	<p>The speech-language pathologist performs the functional communication assessment and SGD evaluation and initiates the prior authorization request with a medical supplier that has a specialty enrollment with MDHHS to provide SGDs. To improve beneficiary access to low-end devices, a medical supplier without a SGD specialty enrollment with MDHHS may provide SGDs with eight minutes or less of speech capability, basic SGD accessories such as switches, buttons, etc., or SGD wheelchair mounting systems. A SGD vendor must enroll through the MDHHS CHAMPS PE on-line system as a medical supplier with a subspecialty of Speech Generating Devices in order to provide the full range of SGDs. (Refer to the Directory Appendix for contact information.)</p> <p>PA is required for all SGDs, eye control mechanisms, upgrades, modifications, accessories, repairs, replacements and device trials. Required documentation must accompany the Special Services Prior Approval—Request/Authorization (MSA-1653-B) when requesting authorization for all original and replacement/upgrade SGD requests.</p> <p>A copy of the physician prescription must be submitted with the request for an SGD. The prescription must be based on the evaluation of an individual's communication abilities and medical needs made by a speech-language pathologist and other evaluation team members (as appropriate).</p>
	<p>Modifications/Upgrades - Indicate the procedure code that defines the modification(s) or upgrades.</p> <p>Providers have six months from the prior authorization approval date to provide all approved items, including the SGD, mount and accessories. After six months, a new prior authorization request must be submitted.</p> <p>Repairs - For a repair, report HCPCS code K0739 (for the labor charge) and HCPCS code E1399 (for the replacement part). PA is required for all repairs. If repair charges exceed \$150, a speech-language pathologist, occupational therapist, or physical therapist must conduct an evaluation. A statement must be included in the evaluation indicating whether the current SGD continues to meet the beneficiary's functional needs. If the beneficiary's needs are being met with the current system, PA may be granted.</p> <p>Each repair must consist of a thorough assessment of the general working condition of the entire system so that frequent repairs may be avoided. If additional repairs to the system are needed, PA for those additional services must be obtained.</p> <p>In some cases, it may be more costly to repair the SGD than to replace it. When requesting PA for a repair, provide the cost of the repair and the cost of the replacement so that determination can be made by MDHHS whether to repair or replace the device.</p>
	<p>Replacements - All replacements (identical, upgrades, downgrades) of an SGD require PA.</p>
<p>Follow-Up Services</p>	<p>The provision of speech therapy services for training following the purchase of an SGD is expected to occur within the 12 months following the beneficiary's receipt of the device. (Refer to the Therapy Services Chapter and the Medicaid Code and Rate Reference tool for PA and coverage parameters.) During this time, the SLP and SGD provider are required to ensure that a support team is in place to assist the beneficiary and/or their family with all follow-up SGD needs and therapy.</p>



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<p>Frequency</p>	<p>The program will purchase new equipment only. Only one SGD will be purchased within a three-year period for beneficiaries under age 21. Only one SGD will be purchased within five years for beneficiaries age 21 and older. Exceptions may be considered in situations where there has been a recent and significant change in the beneficiary's medical or functional status relative to the beneficiary's communication skills.</p>
<p>Warranty</p>	<p>The warranty period begins at the point when the device is in the beneficiary's home and the beneficiary has received adequate training to use the system for functional communication.</p>
<p>Repairs</p>	<p>Repairs for speech generating devices (SGD) are covered after the warranty expires for no more than one SGD per beneficiary. Additionally, repair of an SGD not purchased by MDHHS is covered only if the SGD is determined to be necessary to meet basic functional communication needs in accordance with the criteria for SGD coverage.</p> <p>For a repair, report HCPCS code K0739 (for the labor charge) and HCPCS code E1399 (for the replacement part). PA is required for all repairs. If repair charges exceed \$150, a speech-language pathologist, occupational therapist, or physical therapist must conduct an evaluation. A statement must be included in the evaluation indicating whether the current SGD continues to meet the beneficiary's functional needs. If the beneficiary's needs are being met with the current system, PA may be granted.</p> <p>Each repair must consist of a thorough assessment of the general working condition of the entire system so that frequent repairs may be avoided. If additional repairs to the system are needed, PA for those additional services must be obtained.</p> <p>In some cases, it may be more costly to repair the SGD than to replace it. When requesting PA for a repair, provide the cost of the repair and the cost of the replacement so that determination can be made by MDHHS whether to repair or replace the device.</p> <p>Technological improvements and upgrades are not considered repairs and must not be requested as such.</p> <p>The prior authorization request for repair must include:</p> <ul style="list-style-type: none"> ▪ Documentation from the SLP (or if not currently receiving speech services, a physician, a PT or OT, or teacher) confirming the current device is used by the beneficiary on a regular basis and continues to meet the beneficiary's needs; ▪ Part number(s), description(s), manufacturer name, Healthcare Common Procedure Coding System (HCPCS) codes; and ▪ Warranty information and catalog number(s) for the part number(s) to be used for the repair. <p>Repairs must extend the useful lifetime of the SGD by at least one year from the date of the repair request.</p>



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<p>Replacements</p>	<p>All replacements (identical, different, upgrades, downgrades) of an SGD require PA.</p> <p>Replacements may be covered when there has been a significant medical/functional change in the beneficiary's ability to use the SGD, the device is no longer repairable, or the cost of repairs exceeds the cost of replacement. Limits for replacement are based on medical/functional need and the operating condition of the beneficiary's current device.</p> <p>Manufacturer suggested replacement schedules are not considered a reason for replacement.</p> <p>When a current SGD needs replacement and the replacement is identical to the SGD previously purchased by MDHHS, the documentation required to be submitted with the prior authorization request is:</p> <ul style="list-style-type: none"> ▪ Clinical confirmation by the speech-language pathologist the device continues to be suitable for the beneficiary's needs; ▪ The SLP, OT or PT confirmation of the beneficiary's functional ability to use the SGD; and ▪ Cost to repair and cost to replace. <p>If an identical SGD is no longer available, a new unit that is equivalent to the original in function, utility and user adaptability will be furnished.</p> <p>When a current SGD needs replacement with an SGD that is different than the SGD previously purchased by the program, the documentation to be submitted with the prior authorization is:</p> <ul style="list-style-type: none"> ▪ A new speech and language evaluation; and ▪ A statement (to be included with the evaluation) indicating why and how the current SGD no longer meets the beneficiary's functional communication needs. <p>All other standards of coverage requirements must be met for coverage consideration.</p> <p>Replacement requests due to loss, damage or theft must include the policy or fire marshal report, as applicable, and a plan to prevent recurrence. MDHHS does not cover replacement of SGDs due to misuse or abuse.</p>
<p>Payment Rules</p>	<p>Purchase - MDHHS will purchase new equipment only. The serial number of the device purchased must be maintained on file by the vendor for audit purposes.</p> <p>Shipping and handling fees relating to the SGD equipment are not separately reimbursed.</p> <p>Reimbursement includes the charges for the SGD and all approved components.</p> <p>The provider's charge for an SGD must be based on the usual and customary charge. Reimbursement will be the lesser of the provider's charge and/or the Medicaid fee screen.</p>



	<p>Rental – Equipment will not be rented for a period of less than 30 days and may be rented for a maximum period of 90 days. The monthly rental reimbursement rate will be 1/10 of the maximum purchase reimbursement. The amount reimbursed for rental will be deducted from the total purchase price.</p> <p>MDHHS will apply the trial period rental to the purchase of the SGD. For an SGD device(s) approved for a trial period and ruled out (by the SLP, the beneficiary and/or legal guardian, DME provider, etc.) at some point during the trial period (first, second or third month), MDHHS will reimburse the SGD provider for the period of time the device was trialed. (Refer to the Medical Supplier Database and the Medicaid Code and Rate Reference tool for specific HCPCS codes and rental rates.)</p>
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2.39 SUPPORT SURFACES – GROUP 1

Definition	<p>Pressure Reducing Support Surfaces – Group 1 includes, but is not limited to, alternating pressure pad and pump; water, air, or dry pressure mattresses; or gel or gel-like pressure pads. A Group 1 support surface must provide both a waterproof cover and adequate support to prevent the beneficiary from "bottoming out" with the use of the item.</p>
Standards of Coverage	<p>A Group 1 mattress overlay or mattress may be covered if one of the following applies. The beneficiary:</p> <ul style="list-style-type: none"> ▪ Is completely immobile (i.e., cannot make changes in body position without assistance). ▪ Has limited mobility (i.e., cannot independently make changes in body position significant enough to alleviate pressure) with the presence of at least one of these additional conditions: <ul style="list-style-type: none"> ➢ Impaired nutritional status; ➢ Fecal or urinary incontinence; ➢ Altered sensory perception; or ➢ Compromised circulatory status. ▪ Has any stage pressure ulcer on the trunk or pelvis with the presence of at least one of these additional conditions: <ul style="list-style-type: none"> ➢ Impaired nutritional status; ➢ Fecal or urinary incontinence; ➢ Altered sensory perception; or ➢ Compromised circulatory status.
Documentation	<p>Documentation must be less than 30 days old and include the following:</p> <ul style="list-style-type: none"> ▪ Education of the beneficiary and/or caregiver on the prevention and/or management of pressure ulcers. ▪ Diagnosis/medical condition related to need for the item. ▪ Regular assessment by a nurse, physician, or other licensed healthcare practitioner. ▪ Appropriate turning and positioning.



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	<ul style="list-style-type: none"> ▪ Appropriate wound care (for a Stage II, III, or IV ulcer). ▪ Appropriate management of moisture/incontinence. ▪ Wound size, stage and location (for a Stage II, III or IV ulcer). ▪ Nutritional assessment and intervention consistent with the overall plan of care.
<p>PA Requirements</p>	<p>PA is not required for HCPCS codes A4640, E0184, E0185, E0186, E0187 or E0197 if the Standards of Coverage are met and one of the following diagnoses is present:</p> <ul style="list-style-type: none"> ▪ Alteration of Consciousness, Coma or Transient Alteration of Awareness ▪ Anoxic Brain Damage ▪ Anterior Horn Cell Disease ▪ Cerebral Degenerations Usually Manifested in Childhood ▪ Cerebral Edema ▪ Compression of Brain ▪ Congenital or Hereditary Progressive Muscular Dystrophy, Myotonic Disorders, Familial Periodic Paralysis ▪ Decubitus Ulcer ▪ Encephalophy, Unspecified ▪ Fracture of the Cervical or Dorsal Areas (open or closed) ▪ Hemiplegia and Hemiparesis ▪ Huntington's Chorea ▪ Infantile Cerebral Palsy ▪ Multiple Sclerosis ▪ Neurofibromatosis ▪ Other Congenital Anomalies of Nervous System ▪ Other Demyelinating Disease of Central Nervous System ▪ Other Paralytic Syndromes ▪ Parkinson's Disease ▪ Spina Bifida ▪ Spinocerebellar Disease <p>PA is required for:</p> <ul style="list-style-type: none"> ▪ Medical need beyond the Standards of Coverage. ▪ All other diagnoses. ▪ Replacement in less than three years.



Payment Rules	<p>A Group 1 support surface may be a capped rental or purchase depending on the specific HCPCS code. Only a single Group 1 support surface will be considered for a purchase/rental at any given time.</p> <p>If unit is billed as a capped rental, the rental payment would be inclusive of the following:</p> <ul style="list-style-type: none"> ▪ All accessories needed to use the equipment (e.g., pump, pad, cards etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacement to make the unit functional.
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2.40 SUPPORT SURFACES – GROUP 2

Definition	<p>Pressure Reducing Support Surfaces - Group 2 includes, but is not limited to, powered air flotation beds; powered pressure-reducing air mattresses; powered air overlay for mattress; or nonpowered advance pressure reducing mattress. A Group 2 support surface must provide both a waterproof cover and adequate support to prevent the beneficiary from "bottoming out" with the use of the item.</p>
Standards of Coverage	<p>A Group 2 mattress support may be covered up to three months when one of the following applies:</p> <ul style="list-style-type: none"> ▪ Multiple Stage II pressure ulcers are located on the trunk or pelvis and the beneficiary has participated with a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate Group 1 support surface, and the wound has worsened or had no change. ▪ Large or multiple Stage III or IV pressure ulcer(s) on the trunk or pelvis. ▪ Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days) and the beneficiary has been on a Group 2 or 3 surface immediately after a recent discharge from a hospital or nursing facility (discharge within the past 30 days). <p>Continued Use of a Group 2 support surface - Continued use of a Group 2 support surface on a monthly basis may be covered for restorative purposes only when healing continues to progress.</p> <p>Continued use of a Group 2 support surface on a monthly basis will not be reauthorized for coverage if:</p> <ul style="list-style-type: none"> ▪ The beneficiary is noncompliant with care plan; or ▪ The documentation in the medical record demonstrates that other aspects of the plan of care are not being modified to promote healing.
Documentation	<p>Documentation must be less than 14 days old and include the following:</p> <ul style="list-style-type: none"> ▪ Diagnosis/medical condition related to need for item. ▪ Size, stage and location of the ulcer. ▪ Other treatment modalities/surfaces already tried.



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	<ul style="list-style-type: none"> Education of the beneficiary and caregiver on the prevention and/or management of pressure ulcers. Regular assessment by a nurse, physician, or other licensed healthcare practitioner. Appropriate turning and positioning. Current appropriate wound care (for a Stage II, III, or IV ulcer). Appropriate management of moisture/incontinence. Nutritional assessment and intervention consistent with the overall plan of care.
PA Requirements	PA is required for all Group 2 support surfaces.
Payment Rules	<p>A Group 2 support surface may be a capped rental or purchase depending on the specific HCPCS procedure code. A powered air flotation bed is a rental only and must be billed as a daily rate by reporting total number of days used as units. If the unit is billed as a capped rental, the rental payment would be inclusive of the following:</p> <ul style="list-style-type: none"> All accessories needed to use the equipment. Education on the proper use and care of the equipment. Routine servicing and all necessary repairs or replacements to make the unit functional. <p>For a powered air flotation bed, if use exceeds a ten-month time frame, report the "MS" modifier after six months of continued maintenance and servicing of the item. (MS - six-month maintenance and servicing fee for reasonable and necessary parts and labor that are not covered under any manufacturer or supplier warranty).</p>

2.41 SUPPORT SURFACES – GROUP 3

Definition	Pressure Reducing Support Surfaces – Group 3 are fully integrated air fluidized beds for the purpose of alleviating pressure. The surface uses the circulation of filtered air through silicone coated ceramic beads that creates the characteristics of fluid.
Standards of Coverage	<p>A Group 3 air-fluidized bed is covered for up to 90 days if all of the following applies:</p> <ul style="list-style-type: none"> The beneficiary has a Stage III (full thickness tissue loss) or Stage IV (deep tissue destruction) pressure ulcer. The beneficiary is bedridden or chairbound as a result of severely limited mobility. The beneficiary's attending physician orders in writing an air-fluidized bed based on a comprehensive assessment and evaluation of the beneficiary after conservative treatment has been tried without success. A trained adult caregiver is available to assist the beneficiary with ADLs, fluid balance, dry skin care, repositioning, recognition and management of altered mental status, dietary needs, prescribed treatments and management of the air-fluidized bed. A physician directs the home treatment regimen and re-evaluates the need for the air-fluidized bed on a monthly basis. All other conservative treatment methods have been tried without success (e.g., Group 1 or Group 2 support surfaces).



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	<p>Continued Use of a Group 3 support surface - Continued use of a Group 3 support surface may be covered for restorative purposes only when healing continues to progress.</p> <p>Continued use of a Group 3 support surface will not be reauthorized for coverage if:</p> <ul style="list-style-type: none"> ▪ Beneficiary is noncompliant with care plan; or ▪ Documentation in the medical record demonstrates that other aspects of the plan of care are not being modified to promote healing.
<p>Noncovered Support Services</p>	<p>Group 3 support surfaces are noncovered if:</p> <ul style="list-style-type: none"> ▪ Beneficiary requires treatment with wet soaks or moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material. ▪ Caregiver is unwilling or unable to provide the type of care required by the beneficiary on a air-fluidized bed. ▪ Structural support is inadequate to support the weight of the air-fluidized bed system. ▪ Electrical system is insufficient for the anticipated increase in energy consumption. ▪ Other known contraindications exist.
<p>Documentation</p>	<p>Documentation must be less than 14 days old and include the following:</p> <ul style="list-style-type: none"> ▪ Diagnosis/medical condition related to the need for the bed. ▪ Size, stage and location of the ulcer. ▪ Other treatment modalities already tried. ▪ Education of the beneficiary and/or caregiver on the prevention and/or management of pressure ulcers. ▪ Monthly assessment by a nurse, physician, or other licensed healthcare practitioner. ▪ Appropriate turning and positioning. ▪ Current appropriate wound care (for a Stage II, III, or IV ulcer). ▪ Appropriate management of moisture/incontinence. ▪ Nutritional assessment and intervention consistent with the overall plan of care.
<p>PA Requirements</p>	<p>PA is required for all Group 3 support surface requests.</p>
<p>Payment Rules</p>	<p>A Group 3 support surface or air fluidized bed is a rental only item and must be billed as a daily rate by reporting total number of days used as units. The rental payment is considered to include the following:</p> <ul style="list-style-type: none"> ▪ All accessories needed to use the equipment. ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional. <p>If use exceeds a 10-month timeframe, report the "MS" modifier after six months of continued maintenance and servicing of the item.</p>



2.42 SURGICAL DRESSINGS

Definition	Surgical dressings include a primary dressing (used as a protective covering applied directly to the wound or lesion) and/or a secondary dressing (used to secure a primary dressing in place). Many of the primary dressings covered by MDHHS are self-adhesive and would not require a secondary dressing to be placed as well. Examples of surgical dressing are adhesive tape, roll gauze, and elastic bandages.
Standards of Coverage	Surgical dressings are covered for one or more of the following: <ul style="list-style-type: none"> ▪ To treat a wound or opening in the skin. ▪ To debride a wound or lesion. ▪ To treat pressure ulcers.
	Coverage of the quantity or type of dressing is based on: <ul style="list-style-type: none"> ▪ Size, stage, location and current status of the wound/lesions being treated. ▪ Number of wounds/lesions. ▪ Number of body locations involved. ▪ Frequency of dressing change.
Documentation	Documentation must be less than 30 days old and include the following: <ul style="list-style-type: none"> ▪ Diagnosis/medical condition related to the need for the items(s). ▪ Item to be dispensed. ▪ Quantity of item needed per dressing change. ▪ Anticipated frequency of dressing change. ▪ Size, stage, location, and number of wounds/lesions. For dressing requests of quantities over established limits, documentation to substantiate medical need is required.
PA Requirements	PA is required for: <ul style="list-style-type: none"> ▪ Collagen dressings or wound fillers. ▪ Silicone gel sheets. ▪ Composite dressings. ▪ Quantities beyond Medicaid's established limits.
	PA is not required for all other types of surgical dressings unless usage exceeds established quantity limitations.
Payment Rules	All items are considered a purchase up to the allowable quantities. Modifiers A1 through A9 must be reported in addition to the HCPCS code to report the appropriate number of wounds being treated. The modifiers are as follows: <ul style="list-style-type: none"> ▪ A1 - Dressing for one wound ▪ A2 – Dressing for two wounds ▪ A3 – Dressing for three wounds



	<ul style="list-style-type: none"> ▪ A4 – Dressing for four wounds ▪ A5 – Dressing for five wounds ▪ A6 – Dressing for six wounds ▪ A7 – Dressing for seven wounds ▪ A8 – Dressing for eight wounds ▪ A9 – Dressing for nine or more wounds <p>Dressings related to infusion pumps, parenteral/enteral nutrition, tracheostomy, or gastrostomy are included in either the daily rate or in established all-inclusive kit codes and are not separately reimbursable.</p>
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2.43 TRACHEOSTOMY CARE SUPPLIES

Definition	Tracheostomy care supplies include, but are not limited to, tracheostomy filters, tubes, masks, care kits, cleaning brushes, shower protectors and suction catheters.
Standards of Coverage	<p>Tracheostomy care supplies are covered to support the care of a beneficiary with a tracheostomy.</p> <p>A tracheostomy starter kit may be covered for the four weeks following the initial tracheostomy surgery. The kit code includes the following items: Plastic tray, basin, sterile gloves, tube brush, pipe cleaners, a pre-cut tracheostomy dressing, a roll of gauze, drain sponges, cotton tip applicators, tracheostomy tube ties, or twill tape.</p> <p>After the initial four weeks, the established tracheostomy kit may be covered. The kit code includes the following items: Tube brush, pipe cleaners, cotton tip applicators, tracheostomy tube ties or twill tape, and drain sponges.</p>
Documentation	<p>Documentation must be less than 90 days old and include the following:</p> <ul style="list-style-type: none"> ▪ Diagnosis/medical condition. ▪ Specific items required.
PA Requirements	<p>PA is not required when the Standards of Coverage are met and established quantity limits are not exceeded.</p> <p>PA is required when:</p> <ul style="list-style-type: none"> ▪ Standards of Coverage are not met. ▪ Quantities requested exceed the established limits. ▪ Other items not part of one of the kit codes may be considered for separate reimbursement. (Refer to the Medicaid Code and Rate Reference tool for additional information.)
Payment Rules	Payment is purchase only . All quantities reported should reflect a 30-day supply.

2.44 TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR

Definition	A Transcutaneous Electrical Nerve Stimulator (TENS) is a device that utilizes electrical current delivered through electrodes placed on the surface of the skin to decrease the beneficiary's perception of pain by inhibiting the transmission of afferent pain nerve impulses and/or stimulating the release of endorphins.
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<p>Standards of Coverage</p>	<p>A TENS unit is covered for reduction of pain for beneficiaries with either chronic, intractable pain of at least three months duration, or acute post-operative pain limited to 30 days from the date of surgery, or pain related to cancer, when:</p> <ul style="list-style-type: none"> ▪ The beneficiary is able to use the TENS device. ▪ There is effective control of pain. ▪ Other treatment modalities have been ineffective.
<p>Documentation</p>	<p>Documentation must be less than 30 days old and must include all of the following:</p> <ul style="list-style-type: none"> ▪ Diagnosis/medical condition related to the need for a TENS (including type and location of pain). ▪ Alternative treatments for pain tried and the results. ▪ Other modalities of treatment still being used (type and duration must be detailed). <p>For coverage beyond 90 days, include documentation addressing continued effective pain control.</p> <p>Continued Use after the initial 90 days - The documentation must be included with the PA request to describe the effectiveness of the treatment received. For continued coverage for chronic intractable pain, the documentation must be within 30 days and include the following:</p> <ul style="list-style-type: none"> ▪ Medication regimen, before and after use. ▪ Functional level (affected by pain) before and after.
<p>PA Requirements</p>	<p>PA is required for all requests.</p>
<p>Payment Rules</p>	<p>A TENS unit may be considered as a capped rental. The rental payment is inclusive of the following:</p> <ul style="list-style-type: none"> ▪ All accessories needed to use the equipment (e.g., electrodes, lead wires, cables, etc.). ▪ Education on the proper use and care of the equipment. ▪ Routine servicing and all necessary repairs or replacements to make the unit functional.



2.45 WALKERS

Definition	Walkers include, but are not limited to, rigid, wheeled, heavy duty, and folding.
Standards of Coverage	Walkers may be covered when the beneficiary has impaired ambulation and requires a walker for safe and independent ambulation.
Documentation	<p>Documentation must be less than six months old and include:</p> <ul style="list-style-type: none"> ▪ Diagnosis/medical condition related to the need for the service. ▪ Functional level possible with use of walker. ▪ Medical reason for type of attachment or modification, if applicable. ▪ Medical reason for heavy-duty walker (e.g., obesity, severe neurological disorder, or restricted use of hands). ▪ Duration of need and frequency of use. ▪ Identification of other specific economic alternatives ruled out. ▪ Identification of make, model, serial number, and warranty information. ▪ Statement of medical need for the specific walker requested. <p>In addition, for each walker type, the following must be included:</p> <ul style="list-style-type: none"> ▪ Standard Walkers <ul style="list-style-type: none"> ➢ Medical/functional reason a cane would not meet the beneficiary’s ability to perform MRADL ▪ Walker with Trunk Support <ul style="list-style-type: none"> ➢ Medical/functional reason a standard walker would not meet the beneficiary’s ability to perform MRADL ▪ Enclosed Walker with Posterior Seat <ul style="list-style-type: none"> ➢ Medical/functional reason a standard walker would not meet the beneficiary’s ability to perform MRADL ▪ Heavy-Duty Walker <ul style="list-style-type: none"> ➢ Medical/functional reason for a heavy-duty walker (e.g., obesity, severe neurological disorder, restricted use of hands)
PA Requirements	PA is not required for walkers if the Standards of Coverage and Documentation are met.
	<p>PA is required for:</p> <ul style="list-style-type: none"> ▪ Replacement within five years. ▪ Additional attachments (e.g., arm troughs). ▪ Replacement within five years for age 21 and over. ▪ Replacement within two years for under age 21.
Payment Rules	Walkers may be a capped rental or purchase item. After the first ten months of rental, necessary repairs and/or replacements of accessories are separately reimbursable.



2.46 WEARABLE CARDIOVERTER-DEFIBRILLATORS

<p>Definition</p>	<p>A wearable cardioverter-defibrillator (WCD) is an external device intended to perform the same tasks as an implantable cardioverter-defibrillator (ICD) without requiring an invasive procedure. It is considered a bridge to permanent ICD placement.</p> <p>The WCD consists of a vest, worn continuously underneath clothing, and contains cardiac monitoring electrodes that deliver a counter shock. The vest is connected to a monitor with a battery pack and alarm module that interprets the cardiac rhythm and determines when a counter shock is necessary. An alarm module alerts the patient to certain conditions by lights or voice messages.</p>
<p>Standards of Coverage</p>	<p>The WCD may be considered medically necessary only as an interim treatment for patients at high risk of sudden cardiac arrest who:</p> <ul style="list-style-type: none"> ▪ Have a left ventricular ejection fraction of 35% or less; ▪ Have a temporary contraindication to receiving an ICD (i.e., a systemic infection) at the current time; and ▪ Have experienced a documented episode of ventricular fibrillation or sustained (lasting 30 seconds or longer) ventricular tachyarrhythmia that was not due to a transient or reversible cause and did not occur during the first 48 hours of an acute myocardial infarction; and ▪ Are tentatively scheduled for an ICD placement procedure based on one of the following: <ul style="list-style-type: none"> ➢ Received treatment with the goal of an ICD placement and have been scheduled for the ICD placement within three months; or ➢ Had an ICD removed and have been scheduled for placement of another ICD once the contraindication has been treated. <p>WCDs will not be covered for investigational procedures or patient preference.</p>
<p>Documentation</p>	<p>Documentation must include the following and be made available upon request unless otherwise noted in the Standards of Coverage and PA Requirements sections of this policy:</p> <ul style="list-style-type: none"> ▪ Diagnosis/medical condition related to the need for the item. ▪ Specific item(s) required. ▪ Medical reason why receiving an ICD is not currently plausible. ▪ Current treatment plan and updated recommendations. ▪ Tentative scheduled date for ICD placement and/or date other ICD removed.
<p>PA Requirements</p>	<p>Food and Drug Administration (FDA)-registered WCDs are covered under the Medicaid and CSHCS programs with prior authorization (PA). Requests for PA (form MSA-1653-B) may only be submitted by the beneficiary's managing cardiologist and must include a current treatment plan and updated recommendations.</p> <p>PAs are approved for 30 days at a time for a maximum of three months.</p> <p>For continued medical need beyond 30 days, a new PA request must be submitted documenting all of the following:</p> <ul style="list-style-type: none"> ▪ The beneficiary's response to and continued need for the WCD; ▪ The anticipated date of the ICD procedure; and



	<ul style="list-style-type: none"> Documentation of the beneficiary’s compliance with wearing the WCD. The compliance report should demonstrate a compliance rate of at least 92% for the previous 30-day period. <p>Requests for continued PA beyond the maximum of three months will be considered on a case-by-case basis.</p>
Payment Rules	WCDs are rental only items. The rental fee includes the vest, monitoring electrodes, therapy electrodes and batteries. The batteries, garments and electrodes may be replaced due to normal use and wear of the WCD and require PA.

2.47 WHEELCHAIRS, PEDIATRIC MOBILITY AND POSITIONING MEDICAL DEVICES, AND SEATING SYSTEMS

2.47.A. DEFINITIONS

Wheelchair	A wheelchair has special construction consisting of a frame and wheels with many different options and includes, but is not limited to, standard, light-weight, high-strength, powered, etc.
Pediatric Mobility Product	Pediatric mobility products are pediatric-sized mobility and positioning medical devices (as defined by PDAC) that have a special light-weight construction consisting of a frame and wheels/base with many different options. Pediatric mobility devices include pediatric wheelchairs, transport chairs, hi/low chairs with outdoor/indoor bases, and standing systems designed specifically for children with special needs. These products must meet the definition of Durable Medical Equipment (DME) (refer to the Program Overview section of this chapter) and are not available as a commercial product or for which a commercial product can be used as an economic alternative.
Licensed Medical Professional	<p>A licensed medical professional is defined as an occupational or physical therapist or a rehabilitation RN who has at least two years' experience in rehabilitation seating and is not an employee of the medical supplier.</p> <p>Medicaid policy requires that assessments must be performed by a licensed medical professional. A physical therapy assistant (PTA) or a licensed occupational therapy assistant (OTA) may not perform any part of the assessment or evaluation and may not complete or sign the MSA-1656.</p>
Pediatric Subspecialist	A pediatric subspecialist is a physician who is board-certified in a pediatric subspecialty (such as a physiatrist, neurologist, or orthopedist). A pediatrician is not considered a pediatric subspecialist relative to this policy.
Institutional Residential Setting	An institutional residential setting refers to a nursing facility, State Veterans’ Home, hospital long-term care unit, or county medical care facility.
Community Residential Setting	A community residential setting is defined as a non-institutional setting in the community, i.e., beneficiary's own home, Adult Foster Care (AFC), Assisted Living or Group Home.



2.47.B. STANDARDS OF COVERAGE

<p>Manual Wheelchair in Community Residential Setting</p>	<p>May be covered if all of the following are met:</p> <ul style="list-style-type: none"> ▪ Has a diagnosis/medical condition that indicates a lack of functional ambulatory status and ambulates less than 150 feet within one minute with or without an assistive medical device. ▪ Must be able to regularly use the wheelchair throughout the day. ▪ Must be able to be positioned in the chair safely and without aggravating any medical condition or causing injury. ▪ Purchase of a wheelchair is required for long-term use (greater than 10 months). ▪ Must be able to use the wheelchair in the home environment (e.g., wheelchair must be able to fit through doorways and cross thresholds) ▪ Must identify other economic alternatives considered. ▪ Must have a method to propel wheelchair, which may include: <ul style="list-style-type: none"> ➢ Ability to self-propel for at least 60 feet over hard, smooth, or carpeted surfaces. ➢ The beneficiary has a willing and able caregiver to push the chair if needed. <p>In addition:</p> <p>A standard hemi-wheelchair may be covered when a lower seat to the floor is required.</p> <p>A standard light-weight wheelchair may be covered when the beneficiary is unable to propel a standard wheelchair due to decreased upper extremity strength or secondary to a medical condition that affects endurance.</p> <p>A heavy-duty standard wheelchair may be covered if the beneficiary's weight is more than 250 pounds but does not exceed 300 pounds. (Include patient's weight in the beneficiary's file.)</p> <p>An extra heavy-duty standard wheelchair is covered if the beneficiary's weight exceeds 300 pounds. (Include patient's weight in the beneficiary's file.)</p> <p>A high-strength light-weight or ultra-light standard wheelchair may be covered when required for a specific functional need.</p> <p>A back-up or secondary standard manual wheelchair may be considered when:</p> <ul style="list-style-type: none"> ▪ The beneficiary is primarily a power wheelchair user but needs a manual wheelchair to have access to the community or independent living. ▪ The beneficiary's medical condition requires a power wheelchair that cannot accommodate public transportation and, therefore, requires another transport device.
<p>Manual Wheelchair in Institutional Residential Setting</p>	<p>Coverage and reimbursement for all standard manual wheelchairs for an institutional residential setting is included in the per diem rate.</p>



<p>Manual Wheelchair with Custom-Fabricated Seating System in both Community Residential and Institutional Residential Settings</p>	<p>May be covered if all of the following are met, in addition to the Standards of Coverage listed under Manual Wheelchair in Community Residential Setting:</p> <ul style="list-style-type: none"> ▪ Medical documentation provides a clinical assessment of the specific functional/clinical need for a custom-fabricated seating system. Documentation must specifically rule out other standard seating systems. The seating system must also meet standards of coverage. ▪ Must accommodate growth and adjustments for custom-fabricated seating systems a minimum of 3" in depth and 2" in width. ▪ Is an integral part of the care regimen in the community residential setting or the daily nursing plan of care in an institutional residential setting.
<p>Power Wheelchair or Power-Operated Vehicle (POV) in Both Community Residential and Institutional Residential Settings</p>	<p>May be covered if the beneficiary meets all of the following:</p> <ul style="list-style-type: none"> ▪ Lacks ability to propel a manual wheelchair, or has a medical condition that would be compromised by propelling a manual wheelchair, for at least 60 feet over hard, smooth, or carpeted surfaces with or without rest intervals. ▪ Requires use of a wheelchair for at least four hours throughout the day. ▪ Is able to safely operate, control and maneuver the wheelchair in their environmental setting, including through doorways and over thresholds up to 1½", as appropriate. ▪ Has a cognitive, functional level that permits safe operation of a power mobility device with or without training. ▪ Has visual acuity that permits safe operation of a power mobility device. ▪ For a three-wheeled power mobility device, has sufficient trunk control and balance.
<p>Pediatric Mobility Devices and Wheelchairs</p>	<p>May be covered if all of the following are met for each type of device. For CSHCS beneficiaries, a medical referral from an appropriate board-certified pediatric subspecialist or an Office of Medical Affairs (OMA)-approved physician is required. MDHHS also reserves the right to require a medical referral from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries.</p> <p>For manual pediatric wheelchairs:</p> <ul style="list-style-type: none"> ▪ Has a diagnosis/medical condition that indicates a lack of functional ambulatory status with or without an assistive medical device or has a willing and able caregiver to push the chair and the wheelchair is required in a community residential setting. ▪ Is required for long-term use (greater than 10 months). ▪ Must accommodate growth and adjustments for seating systems a minimum of 3" in depth and 2" in width. ▪ Is designed to be transportable. ▪ Is the most economical alternative available to meet the beneficiary's mobility needs. <p>For power wheelchairs:</p> <ul style="list-style-type: none"> ▪ Lacks ability to propel a manual wheelchair, or has a medical condition that would be compromised by propelling a manual wheelchair, for at least 60 feet over hard, smooth, or carpeted surfaces (this includes the need to rest at intervals).



- Is able to safely control the wheelchair through doorways and over thresholds up to 1½".
- Has a cognitive, functional level that is adequate for power wheelchair mobility.
- Has visual acuity that permits safe operation of a power mobility device.
- Must accommodate growth and adjustments for custom-fabricated seating systems a minimum of 3" in depth and 2" in width.
- For a three-wheeled power mobility device, has sufficient trunk control and balance.

For transport mobility medical devices (e.g., strollers):

- Is over three years of age or has a medical condition that cannot be accommodated by commercial products.
- Will be the primary mobility device due to inability to self-propel a manual wheelchair or operate a power wheelchair.
- Is required as a transport device when the primary wheelchair cannot be designed to be transportable.
- Must accommodate growth and adjustments for seating systems a minimum of 3" in depth and 2" in width.
- Is the most economical alternative available to meet the beneficiary's mobility needs.
- Is required for use in the community residential setting.

For pediatric standing systems with or without wheels:

- Is able to utilize the product without being compromised medically or functionally.
- Has a plan of care that documents how the standing system will be used in the community residential setting.
- Documentation addresses economic alternatives, including dynamic vs. non-dynamic factors.
- Other economic alternatives have been ineffective.
- Must accommodate growth and adjustments for seating systems a minimum of 3" in depth and 2" in width.

For CSHCS beneficiaries, a medical referral from an appropriate board-certified pediatric subspecialist or an Office of Medical Affairs (OMA)-approved physician is required. MDHHS also reserves the right to require a medical referral from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries.

For pediatric hi/low chairs:

- Positioning cannot be accommodated by use of other mobility devices or commercial products.
- Is required for independent transfers.
- All mobility products with interchangeable bases and seating systems have been ruled out as economic alternatives.
- Must accommodate growth and adjustments for seating systems a minimum of 3" in depth and 2" in width.



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<p>Standard Seating System in Community Residential Setting</p>	<p>May be covered when required to assure safe mobility and functional positioning when the beneficiary has postural deformities, contractions, tonal abnormalities, functional impairments, muscle weakness, pressure points, and seating balance difficulties.</p> <p>May be covered if all of the following are met:</p> <ul style="list-style-type: none"> ▪ Two or more of the above clinical indications are documented in the medical record and in the mobility assessment. ▪ Must accommodate growth and adjustments a minimum of 3" in depth and 2" in width. ▪ Must document the reason for the selection when the system cannot be used in more than one mobility device. ▪ Is the most economical alternative available to meet the beneficiary's mobility needs. <p>For CSHCS pediatric beneficiaries, a written order from an appropriate board-certified pediatric subspecialist or an Office of Medical Affairs (OMA)-approved physician is required. MDHHS also reserves the right to require a written order from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries.</p>
<p>Custom-Fabricated Seating Systems</p>	<p>May be covered when required to assure safe mobility and functional positioning when the beneficiary has postural deformities, contractions, tonal abnormalities, functional impairments, muscle weakness, pressure points, and seating balance difficulties. May be covered if all of the following are met:</p> <ul style="list-style-type: none"> ▪ Two or more of the above clinical indications are documented in the medical record and in the mobility assessment, and the severity of the clinical indications cannot be accommodated by a standard seating system. ▪ Must accommodate growth and adjustments a minimum of 3" in depth and 2" in width. ▪ Must document the reason for the selection when the system cannot be used in more than one mobility device. ▪ Is the most economical alternative available to meet the beneficiary's mobility needs. <p>For CSHCS pediatric beneficiaries, a written order from an appropriate board-certified pediatric subspecialist or an Office of Medical Affairs (OMA)-approved physician is required. MDHHS also reserves the right to require a written order from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries.</p>
<p>Manual or Power Recline Feature</p>	<p>May be covered when needed for relief of pressure on the seat and/or back, and one of the following applies:</p> <ul style="list-style-type: none"> ▪ History of skin breakdown or current indication of imminent skin breakdown that cannot be controlled (or has not in the past) by less costly modalities (such as pressure relief cushions or manual pressure relief techniques). ▪ Has ability to tolerate a 90-135 degree range of motion at the hip, needed for reclining without triggering excessive abnormal tone. ▪ Is unable to tolerate an upright position in a wheelchair for long periods of time due to fatigue, shortness of breath, increased tone, or discomfort related to pressure that cannot be manually relieved.



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	<p>A low shear recline back is covered when the beneficiary does not have the ability to reposition themselves in the wheelchair following reclining and the shearing would result in skin breakdown.</p>
<p>Manual Tilt-in-Space or Recline Function in Community Residential Setting</p>	<p>Manual tilt-in-space function allows the seat and back of the wheelchair to move as a unit, such that the angle of the back to the floor changes from approximately 90 degrees to 45 degrees or less. This change in position does not affect the hip-to-knee angle. The seat may be tilted manually.</p> <p>The tilt-in-space function for a wheelchair may be covered if one or more of the following apply:</p> <ul style="list-style-type: none"> ▪ History of skin breakdown or current indication of imminent skin breakdown that cannot be controlled (or has not in the past) by less costly modalities (such as pressure relief cushions or manual pressure relief techniques). ▪ Excessive extensor or flexor muscle tone that is exacerbated by change in hip angle and makes positioning in any upright chair ineffective. State reason why changing angles of position is medically necessary. ▪ Very low muscle tone that cannot maintain upright positioning against gravity, causing spinal anomalies. ▪ Beneficiary has knee contractures and a custom-molded seating system. <p>Coverage of both a manual tilt-in-space and recline function for a wheelchair requires medical need (such as high probability of the development of hip contractures) if only a tilt-in-space without recline is used. Also, there is a medical contraindication to using recline-only without the tilt-in-space function.</p>
<p>Power Tilt-in-Space or Recline Function in Both Community Residential and Institutional Residential Settings</p>	<p>Power tilt-in-space or recline function may be covered if all of the following exist:</p> <ul style="list-style-type: none"> ▪ An existing medical condition results in the inability to reposition self without the use of a power tilt or recline mechanism. ▪ The frequency of repositioning is clinically indicated and is an integral part of the nursing facility plan of care. ▪ Beneficiary requires assistance to use a manual tilt-in-space or recline system, and there are regular periods of time that the beneficiary is without assistance. ▪ Beneficiary requires assistance to use a manual tilt-in-space or recline system, and is able to independently care for himself when provided a power tilt-in-space or recline modification. <p>For CSHCS pediatric beneficiaries, a written order from an appropriate board-certified pediatric subspecialist or an Office of Medical Affairs (OMA)-approved physician is required. MDHHS also reserves the right to require a written order from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries.</p>
<p>Wheelchair Accessories</p>	<p>Reimbursement may be made for separate wheelchair accessories that have designated HCPCS codes. Separate reimbursement may be considered for specific wheelchair accessory codes when provided in conjunction with the purchase of a manual wheelchair, power wheelchair, or an addition to an existing wheelchair if:</p> <ul style="list-style-type: none"> ▪ It is required to provide safety. ▪ It is required for appropriate positioning. ▪ It is the most economical alternative.



	<p>For additions to an existing wheelchair, the physician or the occupational or physical therapist must address the status/condition of the current wheelchair and include the brand, model, serial number, and age of the current wheelchair. If MDHHS did not purchase the wheelchair being modified, all documentation requirements must be provided as if the request is for a new or initial wheelchair. Refer to the Non-Covered Items section of this chapter for information on accessories that are not covered.</p>
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2.47.C. PRIOR AUTHORIZATION FOR PURCHASE, RENTALS, REPAIRS, AND/OR REPLACEMENT OF MOBILITY DEVICES

<p>Prior Authorization</p>	<p>The Medicaid Utilization Analyst (Program Review Division) is the authorized Medicaid representative who determines if the service requested falls within the standards of coverage. A prior authorization request may be returned or denied if the documentation is incomplete and not specific to the beneficiary and device requested.</p> <p>MDHHS reserves the right to request additional documentation to determine medical necessity. For CSHCS beneficiaries, a medical referral from an appropriate board-certified pediatric subspecialist or an Office of Medical Affairs (OMA)-approved physician is required. MDHHS also reserves the right to require a medical referral from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries.</p> <p>For beneficiaries in the community residential setting, the decision notice is sent to the medical supplier with a copy to the beneficiary.</p> <p>For beneficiaries in the institutional residential setting, the decision notice is sent to the institutional residence with a copy to the beneficiary.</p> <p>Prior authorization is required for:</p> <ul style="list-style-type: none"> ▪ Power wheelchairs, power-operated vehicles, seating, and accessories. ▪ New and replacement custom-fabricated seating systems, and the addition of functions for tilt-in-space and/or recline (power or manual). ▪ Diagnosis/medical conditions that are not listed as approved to bypass prior authorization for pediatric mobility items. ▪ Replacement of standard wheelchairs beyond established timeframes. <p>Standard wheelchairs with specified accessories/add-ons do not require prior authorization if the Standards of Coverage and Documentation requirements are met. Consult the Medicaid Code and Rate Reference tool and the Wheelchair/Power-Operated Mobility Accessory Reimbursement document on the MDHHS website for accessories/add-on items that require prior authorization and/or are included in the wheelchair base. (Refer to the Directory Appendix for website information.)</p>
<p>Clinical Documentation</p>	<p>The evaluation and clinical documentation (MSA-1656) must be submitted within 90 days of the date the evaluation was completed. Clinical documentation must include how the requested seating or mobility device is the most appropriate to assist in performing MRADL.</p> <p>For CSHCS beneficiaries, a medical referral from an appropriate board-certified pediatric subspecialist or an Office of Medical Affairs (OMA)-approved physician is required. MDHHS also reserves the right to require a medical referral from an appropriate board-certified pediatric subspecialist for Medicaid beneficiaries.</p>



<p>Prior Authorization Exceptions</p>	<p>Prior authorization is not required for the following if standards of coverage are met:</p> <ul style="list-style-type: none"> ▪ Specific accessory codes and/or repair codes. ▪ Specific pediatric mobility devices that do not include any accessories if the related diagnosis/condition is one of the following: <ul style="list-style-type: none"> ➤ Spinal Muscular Atrophy ➤ Motor Neuron Disease ➤ Anterior Horn Cell Disease, Unspecified ➤ Other Anterior Horn Cell Disease ➤ Hemiplegia and Hemiparesis ➤ Infantile Cerebral Palsy ➤ Myoneural Disorders, Unspecified ➤ Other Specified Myoneural Disorders ➤ Spina Bifida with Hydrocephalus ➤ Spina Bifida without Mention of Hydrocephalus ➤ Spina Bifida (Other Congenital Anomalies of Nervous System) ➤ Microcephalus ➤ Reduction Deformities of Brain ➤ Congenital Hydrocephalus ➤ Muscular Dystrophies and Other Myopathies <p>NOTE: If prior authorization is required for any component of the mobility device (including accessories), then PA is required for the device as well. For example, if a custom-fabricated seating system is required, then prior authorization for the pediatric mobility device is also required.</p>
<p>Rentals, Repairs and Replacement</p>	<p>A wheelchair can be considered a capped rental or a purchase item.</p> <p>Repairs</p> <p><u>Labor (K0739):</u> MDHHS developed a Wheelchair Repair/Labor Guide for providers to use to determine the maximum allowed number of units of labor for repairs to wheelchairs using replacement parts/accessories with identified HCPCS codes. The guide is posted on the Provider Specific (Medical Supplier) page of the MDHHS website. (Refer to the Directory Appendix for website information.)</p> <p>To request labor, report HCPCS code K0739 and the total number of units on the prior authorization request. Providers may request no more than the allowable number of labor units listed in the Wheelchair Repair/Labor Guide for each replacement part regardless of actual repair time.</p> <p>All repairs include screws, nuts and bolts unless otherwise stipulated in the Guide.</p> <p>Labor associated with the removal of the original component part, replacement with a new component, and finishing is included in the total number of labor units indicated in the Wheelchair Repair/Labor Guide.</p>



All costs to repair the wheelchair must be included on the PA request, including cost for parts and labor.

The estimated cost to repair versus replace the wheelchair must be included on the PA request when requesting repairs using multiple component parts/accessories.

Beneficiary-owned and purchased by MDHHS:

- Covered only after the manufacturer's warranty has been exhausted.
- If the DME provider is the same provider that originally supplied the wheelchair, a new certificate of medical necessity (CMN) and/or physician's order is not necessary.
- The treating physician or the DME provider must document the repair is reasonable and necessary. Generalized statements (e.g. "item worn out") are not specific enough to confirm the need for the repair(s).
- The DME provider must document the reason for the repair(s), submit this information with the PA request, and keep a copy of the documentation in the beneficiary file.

MDHHS did not purchase the original wheelchair:

- Covered only after the manufacturer's warranty has expired.
- Requires a new physician order, CMN, and required documentation indicated in the wheelchair and repair policies must be completed and submitted with the PA request.
- The DME provider must document the repair is reasonable and necessary. Generalized statements (e.g. "item worn out") are not specific enough to confirm the need for the repair(s).
- The DME provider must document the reason for the repair(s), submit this information with the PA request, and keep a copy of the documentation in the beneficiary file.

It is the responsibility of the provider to supply loaner equipment while the original item is being serviced.

MDHHS will not pay for repairs to parts/accessories that are not typically covered by Medicaid or that were not approved for the initial purchase of the wheelchair/accessory.

The repair of a second (older) manual or power wheelchair used as a back-up wheelchair is not covered.

Routine cleaning of wheelchairs or parts is not covered.

MDHHS does not reimburse for labor and repairs:

- For initial purchases;
- During rental periods; or
- For items under warranty.

Refer to the Repairs and Replacement Parts subsection of this chapter for further repair policy.



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	<p>Replacement of a mobility device is subject to the manufacturer's warranty and/or cost of repairs. The replacement may also be considered when a significant change in the beneficiary's condition has occurred or the item cannot be restored to a serviceable condition. Replacement of wheelchairs for youth will be evaluated on an individual basis due to the expected growth pattern. Based on these conditions, a wheelchair may be considered for replacement every five years for adults and every two years for children.</p> <p>Medicaid will not authorize coverage of replacement of any DME item or accessory that is requested solely because new technology is available. Replacement or modifications must be medically necessary and required as a result of a change in the medical condition that makes the covered service unusable or contraindicated.</p>
<p>Prior Authorization Process for Beneficiaries in the Community Residential Setting</p>	<p>The prior authorization process for beneficiaries in the community residential setting is initiated by the treating physician's written order for a seating/mobility evaluation that includes the reason for the referral. The evaluation must be completed by a licensed medical professional using the Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices form (MSA-1656).</p> <p>(Refer to the Prior Authorization Form subsection and the Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices Form subsection of this chapter for additional information.)</p>
<p>Prior Authorization Process for Beneficiaries in the Institutional Residential Setting</p>	<p>Prior authorization is required for Medicaid coverage and separate reimbursement for medically necessary power-operated vehicles and power or manual wheelchairs with custom-fabricated seating systems. The request for a resident assessment must be initiated by the treating physician with the stated medical reason for the referral. Facility clinicians who are responsible for the overall nursing plan of care and treatment of the resident will prepare and submit prior authorization requests and medical documentation directly to the MDHHS Program Review Division.</p> <p>Refer to the Nursing Facility Coverages chapter for additional information regarding prior authorization of wheelchairs and custom-fabricated seating systems for beneficiaries in an institutional residential setting.</p> <p>(Refer to the Prior Authorization Form subsection and the Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices Form subsection of this chapter for additional information.)</p>

2.48 VENTILATORS

<p>Definition</p>	<p>A ventilator is a device designed to intermittently or continuously assist or control pulmonary ventilation.</p> <ul style="list-style-type: none"> ▪ A negative pressure ventilator exerts negative (subatmospheric) pressure on the exterior chest wall. ▪ A positive pressure ventilator ventilates the lungs as the result of a positive pressure applied to the airway.
<p>Standards of Coverage</p>	<p>Negative and positive pressure ventilators may be covered when there is a respiratory related diagnosis (e.g., neuromuscular disease, thoracic restrictive disease, chronic respiratory failure) and the beneficiary requires ventilator assistance.</p>



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Documentation	Documentation must be less than 90 days old and include the following: <ul style="list-style-type: none">▪ Respiratory diagnosis/medical condition related to the need for the ventilator.▪ Type of ventilator ordered.▪ Ventilator settings.▪ Number of hours beneficiary is required to use the ventilator.
PA Requirements	PA is required for all ventilators.
Payment Rules	All ventilators are a rental only item and are inclusive of the following: <ul style="list-style-type: none">▪ All accessories needed to use the unit (e.g., circuits, water feed sets, adaptors, temperature probes, filters, heated or nonheated humidifier, oxygen analyzer, water or saline for humidifier, etc.).▪ Education on the proper use and care of the equipment.▪ Routine servicing and all necessary repairs or replacements to make the unit functional. <p>An additional ventilator may only be covered to allow a beneficiary access to the community. When billing more than one vent, the additional vent must be reported using a NOC code. A backup ventilator in case of a power failure is not separately reimbursable.</p>



MI CHOICE WAIVER

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SECTION 1 – GENERAL INFORMATION

MI Choice is a waiver program operated by the Michigan Department of Health and Human Services (MDHHS) to deliver home and community-based services to elderly persons and persons with physical disabilities who meet the Michigan nursing facility level of care criteria. The waiver is approved by the Centers for Medicare & Medicaid Services (CMS) under sections 1915(b) and 1915(c) of the Social Security Act. MDHHS carries out its waiver obligations through a network of enrolled providers that operate as Prepaid Ambulatory Health Plans (PAHPs). These entities are commonly referred to as waiver agencies. MDHHS and its waiver agencies must abide by the terms and conditions set forth in the approved waivers.

MI Choice services are available to qualified participants throughout the state, and all provisions of the program are available to each qualified participant unless otherwise noted in this policy and approved by CMS. MDHHS will not enact any provision to the MI Choice program that prohibits or inhibits a participant's access to a person-centered service plan, discourages participant direction of services, interferes with a participant's right to have grievances and complaints heard, or endangers the health and welfare of a participant. The program must monitor and actively seek to improve the quality of services delivered to participants. Safeguards are utilized to ensure the integrity of payments for waiver services and the adequacy of systems to maintain compliance with federal requirements.

Waiver agencies are required to provide oral and written assistance to all Limited English Proficient applicants and participants. Agencies must arrange for translated materials to be accessible or make such information available orally through bilingual staff or the use of interpreters.



SECTION 2 – ELIGIBILITY

The MI Choice program is available to persons who are either elderly (age 65 or older) or adults with disabilities aged 18 or older and meet the following eligibility criteria:

- An applicant must establish their financial eligibility for Medicaid services as described in the Financial Eligibility subsection of this chapter.
- Must be categorically eligible for Medicaid as aged or disabled.
- The applicant must meet functional eligibility requirements through the online version of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD).
- It must be established that the applicant requires at least two waiver services, one of which must be Supports Coordination, and that the service needs of the applicant cannot be fully met by existing State Plan or other services.

All criteria must be met to establish eligibility for the MI Choice program. MI Choice participants must continue to meet these eligibility requirements on an ongoing basis to remain enrolled in the program.

2.1 FINANCIAL ELIGIBILITY

Medicaid reimbursement for MI Choice services requires a determination of Medicaid financial eligibility for the applicant by MDHHS. As a provision of the waiver, MI Choice applicants benefit from an enhanced financial eligibility standard compared to basic Medicaid eligibility. Specifically, MI Choice is available to participants in the special home and community-based group under 42 CFR §435.217 with a special income level up to 300% of the Supplemental Security Income (SSI) Federal Benefit Rate. Medicaid eligibility rules stipulate that participants are not allowed to spend-down to the income limit to become financially eligible for MI Choice.

To initiate a financial eligibility determination, MI Choice waiver agencies must enter enrollment notifications electronically in the Community Health Automated Medicaid Processing System (CHAMPS). Once the electronic enrollment is completed in CHAMPS, the participant will be assigned an associated MI Choice Program Enrollment Type (PET) code. MI Choice waiver agencies must enter disenrollment notifications electronically in CHAMPS to notify MDHHS of participants who are no longer enrolled in MI Choice. Once an electronic disenrollment is completed in CHAMPS, the participant's PET code will end to reflect a disenrollment date. Proper recordkeeping requirements must be followed and reflected in the applicant's or participant's case record.

2.2 FUNCTIONAL ELIGIBILITY

The MI Choice waiver agency must verify an applicant's functional eligibility for program enrollment using the LOCD application in CHAMPS. Waiver agencies must conduct an LOCD in person with an applicant and submit that information in the LOCD application in CHAMPS, or the agency may adopt the current existing LOCD conducted by another provider. The information submitted is put through an algorithm within the application to determine whether the applicant meets LOCD criteria. Only the LOCD application in CHAMPS can determine functional eligibility for the nursing facility level of care. Additional information can be found in the Nursing Facility Level of Care Determination Chapter and is applicable to MI Choice applicants and participants.



2.2.A. FREEDOM OF CHOICE

Prior to MI Choice enrollment, all applicants and their legal representatives must be given information regarding all Medicaid long-term services and supports options for which they qualify through the nursing facility LOCD, including MI Choice, Nursing Facility, MI Health Link, and the Program of All-Inclusive Care for the Elderly (PACE). Qualified applicants may only enroll in one long-term services and supports program at any given time. Nursing facility, PACE, MI Choice, MI Health Link, and Adult Home Help services cannot be chosen in combination with each other. Applicants must indicate their choice, subject to the provisions of the Need for MI Choice Services subsection of this chapter, and document via their signature and date that they have been informed of their options via the Freedom of Choice (FOC) form that is provided to an applicant at the conclusion of any LOCD process. Applicants must also be informed of other service options that do not require Nursing Facility Level of Care, including Home Health and Home Help State Plan services, as well as other local public and private service entities. The FOC form must be signed and dated by the supports coordinator and the applicant (or their legal representative) seeking services and is to be maintained in the applicant's case record and provided to the applicant or participant upon request.

2.3 NEED FOR MI CHOICE SERVICES

In addition to meeting financial and functional eligibility requirements and to be enrolled in the program, MI Choice applicants must demonstrate the need for a minimum of two covered services, one of which must be Supports Coordination, as determined through an in-person assessment and the person-centered planning process. Applicants must also agree to receive MI Choice services on a regular basis, at least every 30 days.

An applicant cannot be enrolled in MI Choice if their service and support needs can be fully met through the intervention of State Plan or other available Medicaid services. State Plan and MI Choice services are not interchangeable. MI Choice services differ in nature and scope from similar State Plan services and often have more stringent provider qualifications.

2.3.A. INITIAL ASSESSMENT OF PARTICIPANTS

The MI Choice program has established the Resident Assessment Instrument – Home Care (iHC) as the approved assessment instrument for assessing the functional status of participants. The MI Choice Intake Guidelines, LOCD, and iHC are not interchangeable tools. (Documents are available on the MDHHS website. Refer to the Directory Appendix for website information.)

Initial assessments are conducted by teams consisting of a minimum of a registered nurse and a social worker, both of whom are properly licensed by the State of Michigan.

2.3.B. REASSESSMENT OF PARTICIPANTS

Reassessments are conducted by either a properly licensed registered nurse or a social worker, whichever is most appropriate to address the circumstances of the participant. A team approach that includes both disciplines is encouraged whenever warranted by the



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needs of the beneficiary. Reassessments are done in person with the participant at the participant's home.

The supports coordinator documents that the participant continues to meet the nursing facility level of care within the case record, specifying the appropriate "door" through which the participant meets level of care criteria. Reassessments are conducted in person 90 days after the initial assessment, with an annual reassessment conducted thereafter, or sooner upon a significant change in the participant's condition. Supports coordinators track reassessment dates within the waiver agency's information systems. If a supports coordinator suspects the participant no longer meets the nursing facility level of care, the supports coordinator must conduct a face-to-face LOCD and input the data into the LOCD application in CHAMPS. When CHAMPS confirms the individual no longer meets LOCD criteria, the supports coordinator initiates program discharge procedures and provides the participant with notice and information on appeal rights. A refusal which prevents a timely redetermination is cause for termination from the program.



SECTION 3 – ENROLLMENT

MI Choice waiver agencies determine the enrollment dates upon MDHHS financial eligibility verification, and termination dates for each participant for whom they provide waiver services. No applicant shall be granted enrollment status without fully meeting all eligibility requirements. MI Choice applicants require at least two waiver services on a continual basis, one of which must be Supports Coordination, in order to be enrolled in MI Choice. When a potentially eligible applicant cannot be enrolled due to the waiver agency being at capacity, the applicant is placed on a waiting list. Refer to the Waiting Lists subsection for additional information. MDHHS reviews and provides final approval for determinations that result in enrollment, denials or terminations for MI Choice.

3.1 GENERAL PROVISIONS OF PARTICIPATION

There are a number of circumstances that play a role in the eligibility status of MI Choice participants. The following subsections define these impacts.

3.1.A. ENROLLMENT IN MEDICAID HEALTH PLANS AND OTHER PROGRAMS

A program participant cannot be simultaneously enrolled in both MI Choice and a Medicaid Health Plan, PACE program, MI Health Link, or any other §1915(c) waiver program. Applicants must choose one program in which they wish to enroll. It is not necessary to either delay MI Choice enrollment or withhold MI Choice services pending the disenrollment process from any of the Medicaid Health Plans, but some programs require the individual to enroll on the first day of the month and disenroll only on the last day of the month. Enrollment and disenrollment policies for other programs must be followed for deciding when to enroll someone in MI Choice.

3.1.B. INSTITUTIONAL STAYS

There are occasions when a MI Choice participant requires a short-term admission to an institutional setting for treatment. The impact of such an institutional stay is dependent on the type of admission and the length of the stay.

A short-term hospital admission does not necessarily impact a participant's MI Choice enrollment status. The participant's supports coordinator must temporarily suspend the delivery of MI Choice waiver services during the hospital stay to avoid duplication of services from the hospital and MI Choice; however, the participant may remain enrolled in MI Choice. A participant who is hospitalized for more than 30 consecutive days must be disenrolled.

A participant admitted to a nursing facility for rehabilitation services or for any reason other than an approved short-term out-of-home respite stay must be disenrolled from MI Choice on the date prior to the nursing facility admission. The individual may be re-enrolled into MI Choice upon discharge from the nursing facility as long as the individual meets eligibility criteria as described in the Eligibility section of this chapter.



3.2 MI CHOICE INTAKE GUIDELINES

The MI Choice Intake Guidelines is a list of questions designed to screen applicants for eligibility and further assessment. Additional probative questions are permissible when needed to clarify eligibility. The MI Choice Intake Guidelines does not, in itself, establish program eligibility. A properly completed MI Choice Intake Guidelines is mandatory for MI Choice waiver agencies prior to placing applicants on a MI Choice waiting list when the waiver agency is operating at its capacity. Individuals who score as Level C, Level D, Level D1 or Level E are those applicants determined potentially eligible for program enrollment and will be placed on the waiver agency's MI Choice waiting list. The date of the MI Choice Intake Guidelines contact establishes the chronological placement of the applicant on the waiting list. The MI Choice Intake Guidelines may be found on the MDHHS website. (Refer to the Directory Appendix for website information.)

When the waiver agency is at capacity, applicants requesting enrollment in MI Choice must either be screened by telephone or in person using the MI Choice Intake Guidelines at the time of their request for proper placement on the waiting list. If a caller is seeking services for another individual, the waiver agency will either contact the applicant for whom services are being requested or complete the MI Choice Intake Guidelines to the extent possible using information known to the caller. For applicants who are deaf, hearing impaired, or otherwise unable to participate in a telephone interview, the waiver agency must use the applicant's preferred means of communication. It is acceptable to use an interpreter, a third-party in the interview, or assistive technology to facilitate the exchange of information.

As a rule, nursing facility residents who are seeking to transition into MI Choice are not contacted by telephone but rather are interviewed in the nursing facility. For the purposes of establishing a point of reference for the waiting list, the date of the initial nursing facility visit (introductory interview) shall be considered the same as conducting a MI Choice Intake Guidelines, so long as the functional objectives of the MI Choice Intake Guidelines are met. (Refer to the Waiting Lists subsection for additional information.) Specifically, the introductory meeting must establish a reasonable expectation that the applicant will meet the functional and financial eligibility requirements of the MI Choice program within the next 60 days.

Applicants who are expected to be ineligible based on MI Choice Intake Guidelines information may request a face-to-face evaluation using the Michigan Medicaid Nursing Facility Level of Care Determination and financial eligibility criteria. Such evaluations should be conducted as soon as possible, but must be done within 10 business days of the date the MI Choice Intake Guidelines was administered. MI Choice waiver agencies must issue an adverse action notice advising applicants of any and all appeal rights when the applicant appears ineligible either through the MI Choice Intake Guidelines or a face-to-face evaluation.

When an applicant appears to be functionally eligible based on the MI Choice Intake Guidelines but is not expected to meet the financial eligibility requirements, the MI Choice waiver agency must place the applicant on the waiting list if it is anticipated that the applicant will become financially eligible within 60 days.

The MI Choice Intake Guidelines is the only recognized tool accepted for telephonic screening of MI Choice applicants and is only accessible to MI Choice waiver agencies. It is not intended to be used for any other purpose within the MI Choice program, nor any other Medicaid program. MI Choice waiver agencies must collect MI Choice Intake Guidelines data electronically using software through the MDHHS contracted vendor.



3.3 ENROLLMENT CAPACITY

MI Choice capacity is limited to a maximum number of participants served at any point in the fiscal year as specified in the approved waiver application. Waiver agencies are allocated a specific number of slots each fiscal year and are responsible for managing enrollment so as not to exceed the maximum number of participants served at any point in the fiscal year. MDHHS reserves the right to reallocate slots as necessary to best meet MI Choice program demands.

3.4 WAITING LISTS

Whenever the number of participants receiving services through MI Choice exceeds the existing program capacity, any screened applicant must be placed on the MI Choice waiting list. The waiting list must be actively maintained and managed by each MI Choice waiver agency. The enrollment process for the MI Choice program is not ever actually or constructively closed. The applicant's place on the waiting list is determined by priority category in the order described below. Within each category, an applicant is placed on the list in chronological order based on the date of their request for services. This is the only approved method of accessing waiver services when the waiver program is at capacity.

Each waiver agency must follow these waiting list removal guidelines when removing an applicant from the MI Choice waiting list. A MI Choice waiver agency may remove an applicant from the MI Choice waiting list if the applicant:

- Enrolled in MI Choice;
- Enrolled in another community-based service or program;
- Was admitted to a nursing facility and is no longer interested in MI Choice;
- Is deceased;
- Moved out of state;
- Is not eligible for MI Choice;
- Is no longer interested in or refuses MI Choice enrollment; or
- Is unable to be contacted by the waiver agency using all of the following methods:
 - The waiver agency called at least three times with a varied day of week and time of day.
 - If the waiver agency was able to leave a message, and the applicant did not return the call within 10 business days.
 - The waiver agency sent a letter to the applicant with a deadline to contact the waiver agency within 12 business days, and the applicant either did not respond or mail was returned.

An Adequate Action Notice must be sent to the applicant no later than the date of removal from the MI Choice waiting list. MI Choice waiver agencies can obtain a template for the Adequate Action Notice on the MDHHS website. (Refer to the Directory Appendix for website information.)



3.4.A. PRIORITY CATEGORIES

Applicants will be placed on the waiting list by priority category and then chronologically by date of request of services. Enrollment in MI Choice is assigned on a first-come/first-served basis using the following categories, listed in order of priority given.

Waiver agencies are required to conduct follow-up phone calls to all applicants on the waiting list. The calls are to determine the applicant's status, offer assistance in accessing alternative services, identify applicants who should be removed from the list, and identify applicants who might be in crisis or at imminent risk of admission to a nursing facility. Each applicant on the waiting list is to be contacted at least once every 90 days. Applicants in crisis or at risk require more frequent contacts. Each waiver agency is required to maintain a record of these follow-up contacts.

3.4.A.1. STATE PLAN PRIVATE DUTY NURSING AGE EXPIRATIONS

This category includes only those applicants who continue to require Private Duty Nursing services at the time such coverage ends due to age restrictions.

3.4.A.2. NURSING FACILITY TRANSITIONS

Nursing facility residents who desire to transition to the community and will otherwise meet enrollment requirements for MI Choice qualify for this priority status. Priority status is not given to applicants whose service and support needs can be fully met by existing State Plan services.

3.4.A.3. ADULT PROTECTIVE SERVICES (APS) AND DIVERSIONS

An applicant with an active Adult Protective Services (APS) case is given priority when critical needs can be addressed by MI Choice services. It is not expected that MI Choice waiver agencies solicit APS cases, but priority is given when necessary.

An applicant is eligible for diversion priority if they are living in the community or are being released from an acute care setting and are found to be at imminent risk of nursing facility admission. Imminent risk of placement in a nursing facility is determined using the Imminent Risk Assessment (IRA), an evaluation developed by MDHHS. Use of the IRA is essential in providing an objective differentiation between those applicants at risk of a nursing facility placement and those at imminent risk of such a placement. Only applicants found to meet the standard of imminent risk are given priority status on the waiting list. Applicants may request that a subsequent IRA be performed upon a change of condition or circumstance.

Supports coordinators must administer the IRA in person. The design of the tool makes telephone contact insufficient to make a valid determination. Waiver agencies must submit a request for diversion status for an applicant to MDHHS. Please refer to the Directory Appendix for details. A final approval of a diversion request is made by MDHHS.



3.4.A.4. CHRONOLOGICAL ORDER BY SERVICE REQUEST DATE

This category includes applicants who do not meet any of the above priority categories or for whom prioritizing information is not known. As stated, applicants will be placed on the waiting list in the chronological order that they requested services as documented by the date of MI Choice Intake Guidelines completion or initial nursing facility introductory meeting.

3.5 ENROLLMENT SLOTS

CMS approves a given number of enrollment slots for the MI Choice program in the waiver application process. A slot consists of the enrollment of a participant for the duration of the fiscal year or, in other words, the total number of slots used is an unduplicated count of participants for the fiscal year. Therefore, a participant who might be enrolled and disenrolled from MI Choice numerous times throughout a given fiscal year utilizes only a single slot. Similarly, a participant might be disenrolled from the program at any given time, yet continues to occupy a slot until the conclusion of the fiscal year. It is an important distinction between that which constitutes enrollment and what is counted as a slot. Having a slot does not infer current enrollment.



SECTION 4 – SERVICES

The array of services provided by the MI Choice program is subject to the prior approval of CMS. Waiver agencies are required to provide any waiver service from the federally approved array that a participant needs to live successfully in the community, that is:

- indicated by the current assessment;
- detailed in the person-centered service plan; and
- provided in accordance with the provisions of the approved waiver.

Services must not be provided unless they are defined in the person-centered service plan and must not precede the establishment of a person-centered service plan. Waiver agencies cannot limit in aggregate the number of participants receiving a given service or the number of services available to any given participant. Participants have the right to receive services from any willing and qualified provider within the waiver agency's provider network. When the waiver agency does not have a willing and qualified provider within their network, the waiver agency must utilize an out-of-network provider at no cost to the participant until an in-network provider can be secured. (Refer to the Providers section of this chapter for information on qualified provider standards.)

MDHHS and waiver agencies do not impose a copayment or any similar charge upon participants for waiver services. MDHHS and waiver agencies do not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.

Although MI Choice participants must have services approved by the waiver agency, participants have the option to select any participating provider in the waiver agency's provider network, thereby ensuring freedom of choice.

Where applicable, the participant must use Medicaid State Plan, Medicare, or other available payers first. The participant's preference for a certain provider is not grounds for declining another payer in order to access waiver services.

4.1 COVERED WAIVER SERVICES

In addition to regular State Plan coverage, MI Choice participants may receive services outlined in the following subsections.

4.1.A. ADULT DAY HEALTH

Adult Day Health services are furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the person-centered service plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a "full nutritional regimen" (i.e., three meals per day). Physical, occupational and speech therapies may be furnished as component parts of this service.

Transportation between the participant's residence and the Adult Day Health center is provided when it is a standard component of the service. Not all Adult Day Health



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centers offer transportation to and from their facility. Additionally, some of those that offer transportation only offer this service in a specified area. When the center offers transportation, it is a component part of the Adult Day Health service. If the center does not offer transportation or does not offer it to the participant's residence, then MI Choice would pay for the transportation to and from the Adult Day Health center separately.

Participants cannot receive Community Living Supports (CLS) while at the Adult Day Health center. Payment for Adult Day Health services includes all services provided while at the center. CLS may be used in conjunction with Adult Day Health services, but cannot be provided at the exact same time.

All Adult Day Health providers must comply with the Home and Community Based Settings rule. Additional information about this rule is found in the Home and Community Based Services Chapter of this manual.

4.1.B. CHORE SERVICES

Chore Services are needed to maintain the home in a clean, sanitary and safe environment. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and tiles, and moving heavy items of furniture in order to provide safe access and egress. Other covered services might include yard maintenance (mowing, raking and clearing hazardous debris such as fallen branches and trees) and snow plowing to provide safe access and egress outside the home. These types of services are allowed only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community or volunteer agency, or third party payer is capable of, or responsible for, their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

4.1.C. COMMUNITY HEALTH WORKER

The Community Health Worker (CHW) works with participants who are re-enrolling in MI Choice, enrolling after a nursing facility or hospital discharge, or otherwise assists participants with obtaining access to community resources. The CHW may also perform the duties of a supports broker, providing assistance throughout the planning and implementation of the service plan, assists the participant in making informed decisions about what works best for the participant, and assists with access to housing and employment. The CHW may offer practical skills training to enable participants to remain independent, including information for recruiting, hiring and managing workers, as well as effective communication and problem solving. The CHW may also coach participants in managing health conditions, assist with scheduling appointments, facilitate coordination between various providers, and assist participants with completion of applications for programs for which they may be eligible.

4.1.D. COMMUNITY LIVING SUPPORTS

Community Living Supports (CLS) facilitate an individual's independence and promote participation in the community. CLS can be provided in the participant's residence or in



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community settings. CLS includes assistance to enable participants to accomplish tasks that they would normally do for themselves if able. The services may be provided on an episodic or a continuing basis. The participant oversees and supervises individual providers on an ongoing basis when participating in self-determination options. Tasks related to ensuring safe access and egress to the residence are authorized only in cases when neither the participant nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision. When transportation incidental to the provision of CLS is included, it shall not also be authorized as a separate waiver service for the participant.

CLS includes:

- Assisting, reminding, cueing, observing, guiding and/or training in household activities, Activities of Daily Living (ADL), or routine household care and maintenance.
- Reminding, cueing, observing or monitoring of medication administration.
- Assistance, support or guidance with such activities as:
 - Non-medical care (not requiring nurse or physician intervention) – assistance with eating, bathing, dressing, personal hygiene, and ADL;
 - Meal preparation, but does not include the cost of the meals themselves;
 - Money management;
 - Shopping for food and other necessities of daily living;
 - Social participation, relationship maintenance, and building community connections to reduce personal isolation;
 - Training and assistance on activities that promote community participation such as using public transportation, using libraries, or volunteer work;
 - Transportation from the participant’s residence to medical appointments, community activities, among community activities, and from the community activities back to the participant’s residence; and
 - Routine household cleaning and maintenance.
- Dementia care including, but not limited to, redirection, reminding, modeling, socialization activities, and activities that assist the participant as identified in the individual’s person-centered service plan.
- Staff assistance with preserving the health and safety of the individual in order that he/she may reside and be supported in the most integrated independent community setting.
- Observing and reporting any change in the participant’s condition and the home environment to the supports coordinator.

These service needs differ in scope, nature, supervision arrangements, or provider type (including provider training and qualifications) from services available in the State Plan. The differences between the waiver coverage and the State Plan are that the provider



qualifications and training requirements are more stringent for CLS tasks as provided under the waiver than the requirements for these types of services under the State Plan.

CLS services cannot be provided in circumstances where they would be a duplication of services available under the State Plan or elsewhere. The distinction must be apparent by unique hours and units in the approved service plan.

4.1.E. COMMUNITY TRANSPORTATION

Community transportation service includes both non-emergency medical transportation and non-medical transportation.

Community transportation services are offered to enable waiver participants to access waiver services and other community services, activities, and resources as specified in the person-centered service plan. The community transportation service may also include expenses related to transportation and other travel expenses determined necessary to secure medical examinations, appointments, documentation, or treatment for participants.

Waiver agencies will ensure MI Choice participants have access to community transportation as needed to obtain medical services. Utilization of family, friends, or community agencies who provide transportation services without charge must be explored before MI Choice will authorize community transportation.

Community transportation services include, but are not limited to, transportation to obtain the following medical services:

- Chronic and ongoing treatment;
- Prescriptions;
- Medical supplies and devices;
- One-time, occasional and ongoing visits for medical care; and
- Services received at a Veterans' Affairs hospital.

Travel expenses related to the provision of community transportation include:

- The cost of transportation for the MI Choice participant by wheelchair vans, taxis, bus passes and tickets, secured transportation containing an occupant protection system that addresses safety needs of disabled or special needs individuals, and other forms of transportation;
- Mileage reimbursement for individuals or volunteers with a valid driver's license utilizing personal vehicles to transport the MI Choice participant;
- The cost of meals and lodging en route to and from medical care, and while receiving medical care;
- The cost of an attendant to accompany the MI Choice participant, if necessary;
- The cost of the attendant's transportation, meals, and lodging when transporting to or from medical care; and



- The attendant's salary, if the attendant is not a volunteer or a member of the MI Choice participant's family who is not already a paid caregiver.

Delivery services for medical items, such as medical supplies or prescriptions, should be utilized before authorizing community transportation services through the MI Choice program.

Community transportation provider standards are outlined in the contract between MDHHS and waiver agencies.

When the costs of transportation are included in the provider rate for another waiver service (e.g., Adult Day Health or CLS), there must be mechanisms to prevent the duplicative billing for transportation services.

4.1.F. COUNSELING

Counseling services seek to improve the participant's emotional and social well-being through the resolution of personal problems or through changes in a participant's social situation.

Counseling services must be directed to participants who are experiencing emotional distress or a diminished ability to function. Family members, including children, spouses or other responsible relatives, may participate in the counseling session to address and resolve the problems experienced by the participant and to prevent future issues from arising. Counseling services are typically provided on a short-term basis to address issues such as adjusting to a disability, adjusting to community living, and maintaining or building family support for community living. Counseling services are not intended to address long-term behavioral or mental health needs.

4.1.G. ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS

Environmental Accessibility Adaptations (EAA) includes physical adaptations to the home required by the participant's person-centered service plan that are necessary to ensure the health and welfare of the participant or that enable the participant to function with greater independence in the home, without which the participant would require institutionalization.

Adaptations may include:

- Installation of ramps and grab bars;
- Widening of doorways;
- Modification of bathroom facilities;
- Modification of kitchen facilities;
- Installation of specialized electrical and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the participant; and



- Environmental control devices that replace the need for paid staff and increase the participant's ability to live independently, such as automatic door openers.

Assessments and specialized training needed in conjunction with the use of such environmental adaptations are included as a part of the cost of the service.

The case record must contain documented evidence that the adaptation is the most cost-effective and reasonable alternative to meet the participant's need(s). An example of a reasonable alternative, based on the results of a review of all options, may include changing the purpose, use or function of a room within the home or finding alternative housing. The participant must agree to the reasonable alternative prior to starting the modifications.

Environmental adaptations required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in a participant's home.

The waiver agency must ensure there is a signed contract or bid proposal with the licensed builder or contractor prior to the start of an environmental adaptation. It is the responsibility of the waiver agency to work with the participant and licensed builder or contractor to ensure the work is completed as outlined in the contract or bid proposal. All services must be provided in accordance with applicable state or local building codes.

The existing structure must have the capability to accept and support the proposed changes.

The environmental adaptation must incorporate reasonable and necessary construction standards, excluding cosmetic improvements. The adaptation cannot result in valuation of the structure significantly above comparable neighborhood real estate values.

The participant, with the direct assistance of the waiver agency's supports coordinator when necessary, must make a reasonable effort to access all available funding sources, such as housing commission grants, Michigan State Housing Development Authority (MSHDA), and community development block grants. The participant's case record must include evidence of efforts to apply for alternative funding sources and the acceptances or denials of these funding sources. The MI Choice program is a funding source of last resort.

Adaptations may be made to rental properties when the lease or rental agreement does not indicate that the landowner is responsible for such adaptations and the landowner agrees to the adaptation in writing. A written agreement between the landowner, the participant, and the waiver agency must specify any requirements for restoration of the property to its original condition if the occupant moves.

Excluded are those adaptations or improvements to the home that:

- Are of general utility.
- Are considered to be standard housing obligations of the participant or homeowner.



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- Are not of direct medical or remedial benefit.

Examples of exclusions include, but are not limited to:

- Carpeting
- Roof repair
- Sidewalks and driveways
- Heating
- Central air conditioning (except under exceptions noted in the service definition)
- Garages and raised garage doors
- Storage and organizers
- Hot tubs, whirlpool tubs, and swimming pools
- Landscaping
- General home repairs

MI Choice does not cover general construction costs in a new home or additions to a home purchased after the participant is enrolled in the waiver. If a participant or the participant's family purchases or builds a home while receiving waiver services, it is the participant's or family's responsibility to ensure the home will meet basic needs, such as having a ground floor bath or bedroom if the participant has mobility limitations. MI Choice funds may be authorized to assist with the adaptations noted above (e.g., ramps, grab bars, widening doorways, bathroom modifications, etc.) for a home recently purchased. If modifications are needed to a home under construction that require special adaptation to the plan (e.g., roll-in shower), the MI Choice program may be used to fund the difference between the standard fixture and the modification required to accommodate the participant's need.

The infrastructure of the home involved in the funded adaptations (e.g., electrical system, plumbing, well or septic, foundation, heating and cooling, smoke detector systems, or roof) must be in compliance with any applicable local codes. Environmental adaptations shall exclude costs for improvements exclusively required to meet applicable state or local building codes.

4.1.H. FISCAL INTERMEDIARY

Fiscal Intermediary Services assist participants who choose the self-determination option in acquiring and maintaining services defined in the participant's person-centered service plan, controlling a participant's budget, and choosing staff authorized by the waiver agency. The Fiscal Intermediary helps a participant manage and distribute funds contained in an individual budget. Funds are used to purchase waiver goods and services authorized in the participant's plan of service. Fiscal Intermediary services include, but are not limited to, the facilitation of the employment of MI Choice service providers by the participant (including federal, state, and local tax withholding or payments, unemployment compensation fees, wage settlements), fiscal accounting, tracking and monitoring participant-directed budget expenditures and identifying



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potential over- and under-expenditures, and ensuring compliance with documentation requirements related to management of public funds. The Fiscal Intermediary may also perform other supportive functions that enable the participant to self-direct needed services and supports. These functions may include verification of provider qualifications, including reference and criminal history reviews, and assisting the participant to understand billing and documentation requirements.

Fiscal Intermediary Services are available only to participants choosing the self-determination option.

4.1.I. GOODS AND SERVICES

Goods and Services are services, equipment or supplies not otherwise provided through either the MI Choice Waiver or the Medicaid State Plan that address an identified need in the person-centered service plan (including improving and maintaining the participant's opportunities for full membership in the community) and meet the following requirements. The item or service would:

- decrease the need for other Medicaid services,
- promote inclusion in the community, and
- increase the participant's safety in the home environment.

These goods and services are only available if the participant does not have the funds to purchase them or they are not available through another source.

Goods and Services are only approved by CMS for participants choosing the self-determination option. Experimental or prohibited treatments are excluded. Goods and Services must be documented in the person-centered service plan.

4.1.J. HOME DELIVERED MEALS

Home Delivered Meals (HDM) is the provision of one to two nutritionally sound meals per day to a participant who is unable to care for their own nutritional needs. The unit of service is one meal delivered to the participant's home or to the participant's selected congregate meal site that provides a minimum of one-third of the current recommended dietary allowance (RDA) for the age group as established by the Food and Nutritional Board of the National Research Council of the National Academy of Sciences. Allowances shall be made in HDMs for specialized or therapeutic diets as indicated in the person-centered service plan. A HDM cannot constitute a full nutritional regimen.

Limitations on participants who may receive a meal include:

- The participant must be unable to obtain food or prepare complete meals.
- The participant does not have an adult living at the same residence or in the vicinity who is able and willing to prepare all meals.
- The participant does not have a paid caregiver who is able and willing to prepare meals for the participant.



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- The provider can appropriately meet the participant's special dietary needs, and the meals available will not jeopardize the participant's health.
- The participant must be able to feed himself/herself.
- The participant must agree to be home when meals are delivered, or contact the program when an absence is unavoidable.

4.1.K. NURSING SERVICES

Nursing Services are covered on an intermittent (separated intervals of time) basis for a participant who requires nursing services for the management of a chronic illness or physical disorder in the participant's home. These services are provided by a registered nurse (RN) or a licensed practical nurse (LPN) under the direct supervision of an RN. Nursing Services are for participants who require more periodic or intermittent nursing than available through the Medicaid State Plan or third party payer resources for the purpose of preventive interventions to reduce the occurrence of adverse outcomes for the participant, such as hospitalizations and nursing facility admissions. MI Choice Nursing Services shall not duplicate services available through the Medicaid State Plan or third party resources.

When the participant's condition is unstable, could easily deteriorate, or significantly changes, MI Choice covers nurse visits for observation and evaluation. The purpose of the observation and evaluation is to monitor the participant's condition and report findings to the participant's physician or other appropriate health professional to prevent additional decline, illness, or injury to the participant. The supports coordinator shall communicate with both the nurse providing this service and the participant's health professional to ensure the nursing needs of the participant are being addressed.

Participants must meet at least one of the following criteria to qualify for this service:

- Be at high risk of developing skin ulcers, or have a history of resolved skin ulcers that could easily redevelop.
- Require professional monitoring of vital signs when changes may indicate the need for modifications to the medication regimen.
- Require professional monitoring or oversight of blood sugar levels, including participant-recorded blood sugar levels, to assist with effective pre-diabetes or diabetes management.
- Require professional assessment of the participant's cognitive status or alertness and orientation to encourage optimal cognitive status and mental function, or identify the need for modifications to the medication regimen.
- Require professional evaluation of the participant's success with a prescribed exercise routine to ensure its effectiveness and identify the need for additional instruction or modifications when necessary.
- Require professional evaluation of the participant's physical status to encourage optimal functioning and discourage adverse outcomes.



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- Have a condition that is unstable, could easily deteriorate, or experience significant changes AND a lack of competent informal supports able to readily report life-threatening changes to the participant's physician or other appropriate health professional.

In addition to the observation and evaluation, a nursing visit may also include, but is not limited to, one or more of the following nursing services:

- Administering prescribed medications that cannot be self-administered (as defined under Michigan Compiled Law (MCL) 333.7103(1)).
- Setting up medications according to physician orders.
- Monitoring participant's adherence to their medication regimen.
- Applying dressings that require prescribed medications and aseptic techniques.
- Providing refresher training to the participant or informal caregivers to ensure the use of proper techniques for health-related tasks such as diet, exercise regimens, body positioning, taking medications according to physician's orders, proper use of medical equipment, performing ADL, or safe ambulation within the home.

This service is limited to no more than two hours per visit. Participants receiving Private Duty Nursing/Respiratory Care services are not eligible to receive MI Choice Nursing Services.

4.1.L. PERSONAL EMERGENCY RESPONSE SYSTEM

A Personal Emergency Response System (PERS) is an electronic device that enables a participant to summon help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is often connected to the participant's phone and programmed to signal a response center once a "help" button is activated. Installation, upkeep and maintenance of devices and systems are also provided. PERS does not cover monthly telephone charges associated with phone service.

The provider may offer this service for cellular or mobile phones and devices. The device must meet industry standards. The participant must reside in an area where the cellular or mobile coverage is reliable. When the participant uses the device to signal and otherwise communicate with the PERS provider, the technology for the response system must meet all other service standards.

4.1.M. PRIVATE DUTY NURSING/RESPIRATORY CARE

Private Duty Nursing/Respiratory Care (PDN/RC) services are skilled nursing or respiratory care interventions provided to a participant age 21 and older on an individual and continuous basis to meet health needs directly related to the participant's physical disorder. PDN/RC includes the provision of skilled assessment, treatment, and observation provided by licensed nurses within the scope of the State's Nurse Practice Act, consistent with physician's orders, and in accordance with the participant's person-centered service plan. Respiratory Care may be provided by a licensed respiratory therapist to a participant who is ventilator dependent. To be eligible for PDN/RC services, the waiver agency must find the participant meets either Medical Criteria I or



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Medical Criteria II, and Medical Criteria III. Regardless of whether the participant meets Medical Criteria I or II, the participant must also meet Medical Criteria III.

The participant's person-centered service plan must provide reasonable assurance of participant safety. This includes a strategy for effective back-up in the event of an absence of providers. The back-up strategy must include informal supports or the participant's capacity to manage his/her care and summon assistance.

PDN/RC for a participant between the ages of 18-21 is covered under the Medicaid State Plan.

Medical Criteria I – The participant is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:

- Mechanical rate-dependent ventilation (four or more hours per day) or assisted rate-dependent respiration (e.g., some models of bi-level positive airway pressure [Bi-PAP]); or
- Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period; or
- Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or
- Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or
- Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter and a documented need for skilled assessment, judgment, and intervention in the rate of oxygen administration. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the P02 level is 55 mm HG or below.

Medical Criteria II – Frequent episodes of medical instability within the past three to six months requiring skilled assessments, judgments, or interventions (as described in III below) as a result of a substantiated medical condition directly related to the physical disorder.

Definitions of Medical Criteria II:

- "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months.
- "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder.



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- “Emergency medical treatment” means covered inpatient and outpatient services that are furnished by a provider who is qualified to furnish such services and that are needed to evaluate or stabilize an emergency medical condition.
- “Emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention would result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- “Directly related to the physical disorder” means an illness, diagnosis, physical impairment, or syndrome that is likely to continue indefinitely, and results in significant functional limitations in three or more ADL.
- “Substantiated” means documented in the clinical or medical record, including the progress notes.

Medical Criteria III – The participant requires continuous skilled care on a daily basis during the time when a licensed nurse or respiratory therapist is paid to provide services.

Definitions of Medical Criteria III:

- “Continuous” means at least once every three hours throughout a 24-hour period, and when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode.
- Equipment needs alone do not create the need for skilled services.
- “Skilled” means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse or respiratory therapist. Skilled care includes, but is not limited to:
 - Performing assessments to determine the basis for acting or a need for action, and documentation to support the frequency and scope of those decisions or actions.
 - Managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the participant four or more hours per day.
 - Deep oral (past the tonsils) or tracheostomy suctioning.
 - Injections when there is a regular or predicted schedule, or prn injections that are required at least once per month (insulin administration is not considered a skilled intervention).
 - Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility.
 - Total parenteral nutrition delivered via a central line and care of the central line.



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- Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter, and a documented need for adjustments in the rate of oxygen administration requiring skilled assessments, judgments and interventions. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 and older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the P02 level is 55 mm HG or below.
- Monitoring fluid and electrolyte balances where imbalances may occur rapidly due to complex medical problems or medical fragility. Monitoring by a skilled nurse would include maintaining strict intake and output, monitoring skin for edema or dehydration, and watching for cardiac and respiratory signs and symptoms. Taking routine blood pressure and pulse once per shift that does not require any skilled assessment, judgment or intervention at least once every three hours during a 24-hour period, as documented in the nursing notes, would not be considered skilled nursing.
- Participants receiving MI Choice Nursing Services are not eligible to receive PDN/RC services.

Other Criteria:

- Where applicable, the participant must use Medicaid State Plan, Medicare, or third party payers first.
- The participant's preference for a certain provider or agency is not grounds for declining another payer in order to access waiver services.
- It is not the intent of the MI Choice program to provide PDN/RC services on a continual 24-hours-per-day/7-days-per-week basis. MI Choice services are intended to supplement informal support services available to the participant. Only under extreme circumstances should 24/7 PDN/RC be authorized for a participant. These circumstances must be clearly described on the person-centered service plan and approved by MDHHS.
- 24/7 PDN/RC services cannot be authorized for participants who cannot direct their own services and supports, make informed decisions for themselves, or engage their emergency back-up plan without assistance. These participants must have informal caregivers actively involved in providing some level of direct services to them on a routine basis.
- All PDN/RC services authorized must be medically necessary as indicated through the MI Choice assessment and meet the medical criteria set forth in this chapter.
- The participant's physician, physician assistant, or nurse practitioner must order PDN/RC services and work in conjunction with the waiver agency and provider agency to ensure services are delivered according to that order.

4.1.N. RESPITE

Respite services are provided to participants unable to care for themselves and are furnished on a short-term basis due to the absence of, or need of relief for, those individuals normally providing services and supports for the participant. Services may be



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provided in the participant's home, in the home of another, or in a Medicaid-certified hospital, nursing facility, or a licensed Adult Foster Care facility. Respite does not include the cost of room and board, except when provided as part of respite furnished in a facility approved by MDHHS that is not a private residence.

Services include:

- Attendant Care (participant is not bed-bound), such as companionship, supervision, and assistance with toileting, eating, and ambulation.
- Basic Care (participant may or may not be bed-bound), such as assistance with ADL, a routine exercise regimen, and self-medication.

There is a 30-days-per-calendar-year limit on respite services provided outside the home. The costs of room and board are not included except when respite is provided in a facility approved by the State that is not a private residence. Respite services cannot be scheduled on a daily basis, except for longer-term stays at an out-of-home respite facility. Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers.

4.1.O. SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

Specialized Medical Equipment and Supplies includes devices, controls, or appliances which enable participants to increase their abilities to perform ADL, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support or to address physical conditions, along with ancillary supplies and equipment necessary to the proper functioning of such items.

This service excludes those items that are not of direct medical or remedial benefit to the participant. Durable and non-durable medical equipment and medical supplies not available under the State Plan that are necessary to address the participant's functional limitations may be covered by this service. Medical equipment and supplies furnished under the State Plan must be procured and reimbursed through that mechanism and not through MI Choice. All items must be specified in the person-centered service plan.

All items shall meet applicable standards of manufacture, design and installation. Coverage includes training the participant or caregiver(s) in the operation and maintenance of the equipment or the use of a supply when initially purchased. Waiver funds may also be used to cover the maintenance costs of equipment.

Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items that are not of direct medical or remedial benefit to the participant.

4.1.P. SUPPORTS COORDINATION

Supports Coordination is provided to ensure the provision of supports and services required to meet the participant's health and welfare needs in a home and community-based setting. Without these supports and services, the participant would otherwise require institutionalization. The supports coordination functions to be performed and the



frequency of face-to-face and other contacts are specified in the person-centered service plan. The frequency and scope of supports coordination contacts must take into consideration health and welfare needs of the participant. Supports Coordination does not include the direct provision of other Medicaid services.

Supports coordinators perform the following functions:

- Conduct the initial and subsequent Nursing Facility Level of Care Determinations per state policy. (Refer to the Nursing Facility Level of Care Determination chapter for additional information.)
- Conduct the initial Resident Assessment Instrument – Home Care (iHC) assessment and periodic reassessments.
- Facilitate a person-centered planning process that is focused on the participant’s preferences; includes family and other allies as determined by the participant; identifies the participant’s goals, preferences and needs; provides information about options; and engages the participant in monitoring and evaluating services and supports.
- Assist the participant with developing a person-centered service plan, including revisions to the plan at the participant’s initiation or as changes in the participant’s circumstances may warrant.
- Referral to, and coordinate with, providers of services and supports, including non-Medicaid services and informal supports. This may include providing assistance with access to entitlements or access to legal representation.
- Monitor MI Choice waiver services and other services and supports necessary for achievement of the participant’s goals. Monitoring includes opportunities for the participant to evaluate the quality of services received and whether those services achieved desired outcomes. This activity includes the participant and other key sources of information as determined by the participant.
- Provide social and emotional support to the participant and allies to facilitate life adjustments and reinforce the participant’s sources of support. This may include arranging services to meet those needs.
- Provide advocacy in support of the participant’s access to benefits, ensuring the participant’s rights as a program beneficiary, and supporting the participant’s decisions.
- Maintain documentation of the above-listed activities to ensure successful support of the participant, comply with Medicaid and other applicable policies, and meet the performance requirements delineated in the waiver agency’s contract with MDHHS.

Additional guidance for Supports Coordination is located in the contract between MDHHS and MI Choice waiver agencies which is available online. (Refer to the Directory Appendix for website information.) In addition to requiring and accepting Supports Coordination services, applicants must also require and agree to accept one additional MI Choice service which is needed by the applicant every 30 calendar days in order to qualify for the program.



4.1.Q. TRAINING

Training services consist of instruction provided to a MI Choice participant or caregiver(s) in either a one-to-one situation or a group basis to teach a variety of independent living skills, including the use of specialized or adaptive equipment or medically-related procedures required to maintain the participant in a community-based setting. The training needs must be identified in the comprehensive assessment or in a professional evaluation and included in the participant's person-centered service plan. Training is covered for areas such as ADL, adjustment to home or community living, adjustment to mobility impairment, adjustment to serious impairment, management of personal care needs, the development of skills to deal with service providers and attendants, and effective use of adaptive equipment. For participants self-directing services, training services may also include the training of independent supports brokers, developing and managing individual budgets, staff hiring and supervision, or other areas related to self-direction.

4.2 STATE PLAN SERVICES

MI Choice services are designed to address the unique needs and circumstances of program participants. Some waiver services appear to be the same as services offered in the State Plan; however, they differ in terms of key elements, such as scope of coverage or provider qualifications. Inasmuch as waiver services are designed to meet the specific demands of participants, it is expected that a waiver service will be more appropriate for a participant than a similar State Plan service. Under no circumstances shall the participant receive both services. As a Prepaid Ambulatory Health Plan (PAHP), waiver agencies have authority to authorize payment only for MI Choice services for which they receive a capitated payment. Payments to the waiver agency for State Plan services may occur when the waiver agency is a properly enrolled provider for the specified service and conforms to conflict of interest protections.

4.3 HOSPICE OR PALLIATIVE CARE

MI Choice participants may receive State Plan hospice or palliative care services while participating in MI Choice. Participants must meet all hospice or palliative care eligibility requirements outlined in the Hospice Chapter. If the beneficiary is receiving hospice or palliative care and becomes eligible to receive waiver services, the waiver agency contacts the hospice or palliative care provider to establish the first date of service for the waiver services.

State Plan hospice services or palliative care must be used to the fullest extent before similar MI Choice services are authorized. Inappropriate services (e.g., duplicative, non-covered) are subject to MDHHS recovery of the amounts paid for those services from the waiver agency.

A joint plan of service for hospice or palliative care and MI Choice must be developed and maintained by both the waiver agency and the hospice or palliative care provider. It is important that the waiver agency understand the hospice or palliative care philosophy so the two entities work for a common goal and avoid redundant services. Ongoing communication and coordination must occur between the MI Choice supports coordinator and the hospice or palliative care provider during the time they are serving the participant. Written documentation of this communication and coordination must be kept in the participant's record at each agency.



4.4 MEDICATION ADMINISTRATION

Medication administration in MI Choice is established through the provision of Nursing Services. Some functions may be provided through CLS under supervision of a licensed nurse.

4.5 OPERATING STANDARDS

MDHHS maintains and publishes the "Minimum Operating Standards for MI Choice Waiver Program Services" (known as the Minimum Operating Standards) document. This document defines both general and specific operating criteria for the program. All waiver agencies and service providers are subject to the standards, definitions, limits, and procedures described therein.

For each service offered in MI Choice, the Minimum Operating Standards are used to set the minimum qualifications for all direct service providers, including required certifications, training, experience, supervision, and applicable service requirements. Billing codes and units are also defined in the document.

4.6 SERVICES IN LICENSED OR PROVIDER CONTROLLED SETTINGS

Licensing rules for residential setting providers reflect an attempt to make residing in these settings much like it would be in a home. Providers of licensed residential settings must meet the standards of providing a non-institutional setting licensed by the State of Michigan. For further details on what constitutes a home and community-based setting, refer to 42 CFR §441.530. Both licensed and non-licensed settings in which the provider has control over staffing arrangements and where MI Choice services are furnished must comply with the requirements of the Home and Community Based Services Chapter.



SECTION 5 – NURSING FACILITY TRANSITIONS

Serving individuals who require long-term supports and services in the least restrictive setting of their choice is a priority of MDHHS. The tenet of rebalancing the spectrum of long-term services and supports in Michigan was given impetus by the 1999 United States Supreme Court decision in *Olmstead v. L. C.*. Waiver agencies must enroll individuals who are transitioning or discharging from an institutional setting and who qualify for and choose the MI Choice program as slot capacity allows and according to waiting list prioritization. Waiver agencies will work with the transition navigator or discharge planner to ensure MI Choice enrollment occurs on the date of transition or discharge for the individual to ensure the continuation of services for the individual.



SECTION 6 – SUPPORTS COORDINATION

Supports coordination facilitates access to, and arrangement of, services and supports needed and chosen by MI Choice participants. These are detailed and documented in the person-centered service plan. Refer to the Supports Coordination service description in the Services section of this chapter for additional information.

Supports coordinators use a person-centered approach in working with a participant to determine how their needs will be met. Supports coordinators also monitor the quality of services received by the participant and explore other funding options and service opportunities when personal goals exceed the scope of available MI Choice services. For participants choosing the self-determination option for service delivery, the supports coordinator assists in the selection, coordination, and management of those services and providers.

MDHHS includes a Supports Coordination Performance Standards document as an attachment to all waiver agency provider contracts. The document prescribes acceptable standards and protocols for the provision of supports coordination services. It is reviewed and amended as necessary.

6.1 PERSON-CENTERED PLANNING

Person-centered planning (PCP) is a process for planning and supporting a participant receiving services that builds on the participant's desire to engage in lawful activities that promote community life and that honor the participant's preferences, choices, and abilities. The PCP process involves families, friends, and professionals as the participant desires or requires. Waiver agencies and direct service providers must utilize a PCP process, informing the participant of service options in ways that are meaningful to the participant. This includes assessing the needs and desires of the participant, developing the person-centered service plan, and continuously updating and revising those plans as needs and desires change. The participant and their chosen representative(s) must be provided with written information from the waiver agency detailing the right to participate in the PCP process. Waiver agencies and direct service providers implement PCP in accordance with the MDHHS Person-Centered Planning Guideline document that is an attachment to the waiver agency provider contract.

PCP meetings are conducted when the participant is not in crisis and at a time of the participant's choice. The participant has authority to determine who will be involved in the PCP process as well as a time and location that meets the needs of all individuals involved in the process. An interim plan of service may be developed by the supports coordinator when the participant is experiencing a crisis situation that requires immediate services and the participant is not ready to fully participate in PCP. Interim care plans are authorized for no more than 30 days without a follow-up visit (or planning meeting) to determine the participant's status.

6.2 PERSON-CENTERED SERVICE PLAN

The participant's person-centered service plan is an individualized, comprehensive document developed by the participant, their chosen representative(s), and the supports coordinator prior to the provision of services. Using a person-centered process, waiver agencies must establish a written person-centered service plan for each participant that identifies the participant's strengths, weaknesses, needs, goals, expected outcomes, and planned interventions. This document includes all services provided to, or needed by, the participant regardless of funding source. The person-centered service plan is developed when the participant is not in crisis and may build upon an interim care plan, but should be completed



within 90 days of MI Choice enrollment. The participant must approve all services and interventions before implementation and the waiver agency must document participant approval. MI Choice services must be stipulated in the PCP process and the participant assessment. Requirements for the person-centered service plan are defined in the Home and Community Based Services chapter.

6.3 SELF-DETERMINATION

Self-Determination provides MI Choice participants the option to direct and control their own waiver services. Not all MI Choice participants choose to participate in self-determination. For those that do, the participant (or chosen representative(s)) has decision-making authority over staff who provide waiver services, including:

- Recruiting staff
- Referring staff to an agency for hiring (co-employer)
- Selecting staff from worker registry
- Hiring staff (common law employer)
- Verifying staff qualifications
- Obtaining criminal history review of staff
- Specifying additional service or staff qualifications based on the participant's needs and preferences so long as such qualifications are consistent with the qualifications specified in the approved waiver application and the Minimum Operating Standards
- Specifying how services are to be provided and determining staff duties consistent with the service specifications in the approved waiver application and contract attachments
- Determining staff wages and benefits, subject to State limits (if any)
- Scheduling staff and the provision of services
- Orienting and instructing staff in duties
- Supervising staff
- Evaluating staff performance
- Verifying time worked by staff and approving timesheets
- Discharging staff (common law employer)
- Discharging staff from providing services (co-employer)
- Reallocating funds among services included in the participant's budget
- Identifying service providers and referring for provider enrollment
- Substituting service providers
- Reviewing and approving provider invoices for services rendered

Participant budget development for participants in self-direction occurs during the PCP process and is intended to involve individuals the participant chooses. Planning for the person-centered service plan precedes the development of the participant's budget so that needs and preferences can be accounted for without arbitrarily restricting options and preferences due to cost considerations. A participant's



budget is not authorized until both the participant and the waiver agency have agreed to the amount and its use. In the event that the participant is not satisfied with the authorized budget, he/she may reconvene the PCP process. The waiver services of Fiscal Intermediary and Goods and Services are available specifically to self-determination participants to enhance their abilities to more fully exercise control over their services.

The participant may, at any time, modify or terminate the self-determination option. The most effective method for making changes is the PCP process in which individuals chosen by the participant work with the participant and the supports coordinator to identify challenges and address problems that may interfere with the success of self-determination. The decision of a participant to terminate participation in self-determination does not alter the services and supports identified in the person-centered service plan, with the exception of the termination of the self-determination only services, Fiscal Intermediary, and Goods and Services. When the participant terminates self-determination, the waiver agency has an obligation to assume responsibility for ensuring the provision of all other services identified in the person-centered service plan through its provider network.

A waiver agency may terminate self-determination for a participant when problems arise due to the participant's inability to effectively direct services and supports. Prior to terminating self-determination (unless it is not feasible), the waiver agency informs the participant in writing of the issues that have led to the decision to terminate this option. The waiver agency will continue efforts to resolve the issues that led to the termination.



SECTION 7 – ADMINISTRATION

MDHHS serves as the single state agency in the operation of the MI Choice program. MDHHS contracts with entities to administer the program throughout the state. Certain administrative functions are assigned to the local agencies as defined in the Medicaid waiver application to CMS, as renewed and amended. To assist MDHHS in operating MI Choice, agencies are required to submit periodic reports as detailed in this section.

7.1 WAIVER AGENCIES AS PREPAID AMBULATORY HEALTH PLANS

MDHHS contracts with waiver agencies that operate as PAHPs to perform administrative functions. They are responsible for disseminating waiver information to applicants, assisting applicants with waiver enrollment (which includes assisting applicants with completion of the Medicaid application to secure financial eligibility), managing waiver enrollment against approved limits, monitoring expenditures against approved limits, conducting assessments and LOCD evaluations, reviewing person-centered service plans to ensure that waiver requirements are met, conducting utilization reviews and quality management reviews, recruiting providers, and executing Medicaid provider agreements.

Each waiver agency must sign a provider contract with MDHHS assuring that it meets all program requirements.

Waiver agencies are responsible for securing qualified service providers to deliver services. Eligible provider applicants include public, private non-profit or for-profit organizations that provide services meeting established service standards, certifications or licensure requirements. Participants may only use providers in the waiver agency's provider network, unless no willing provider is available within the waiver agency's network. Waiver agencies must ensure MI Choice services identified in the person-centered service plan are furnished according to the plan, which may include utilizing providers outside of the provider network, as specified in 42 CFR §438.206, until such time as a network provider is able to furnish the service.

7.2 WAITING LIST REPORTING

Waiting list data is collected and maintained on a secure, web-based application. Waiver agencies must complete all required fields for each qualified MI Choice applicant. Waiting list data must be entered online within one business day after completion of the MI Choice Intake Guidelines. If an applicant is removed from the MI Choice waiting list, the data must be completed online within five business days and include the reason for removal.

7.3 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

All MI Choice waiver agencies and providers are required to comply with the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any subsequent revisions. Compliance is required in areas that include privacy and security rules, data sharing, and disclosure.



SECTION 8 – FINANCING AND REIMBURSEMENT

Annual funding levels for MI Choice are subject to appropriation allocations made by the Michigan Legislature. MDHHS contracts annually with waiver agencies to operate the MI Choice program, and all waiver agency budget and reimbursement requirements and considerations must be defined in the contract, as amended. Any additional consideration or compensation to the waiver agency must also be included in the annual contract, as amended. Waiver agencies are paid through capitation payments and are required to submit all encounter data to MDHHS as outlined in the Encounter Data Reporting subsection of this chapter. Encounter data is processed through the CHAMPS. Waiver agencies are required to submit all financial reports as detailed in the annual contract. Each agency is subject to review or audit by MDHHS, the State of Michigan, or their designee.

8.1 REIMBURSEMENT SCHEDULE

At the end of each month, MDHHS will run the 834 Enrollment file for each waiver agency. This file contains an electronic listing of individuals who are enrolled in the MI Choice program with each provider. The Medicaid Management Information System (MMIS) then performs quality checks, including:

- Verification of current Medicaid eligibility;
- A valid LOCD indicating the participant meets nursing facility level of care; and
- The participant is not enrolled in any other long-term care program.

On the fourth pay cycle of each month, the 820 premium payment will run and will electronically transfer the appropriate per member per month capitation payment for each participant enrolled with each waiver agency.

8.2 ENCOUNTER DATA REPORTING

Medicaid is established as the payer of last resort. Waiver agencies must pursue and secure all third party liability (TPL) sources possible. Agencies must make every effort to enroll and utilize dually certified (Medicare and Medicaid) providers. Agencies cannot use waiver funds for services that are covered through another payment source.

Each waiver agency must submit all encounter data to MDHHS within 180 calendar days of the date that services were rendered. Waiver agencies must resolve issues related to encounters that are rejected by CHAMPS within 30 calendar days of notification by MDHHS or its designee. Agencies have 10 calendar days after the expiration of the 30-day resolution window to report on issues that cannot be resolved.

8.3 ADMINISTRATIVE EXPENSE AND OTHER FINANCIAL REPORTING

Each waiver agency must submit an Administrative Expense Report (AER) to MDHHS as specified in the contract. The expenses reported must be actual expenses incurred by the waiver agency. Each AER shall cover one calendar month and is due within 30 calendar days after the conclusion of that month. Waiver agencies must submit additional financial reports and information as requested by MDHHS. MDHHS must communicate requirements for such additional information to the waiver agency in writing and allow sufficient time for a response.



8.4 FINANCIAL AUDIT REQUIREMENTS

MI Choice waiver agencies are contractually obligated to comply with, and ensure compliance by, its subcontractors with all requirements of the Single Audit Act and any amendments to this act. Waiver agencies must submit to MDHHS a Single Audit, Financial Statement Audit, or Audit Status Notification Letter. If submitting a Single Audit or Financial Statement Audit, waiver agencies must also submit a Corrective Action Plan for any audit findings that impact MDHHS-funded programs and a management letter (if issued) with a response.

Waiver agencies that expend \$750,000 or more in federal awards during the agency's fiscal year must submit to MDHHS a Single Audit that is consistent with the Single Audit Act Amendments of 1996 and Office of Management and Budget (OMB) Title 2 CFR Subpart F and include all components described in 2 CFR §200.512(c).

Waiver agencies exempt from the Single Audit requirements that receive \$750,000 or more in total funding from MDHHS in state and federal grant funding must submit to MDHHS a Financial Statement Audit prepared in accordance with Generally Accepted Auditing Standards (GAAS). Waiver agencies exempt from the Single Audit requirements that receive less than \$750,000 of total MDHHS grant funding must submit to MDHHS a Financial Statement Audit prepared in accordance with GAAS if the audit includes disclosures that negatively impact MDHHS-funded programs including, but not limited to, fraud, financial statement misstatements, and violations of contract and grant provisions.

Waiver agencies exempt from both the Single Audit and Financial Statement Audit requirements (sections a and b) must submit an Audit Status Notification Letter that certifies these exemptions. The template for the Audit Status Notification Letter and further instructions are available on the MDHHS website. (Refer to MI Choice Waiver Resources in the Directory Appendix for additional information.)

The required audit and any other required submissions (i.e., Corrective Action Plan and management letter with a response, or Audit Status Notification Letter) must be submitted within nine months following the end of the contractor's fiscal year to the MDHHS Office of Quality Assurance and Internal Controls. (Refer to the Directory Appendix for contact information.)

Waiver agencies and each of their contractors are subject to the provisions of, and must comply with, the cost principles set forth in OMB Title 2 CFR Part 200 titled Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards Subparts A, B, and E.



SECTION 9 – PROVIDERS

Authorization for provision of waiver services is the responsibility of the waiver agencies. They determine the status of the qualifications and certifications (if applicable) for all direct service providers, negotiate and enter into contracts with the providers, and reimburse providers.

9.1 ENROLLMENT OF SERVICE PROVIDERS

Waiver agencies must use written contracts meeting the requirements of 42 CFR 434.6 to purchase services. Entities or individuals under subcontract with the waiver agencies must meet provider standards defined in the Minimum Operating Standards for MI Choice Waiver Program Services which is maintained by MDHHS and attached to each annual waiver agency contract. Only providers meeting the requisite waiver requirements are permitted to participate in the waiver program.

To ensure network capacity, as well as choice of providers, each waiver agency must have a provider network with capacity to service at least 125% of their monthly slot utilization for each MI Choice service and at least two providers for each MI Choice service. When waiver agencies cannot ensure this choice within 30 miles or 30 minutes travel time for each participant, they may request a rural area exception from MDHHS.

9.2 FAMILY MEMBERS AS SERVICE PROVIDERS

Waiver agencies may pay relatives of MI Choice participants to furnish services. This authorization excludes legally responsible individuals and legal guardians. The MI Choice participant must specify his/her preference for a relative to render services. The relative must meet the same provider standards as established for non-related caregivers. All waiver services furnished shall be included in the person-centered service plan and authorized by the supports coordinator. The supports coordinator must periodically evaluate the effectiveness of the relative in rendering the needed service. If the supports coordinator finds that the relative fails to meet established goals and outcomes or fails to render services as specified in the person-centered service plan, the supports coordinator must rescind the authorization of that relative to provide waiver services to the participant. When the supports coordinator finds the relative has failed to render services, payments must not be authorized.

9.3 REIMBURSEMENT RATES FOR PROVIDERS

Each waiver agency is responsible for sub-contracting with provider entities and for ensuring access to services. The process of rate determination for providers resides in the contract negotiation between the waiver agency and the provider. MDHHS does not play a role in this process.

Rates paid for services provided through the waiver must be adequate to ensure access to services needed by participants.

MDHHS does not make payment to legally responsible individuals for furnishing CLS or similar services.



9.4 CRIMINAL HISTORY REVIEWS

Each waiver agency and direct provider of home-based services must conduct a criminal history review through the Michigan State Police for each paid staff or volunteer who will be entering a participant's residence. The waiver agency and direct provider shall have completed reference and criminal history checks before authorizing an employee or volunteer to furnish services in a participant's residence. The scope of the investigation is statewide.

Both waiver agencies and MDHHS conduct administrative monitoring reviews of providers annually to verify that mandatory criminal history checks have been conducted in compliance with operating standards. Waiver agencies must comply with additional criminal history reviews mandated by the State for home and community-based services providers.

Waiver agencies must also check the list of sanctioned providers and must not contract with any providers on this list for the duration of the sanction period until approved by MDHHS to resume providing services. The MDHHS Sanctioned Provider List is located in the Directory Appendix under Billing Resources.

9.5 USE OF RESTRAINTS, SECLUSION OR RESTRICTIVE INTERVENTIONS

Providers are prohibited from using seclusion or restrictive interventions in addition to using restraints. Qualified reviewers conduct Clinical Quality Assurance Reviews and home visits which include a discovery process to examine the use of restraints, seclusion or restrictive interventions by family or caregivers. Supports coordinators have the primary responsibility for identifying and addressing the use of restraints, seclusion or restrictive interventions.



SECTION 10 – PROGRAM QUALITY

The process of ensuring the highest quality program involves a continuous cycle of discovery, intervention, and evaluation. MDHHS is resolute about ensuring and improving the quality of services and protections it provides. To ensure that level of service, MDHHS operates a comprehensive quality management system that incorporates reviews of the administrative operations of the waiver agencies, clinical reviews of participant records, home reviews with participants, participant satisfaction surveys, continuous quality management and planning, and timely and effective responses to critical incidents.

10.1 ADMINISTRATIVE QUALITY ASSURANCE REVIEWS

MDHHS conducts periodic on-site Administrative Quality Assurance Reviews (AQAR) of each waiver agency, ensuring MDHHS reviews each waiver agency at least once every two to three years. MDHHS seeks evidence of compliance to the AQAR standards during the on-site review through examination of waiver agency policies and procedures, provider contracts, financial systems, encounter accuracy, and quality management plans.

Each waiver agency shall adhere to the MDHHS MI Choice Waiver Program Provider Monitoring Plan (known as the Monitoring Plan). The document defines the procedures and standards used by the waiver agency in reviewing providers included in the waiver agency's provider network. It includes the required protocols used to identify provider deficiencies and identifies timelines for remediation. (Refer to the Directory Appendix for additional information.) MDHHS will review each waiver agency's process in detail during the AQAR.

MDHHS notifies each waiver agency in writing of deficiencies requiring corrective action and provides a date for the waiver agency to provide a corrective action plan to MDHHS. In the event of a continued deficiency, MDHHS has the authority to take action toward the waiver agency, including the imposition of sanctions as defined in the MI Choice Contract. MDHHS has the option to suspend or terminate the contract of any waiver agency that fails to correct stated deficiencies identified on a second review.

10.2 QUALITY MANAGEMENT PLANS

Each waiver agency must have a written quality management plan that meets requirements specified in the MDHHS Quality Management Plan. The Quality Management Plan addresses quality assurance and improvement using measurable goals and quality performance indicators.

MDHHS reviews quality management plans annually. Waiver agencies are required to submit an annual report to MDHHS highlighting their quality management plan activities and improvements. (Refer to MI Choice Waiver Resources in the Directory Appendix for additional information.)

10.3 CLINICAL QUALITY ASSURANCE REVIEWS

MDHHS contracts with an External Quality Assurance Review agency to conduct an annual Clinical Quality Assurance Review (CQAR) of each waiver agency. The review is to determine whether the authorized services in the person-centered service plan are sufficient to protect the health and welfare of the participant and to determine whether the waiver agency is abiding by the laws, rules, and regulations that govern the MI Choice program.



Randomly selected records are reviewed. Samples are derived using federally-approved sampling techniques with a minimum of 10 records reviewed at each agency. In addition, a minimum of five home visits are conducted to verify information in the records. The review is conducted by a team of trained and qualified reviewers.

10.4 CRITICAL INCIDENT RESPONSE AND REPORTING

MI Choice is required to track and to report certain events that might indicate exceptional risk to the participant. Not only are these requirements defined in regulation, but also in law.

10.4.A. TYPES OF CRITICAL INCIDENTS AND SERIOUS EVENTS

The following are specific critical incidents or serious events that must be reported to MDHHS:

- Exploitation
- Illegal activity in the home with potential to cause a serious or major negative event
- Neglect
- Physical abuse
- Provider no-shows, particularly when the participant is bed-bound all day or there is a critical need for the service to be provided
- Sexual abuse
- Theft
- Verbal abuse
- Worker consuming drugs/alcohol on the job
- Unexplained death that is related to providing services, supports, or care
- Medication errors resulting in emergency medical treatment or hospitalization
- Restraints, seclusion or restrictive interventions
- Hospitalization or emergency department visits within 30 days of previous hospitalization due to neglect or abuse

10.4.B. CRITICAL INCIDENT RESPONSE

MI Choice waiver agencies have the initial responsibility for identifying, investigating, evaluating and responding to critical incidents that occur with participants as listed above. All suspected incidents of abuse, neglect and exploitation require reporting to MDHHS Adult Protective Services (MDHHS-APS) for investigation and follow-up. Agencies shall begin investigating and evaluating critical incidents within two business days of the date that it was noted that an incident occurred. Unexplained death that is also reported to law enforcement agencies must be reported to MDHHS within two business days.



Each waiver agency is required to maintain written policy and procedures defining appropriate action to take upon suspicion or determination of abuse, neglect or exploitation. The policies and procedures must include procedures for follow-up activities with MDHHS-APS to determine the result of the reported incident and the steps to be taken if the results are unsatisfactory. All reports to MDHHS-APS must be maintained in the participant's case record.

10.4.C. CRITICAL INCIDENT REPORTING

Waiver agencies are responsible under contract for tracking and responding to individual critical incidents using the Critical Incident Reporting web-based system. Waiver agencies are required to report the type of critical incidents, the responses to those incidents, and the outcome and resolution of each event within 30 days of the date of knowledge of the incident. The online system allows MDHHS to review the reports in real time and ask questions or address concerns with the waiver agencies. MDHHS must receive notification from waiver agencies of suspicious deaths within two business days.



SECTION 11 – GRIEVANCES AND APPEALS

MDHHS has established participant and provider appeal processes that are applicable to MI Choice. The participant appeals process conforms to the Medicaid fair hearing requirements found in federal law.

11.1 PARTICIPANT GRIEVANCES

Waiver agencies must establish their own internal grievance process. Participants may file a grievance orally or in writing when they are dissatisfied with the quality of services received. A grievance may be submitted to the waiver agency at any time. Waiver agencies must address grievances according to the time frames and requirements set in federal law and in the MI Choice Waiver contract.

11.2 PARTICIPANT INTERNAL APPEALS

Waiver agencies must establish their own internal appeal process for participants to file an appeal with the agency. The internal appeal process must conform to requirements and time frames set by federal law and the MI Choice Waiver contract. The internal appeal process applies only to MI Choice enrolled participants and in the following situations:

- The waiver agency is denying a requested service that is not already in place,
- The waiver agency is terminating, suspending or reducing a service that is already in place,
- The waiver agency is taking action or making an adverse determination based on suspicion of fraud, or
- In areas with only one waiver agency, the denial of a participant's request to exercise his or her right to obtain services outside the network.

Waiver agencies must send the participant an Adverse Benefit Determination notice when making any of the adverse decisions listed above. The Adverse Benefit Determination notice must meet the requirements specified in federal law and the MI Choice Waiver contract. Participants have 60 calendar days from the date of the Adverse Benefit Determination to request an internal appeal.

If the internal appeal decision upholds the action described in the Adverse Benefit Determination and the participant remains unsatisfied, the participant or legal representative may request a State Fair Hearing.

11.3 STATE FAIR HEARING

Applicants for MI Choice may request a state fair hearing when the waiver agency makes an adverse determination. MI Choice participants may request a state fair hearing when the waiver agency issues an internal appeal decision that upholds the action described in the Adverse Benefit Determination or when the waiver agency does not adhere to the time frames required for making a decision in an internal appeal.

Waiver agencies must provide adequate or advance notice to the applicant or participant that conforms to the requirements and time frames specified in federal law and the MI Choice Waiver contract.



11.4 PROVIDER AND WAIVER AGENCY APPEALS

Medicaid providers, including waiver agencies, are afforded appeal rights under the Michigan Social Welfare Act (Public Act 280 of 1939, as amended) and the Michigan Administrative Code. Adverse actions that may be appealed by providers include, but are not limited to, the suspension or termination of participation in the Medicaid program; or a reduction, suspension, or adjustment of provider payments.

Information regarding the MDHHS appeal process is available in the General Information for Providers Chapter and on the MDHHS website. (Refer to the Directory Appendix for website information.)



MI HEALTH LINK

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SECTION 1 – GENERAL INFORMATION

Effective March 1, 2015, the Michigan Department of Health and Human Services (MDHHS), in partnership with the Centers for Medicare & Medicaid Services (CMS), implemented a new managed care program called MI Health Link. This program integrates into a single coordinated delivery system all physical health care, pharmacy, long term supports and services, and behavioral health care for individuals who are dually eligible for full Medicare and full Medicaid. The goals of the program are to improve coordination of supports and services offered through Medicare and Medicaid, enhance quality of life, improve quality of care, and align financial incentives.

MDHHS and CMS have signed a three-way contract with managed care entities called Integrated Care Organizations (ICOs) to provide Medicare and Medicaid covered acute and primary health care, pharmacy, dental, and long term supports and services (nursing facility and home and community based services). The MI Health Link program also includes a home and community-based services (HCBS) waiver for MI Health Link enrollees who meet nursing facility level of care, choose to live in the community rather than an institution, and have a need for at least one of the waiver services as described in this chapter. This waiver is called the MI Health Link HCBS Waiver.

The Michigan Prepaid Inpatient Health Plans (PIHPs) in the four demonstration regions are responsible for providing all Medicare and Medicaid behavioral health services for individuals who have mental illness, intellectual/developmental disabilities, and/or substance use disorders. The Eligibility and Service Areas section provides a list of the regions and related counties.



SECTION 2 – ELIGIBILITY AND SERVICE AREAS

Individuals who are eligible to participate are those who are age 21 or older, eligible for Medicare and Medicaid, and reside in one of the four demonstration regions:

Region	Counties in the Region
1	Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft
4	Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren
7	Wayne
9	Macomb

Excluded populations:

- Individuals under age 21
- Individuals previously disenrolled due to special disenrollment from Medicaid managed care as defined in 42 CFR 438.56
- Individuals not living in one of the four demonstration regions
- Individuals with Additional Low Income Medicare Beneficiary/Qualified Individual (ALMB/QI) program coverage
- Individuals without full Medicaid coverage (they have spenddowns or deductibles)
- Individuals with Medicaid who reside in a state psychiatric hospital
- Individuals with commercial Health Maintenance Organization (HMO) coverage
- Individuals with elected hospice services prior to MI Health Link program enrollment
- Individuals with Medicaid who reside in a State Veterans' Home



SECTION 3 – ENROLLMENT PROCESS

Enrollment in the MI Health Link program occurs in two ways: 1) voluntary enrollment, and 2) passive enrollment. For voluntary enrollment, the eligible individual must call the enrollment broker contracted by the state for Medicaid managed care programs. The individual selects the ICO in which they wish to enroll, using the ICO provider networks and drug formularies to assist in making choices.

Eligible individuals who do not voluntarily enroll in the program will receive a notification letter at least 60 days prior to the enrollment effective date informing them they will be passively enrolled. Eligible individuals will have a period of 60 days to opt out of the program if they choose to do so prior to the enrollment effective date. Individuals may opt out by calling the entities as indicated in the notification letter. Individuals who do not opt out of the program prior to the effective date will be passively enrolled and an ICO will be assigned to them. Prior to the enrollment effective date, and at any time thereafter, individuals will have the opportunity to select a different ICO than the one assigned to them if there is another ICO option in the region.

After enrollment, individuals are issued an identification (ID) card that is specific to the MI Health Link program. This ID card is used instead of the traditional Medicare and Medicaid ID cards, and identifies the name of the ICO responsible for coverage along with the MI Health Link logo. Individuals will be enrolled in the benefit plan called ICO-MC, which is a benefit plan specific to the MI Health Link program. (Refer to the Beneficiary Eligibility Chapter for additional information.)

Individuals who are enrolled in the MI Choice waiver or the Program of All-Inclusive Care for the Elderly (PACE) are not passively enrolled into MI Health Link. These individuals may enroll in MI Health Link voluntarily, but must disenroll from MI Choice or PACE before the MI Health Link enrollment is effective. MDHHS will assist in this process to ensure a smooth transition between programs. Individuals who are enrolled in MI Choice or PACE and wish to enroll in MI Health Link must call the enrollment broker to start the enrollment process. The enrollment broker will send a message to MDHHS notifying MDHHS that the individual has chosen to enroll in MI Health Link. MDHHS staff will contact the appropriate MI Choice waiver agency or PACE organization to obtain current information and assessments for the individual. MDHHS will review the information received to determine if the individual's needs can be met through MI Health Link. MDHHS will contact the individual to discuss whether his/her needs can be met in MI Health Link. If the individual still chooses to join MI Health Link at that time, MDHHS will initiate the formal enrollment in the program and will notify the ICO accordingly.

Individuals may choose to disenroll from MI Health Link at any time. Disenrollment is effective on the first day of the following month.



SECTION 4 – PROGRAM ENROLLMENT TYPES

For individuals enrolled with an ICO and who are residing in a NF or County Medical Care Facility (CMCF), the ICO-NFAC or ICO-CMCF PET codes will be updated in CHAMPS when the NF or CMCF completes the Nursing Facility Admission in CHAMPS. The ICO-NFAC or ICO-CMCF PET code will be removed upon the facility completing the NF discharge information in CHAMPS when the individual is discharged from the facility.

Similarly, when a MI Health Link enrollee elects hospice services, the ICO-HOSC, ICO-HOSW, ICO-HOSN, ICO-HOSR or ICO-HOSH PET codes will be updated in CHAMPS when the hospice provider completes the Hospice Admission in CHAMPS. When the individual expires or otherwise is discharged from hospice services, the hospice provider must complete the Hospice Discharge in CHAMPS, which then removes the hospice-related PET codes.

When the MI Health Link enrollee receives hospice services while residing in a NF or CMCF, the hospice provider must indicate the facility of residence on the Hospice Admission in CHAMPS so the ICO can receive the appropriate capitation rate.



SECTION 5 – COVERED SERVICES

MI Health Link offers the following services:

- Medicare covered services, including pharmacy
- Medicaid State Plan services, including personal care services and hearing aid coverage
- Dental services
 - Equivalent to the Medicaid adult dental benefit as described in the Dental Chapter of this manual.
- Long Term Supports and Services (LTSS)
 - Nursing facility services
 - State Plan personal care services
 - Supplemental Services for individuals who live in the community and do not meet nursing facility level of care as determined by the LOCD.
 - MI Health Link HCBS Waiver services for individuals who live in the community and meet nursing facility level of care as determined by the LOCD
- Services provided through PIHPs for individuals' needs related to behavioral health (BH), intellectual/developmental disability (I/DD) and substance use disorders (SUD)

The MI Health Link program waives the requirement for a three-day hospital stay prior to receiving rehabilitation or skilled care in a Michigan licensed nursing facility. Admission requirements include a physician-written order for nursing facility services, a completed LOCD, and a completed Pre-Admission Screening and Resident Review (PASRR).

5.1 STATE PLAN PERSONAL CARE SERVICES

For individuals enrolled in the MI Health Link program, State Plan personal care services will be provided and paid for by the ICO and will no longer be provided through the Medicaid Home Help program. Personal care services are available to individuals who require hands-on assistance in activities of daily living (ADLs) (i.e., eating, toileting, bathing, grooming, dressing, mobility, and transferring) as well as hands-on assistance in instrumental activities of daily living (IADLs) (i.e., personal laundry, light housekeeping, shopping, meal preparation and cleanup, and medication administration).

Personal care services are available to individuals living in their own homes or the home of another. Services may also be provided outside the home for the specific purpose of enabling an individual to be employed.

Providers shall be qualified individuals who work independently, contract with, or are employed by an agency. The ICO may directly hold provider agreements or contracts with independent care providers of the individual's choice, if the provider meets MDHHS qualification requirements, to provide personal care services. Individuals who currently receive personal care services from an independent care provider may elect to continue to use that provider. The individual may also select a new provider if that provider meets State qualifications. Paid family caregivers will be permitted to serve as a personal care provider in accordance with the state's requirements for Medicaid State Plan personal care services.



5.1.A. PROVIDER QUALIFICATIONS

A criminal history screen must be conducted for all personal care providers. In addition, the provider must meet the following qualifications:

- Be 18 years of age or older;
- Be able to follow instructions, personal care procedures, perform the services required and handle emergencies;
- Be physically able to perform the needed services;
- Be knowledgeable about when to seek assistance from appropriate sources in the event of an emergency;
- Be dependable and able to meet job demands; and
- Be willing to participate in available training programs if necessary.

5.1.B. ASSESSMENT REQUIREMENTS

During the Level I Assessment, ICO Care Coordinators (or designee who meets the qualifications for an ICO Care Coordinator) must consider if the individual may need personal care services. If the ICO Care Coordinator believes the individual may be eligible for MI Health Link personal care services, the ICO Care Coordinator will conduct the Personal Care Assessment. The face-to-face, comprehensive assessment is the basis for determining and authorizing the amount, scope and duration, and payment of services. The individual needs to be reassessed at least quarterly or with a change of functional and/or health status to determine and authorize the amount, scope and duration, and payment of services. The reassessment must be face-to-face.

ADLs and IADLs are ranked by the ICO Care Coordinator during the Personal Care Assessment. Through the assessment, ADLs and IADLs are assessed according to the following five point scale, where 1 is totally independent and 5 requires total assistance.

Independent	The individual performs the activity with no human assistance.
Verbal assistance	The individual performs the activity with verbal assistance such as reminding, guiding or encouraging.
Minimal human assistance	The individual performs the activity with some direct physical assistance and/or assistance technology.
Moderate human assistance	The individual performs the activity with a great deal of human assistance and/or assistive technology.
Dependent	The individual does not perform the activity even with human assistance and/or assistance technology.

An individual must be assessed with need for assistance with at least one ADL to be eligible to receive personal care services. Payment for personal care services may only be authorized for needs assessed at the level three (3) ranking or greater. In addition, the individual must have an ADL functional ranking of three (3) or greater to be eligible



for IADL services. Once an individual is determined eligible for personal care services, his/her authorized ADL and IADL services and the amount, scope and duration must be included in the Individual Integrated Care and Supports Plan (IICSP).

5.1.C. PERSONAL CARE SERVICES AND THE MI HEALTH LINK HCBS WAIVER

If an individual ranks at a level 1 or 2, he/she will not be eligible for State Plan Personal Care Services through MI Health Link. If an individual ranks at a level 2, he/she may be eligible for ADL assistance through the MI Health Link HCBS waiver Expanded Community Living Supports (ECLS) benefit if the individual requires prompting, cueing, guiding, teaching, observing, or reminding to complete ADLs. Through the MI Health Link HCBS waiver, an individual may receive IADL assistance if he/she receives prompting, cueing, guiding, etc. to complete ADLs.

ECLS may be provided in addition to State Plan Personal Care Services if the individual requires hands-on assistance with some ADLs, as covered under Personal Care Services, but requires prompting, cueing, guiding, teaching, observing, reminding, or other support (not hands-on) to complete other ADLs and IADLs independently to ensure safety, health, and welfare of the individual.

5.1.D. REASONABLE TIME AND TASK

When a task (activity) is assigned to a specific provider, the rank of the activity is used against a Reasonable Time Schedule (RTS) table to determine the recommended time that activity should be assigned. Providers should use the RTS table provided by MDHHS to record and report minutes spent delivering services. The maximum amount is across all assigned providers for an individual, so these are case maximums. When an individual's needs exceed the hours recommended by the RTS, a rationale must be provided and maintained in the individual's record.

5.1.E. COMPLEX CARE NEEDS

Complex care refers to conditions requiring intervention with special techniques and/or knowledge. These complex care tasks are performed for individuals whose diagnoses or conditions require more management. The conditions may also require special treatment and equipment for which specific instructions by a health professional or individual may be required in order to perform.

- Eating and feeding
- Catheters or legs bags
- Colostomy care
- Bowel program
- Suctioning
- Specialized skin care
- Range of motion exercises
- Peritoneal dialysis



- Wound care
- Respiratory treatment
- Ventilators
- Injections

The ICO Care Coordinator will allocate time for each task assessed a rank of 3 or greater based on interviews with the individual and provider, observation of the individual's abilities, and use of the RTS as a guide. When hours exceed the RTS, a rationale must be provided and maintained in the individual's record.

An assessment of need at a ranking of 3 or greater does not automatically guarantee the maximum allotted time allowed by the RTS. The ICO Care Coordinator must assess each task according to the actual time required for its completion.

5.1.F. REIMBURSEMENT AND RATES

After enrollment and according to the requirements of the three-way contract, the ICO must maintain the individual's current personal care providers and amount, scope and duration of services until the IICSP is reviewed and updated and providers are secured with individual approval. An ICO should use the Medicaid Home Help Payment Schedule to continue paying providers as scheduled. (Refer to the Directory Appendix for additional information.) An ICO should follow this schedule until the ICO and personal care provider agree upon a new payment schedule, which should be defined in the contract between the ICO and the personal care provider. The ICO must publish a pay cycle and must pay these claims on the next available pay cycle date.

Furthermore, an ICO should use the Individual and Agency County Rates to determine payment rates for the transition period until the ICO and personal care provider agree upon a rate that is defined in the ICO and personal care provider contract. (Refer to the Directory Appendix for additional information.)

After the transition period, payment rates for personal care services are established by the ICO. Tasks are assigned minute values which are converted to hours and billed as a total at the end of the ICO's preferred pay period. Reimbursement is subject to any state or federal laws that may be applicable in the future.

A request for higher or lower hours than shown on the RTS is permissible. A textual rationale is required if the amount of services needed is different than the RTS. Possible reasons for using higher hours include incontinence, severely impaired speech, paralysis and obesity. Possible reasons for lower hours include shared living arrangements (specifically for IADLs, except for administering medications) and responsible relatives able and available to assist.

If the individual does not require the maximum allowable hours for IADLs, only the amount of time needed for each task shall be authorized. Assessed hours for IADLs (except medication administration) must be **prorated by one half** in shared living arrangements where other adults reside in the home as personal care services are only for the benefit of the individual. This does not include situations where others live in



adjoined apartments, flats or in a separate home on shared property and there is no shared common living area. In shared living arrangements where it can be clearly documented that IADLs for the enrolled individual are completed separately from others in the home, hours for IADLs do not need to be prorated.

5.1.G. RESPONSIBLE RELATIVES AND GUARDIANS

Adult children (18 years of age or older) may provide personal care services to a parent. An individual's spouse cannot be paid to provide personal care services to the individual as they are considered responsible relatives. Couples who are separated must provide verification that they are no longer residing in the same home. Verification may include a driver's license, rent receipt or utility bill reflecting their separate mailing address. A spouse who is legally separated from a spouse cannot be paid to provide personal care services. ADLs may be approved when an individual's spouse is unavailable or unable to provide these services. "Unavailable" means absence from the home for an extended period due to employment, school or other legitimate reasons. The responsible relative must provide a work or school schedule to verify they are unavailable to provide care. "Unable" means the responsible person has disabilities of their own which prevent them from providing care.

Shopping, laundry, or light housecleaning shall not be approved when a responsible relative of the individual resides in the home unless they are unavailable or unable to provide these services. These findings must be documented.

5.1.H. INDIVIDUALS IN ADULT FOSTER CARE FACILITIES AND HOME FOR THE AGED

For individuals in adult foster care facilities or home for the aged, a flat monthly supplement rate is established annually by the state legislature for those Medicaid beneficiaries who, according to a standardized assessment, have a documented need for personal care services. The supplement rate is included in the ICO rates, and the ICOs must pay this rate to adult foster care homes and homes for the aged providers for individuals enrolled in MI Health Link. ICOs and Adult Foster Care facilities and Homes for the Aged must use the billing invoice provided by MDHHS.

5.2 SUPPLEMENTAL SERVICES

MI Health Link supplemental services are available for any individuals who live in the community, wish to move from a nursing facility to the community, do not meet LOCD and are not enrolled in the MI Health Link HCBS waiver. The four supplemental services are Adaptive Medical Equipment and Supplies, Community Transition Services, Personal Emergency Response System, and Respite.

5.2.A. ADAPTIVE MEDICAL EQUIPMENT AND SUPPLIES

This service includes devices, controls, or appliances specified in the IICSP that enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support or to address physical conditions, along with ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and medical supplies not available under the Medicaid State



Plan and Medicare that are necessary to address individual functional limitations. This will also cover the costs of equipment maintenance. The coverage includes training the individual and/or caregivers in the operation and/or maintenance of the equipment and the use of a supply when initially purchased. The ICO shall not authorize payment for herbal remedies, nutraceuticals, and/or other over-the-counter medications for uses not approved by the United States Food and Drug Administration (FDA).

All items shall meet applicable standards of manufacture, design, and installation. Each direct service provider must enroll in Medicare and/or Medicaid as a Durable Medical Equipment (DME) provider, pharmacy, etc., as appropriate. This must be verified at the beginning of service delivery and annually thereafter. The ICO may obtain some items directly from a retail store that offers the item to the general public. When utilizing retail stores, the ICO must ensure the item purchased meets the service standards. The ICO may choose to open a business account with a retail store for such purchases. The ICO must maintain the original receipts and maintain accurate systems of accounting to verify the specific individual who received the purchased item. Items must be of direct medical or remedial benefit to the individual, and this benefit must be documented in the individual's record.

It must be documented on the IICSP or Care Bridge Record that the item is the most cost-effective alternative to meeting the individual's needs. There must be documentation on the IICSP or Care Bridge record that the best value in warranty coverage was obtained at the time of purchase. Liquid nutritional supplement orders must be renewed every six months by a physician, physician's assistant, or nurse practitioner (in accordance with Michigan Scope of Practice laws). Where feasible, the ICO and/or direct service provider shall seek confirmation of the need for the item from the individual's physician.

5.2.B. COMMUNITY TRANSITION SERVICES

Community Transition Services (CTS) include non-reoccurring expenses for individuals transitioning from a nursing facility to another residence where the individual is responsible for his/her own living arrangement. Person-centered planning must be used throughout the entire community transition process. The ICO shall begin CTS no more than six months before the expected discharge from the nursing facility. Allowable transition costs include the following:

- Housing or security deposit: A one-time expense to secure housing or obtain a lease.
- Utility hook-ups and deposits: A one-time expense to initiate and secure utilities (television service and internet are excluded).
- Furniture, appliances, and moving expenses: One-time expenses necessary to occupy and safely reside in a community residence (diversion or recreational devices are excluded).
- Cleaning: A one-time cleaning expense to ensure a clean environment, including pest eradication, allergen control, and over-all cleaning.
- Coordination and support services: To facilitate transitioning of an individual to a community setting.



- Other services deemed necessary and documented within the individual's plan of service to accomplish the transition into a community setting.

Ongoing monthly rental or mortgage expense, ongoing utility charges, or items that are intended for purely diversional or recreational purposes are excluded under this service.

5.2.C. PERSONAL EMERGENCY RESPONSE SYSTEM

A Personal Emergency Response System (PERS) is an electronic device that enables individuals to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the individual's phone and programmed to signal a response center once the "help" button is activated. The PERS provider may offer this service for cellular or mobile phones and devices. The device must meet industry standards. The individual must reside in an area where cellular or mobile coverage is reliable. When the individual uses the device to signal and otherwise communicate with the PERS provider, the technology for the response system must meet all other service standards. The PERS provider must ensure at least monthly testing of each PERS unit to maintain proper functioning.

PERS does not cover monthly telephone charges associated with phone service. This service is limited to persons who either live alone or who are left alone for significant periods of time on a routine basis and who could not summon help in an emergency without this device. The ICO may authorize PERS units for individuals who do not live alone if both the waiver individual and the person with whom they reside would require extensive routine supervision without a PERS unit in the home. An example of this is two individuals who live together and both are physically and/or cognitively unable to assist the other individual in the event of an emergency.

The Federal Communication Commission (FCC) must approve the equipment used for the response system. The equipment must meet UL[®] safety standards 1637 specifications for Home Health Signaling Equipment.

The provider must staff the response center with trained personnel 24 hours per day, 365 days per year. The response center will provide accommodations for persons with limited English proficiency. The response center must maintain the monitoring capacity to respond to all incoming emergency signals. The response center must have the ability to accept multiple signals simultaneously. The response center must not disconnect calls for a return call or put on a first call, first serve basis. The provider will furnish each responder with written instructions and provide training, as appropriate.

5.2.D. RESPITE

Respite services may be provided at the individual's home, in the home of another person, or at another setting outside the individual's home. Respite service criteria are different depending on the setting. Respite services are limited to a total of 14 overnight stays per 365 days regardless of the setting. The ICO may provide more respite services as an optional benefit. For individuals receiving respite services through the PIHP, they



must first exhaust the respite benefit through the PIHP before using this respite service as an ICO supplemental service.

5.2.D.1. RESPITE PROVIDED AT THE INDIVIDUAL'S HOME OR IN THE HOME OF ANOTHER PERSON

Respite care services are provided on a short-term, intermittent basis to relieve the individual's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.

Respite services include:

- Attendant care (individual is not bed-bound), such as companionship, supervision, and/or assistance with toileting, eating, and ambulation.
- Basic care (individual may or may not be bed-bound), such as assistance with ADLs, a routine exercise regimen, and self-medication.

Members of an individual's family who are not the individual's regular caregiver may provide respite for the regular caregiver. However, the ICO shall not authorize funds to pay for services furnished to an individual by that person's spouse. Family members who provide respite services must meet the same standards as providers who are unrelated to the individual.

Respite services cannot be scheduled on a long term daily basis. Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. The costs of room and board are not included in the payment for respite services.

5.2.D.2. RESPITE PROVIDED OUTSIDE THE HOME

Respite care services are provided on a short-term, intermittent basis to relieve the individual's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.

Each out of home respite service provider must be a licensed group home as defined in Michigan Compiled Law (MCL) 400.701ff, which includes adult foster care homes and homes for the aged. Respite may include the cost of room and board if the service is provided in a licensed Adult Foster Care home or licensed Home for the Aged.

Respite services include:

- Attendant care (individual is not bed-bound) such as companionship, supervision and/or assistance with toileting, eating, and ambulation.



- Basic care (individual may or may not be bed-bound) such as assistance with ADLs, a routine exercise regimen, and self-medication.

Out-of-home respite may be scheduled for several days in a row depending upon the needs of the individual and the individual's caregivers.

5.3 MI HEALTH LINK HCBS WAIVER SERVICES

These services are intended for individuals who meet all of the following criteria:

- are enrolled in the MI Health Link program,
- meet nursing facility level of care as determined by the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) tool,
- demonstrate a need for one or more of the services listed below, which must be identified in the IICSP.

Individuals must receive at least one waiver service each month to remain on the waiver. The ICO and direct service providers must adhere to the service definition and operating standards to be eligible to receive payment of waiver expenses.

5.3.A. ADAPTIVE MEDICAL EQUIPMENT AND SUPPLIES

For the definition of the Adaptive Medical Equipment and Supplies service, refer to the Supplemental Services section, Adaptive Medical Equipment and Supplies.

5.3.B. ADULT DAY PROGRAM

Adult Day Program services are furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the IICSP, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regimen," i.e., three meals per day. Physical, occupational and speech therapies may be furnished as component parts of this service.

Transportation between the individual's residence and the Adult Day Program center is provided when it is a standard component of the service. Not all Adult Day Program centers offer transportation to and from their location. Adult Day Program centers that do offer transportation may only offer it in a specified area. When the Adult Day Program center offers transportation, it is a component part of the Adult Day Program service. If the center does not offer transportation, then the ICO will pay for the transportation to and from the Adult Day Program center separately.

Individuals cannot receive personal care services or Expanded Community Living Supports during the time spent at the Adult Day Program facility. Payment for Adult Day Program includes all services provided while at the facility. Personal care services and Expanded Community Living Supports may be used in conjunction with Adult Day Program services, but cannot be provided at the same time unless the specific



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component of the service includes laundry, housecleaning, etc., that does not require the individual to be present.

Adult Day Program may be authorized only if the individual meets at least one of the following criteria:

- Requires regular supervision to live in his/her own home or the home of a relative.
- If he/she has a caregiver, the individual must require a substitute caregiver while his/her regular caregiver is unavailable.
- Has difficulty or is unable to perform ADLs without assistance.
- Capable of leaving the residence with assistance to receive services.
- In need of intervention in the form of enrichment and opportunities for social activities to prevent and/or postpone deterioration that may lead to institutionalization.

A referral from an ICO for a waiver individual shall replace any screening or assessment activities performed for other Adult Day Program individuals at the setting. The direct Adult Day Program service provider shall accept copies of the ICO's assessments and IICSP to eliminate duplicate assessment and service planning activities.

Each program shall provide directly, or coordinate with the ICO to arrange for the provision of the following services.

- Transportation
- Personal Care
- Nutrition: one hot meal per eight-hour day which provides one-third of the recommended daily allowances and follows the meal pattern specified in the home delivered meals service standard. Individuals in attendance from eight to fourteen hours per day shall receive an additional meal to meet a combined two-thirds of the recommended daily allowances. Modified diet menus should be provided where feasible and appropriate. Such modifications shall take into consideration individual choice, health, religious and ethnic diet preferences.
- Recreation: consisting of planned activities suited to the needs of the individual and designed to encourage physical exercise, to maintain or restore abilities and skill, to prevent deterioration, and to stimulate social interaction.

If the program arranges for provision of any service at a place other than program-operated facilities, a written agreement specifying supervision requirements and responsibilities shall be in place. The ICO shall provide care coordination.

Each program shall keep all individuals' files confidential in controlled access files. Each program shall use a standard release of information form that is time limited and specific as to the released information.

Each provider shall employ a full-time program director with a minimum of a bachelor's degree in a health or human services field or be a qualified health professional. The provider shall continually provide support staff at a ratio of no less than one staff person



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for every ten participants. The provider may only provide health support services under the supervision of a Registered Nurse (RN). If the program acquires either required or optional services from other individuals or organizations, the provider shall maintain a written agreement that clearly specifies the terms of the arrangement between the provider and other individual or organization.

Each program shall establish written procedures (reviewed and approved by a consulting pharmacist, physician, or RN) that govern the assistance given by staff to individuals taking their own medications while participating in the program. The policies and procedures must minimally address:

- Written consent from the individual or individual's representative to assist with medications.
- Verifications of the individual's medication regimen, including prescriptions and dosages.
- The training and authority of staff to assist individuals with taking their own prescribed or non-prescription medications and under what conditions such assistance may take place.
- Procedures for medication set up.
- Secure storage of individuals' medications. Medications must be returned to the individual.
- Instructions for entering medication information in individual files, including times and frequency of assistance.

Program staff shall have basic first-aid training and any other training as required by MDHHS and the ICO.

If the provider operates its own vehicles for transporting individuals to and from the program site, the provider shall meet the following transportation minimum standards:

- The Secretary of State shall appropriately license all drivers and vehicles and all vehicles shall be appropriately insured.
- All paid drivers shall be physically capable and willing to assist persons requiring help to get in and out of vehicles. The provider shall make such assistance available unless expressly prohibited by either a labor contract or an insurance policy.
- All paid drivers shall be trained to cope with medical emergencies unless expressly prohibited by a labor contract.
- Each program shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

The provider shall maintain all equipment and furnishings used during program activities or by program participants in safe and functional condition. Each Adult Day Program center must have the following furnishings:

- At least one straight back or sturdy folding chair for each individual and staff person.
- Lounge chairs and/or day beds as needed for naps and rest periods.
- Storage space for individuals' personal belongings.



- Tables for both ambulatory and non-ambulatory individuals.
- A telephone accessible to all individuals.
- Special equipment as needed to assist persons with disabilities.

Each provider shall post emergency procedures (fire, severe weather, etc.) in each room of the program site. Practice drills of emergency procedures must occur once every six months. The program shall maintain a record of all practice drills.

Each Adult Day Program center must document that it is in compliance with:

- Barrier-free design specification of Michigan and local building codes.
- Fire safety standards.
- Applicable Michigan and local public health codes.

Adult Day Program settings must be compliant with the HCBS Final Rule as indicated in the Home and Community-Based Residential and Non-Residential Settings subsection.

5.3.C. ASSISTIVE TECHNOLOGY

The Assistive Technology service includes technology items used to increase, maintain, or improve an individual's functioning and promote independence. The service may include assisting the individual in the selection, design, purchase, lease, acquisition, application, or use of the technology item. This service also includes vehicle modifications to the vehicle that is the individual's primary method of transportation. This service includes repairs and maintenance of assistive technology devices. Vehicle modifications must be of direct medical or remedial benefit to the individual and specified under the IICSP. Some examples of assistive technology include, but are not limited to, van lifts, hand controls, computerized voice system, communication boards, voice activated door locks, power door mechanisms, adaptive or specialized communication devices, assistive dialing device, adaptive door opener and specialized alarm or intercom.

Cost limits for this service are as follows:

- \$15,000 maximum for van lifts, including tie-downs, for the duration of the 5-year waiver period
- \$5,000 yearly (waiver year) maximum for all other assistive technology devices

Items must be of direct medical or physical benefit to the individual. Where feasible, the ICO and/or direct service provider must seek confirmation of the need for the item from the individual's physician. It must be documented in the IICSP that the item is the most cost-effective alternative to meeting the individual's needs. Items must meet applicable standards of manufacture, design, and installation. There must be documentation that the best value in warranty coverage was obtained at the time of purchase.

Modifications will only be made to vehicles with proper insurance coverage, with the exception of new vehicles coming directly from an automotive factory to the entity performing the modification.



Direct service providers must enroll in Medicare and Medicaid as a Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) provider, pharmacy, etc., as appropriate. Verification of provider qualifications must be conducted prior to service delivery and annually thereafter. Other contracted or subcontracted providers must have written policies and procedures compatible with requirements as specified in the contract between MDHHS and the ICO and/or the three-way contract. Contracted/subcontracted providers must have appropriate state licensure or certification required to complete or provide the service or item. Verification of provider qualifications must be conducted prior to service delivery and annually thereafter.

Items like cell phones, internet service, and full-home wiring systems are excluded from this benefit. This service also does not include paying for or leasing vehicles, vehicle insurance and vehicle repairs.

5.3.D. CHORE SERVICES

Chore Services include those duties needed to maintain the home in a clean, sanitary, and safe environment to provide safe access inside the home, and yard maintenance and snow plowing to provide access to and egress outside of the home. This service includes tasks such as heavy household chores (washing floors, windows, and walls), tacking loose rugs and tiles, moving heavy items of furniture, mowing, raking, cleaning hazardous debris such as fallen branches and trees, weatherization, and pest control. The service may include materials and disposable supplies used to complete chore tasks. The ICO may also use waiver funds to purchase or rent the equipment or tools used to perform chore tasks for waiver individuals.

Chore services are covered only in cases when neither the individual nor anyone else in the household is capable of performing or financially paying for them, and where no other relative, caregiver, landlord, community or volunteer agency, or third party payer is capable of, or responsible for, their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

Verification of provider qualifications must be conducted prior to service delivery and annually thereafter. Providers must have previous relevant experience and/or training for the tasks specified and authorized in the IICSP. The ICO must deem the chosen provider capable of performing the required tasks. Pest control suppliers must be properly licensed.

5.3.E. COMMUNITY TRANSITION SERVICES

For the definition of Community Transition Services (CTS), refer to Community Transition Services in the Supplemental Services subsection.

For persons expected to enroll in the MI Health Link HCBS waiver, when a transitioning individual requires a home modification (ramp, widened doorways, etc.) before the transition can take place, the ICO shall authorize only those modifications immediately necessary for community transition as CTS. The ICO shall authorize all other needed



modifications as Environmental Modifications services or Chore services through the waiver, as appropriate.

5.3.F. ENVIRONMENTAL MODIFICATIONS

The Environmental Modifications service covers physical adaptations to the home, required in the individual's IICSP, that are necessary to ensure the health and welfare of the individual or that enable the individual to function with greater independence in the home. Such adaptations include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies necessary for the welfare of the individual. Complex kitchen and bathroom modifications may be completed if medically necessary for the individual. Environmental modifications are those which are installed in the residence versus enhanced equipment or assistive technology which are portable from residence to residence. A ramp or lift will be covered for only one exterior door or other entrance.

The modification/adaptation must be for a primary residence, but may include additional residences subject to prior authorization by the ICO. Examples of additional residences might be a family member's cottage or the individual's second home or cottage so the individual can go there to be with family.

The modification/adaptation must be the most cost-effective and reasonable alternative. Any modifications/adaptations shall only be used to modify existing spaces or structures. The existing structure must have the capability to accept and support the proposed changes. Repairs, modifications, or adaptations shall not be performed on a condemned structure. Modifications must comply with local building codes. The infrastructure of the home involved in the funded adaptations (e.g., electrical system, plumbing, well or septic, foundation, heating and cooling, smoke detector systems, or roof) must be in compliance with any applicable local codes.

Environmental modifications/adaptations required to support proper functioning of medical equipment, such as electrical upgrades, are limited to the requirements for safe operation of the specified equipment and are not intended to correct existing code violations in an individual's home.

The ICO may use MI Health Link funds for labor costs and to purchase materials used to complete the modification to prevent or remedy a safety hazard. The direct service provider shall provide the equipment or tools needed to perform the tasks unless another source can provide the equipment or tools at a lower cost or free of charge and the provider agrees to use those tools.

Prior to the start of the modification of a rental property or unit, the landlord must approve the modification plan. A written agreement between the landlord, the individual, and the ICO must specify that the ICO and individual are not responsible for any costs to restore the property to the original condition.

Excluded from this service are those adaptations or improvements to the home that:

- Are of general utility.



- Are considered to be standard housing obligations of the individual or homeowner.
- Are not of direct medical or remedial benefit to the individual. For example, kitchen modifications must be required for the individual to prepare his/her own meals.
- Modifications to rental properties if the rental agreement states that it is the responsibility of the landlord to provide such modifications.
- Are used for upgrades to the home or for additions to homes (adding square footage, etc.).
- Are improvements exclusively required to meet local building codes and not directly related to an individual's medical or physical condition.

Some examples of exclusions include, but are not limited to, carpeting, roof repair, sidewalks, driveways, heating, central air conditioning (unless it is the most cost effective and reasonable alternative), garages, raised garage doors, storage and organizers, hot tubs, whirlpool tubs, swimming pools, landscaping and general home repairs.

The ICO shall not cover general construction costs in a new home or additions to a home purchased after the individual is enrolled in the waiver. If an individual or the individual's family purchases or builds a home while receiving waiver services, it is the individual's or family's responsibility to ensure the home will meet basic needs, such as having a ground floor bath or bedroom if the individual has mobility limitations. However, MI Health Link funds may be authorized to assist with the adaptations noted above (e.g. ramps, grab bars, widening of doorways, bathroom modifications, etc.) for a home recently purchased. If modifications are needed to a home under construction that require special adaptation to the plan (e.g. roll-in shower), the ICO may fund the difference between the standard fixture and the modification required to accommodate the individual's need.

Contracted providers (such as licensed building contractors) must have appropriate certification or licensure under Michigan regulations and law such as MCL 339.601(1), MCL 339.601.2401, or MCL 339.601.2403(3). Verification of certification, licensure, or other provider qualifications must be done prior to execution of the contract related to the modification project to be done.

5.3.G. EXPANDED COMMUNITY LIVING SUPPORTS

To receive ECLS, individuals MUST need prompting, cueing, observing, guiding, teaching, and/or reminding to independently complete ADLs. ECLS does not include hands on assistance for ADLs unless something occurs incidental to this service. ECLS includes social/community participation, relationship maintenance, and attendance at medical appointments.

ECLS includes:

- Assisting, reminding, cueing, observing, guiding and/or training in the following activities:
 - Meal preparation
 - Laundry
 - Routine, seasonal, and heavy household care and maintenance



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- ADLs such as bathing, eating, dressing, and personal hygiene
- Shopping for food and other necessities of daily living
- Assistance, support, and/or guidance with activities such as:
 - Money management
 - Non-medical care (not requiring nursing or physician intervention)
 - Social participation, relationship maintenance, and building community connections to reduce personal isolation
 - Transportation (excluding to and from medical appointments) from the individual's residence to community activities, among community activities, and from the community activities back to the individual's residence
 - Participation in regular community activities incidental to meeting the individual's community living preferences
 - Attendance at medical appointments
 - Acquiring or procuring goods and services necessary for home and community living
- Reminding, cueing, observing, and/or monitoring of medication administration
- Staff assistance with preserving the health and safety of the individual in order that he/she may reside and be supported in the most integrated independent community setting.
- Training or assistance on activities that promote community participation, such as using public transportation, using libraries, or volunteer work.
- Dementia support, including but not limited to redirection, reminding, modeling, socialization activities, and activities that assist the individual as identified in the individual's IICSP.
- Observing and reporting to the ICO Care Coordinator any changes in the individual's condition and the home environment.

Individual providers chosen by the individual must meet the following provider qualifications (qualifications must be verified prior to initial service delivery and annually thereafter):

- Providers must be at least 18 years of age, have ability to communicate effectively both orally and in writing and follow instructions, be trained in first aid and cardiopulmonary resuscitation, be able to prevent transmission of communicable disease and be in good standing with the law as validated by a criminal history review. If providing transportation related to this service, the provider must possess a valid Michigan driver's license.
- Providers of ECLS must have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, recording information, and reporting and identifying abuse and neglect. The individual(s) must also be trained on the individual's specific needs as identified in the IICSP. Additionally, skills, knowledge, and experience with food preparation, safe food handling procedures are highly desirable.



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- Previous relevant experience and training to meet MDHHS operating standards. Refer to the Three-Way Contract, supporting documentation, and agreements within the provider's contract with the ICO.
- Must be deemed capable of performing the required tasks by ICO.

Home Care agency providers must meet the following provider qualifications (qualifications must be verified prior to initial service delivery and annually thereafter):

- Providers must be at least 18 years of age, have the ability to communicate effectively both orally and in writing and follow instructions, be trained in first aid, be trained in universal precautions and blood-borne pathogens, and be in good standing with the law as validated by a criminal history review.
- A RN licensed to practice nursing in the State shall furnish supervision of ECLS providers. At the State's discretion, other qualified individuals may supervise ECLS providers. The direct care worker's supervisor shall be available to the worker at all times the worker is furnishing ECLS services.
- The ICO and/or provider agency must train each worker to properly perform each task required for each individual the worker serves before delivering the service to that individual. The supervisor must ensure that each worker can competently and confidently perform every task assigned for each individual served. MDHHS strongly recommends each worker delivering ECLS services complete a certified nursing assistance training course.
- ECLS providers may prompt, cue, or supervise the individual to perform higher-level, non-invasive tasks such as maintenance of catheters and feeding tubes, minor dressing changes, and wound care if the direct care worker has been individually trained and supervised by an RN for each individual who requires such care. The supervising RN must ensure each worker's confidence and competence in the performance of each task required.
- ECLS service providers must have previous relevant experience or training and skills in housekeeping, household management, good health practices, observation, reporting, and recording information. Additionally, skills, knowledge, and/or experience with food preparation, safe food handling procedures, and reporting and identifying abuse and neglect are highly desirable.
- Previous relevant experience and training to meet MDHHS operating standards. Refer to the Three-Way Contract, supporting documentation, and agreements within the provider's contract with the ICO.

When the ECLS services include transportation, the following standards apply:

- The ICO may not use MI Health Link funds to purchase or lease vehicles for providing transportation services to waiver individuals.
- The Secretary of State must appropriately license all drivers and register all vehicles used for transportation supported all or in part by MI Health Link funds. The provider must cover all vehicles used with liability insurance.



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- All paid drivers for transportation providers supported entirely or in part by MI Health Link funds shall be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. The provider shall offer such assistance unless expressly prohibited by either a labor contract or insurance policy.
- The provider shall train all paid drivers for transportation programs supported entirely or in part by MI Health Link funds to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy.
- Each provider shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

Each direct service provider who chooses to allow staff to assist individuals with self-medication shall establish written procedures that govern the assistance given by staff. These procedures shall be reviewed by a consulting pharmacist, physician, or RN and shall include, at a minimum:

- The provider staff authorized to assist individuals with taking their own prescription or over-the-counter medications and under what conditions such assistance may take place. This must include a review of the type of medication the individual takes and its impact upon the individual.
- Verification of prescription medications and their dosages. The individual shall maintain all medications in their original, labeled containers.
- Instructions for entering medication information in individual files.
- A clear statement of the individual's and his/her legal representative's responsibility regarding medications taken by the individual and the provision for informing the individual and his/her legal representative of the provider's procedures and responsibilities regarding assisted self-administration of medications.

ECLS providers may only administer medications in compliance with Michigan Administrative Rule 330.7158:

- A provider shall only administer medication at the order of a physician and in compliance with the provisions of section 719 of the act, if applicable.
- A provider shall ensure that medication use conforms to federal standards and the standards of the medical community.
- A provider shall not use medication as punishment, for the convenience of the staff, or as a substitute for other appropriate treatment.
- A provider shall review the administration of a psychotropic medication periodically as set forth in the individual's IICSP and based upon the individual's clinical status.
- If an individual cannot administer his/her own medication, a provider shall ensure that medication is administered by or under the supervision of personnel who are qualified and trained.
- A provider shall record the administration of all medication in the individual's record. The ICO may do this electronically or via paper format, but the records must be readily available if requested by MDHHS.



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- A provider shall ensure that medication errors and adverse drug reactions are immediately and properly reported to a physician and recorded in the individual's record.

ECLS cannot be provided in circumstances where they would be a duplication of services available through MI Health Link. The distinction must be apparent by unique hours and units in the approved IICSP.

ECLS may be furnished outside the individual's home.

The individual oversees and supervises individual providers on an on-going basis when participating in arrangements that support self-determination. This may also include transportation to allow people to get out into the community when it is incidental to the IICSP. When transportation incidental to the provision of ECLS is included, the ICO shall not also authorize transportation as a separate waiver service for the individual.

Members of an individual's family may provide ECLS to the individual. However, the ICO shall not directly authorize funds to pay for services furnished to an individual by that person's spouse or legal guardian or other financially responsible person. Family members who provide this service must meet the same standards as providers who are unrelated to the individual. Roommates or other individuals who live with the individual may provide ECLS services, but payment for services must be pro-rated by one-half if the service will also benefit the person performing the service (i.e., meal preparation, laundry, housecleaning, etc.). Paid ECLS services are only for the benefit of the individual receiving the services.

In shared living arrangements where there is more than one person in the home receiving the service by the same caregiver, payment for services must be based on a pro-rated percentage/fraction relative to the care each person receives. When services can be clearly documented separately from other individuals in the home, payment need not be pro-rated. Providers must be trained to perform each required task prior to service delivery. The supervisor must ensure the provider can competently and confidently perform each assigned task.

With the assistance of the individual and/or individual's caregiver, the ICO or direct service provider shall determine an emergency notification plan for each individual, pursuant to each visit for emergencies and provider no-shows or late arrivals.

ECLS does not include the cost associated with room and board. ECLS also excludes nursing and skilled therapy services.

ECLS provided in a licensed setting includes only those supports and services that are in addition to, and shall not replace, usual and customary care furnished to residents in the licensed setting. Documentation in the individual's record must clearly identify the individual's need for additional supports and services not covered by licensure. The IICSP must clearly identify the portion of the individual's supports and services covered by ECLS. The setting must comply with the requirements of the Home and Community-Based Services (HCBS) Final Rule as described in the Home and Community-Based Residential and Non-Residential Settings subsection.



5.3.H. FISCAL INTERMEDIARY

Fiscal Intermediary (FI) services assist the individual to live independently in the community while controlling his/her individual budget and choosing the staff to work with him/her. The FI helps the individual to manage and distribute funds contained in the individual budget. The individual uses funds to purchase home and community based services authorized in the IICSP. FI services include, but are not limited to, the facilitation of the employment of service workers by the individual, including federal, state, and local tax withholding/payments, unemployment compensation fees, wage settlements; fiscal accounting; tracking and monitoring individual-directed budget expenditures and identify potential over and under expenditures; ensuring compliance with documentation requirements related to management of public funds. The FI helps the individual manage and distribute funds contained in the individual budget. The FI also assists with training the individual and providers, as necessary, in tasks related to the duties of the FI including, but not limited to, billing processes and documentation requirements.

FI services are available only to individuals participating in arrangements that support self-determination. Additionally, FI services may not be provided by the individual's family, guardian, or providers of other services for the same individual. The ICO and fiscal intermediary must abide by the Self-Determination Implementation Technical Advisory and any other requirements provided by MDHHS. FI services through the MI Health Link HCBS waiver must only be used for MI Health Link HCBS services as identified in the CMS-approved 1915(c) waiver application.

Each FI must:

- Be bonded and insured. The insured amount must exceed the total budgetary amount the FI is responsible for administering.
- Demonstrate the ability to manage budgets and perform all functions of the FI including all activities related to employment taxation, worker's compensation, and state, local, and federal regulations.
- Demonstrate competence in managing budgets and performing other functions and responsibilities of a fiscal intermediary.
- Provide four basic areas of performance:
 - Function as the employer agency for individuals directly employing workers to ensure compliance with payroll tax and insurance requirements;
 - Ensure compliance with requirements related to management of public funds, the direct employment of workers by individuals, and contracting for other authorized supports and services;
 - Facilitate successful implementation of the self-determination arrangements by monitoring the use of the budget and providing monthly budget status reports to each individual and ICO; and
 - Offer supportive services to enable individuals to self-determine and direct the supports and services they need.



5.3.I. HOME DELIVERED MEALS

This service is the provision of one to two nutritious meals per day to individuals who are unable to care for their nutritional needs. This service must include and prioritize healthy meal choices that meet any established criteria under state or federal law. Meal options must meet individual preferences in relation to specific food items, portion size, dietary needs, and cultural and/or religious preferences. ICOs must follow the minimum operating standards for this service as provided by MDHHS.

Each ICO must have written eligibility criteria for persons receiving home delivered meals through the waiver which include, at a minimum:

- The individual must be unable to obtain food or prepare complete meals.
- The individual does not have an adult living at the same residence or in the vicinity that is able and willing to prepare all meals.
- The individual does not have a paid caregiver that is able and willing to prepare meals for the individual.
- The provider can appropriately meet the individual's special dietary needs, and the meals available would not jeopardize the health of the individual.
- The individual must agree to be home when meals are delivered. For any unavoidable absence, the provider or ICO must be contacted. If the ICO is contacted, they must contact the provider.

5.3.J. NON-MEDICAL TRANSPORTATION

This service is offered to enable individuals to gain access to waiver and other community services, activities, and resources, specified by the Individual Integrated Care and Supports Plan (IICSP). Whenever possible, the ICO shall utilize family, neighbors, friends, or community agencies that can provide this service free of charge. Need for this service and details as to whom and how it will be provided should be discussed in the person-centered planning meeting and documented in the IICSP.

Direct service providers shall be a centrally organized transportation company or agency. Transportation may be provided by any of the following methods:

- Demand/Response: Characterized by scheduling of small vehicles to provide door-to-door or curb-to-curb service on demand. The provider may include a passenger assistance component and either or both of the following variations:
 - Route Deviation Variation: A normally fixed-route vehicle leaves the scheduled route upon request to pick up the individual.
 - Flexible Routing Variation: Providers constantly modify routes to accommodate service requests.
- Public Transit: Characterized by partial or full payment of the cost for an individual to use an available public transit system. (This can be either a fixed route or demand/response). The provider may include a passenger assistance component.



- **Volunteer:** Characterized by reimbursement of out-of-pocket expenses for individuals who transport individuals in their private vehicles. The provider may include a passenger assistance component.
- **Ambu-cab:** Characterized by a wheelchair-equipped van to provide door-to-door service on demand. The provider shall include a passenger assistance component.

Transportation vehicles must be properly licensed and registered by the State and must be covered with liability insurance. MI Health Link funds may not be used to purchase or lease vehicles for providing transportation services to waiver individuals. All paid drivers for transportation providers supported entirely or in part by MI Health Link funds shall be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. The provider shall offer such assistance unless expressly prohibited by either a labor contract or insurance policy. The provider shall train all paid drivers for transportation programs supported entirely or in part by waiver funds to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy. Each provider shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

MI Health Link funds shall not be used to reimburse caregivers (paid or informal) to run errands for individuals when the individual does not accompany the driver of the vehicle.

5.3.K. PERSONAL EMERGENCY RESPONSE SYSTEM

For the definition of the Personal Emergency Response System (PERS) definition, refer to Personal Emergency Response System in the Supplemental Services subsection.

5.3.L. PREVENTIVE NURSING SERVICES

Preventive Nursing Services are covered on a part-time, intermittent (separated intervals of time) basis for an individual who generally requires nursing services for the management of a chronic illness or physical disorder in the individual's home and are provided by a RN or a licensed practical nurse (LPN) under the supervision of a RN. Nursing services are for individuals who require more periodic or intermittent nursing than otherwise available for the purpose of preventive interventions to reduce the occurrence of adverse outcomes for the individual such as hospitalizations and nursing facility admissions. An individual using this service must demonstrate a need for observation and evaluation.

When the individual's condition is unstable, could easily deteriorate, or when significant changes occur, the ICO covers nurse visits for observation and evaluation. The purpose of the observation and evaluation is to monitor the individual's condition and report findings to the individual's physician or other appropriate health care professional such as the ICO Care Coordinator to prevent additional decline, illness, or injury to the individual. The ICO Care Coordinator shall communicate with both the nurse providing this service and the individual's health care professional to ensure the nursing needs of the individual are being addressed.



Individuals must meet at least one of the following criteria to qualify for this service:

- Be at high risk of developing skin ulcers, or have a history of resolved skin ulcers that could easily redevelop.
- Require professional monitoring of vital signs when changes may indicate the need for modifications to the medication regimen.
- Require professional monitoring or oversight of blood sugar levels, including individual-recorded blood sugar levels, to assist with effective pre-diabetes or diabetes management.
- Require professional assessment of the individual's cognitive status or alertness and orientation to encourage optimal cognitive status and mental function or identify the need for modifications to the medication regimen.
- Require professional evaluation of the individual's success with a prescribed exercise routine to ensure its effectiveness and identify the need for additional instruction or modifications when necessary.
- Require professional evaluation of the individual's physical status to encourage optimal functioning and discourage adverse outcomes.
- Have a condition that is unstable, could easily deteriorate, or experience significant changes AND a lack of competent informal supports able to readily report life-threatening changes to the individual's physician or other health care professional.

In addition to observation and evaluation, a nursing visit may also include, but is not limited to, one or more of the following nursing services:

- Administering prescribed medications that cannot be self-administered (as defined under Michigan Compiled Law (MCL) 333.7103(1)).
- Setting up medications according to physician orders.
- Monitoring individual adherence to his/her medication regimen.
- Applying dressings that require prescribed medications and aseptic techniques.
- Providing refresher training to the individual or informal caregivers to ensure the use of proper techniques for health-related tasks such as diet, exercise regimens, body positioning, taking medications according to physician's orders, proper use of medical equipment, performing ADL, or safe ambulation within the home.

This service is limited to **no more than two hours per visit**.

Individuals receiving Private Duty Nursing services are not eligible to receive Preventive Nursing Services.

All providers must be licensed in the State of Michigan as a RN or LPN.

5.3.M. PRIVATE DUTY NURSING

Private Duty Nursing (PDN) services are skilled nursing interventions provided to an individual age 21 or older on an individual and continuous basis, **up to a maximum of**



16 hours per day, to meet the individual's health needs directly related to the individual's physical disability.

Medical Criteria

To be eligible for PDN services, the ICO must find the individual meets either Medical Criteria I or Medical Criteria II, and Medical Criteria III (see criteria below). Regardless of whether the individual meets Medical Criteria I or II, the individual must also meet Medical Criteria III.

- **Medical Criteria I** – The individual is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:
 - Mechanical rate-dependent ventilation (four or more hours per day), or assisted rate dependent respiration (e.g., some models of Bi-PAP); or
 - Deep oral (past the tonsils) or tracheostomy suctioning eight or more times in a 24-hour period; or
 - Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or
 - Total parenteral nutrition (TPN) delivered via a central line, associated with complex medical problems or medical fragility; or
 - Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter and a documented need for skilled nursing assessment, judgment, and intervention in the rate of oxygen administration. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for individuals 21 years of age or older when tested at rest while breathing room air and the oxygen saturation rate is 88 percent or below, or the PO₂ level is 55 mm HG or below.
- **Medical Criteria II** – Frequent episodes of medical instability within the past three to six months, requiring skilled nursing assessments, judgments, or interventions (as described in III below) as a result of a substantiated medical condition directly related to the physical disorder. Definitions:
 - "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months.
 - "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder.
 - "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition.



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- "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention would result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- "Directly related to the physical disorder" means an illness, diagnosis, physical impairment, or syndrome that is likely to continue indefinitely, and results in significant functional limitations in three or more ADL.
- "Substantiated" means documented in the clinical or medical record, including the nursing notes.
- **Medical Criteria III** – The individual requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services. Definitions:
 - "Continuous" means at least once every three hours throughout a 24-hour period, and when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode. Equipment needs alone do not create the need for skilled nursing services.
 - "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to:
 - ◆ Performing assessments to determine the basis for acting or a need for action, and documentation to support the frequency and scope of those decisions or actions;
 - ◆ Managing mechanical rate-dependent ventilation or assisted rate-dependent respiration (e.g., some models of Bi-PAP) that is required by the individual four or more hours per day;
 - ◆ Deep oral (past the tonsils) or tracheostomy suctioning;
 - ◆ Injections when there is a regular or predicted schedule, or injections that are required as the situation demands (prn), but at least once per month (insulin administration is not considered a skilled nursing intervention);
 - ◆ Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, or is associated with complex medical problems or medical fragility;
 - ◆ TPN delivered via a central line and care of the central line;
 - ◆ Continuous oxygen administration (eight or more hours per day), in combination with a pulse oximeter, and a documented need for adjustments in the rate of oxygen administration requiring skilled nursing assessments, judgments and interventions. This would not be met if oxygen adjustment is done only according to a written protocol with no skilled assessment, judgment or intervention required. Continuous use of oxygen therapy is a covered Medicaid benefit for beneficiaries age 21 or older when tested at rest while breathing



room air and the oxygen saturation rate is 88 percent or below, or the PO₂ level is 55 mm HG or below;

- ◆ Monitoring fluid and electrolyte balances where imbalances may occur rapidly due to complex medical problems or medical fragility. Monitoring by a skilled nurse would include maintaining strict intake and output, monitoring skin for edema or dehydration, and watching for cardiac and respiratory signs and symptoms. Taking routine blood pressure and pulse once per shift that does not require any skilled assessment, judgment or intervention at least once every three hours during a 24-hour period, as documented in the nursing notes, would not be considered skilled nursing.

All nurses providing PDN to waiver individuals must maintain a current State of Michigan nursing license, and meet licensure requirements and standards according to Michigan laws found under MCL 333.17201-17242. PDN may include medication administration according to MCL 333.7103(1).

This service must be ordered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner. The ICO is responsible for ensuring there is a physician order for the PDN services authorized. The physician may issue this order directly to the provider furnishing PDN services. However, the ICO is responsible for ensuring the PDN provider has a copy of these orders and delivers PDN services according to the orders. The ICO shall maintain a copy of the physician orders in the Care Bridge Record. The individual's physician, physician's assistant, clinical nurse specialist, or nurse practitioner must order PDN services and work in conjunction with the ICO and provider agency to ensure services are delivered according to that order.

Through a person-centered planning process, the ICO shall determine the amount, scope and duration of services provided. The direct service provider shall maintain close contact with the authorizing ICO to promptly report changes in each individual's condition and/or treatment needs upon observation of such changes. The direct service provider shall send case notes to the care coordinator on a regular basis, preferably monthly, but no less than quarterly, to update the care coordinator on the condition of the individual.

Individuals receiving Preventive Nursing Services are not eligible to receive PDN services.

All PDN services authorized must be medically necessary as indicated through the assessment and meet the medical criteria described above.

5.3.N. RESPITE

5.3.N.1. RESPITE PROVIDED AT THE INDIVIDUAL'S HOME OR IN THE HOME OF ANOTHER PERSON

Respite services are provided on a short-term, intermittent basis to relieve the individual's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.



Respite services include:

- Attendant care (individual is not bed-bound), such as companionship, supervision, and/or assistance with toileting, eating, and ambulation.
- Basic care (individual may or may not be bed-bound), such as assistance with ADLs, a routine exercise regimen, and self-medication.

Members of an individual's family who are not the individual's regular caregiver may provide respite for the regular caregiver. However, the ICO shall not authorize funds to pay for services furnished to an individual by that person's spouse. Family members who provide respite services must meet the same standards as providers who are unrelated to the individual.

Respite services cannot be scheduled on a long term daily basis. Respite should be used on an intermittent basis to provide scheduled relief of informal caregivers. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. The costs of room and board are not included in payment for respite services.

5.3.N.2. RESPITE PROVIDED OUTSIDE OF THE HOME

Respite care services are provided on a short-term, intermittent basis to relieve the individual's family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care.

Each out of home respite service provider must be a licensed group home as defined in MCL 400.701ff, which includes AFC homes and HFA. Respite may include the cost of room and board if the service is provided in a licensed AFC or licensed HFA.

Respite services include:

- Attendant care (individual is not bed-bound), such as companionship, supervision and/or assistance with toileting, eating, and ambulation.
- Basic care (individual may or may not be bed-bound), such as assistance with ADLs, a routine exercise regimen, and self-medication.

Out of home respite may be scheduled for several days in a row, depending upon the needs of the individual and the individual's caregivers.

5.4 HOSPICE

Effective November 1, 2016, individuals enrolled in the MI Health Link program who elect hospice services may remain enrolled in the MI Health Link program if they choose.

When a MI Health Link beneficiary elects hospice services, the hospice agency must notify the beneficiary's Integrated Care Organization (ICO) for initiation of care management and authorization of nursing facility room and board, if indicated. The hospice agency will bill Medicare for hospice services



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and other Medicare Part A and Part B services not related to the terminal illness and bill the ICO for room and board when hospice is rendered in a nursing home setting.

A beneficiary has the option of disenrolling from MI Health Link at any time by contacting Michigan's contracted enrollment broker. During the month when disenrollment occurs, the beneficiary will remain with MI Health Link until the first day of the following month, at which time Fee-for-Service (FFS) Medicaid will become effective. Hospice agencies will need to monitor MI Health Link beneficiary enrollment status.



SECTION 6 – CONTINUITY OF CARE

Individuals enrolled in the MI Health Link program must maintain their current Medicare and Medicaid providers, supports and services for the following timeframes after enrollment: Individuals have the right to continue to see providers who are not in the ICO’s network during the Continuity of Care period. Communication between the individual, providers, and the ICO is essential to ensure providers are identified so services can be provided and covered by the ICO. The ICO must work to bring individuals’ current providers into the plan’s network.

ICO Transition Requirement for Individuals receiving services through the HAB waiver and Managed Specialty Services and Supports Program through the PIHPs	
Provider Type	Timeframe for continuing current services
Physician/Other Practitioners	Maintain current provider at the time of enrollment for 180 calendar days. (ICO must honor existing plans of care and prior authorizations (PAs) until the authorization ends or 180 calendar days from enrollment, whichever is sooner).
DME	Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity.
Scheduled Surgeries	Must honor specified provider and PAs for surgeries scheduled within 180 calendar days of enrollment.
Chemotherapy/Radiation	Treatment initiated prior to Enrollment must be authorized through the course of treatment with the specified provider.
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider, PAs and plans of care.
Dialysis Treatment	Maintain current level of service and same provider at the time of enrollment for 180 calendar days.
Vision and Dental	Must honor PAs when an item has not been delivered.
Medicaid Home Health	Maintain current level of service and same provider at the time of enrollment for 180 calendar days.
State Plan Personal Care	Maintain current provider and level of services at the time of enrollment for 180 calendar days. The IICSP must be reviewed and updated and providers secured within 180 calendar days of enrollment.



ICO Transition Requirements for All Other Individuals	
Provider Type	Timeframe for continuing current services
Physician/Other Practitioners	Maintain current provider at the time of Enrollment for 90 calendar days. (ICO must honor existing plans of care and prior authorizations (PAs) until the authorization ends or 180 calendar days from enrollment, whichever is sooner).
DME	Must honor PAs when item has not been delivered and must review ongoing PAs for medical necessity.
Scheduled Surgeries	Must honor specified provider and PAs for surgeries scheduled within 180 calendar days of enrollment.
Chemotherapy/Radiation	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider.
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider, PAs and plans of care.
Dialysis Treatment	Maintain current level of service and same provider at the time of enrollment for 180 calendar days.
Vision and Dental	Must honor PAs when an item has not been delivered.
Medicaid Home Health	Maintain current level of service and same provider at the time of enrollment for 90 calendar days.
Medicaid Nursing Facility Services	Individual may remain at the facility through contract with the ICO or via single case agreements or on an out-of-network basis for the duration of the Demonstration or until the individual chooses to relocate.
Waiver Services	MI Choice HCBS waiver individuals: Maintain current providers and level of services at the time of enrollment for 90 calendar days unless changed during the Person-Centered Planning Process. Not applicable to other individuals.
State Plan Personal Care	Maintain current provider and level of services at the time of enrollment for 90 calendar days. The Individual IICSP must be reviewed and updated and providers secured within 90 calendar days of Enrollment. Not applicable for individuals transitioning from the MI Choice program.

The ICO is required to review Medicare and Medicaid utilization data provided by CMS and MDHHS to determine which providers have existing relationships with individuals. Continuity of care protection is automatic for providers which are verified through utilization data to meet the prior relationship requirement.



The individual must have a relationship with a provider to establish continuity of care. A relationship is deemed to exist in the following circumstances:

Specialists: The individual must have seen the specialist at least once within the 12 months prior to enrollment into a ICO for a nonemergency visit.

Primary Care Provider: The individual must have seen the primary care provider at least twice within the 12 months prior to enrollment into a ICO for a non-emergency visit.

Other Covered Providers: The individual must have received services from other providers within the past 12 months prior to enrollment into a ICO.

If the ICO cannot determine if a relationship exists based on the available data, the ICO shall ask the provider and individual to provide documentation of the visit from the medical record or proof of payment to establish the relationship. An attestation that a relationship exists is not sufficient.

The ICO must ask the individual about any upcoming appointments to ensure agreements are in place with out-of-network providers. If data is not available to establish relationship with the individual's provider, the individual or his/her appointed/legal representative may request continuity of care. The individual's out-of-network provider may also request continuity of care on behalf of the individual. Requests for continuity of care should be made by contacting the ICO's member services department or the individual's ICO Care Coordinator. Requests can be made verbally or in writing. When requesting continuity of care, the name of the provider, contact person, phone number, service type and appointment date, if applicable, should be shared with the ICO.

Generally, ICOs must start processing a request for continuity of care within five working days after the request is received. The ICO has a maximum of 30 days to complete the request. However, if the individual's medical condition requires more immediate attention (e.g., an upcoming appointment); the ICO must complete the request within 15 days. If there is a risk of harm to the individual or rescheduling of the appointment would be required, the request must be completed within three days of the request. The ICO may verbally convey Continuity of Care approval with the requester and record such approval in the individual's record.

If the criteria for the prior relationship as outlined above are satisfied, an out-of-network provider can be reimbursed retroactively for services provided without an approved continuity of care request as long as the provider submits the request for payment within 30 days of the first date of service.

The ICO must cover services during the continuity of care period for providers that do not have documented quality of care concerns that would cause the ICO to exclude the provider based on state or federal requirements.

Pharmacy

ICOs are required to maintain current prescriptions for medications for 180 days if medications are not on the ICO's formulary unless directed otherwise by CMS and MDHHS. The individual can ask the ICO to make an exception to cover a drug that is not on the ICO's formulary.



Nursing Facilities

Out-of-network nursing facilities must be offered Single Case Agreements by the ICO to continue to care for the individual through the life of the program if the nursing facility does not participate in the ICO's network and the individual: 1) resides in the nursing facility at the time of enrollment; 2) has a family member or spouse that resides in the nursing facility; or 3) requires nursing facility care and resides in a retirement community that includes a nursing facility. This continuity of care protection is available as long as the individual resides in the nursing facility. Continuity of care in a nursing facility is automatic. The individual does not have to make a request for continuity of care. The ICO must refill prescriptions for individuals in a nursing facility for a minimum of 91 days and the ICO must refill the drug multiple times during the first 90 days of enrollment, as needed. This allows the prescriber time to change the drugs to those on the drug list or ask for an exception.

Personal Care Providers

The ICO must allow choice of personal care service providers, including non-financially responsible family members or friends, to provide the service if they meet the criteria to enroll in the ICO's network.

The ICO may enter into an agreement for non-agency personal care providers when a permissible exclusion is identified through a background check. The ICO may allow for this exclusion if the individual is informed of the details of the permissible exclusion and agrees, in writing, to allow the person to provide personal care to the individual during the continuity of care period. During this time period, the individual can seek alternatives to receiving personal care services if the ICO does not continue the agreement beyond the required continuity of care period.

Under no circumstance must the ICO enter into an agreement if it is discovered the personal care services provider falls under the policy for mandatory exclusion from providing personal care services.

Other Providers

Continuity of care does not extend to DME providers or ancillary service providers (e.g. suppliers of medical supplies or laboratories). Although continuity of care does not extend to these types of providers, the ICO must still provide continuity of care for services and the ICO is responsible for finding an in-network provider to deliver services without disruption.



SECTION 7 – CARE COORDINATION, ASSESSMENT AND PERSON-CENTERED PLANNING

The MI Health Link program requires coordination of services for all individuals to ensure effective integration and coordination between providers of medical services and supplies, BH, SUD and/or I/DD, pharmacy, and LTSS. This requires coordination between the ICO and the Pre-paid Inpatient Health Plan (PIHP) or the LTSS entities, where applicable. The ICO shall contract with the PIHP to deliver Medicare BH, SUD and/or I/DD services to individuals. This contract and any other downstream contracts related to care coordination activities will be monitored by the CMS and MDHHS contract management team to ensure all delivery system requirements of MI Health Link are met and all individuals receive the appropriate care coordination services. To accomplish this, the ICO must:

- Develop and implement a strategy that uses a combination of initial screenings, assessments, referrals, administrative claims data, and other available information to help prioritize and determine the care coordination needs of each individual.
- Focus on providing services in the most integrated and least restrictive setting.
- Maintain flexibility to use innovative care delivery models and to provide a range of community-based services as a way to promote independent living and alternatives to high-cost institutionally based services.
- Exhaust the use of community-based services before utilizing institutional settings for LTSS.
- Wherever possible, include a person familiar with the needs, circumstances and preferences of the individual when the individual is unable to participate fully in or report accurately to the Integrated Care Team (ICT).
- Ensure that the individual has a primary care provider (PCP) appropriate to meet his or her needs and assist the individual in accessing services.

7.1 THE CARE BRIDGE

The care coordination model for MI Health Link is the Care Bridge, which includes both technology and people through the person-centered planning process. The ICO is required to utilize a care coordination platform supported by web-based technology that is discussed in this section and referred to as the Care Bridge.

The Care Bridge allows secure access to information and enables all individuals and members of the ICT to use and (where appropriate) update information. Through the electronic Care Bridge, the members of the individual's ICT facilitate access to formal and informal supports and services identified in the individual's Individual Integrated Care and Supports Plan (IICSP) developed through a Person-Centered Planning process.

The Care Bridge includes an electronic care coordination platform which will support an Integrated Care Bridge Record (ICBR) to facilitate timely and effective information flow between the members of the ICT. The electronic Care Coordination platform will include a mechanism to alert ICT members of emergency department use or inpatient admissions. The ICBR will allow ICO Care Coordinators, PIHP and LTSS coordinators, where applicable, and providers to post key updates and notify ICT members of changes.

This platform will be compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other relevant laws, and provide for the exchange of data in a standard format.



The approved electronic care coordination platform will generate and maintain an individualized individual record referred to as ICBR including:

- Current integrated condition list;
- Contact information for the ICO Care Coordinator and ICT members;
- Current medications list;
- The date of service and the name of the provider for the most recently provided services;
- Historical and current utilization and claims information;
- Historic Medicaid and Medicare utilization data: MDHHS will provide the ICO with access to the CareConnect360 (CC360) system to view and extract historic utilization data.
- MDHHS will initially provide the ICO with extract files containing historical data for all individuals for the previous 24 months. Updates thereafter are available on a monthly basis or by the frequency identified by the ICO.
- Initial screening, Assessments (Level I and Level II), nursing facility LOCD and Personal Care Assessment results;
- Service outcomes, including specialty provider reports, lab results, and emergency room visits;
- IICSP; and
- Notes and correspondence across provider settings.

7.2 HEALTH PROMOTION AND WELLNESS ACTIVITIES

The ICO must provide a range of health promotion and wellness informational activities for individuals, their family members, and other informal caregivers. The focus and content of this information must be relevant to the specific health status needs and high-risk behavior in the Medicare-Medicaid population. Interpreter services must be available for individuals who are not proficient in English. Examples of health promotion and wellness topics include, but are not limited to, the following:

- Chronic condition self-management;
- Smoking cessation;
- Nutrition; and,
- Prevention and treatment of alcohol and substance abuse.

7.3 INTEGRATED CARE TEAM (ICT)

Every individual shall have access to and input in the development of an ICT to ensure the integration of all the individual's supports and services, including medical, behavioral, psychosocial, and LTSS. The ICT will be person-centered, respecting and incorporating the individual's specific preferences and needs. The ICT will deliver services with transparency, individualization, accessibility, respect, linguistic and cultural competence, and dignity. The ICT will honor the individual's choice about his/her level of participation and interaction with the ICT. This choice will be periodically revisited with the individual by the ICO Care Coordinator.



7.3.A. INTEGRATED CARE TEAM MEMBERS

The ICO Care Coordinator will lead the ICT. It will be the responsibility of the ICO Care Coordinator to set and lead ICT meetings as well as facilitate communication among ICT members. LTSS and PIHP Supports Coordinators will be members of ICTs (as applicable) to encourage communication and collaboration between ICOs, PIHPs and other providers. While the ICO Care Coordinator will be the ICT lead, the individual may request the LTSS or PIHP Supports Coordinator remain his/her main point of contact regarding the ICT.

ICT membership will include the individual and the individual's chosen allies, ICO Care Coordinator, primary care physician, and LTSS Supports Coordinator or PIHP Supports Coordinator (as applicable). Additional membership on the ICT may vary at each meeting depending on the changing needs of the individual. PCPs may designate a licensed medical professional on their staff who has personal knowledge of the enrollee's condition(s) and health care needs to attend in place of the PCP. The ICT may also include the following persons as needed and available:

- Family caregivers and natural supports
- Primary care nurse care manager
- Specialty providers
- Personal care providers
- Hospital discharge planner
- Nursing facility representative
- Others as appropriate

7.3.B. INTEGRATED CARE TEAM RESPONSIBILITIES

The role of ICT is to work collaboratively with the individual to meet goals identified in the IICSP and ensure the best possible health care outcomes. The ICO Care Coordinator is responsible to ensure the completion of tasks listed below for the ICT. ICT members will:

- Ensure the IICSP is developed, implemented, and revised according to the person-centered planning process and the individual's stated goals, including making whatever accommodations are appropriate for individuals whose disabilities create obstacles to full participation with the ICT.
- Participate in the Person-Centered Planning process at the individual's discretion to develop the IICSP;
- Collaborate with other ICT members to ensure the Person-Centered Planning process is maintained;
- Assist the individual in meeting his/her goals;
- Monitor and ensure that their part of the IICSP is implemented in order to meet the individual's goals;



- Update the ICBR as needed pertinent to the ICT member's role on the ICT;
- Review assessment, test results and other pertinent information in the ICBR;
- Address transitions of care when a change between care settings occur;
- Ensure continuity of care requirements are met; and
- Monitor for issues related to quality of care and quality of life.

The operations of ICTs will vary depending on the needs and preferences of the individual. An individual with extensive service needs may warrant periodic meetings with all ICT members. An individual with less intense needs may warrant fewer meetings with selected members of the ICT. Communication among the ICT members will be maintained by the ICO Care Coordinator and other direct communication with ICT members. The ICO Care Coordinator is responsible for facilitating communication among the ICT members.

The ICT will adhere to an individual's determination about the appropriate involvement of his/her medical providers and caregivers at each meeting according to HIPAA and, for individuals in SUD treatment, 42 C.F.R. Part 2.

7.4 ICO CARE COORDINATOR

ICO Care Coordinators must have the experience, qualifications and training including MDHHS required training appropriate to the needs of the individual, and the ICO must establish policies for appropriate assignment of ICO Care Coordinators.

ICO Care Coordinators must have knowledge of physical health, aging and loss, appropriate support services in the community, frequently used medications and their potential negative side-effects, depression, challenging behaviors, Alzheimer's disease and other disease-related dementias, behavioral health, substance use disorder, physical and developmental disabilities, issues related to accessing and using durable medical equipment as appropriate, available community services and public benefits, quality ratings and information about available options such as nursing facilities, applicable legal non-discrimination requirements such as the ADA, person-centered planning, cultural competency, and elder abuse and neglect.

The ICO Care Coordinator must be a Michigan:

- Licensed registered nurse;
- Licensed clinical nurse specialist;
- Licensed nurse practitioner;
- Licensed physician's assistant;
- Limited license Bachelor's prepared social worker;
- Licensed Bachelor's prepared social worker;
- Limited license Master's prepared social worker; or
- Licensed Master's prepared social worker.



ICO Care Coordinator Training

The ICO Care Coordinator will participate in train-the-trainer Person-Centered Planning and Self-Determination educational opportunities offered by MDHHS. The ICO will be responsible for training any new ICO Care Coordinator staff. The ICO will report participation of its ICO Care Coordinators in the MDHHS and ICO trainings as required.

The ICO will participate, train and report on any other training required or offered by MDHHS or its designee.

ICO Care Coordinator Responsibilities

The ICO Care Coordinator will be responsible for care coordination for each individual. The ICO Care Coordinator will conduct the Level I Assessment, ensure the person-centered planning process is complete, prepare the IICSP, coordinate care transitions, and lead the ICT.

The ICO Care Coordinator will be responsible to:

- Support an on-going person-centered planning process;
- Assess clinical risk and needs by conducting an assessment process that includes an Initial Screening, a Level I Assessment, and completion of or referral for a Level II Assessment (as appropriate);
- Facilitate timely access to primary care, specialty care, LTSS, BH, SUD, and I/DD services, medications, and other health services needed by the individual, including referrals to address any physical or cognitive barriers or referrals to the PIHP;
- Create and maintain an ICBR for each individual to manage communication and information regarding referrals, transitions, and care delivery;
- Facilitate communication among the individual's providers through the use of the care coordination platform and other methods of communication including secure e-mail, fax, telephone, and written correspondence;
- Notify the ICT of the individual's hospitalization (psychiatric or acute), and coordinate a discharge plan if applicable;
- Facilitate face-to-face meetings, conference calls, and other activities of the ICT as needed or requested by the individual;
- Facilitate direct communication between the provider and the individual or the individual's authorized representative and/or family or informal supports as appropriate;
- Facilitate individual and family education;
- Coordinate and communicate, as applicable, with the PIHP Supports Coordinator and/or the LTSS Supports Coordinator to ensure timely, non-duplicative supports and services are provided;
- Develop, with the individual and ICT, following the person-centered planning process, an IICSP specific to individual needs and preferences, and monitor and update the IICSP at least annually or following a significant change in needs or other factors;
- Coordinate and make referrals to community resources (e.g., housing, home delivered meals, energy assistance programs) to meet IICSP goals;



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- Perform ongoing care coordination;
- Monitor the implementation of the IICSP with the individual, including facilitating the individual's evaluation of the process, progress and outcomes and identifying barriers and facilitate problem resolution and follow-up;
- Advocate with or on behalf of the individual, as needed, to ensure successful implementation of the IICSP;
- Support transitions in care when the individual moves between care settings including:
 - The ICO Care Coordinator will contact the individual once notified of an emergency room visit to review discharge orders, schedule follow-up appoints, review any medication changes, and evaluate the need for revising the IICSP to include additional supports and services to remain in or return to the community;
 - The ICO Care Coordinator will ensure immediate and continuous discharge planning, including electronic and verbal communication, with the individual and ICT members following an individual's admission to a hospital or nursing facility. Discharge planning will ensure that necessary care, supports and services are in place in the community for the individual when discharged. This includes scheduling an outpatient appointment, ensuring the individual has all necessary medications or prescriptions upon discharge, and conducting follow-up with the individual and/or caregiver.
 - The Care Coordinator shall make every effort to ensure that home and community based services are in place upon hospital discharge to avoid unnecessary nursing facility placements. The ICO Care Coordinator shall be able to arrange for expedited assessments and other mechanisms to ensure prompt initiation of appropriate HCBS. If the individual is being discharged from a nursing facility or hospital, the Care Coordinator shall coordinate efforts with the nursing facility social worker, discharge planner, or other staff to ensure a smooth transition.
 - Evaluating Section Q of the Minimum Data Set (MDS) for individuals currently in a nursing facility and discussing options for returning to the community, revising the IICSP, and transitioning the individual to the most integrated setting.
 - The ICO Care Coordinator will inform the individual of his/her right to live in the most integrated setting, inform the individual of the availability of services necessary to support his/her choices, and record the home and community-based options and settings considered by the individual.
 - Engage in other activities or services needed to assist the individual in optimizing his/her health status, including assisting with self-management skills or techniques; health education; referrals to support groups, services, and advocacy agencies, as appropriate; and other modalities to improve health status;
 - Ensure the Medicaid eligibility redetermination process is completed timely to prevent the loss of benefits; and
 - If the individual is receiving services that require meeting the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) standards, ensure through required Level I and/or Level II assessments that the individual continues to meet the criteria or transitions to services that do not require LOCD standards. The ICO Care Coordinator will ensure appropriate assessments are conducted for individuals



with identified long term care needs, and MDHHS will make final eligibility determinations, unless otherwise directed by the State and CMS.

Individual ICO Care Coordinator Assignments and Change Requests

- The ICO shall allow the individual or his/her authorized representative choice in ICO Care Coordinator.
- The ICO shall ensure every individual has an ICO Care Coordinator with the appropriate experience and qualifications based on the individual's assigned risk level and individual needs (e.g., communication, cognitive, or other barriers).
- The ICO must have a process to ensure that an individual or his/her authorized representative is able to request a change in his/her ICO Care Coordinator at any time including a process for the transition from one ICO Care Coordinator to another.
- The ICO must establish policies for appropriate assignment of ICO Care Coordinators to align with the individual's known or expressed cultural, religious and ethnic preferences by considering the knowledge and experience of the ICO Care Coordinator.

7.5 COORDINATION WITH PIHP AND LTSS SUPPORTS COORDINATORS

The ICO Care Coordinator must collaborate with the applicable PIHP Supports Coordinator or identified behavioral health representative as defined in the contract between the ICO and the PIHP when:

- The individual has received services through a PIHP within the last 12 months, or
- A new individual requests, or is identified as having potential need for, BH, I/DD, or SUD services.

If the individual has need of LTSS, the ICO Care Coordinator will collaborate with the individual's chosen LTSS Supports Coordinator when:

- The individual has received LTSS within the last 12 months, or
- A new individual requests or is identified as having potential need for LTSS.

7.5.A. LTSS SUPPORTS COORDINATOR

LTSS Supports Coordinator will be offered to all individuals who have needs for long term supports and services. The LTSS Supports Coordinator must be a Michigan:

- Licensed registered nurse;
- Licensed clinical nurse specialist;
- Licensed nurse practitioner;
- Licensed physician's assistant;
- Limited license Bachelor's prepared social worker;
- Licensed Bachelor's prepared social worker;
- Limited license Master's prepared social worker; or



- Licensed Master's prepared social worker.

The LTSS Supports Coordinator must:

- Have knowledge of HCBS;
- Have completed a person-centered planning and person-centered direction training;
- Be culturally competent;
- Be able to provide information regarding the quality ratings and licensure status, if applicable, of available options;
- Be knowledgeable about risk factors and indicators of, and resources to respond to, abuse and neglect;
- Be familiar with applicable long term care facility licensing requirements and resources such as the long term care ombudsman program; and
- Have experience conducting LTSS needs assessments.

LTSS Supports Coordinator Responsibilities

The ICO will be responsible to provide, directly or contractually, the following LTSS Supports Coordination services:

- Support an on-going person-centered planning process;
- Assist the individual to take a lead role in the person-centered planning process;
- Provide information to the individual and ICT;
- Communicate and collaborate with the PIHP when BH, SUD, or I/DD needs are identified in the Level I Assessment;
- Participate in the assessment process as needed, including conducting the Level II Assessment specific to the individual's needs;
- Participate on the individual's ICT;
- Develop, with the individual and the ICT, an IICSP;
- Ensure optimal utilization of information and community supports;
- Arrange services as identified in the IICSP;
- Update the ICBR with current individual status information to manage communication and information flow regarding referrals, transitions, and care delivery;
- Monitor service implementation, service outcomes, and the individual's satisfaction;
- Collaborate with the ICO Care Coordinator to assist the individual during transitions between care settings, including full consideration of all community options; and
- Advocate for the individual and support self-advocacy by the individual.

The ICO Care Coordinator may serve as the LTSS Supports Coordinator and complete the required functions of both roles.



7.6 ASSESSMENT TOOLS AND PROCESS

7.6.A. INDIVIDUAL STRATIFICATION

The ICO will develop and implement a strategy that uses a combination of initial screenings, assessments, assessment tools, functional assessments, referrals, administrative claims data, etc. to help prioritize and determine the level of care coordination needed by each individual.

The ICO must review program level data through CHAMPS and CareConnect360 or through file exacts provided by MDHHS as part of the initial screening process. CareConnect360 contains past Medicare and Medicaid utilization data from the MDHHS Data Warehouse. The ICO must review program level data and utilization data within 15 calendar days of enrollment.

Levels of stratification should be based on:

- Individual demographics, medical conditions, functional status, care patterns, resource utilization data; and
- The individual's risk for long term care institutionalization or avoidable hospitalization.
- Individuals receiving services in the Habilitation Supports Waiver (HSW) or an individual transitioning to MI Health Link from the MI Choice waiver are automatically stratified as high risk.
- The ICO will determine the parameters and definitions for other individuals defined as high risk as well as definitions for low or moderate risk individuals.

The ICO may also choose to use existing predictive modeling software to support the screening and assessment requirements are not be required to do so.

7.6.B. INITIAL SCREENING

The purpose of the initial screening is to identify individuals with immediate needs in order to prioritize in-person Level I Assessments. The initial screening is a series of individual reported yes/no questions related to historical and current service usage. This screening is conducted via telephone when individuals call the enrollment broker to enroll in MI Health Link.

For those individuals passively enrolled into the ICO or those not completing the screen during the enrollment call, the ICO must make its best efforts to administer the initial screening within 15 calendar days of enrollment.

The ICO must document attempts in the ICBR to contact the individual for the purpose of scheduling or conducting the initial screening on different days of the week and at different times during the day, including times outside of standard work hours. If the initial contact is not made within 15 calendar days of enrollment, the ICO must continue efforts to contact the individual and document such in the ICBR.



The ICO will review the individual's responses to the initial screening questions to identify current utilization of PIHP services, nursing facility care, community-based supports and services, and hospital care (inpatient or emergency room treatment).

The ICO must document the individual's responses to the initial screening questions in the ICBR.

7.6.C. LEVEL I ASSESSMENTS

Each individual must receive, and be an active participant in (to the extent they desire), a timely Level I Assessment of medical, behavioral health, psychosocial, and LTSS needs completed by the ICO Care Coordinator unless one of the following circumstances applies:

- An individual declines an assessment. Should that occur, the ICO will honor the individual's decision and will only contact the individual regarding an assessment if the individual requests one or a new assessment is needed according to the reassessment requirements.
- An individual is not reachable through the contact information provided by MDHHS or CMS. The ICO must document its attempts to reach the individual and what means of communication were used.
 - The ICO shall attempt to contact the individual at least five times within the first 60 days of enrollment. Attempts must be on different days of the week and at different times during the day, including times outside of standard work hours.
 - ICO shall use community resources where possible to identify and engage individuals.
- The ICO Care Coordinator will identify, through the Level I Assessment, individuals who may require institutional level of care or personal care services.
- The ICO will perform the Level I Assessment using its tool approved by MDHHS to assess each individual's current health, welfare, functional needs and risks.
- The ICO will use the DSM V screening tool as part of or in addition to its Level I Assessment tool to identify Individuals with BH, SUD, and/or I/DD needs.

The ICO Care Coordinator may complete the Level I Assessment in lieu of the initial screening if the Level I Assessment is completed within 15 calendar days of enrollment.

Level I Domains

Level I Assessment domains must include, but not be limited to, the following:

- Individual preferences, strengths, and goals including Self-Determination arrangements;
- Natural supports, including family and community caregiver capacity, and social strengths and needs;
- Communication needs, including hearing, vision, cultural and linguistic needs and preferences, and individual health literacy;



- Current services, including those covered by Medicare and Medicaid, community supports, and care transition needs;
- Medical health risk, status, and history, including but not limited to medications (prescription, over-the-counter, and herbal supplements), frequent falls, and treatment for recurring urinary tract infections;
- BH and SUD risk status; BH, SUD, and I/DD history and needs, including medications;
- Nutritional strengths and needs;
- ADL and IADL, including any assistive technology used or needed and immediate environmental or housing needs;
- Cognitive strengths and needs;
- LTSS;
- Quality of life including physical, mental, and psycho-social well-being;
- Discussion and education related to abuse, neglect, and exploitation; and
- Advance Directives

The ICO may include State-approved domains as appropriate. Additional domains should be included in the ICO's Level I Assessment tool when submitting the tool for approval by MDHHS.

Involvement in the Level I Assessment

The Level I Assessment will be completed by the ICO Care Coordinator (see qualifications above) employed or contracted with the ICO who is accountable for providing Care Coordination services. The ICO may delegate through contract with entities or individuals meeting the Care Coordinator qualifications for performance of Initial Screenings, Level I Assessments and LTSS Level II Assessments, as well as Care Coordination functions. The ICO retains responsibility and accountability for utilization management functions, appeals, and approval of services. The Care Coordinator role cannot be delegated through contract or other means to Long Term Supports and Services providers who are otherwise responsible for providing services to individuals, such as nursing facilities.

- The ICO will include the appropriate PIHP or LTSS Supports Coordinator or nursing facility staff in conducting the Level I Assessment if the individual has been active in the PIHP or LTSS system during the previous 12 months or is currently residing in a nursing facility.
- Family members or other individuals may also be included in the Level I Assessment process to the extent desired by the individual.

Level I Results and Referral

The ICO will use the results of the Level I Assessment to confirm the appropriate acuity or risk stratification level for individual Care Coordinator assignments. The Level I Assessment and the DSM-V screening tool for BH, SUD, I/DD, will be used to determine need for a Level II Assessment, referral for PIHP services, or development of the IICSP.



The ICO will make referrals according to the process identified in ICO/PIHP contract to the PIHP/BH system for individuals identified as having BH, SUD, and/or I/DD needs.

The PIHP will conduct in person or adopt current Level II Assessments for individuals identified as receiving services from the Habilitation Supports Waiver and/or the Specialty Services and Supports Program. The PIHP will conduct a telephonic screen using the MDHHS approved tool to determine:

- If the individual has mild to moderate needs that can be met through referral for additional services; or
- If the individual has needs that require the Level II Assessment.

The PIHP will coordinate service referrals to ICO or PIHP network providers or conduct further assessment as needed. The PIHP will document the results from the telephonic screen and referral in the ICBR.

The ICO Care Coordinator is responsible for ensuring completion of further assessment for individuals with medically complex conditions. The ICO will coordinate with the primary care provider to ensure that further follow-up relevant to these needs is provided to the individual.

The individual will continue to receive any services in any existing care plan prior to the Level I Assessment. The ICO will adhere to all transition requirements for services, as outlined in the Continuity of Care section and any other documentation provided by CMS or MDHHS.

Level I Assessments will be documented in the ICBR and results will be used in the development of the IICSP.

Timing of Level I Assessments

Level I Assessments will be completed within 60 calendar days of enrollment. ICOs approved by CMS and MDHHS to conduct early Level I Assessment may start the assessment no earlier than 20 days before the enrollment effective date. Early assessment does not impact the time frames for completing other assessments. Other Assessments cannot be completed before the enrollment effective date. Individuals identified with immediate needs or as having high risk should have Level I Assessments completed earlier than 60 calendar days from enrollment, as appropriate.

In-person Level I Assessments

The ICO Care Coordinator is encouraged to conduct the Level I Assessment in person. Individuals identified with immediate needs or as having high risk will have assessments completed in person.

Locating Individuals

The ICO shall identify individuals through referrals, transition information, service authorizations, alerts, memos, assessment results, and from families, caregivers, providers, community organizations and ICO personnel. The ICO shall notify the primary



care provider (PCP) of an individual who has not completed a Level I Assessment within the time period set forth above and whom the ICO has been unable to contact. The ICO shall encourage the PCPs to conduct outreach to these individuals and to schedule visits. The ICO shall collaborate with clinics, hospitals, or urgent care centers to identify individual contact information for individuals the ICO has not been able to contact.

7.6.D. TRIGGERS FROM THE LEVEL I ASSESSMENT

Michigan Medicaid Nursing Facility Level of Care Determination (LOCD)

The Michigan Medicaid Nursing Facility Level of Care Determination tool must be conducted for all individuals according to the Michigan Medicaid Nursing Facility Level of Care Determination requirements in the Medicaid policy (refer to the Nursing Facility Level of Care Determination Chapter of the Medicaid Provider Manual) and additional guidance provided by MDHHS. For the MI Health Link program only, the Nursing Facility Level of Care Frailty Review criteria will be applied at the time the LOCD is conducted for the individual if the individual does not meet LOCD criteria under Doors one through seven. Additionally, for the MI Health Link program, the LOCD must be conducted by a Care Coordinator holding a credential as described in the ICO Care Coordinator subsection of this chapter.

PIHP Telephonic Screen

The ICO shall refer individuals identified in the Level I screen as having BH, SUD or I/DD needs to the PIHP for additional assessment. Of this population, those individuals without a known history of PIHP services will receive a telephonic screen to determine service needs. The PIHP will determine if the individual has mild to moderate needs which can be addressed through additional assessment or referral to providers (PIHP or ICO). For all other individuals, the PIHP will complete the appropriate Level II assessment. The PIHP has flexibility to perform the telephonic screening function within the current intake system as long as identification of needs is completed using the prescribed tool.

7.6.E. LEVEL II ASSESSMENT

The ICO Care Coordinator will collaborate with the PIHP to ensure that the Level II Assessment is conducted for individuals identified through the telephonic screen as needing referral to the PIHP for Level II Assessment. The ICO Care Coordinator will ensure that the Level II Assessment is conducted for individuals demonstrating LTSS needs identified in the Level I Assessment.

Level II assessments must be completed using the tools approved by MDHHS.

Qualifications for Completing Level II Assessment

Level II Assessments will be conducted by professionally knowledgeable and trained LTSS Supports Coordinators or PIHP Supports Coordinators or behavioral health case managers, who have experience working with the population. Each Level II Assessment tool has specific qualifications for the person completing the tool.



Timing of Level II Assessments

Any Level II Assessment completed prior to enrollment by the PIHP Supports Coordinator, a trained LTSS Supports Coordinator or a behavioral health case manager may be adopted if it is not past the reassessment date. The Level II Assessment should be reviewed to determine if it is complete, accurate and appropriate for the individual's current status. Level II Assessments will be conducted in person within 15 calendar days of completion of the Level I Assessment. Level II Assessments will be documented in the ICBR and results will be used in the development of the IICSP.

7.6.F. REASSESSMENTS

7.6.F.1. LEVEL I REASSESSMENTS

The ICO is responsible to ensure that an annual Level I reassessment for each individual (including analysis of medical, LTSS, BH, and I/DD utilization data) is completed within 12 months of the last Level I Assessment. If prior to the annual reassessment, the individual experiences a major change impacting health status, the ICO is required to reassess the individual and review and revise the IICSP with members of the ICT as needed. The ICO must ensure that a reassessment and an IICSP update are performed:

- As warranted by the individual's condition but at least every 12 months after the Level I Assessment completion date;
- When there is a change in the individual's health status or needs;
- As requested by the individual, his/her caregiver or authorized representative, or his/her provider; and

The ICO will analyze utilization data of all individuals monthly to identify acuity and risk level changes. As acuity and risk levels change, reassessments will be completed as necessary and IICSP and interventions updated and documented in the ICBR.

The ICO is responsible to complete a reassessment as often as desired by the individual and update the IICSP with members of the ICT as needed. The ICO is encouraged to conduct reassessments in person.

7.6.F.2. LEVEL II REASSESSMENTS

Level II reassessments will be completed according to the reassessment timeframe of each assessment tool utilized. For assessments adopted at the time of enrollment, the next assessment date will follow the annual scheduled described above for each tool unless the individual has a significant change of conditioning requiring a new assessment.

For individuals receiving nursing facility level of care services, the reassessment must confirm that the individual continues to meet the Michigan Medicaid Nursing Facility LOCD standards. If the standards are not met, a new LOCD tool must be completed to allow the individual rights to an appeal. The ICO will initiate planning for transitioning



the individual to more appropriate supports and services. Reassessments will be documented in the ICBR and results will be used in the development of the IICSP.

7.7 CARE PLANNING

Individual Integrated Care and Supports Plan (IICSP)

The ICO Care Coordinator, individual, providers, and other ICT members develop a comprehensive, person-centered, written IICSP for each individual. The person-centered planning process must be conducted in-person unless the individual chooses otherwise. The individual may choose to participate in person-centered planning to the extent he/she desires.

Every individual must have an IICSP. The IICSP should be developed based on the outcome of the person-centered planning meeting unless the individual chooses not to participate and the refusal to participate is documented in the IICSP and ICBR. At a minimum the ICO Care Coordinator or Supports Coordinator must provide his/her contact information to the individual and re-visit the opportunity to participate in person-centered planning and development of the IICSP at the time of reassessment, a change of condition, or upon the individual's request.

The ICO must complete the initial IICSP within 90 calendar days of enrollment. Existing person-centered service plans or plans of care may be incorporated into the IICSP. The ICO must review the adopted plan with the individual to determine if revisions are necessary to address the individual's goals and meet the individual's needs. The IICSP must be contained in the ICBR and shared with the individual and the ICT.

The ICO must discuss advance directives with the individual including the choice to execute a directive, its incorporation in the IICSP, and assurance of provider knowledge of the individual's directive.

The IICSP must:

- Focus on supporting the individual to achieve personally defined goals in the most integrated setting;
- Be developed following MDHHS principles for person-centered planning;
- Include the individual's preferences for care, services, and supports;
- Include the individual's prioritized list of concerns, goals and objectives, and strengths;
- Include specific providers, supports and services including amount, scope, and duration;
- Include a summary of the individual's health status;
- Include the plan for addressing concerns or goals and measures for achieving the goals;
- Include person(s) responsible for specific interventions, monitoring, and reassessment; and
- Include the due date for the interventions and reassessment.

IICSP Monitoring

The ICO will review the individual's IICSP to ensure the IICSP continues to meet the individual's needs and is updated accordingly.



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- The ICO must review IICSPs of high-risk individuals least every 30 calendar days.
- The ICO must review IICSPs of moderate-risk individuals at least every 90 calendar days.
- The ICO must review IICSPs of low-risk individuals at least every 180 calendar days.

The ICO will make contact with the individual to inquire if the IICSP continues to meet the individual's needs. This contact may be telephonic, unless in-person contact is requested by the individual. The ICO must update the individual's IICSP at least annually and more frequently if conditions warrant, or if an individual requests a change.



SECTION 8 – CRITICAL INCIDENT REPORTING

The ICO must report critical incidents to MDHHS and other authorities as required by CMS and the State.

8.1 TYPES OF CRITICAL INCIDENTS THAT NEED TO BE REPORTED

ICOs must report the following:

- Exploitation
- Illegal activity in the home
- Medication Errors
- Neglect
- Physical Abuse
- Provider no shows
- Restraints, Seclusion, or restrictive interventions
- Sexual Abuse
- Suspicious or Unexpected Death
- Theft
- Verbal Abuse
- Worker consuming drugs or alcohol on the job



SECTION 9 – MI HEALTH LINK HCBS WAIVER

The MI Health Link HCBS waiver offers home and community-based services to allow MI Health Link individuals to remain in the community instead of an institution. MI Health Link individuals who require services through this waiver must apply to MDHHS and be approved for enrollment. ICOs or their subcontractors, according to a contractual agreement, must submit an application to MDHHS for review and approval. Waiver eligibility must be re-determined on an annual basis.

Waiver enrollment is limited to a certain number of individuals that has been approved by CMS.

9.1 APPLICATION PROCESS

When a MI Health Link individual is interested in participating in the MI Health Link HCBS waiver, the ICO must submit an application packet to MDHHS for review and approval prior to an individual participating in the waiver. Applications may be submitted to MDHHS electronically via the Waiver Support Application system or via hard copy paper format using U.S. Mail, United Postal Service, FedEx, or fax as directed by MDHHS.

The ICO will be notified by MDHHS of the outcome of the application review, approval, or rejection via telephone, email, U.S. Mail, or the electronic Waiver Support Application system.

9.2 PERSON-CENTERED PLANNING

The person-centered planning process and IICSP for MI Health Link HCBS waiver individuals must be compliant with the Home and Community-Based Services (HCBS) Final Rule (CMS-2249F; CMS- 2296-F) that was released by CMS on January 16, 2014. At a minimum, the IICSP must include the following components:

- The ICO must develop the IICSP before providing services.
- The individual must approve of all services in the service plan.
- The ICO must document individual approval and participation on the IICSP, including:
 - Individual's preferences for care, services, supports, residential settings, and non-residential settings.
 - Supports and services options that were discussed with the individual, and his/her (or legal representative's) choice of those services and providers.
 - When the individual selects controlled residential settings such as licensed AFC or HFA, the following must be included in the IICSP:
 - ◆ The chosen setting.
 - ◆ The individual's resources.
 - ◆ Whether or not the individual chooses to have a roommate as well as any specific preferences for roommates, bathroom schedules, etc.
 - ◆ Preference for engaging in community activities outside the home, and whether or not the individual needs assistance with arranging transportation, finding work, or otherwise getting involved in the community outside the home and how to make that happen.



- ◆ Personal safety risks and any interventions that may affect the individual's ability to engage in community activities outside the home without supervision.
- ◆ Any modifications to existing policy and procedure and home and community-based setting requirements (including HCBS Final Rule) at the home to accommodate an individual's assessed needs; indicate established timeframes for periodic review of these modifications.
 - Individual's health and safety risks.
 - Individual's prioritized list of concerns, goals and objectives, strengths.
 - Summary of the individual's health status.
 - The plan for addressing concerns or goals, actions for achieving the goals, and specific providers, supports and services, including amount, scope and duration.
- The individual's (or legal representative's) rights and choices of specific providers (and alternative providers, if necessary).
- A contingency (backup) plan for providers in the event of unscheduled absence of a caregiver, severe weather, or other emergencies.
 - Person(s) responsible for specific monitoring, reassessment, and evaluation of health and well-being outcomes.
 - Individual's informed consent.
 - Due date for interventions and reassessment.

The IICSP clearly identifies the types of services needed from both paid and non-paid providers of supports and services. The amount (units), frequency, and duration of each waiver service to be provided are included in the IICSP. The individual chooses the supports and services that best meet his/her needs and whether to use the option to self-direct applicable services or rely on a ICO Care Coordinator and/or LTSS Supports Coordinator to ensure the services are implemented and provided according to the IICSP. When an individual chooses to participate in arrangements that support self-determination, information, support and training are provided by the ICO Care Coordinator and/or LTSS Supports Coordinator and others identified in the IICSP and according to the Self-Determination Implementation Technical Advisory. When an individual chooses not to participate in self-determination, the ICO Care Coordinator or LTSS Supports Coordinator ensures that supports and services are implemented as planned. The ICO Care Coordinator and/or LTSS Supports Coordinators, as applicable, oversee the coordination of State Plan and waiver services included in the IICSP. This oversight ensures that waiver services in the IICSP are not duplicative of similar State Plan services available to or received by the individual.

9.3 HOME AND COMMUNITY-BASED RESIDENTIAL AND NON-RESIDENTIAL SETTINGS

The HCBS Final Rule (CMS-2249F; CMS-2296-F) applies to 1915(c) waiver programs. The ICO has been provided with the HCBS Final Rule Federal Register, CMS webinars, and other information regarding the rule. The ICO, and its subcontractors as appropriate, must be familiar with all aspects of the HCBS Final Rule as it applies to the MI Health Link HCBS waiver. All residential settings in which MI Health Link HCBS waiver individuals live must comply with the requirements of the HCBS Final Rule. Similarly, non-residential settings, such as Adult Day Program settings, must comply with the HCBS Final Rule. Residential and non-residential settings must be immediately compliant with the HCBS Final Rule for the



MI Health Link program. This compliance will be assessed prior to the individual's enrollment in the waiver. The ICO must utilize the standard statewide Provider Survey tool produced by MDHHS, and this survey must be conducted in-person with the provider and as directed otherwise by MDHHS. Licensed settings used for the Respite service do not need to be assessed unless the individual stays in the setting for more than 30 days.

9.4 SELF-DETERMINATION

Self-Determination provides MI Health Link HCBS waiver individuals the option to direct and control their own waiver services. For those MI Health Link HCBS waiver individuals who choose to participate in arrangements that support self-determination, the individual (or chosen representative(s)) has decision-making authority over providers of waiver services, including:

- Recruiting staff
- Referring staff to an agency for hiring
- Hiring staff
- Verifying staff qualifications
- Obtaining criminal history review of staff
- Specifying additional service or staff qualifications based on the individual's needs and preferences so long as such qualifications comply with those described in the 1915(c) waiver application approved by CMS, and any additional guidance provided by MDHHS
- Specifying how services are to be provided and determining staff duties consistent with the service guidelines as indicated in the CMS-approved waiver application and additional guidance provided by MDHHS
- Determining staff wages and benefits, subject to State and federal limits if applicable
- Scheduling staff and the provision of services
- Orienting and instructing staff in duties
- Supervising staff
- Evaluating staff performance
- Verifying time worked by staff and approving timesheets
- Discharging staff from providing services
- Reallocating funds among services included in the individual's budget
- Identifying service providers and referring for provider enrollment
- Substituting service providers
- Reviewing and approving provider invoices for services rendered

Budget development for individuals using arrangements that support self-determination occurs during the person-centered planning process and is intended to involve any persons chosen by the individual. Planning for the individual's IICSP precedes the development of the individual's budget so that needs and preferences can be accounted for without arbitrarily restricting options and preferences due to cost considerations. An individual's budget is not authorized until the individual and the ICO have agreed to



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the amount and its use. In the event that the individual is not satisfied with the authorized budget, he/she may reconvene the person-centered planning process. Fiscal Intermediary services are available through the waiver to help individuals more fully exercise control over their services.

At any time, the individual may modify or terminate the arrangements that support self-determination.

The individual, his/her chosen allies, the ICO Care Coordinator and LTSS Supports Coordinator must all work together to identify challenges and address problems that may be a barrier to a successful self-determination arrangement. The decision of an individual to terminate participation in self-determination does not alter the supports and services identified in the IICSP. When the individual no longer wishes to participate in self-determination, the ICO must assume responsibility for ensuring the provision of those services through its network of contracted provider agencies while still maintaining and honoring the individual's choice of providers to extent possible.

An ICO may terminate self-determination for an individual when problems arise due to the individual's inability to effectively direct supports and services. Prior to terminating a self-determination agreement (unless it is not feasible), the ICO informs the individual in writing of the issues that have led to the decision to terminate the arrangement. The ICO will continue efforts to resolve the issues that led to the termination.

9.5 WAIVER SUPPORT APPLICATION SYSTEM

The ICO must utilize the waiver management database in the Waiver Support Application (WSA) system for anything related to MI Health Link HCBS Waiver enrollments, application submission, slot management, and disenrollments. The ICO is required to submit a list of users for this system, and the ICO must keep the list updated on a regular basis as staff come onboard or leave. When approved users leave the organization, the organization must notify the appropriate person as directed by MDHHS.



SECTION 10 – CRIMINAL HISTORY REVIEWS

Each ICO and direct provider of home-based services must conduct a criminal history review through the Michigan State Police (ICHAT), at a minimum, for any paid or volunteer individuals who will be entering the individual's residence. The ICO and direct provider must have completed reference and criminal history reviews before authorizing the person providing services in an individual's residence. At a minimum, the scope of the reference and criminal history investigation is statewide.

ICOs and MDHHS will conduct annual reviews to ensure mandatory criminal history reviews have been conducted in compliance with direction given by MDHHS or otherwise required by federal and state law, policy or operating standards.



SECTION 11 – USE OF RESTRAINTS, SECLUSION, AND RESTRICTIVE INTERVENTIONS

Providers are prohibited from using methods of seclusion, restraint, and/or other restrictive interventions. MDHHS will conduct site reviews to ensure these methods are not used. ICO Care Coordinators and LTSS Supports Coordinators, as applicable, have the primary responsibility for identifying and addressing the use of seclusion, restraints, and/or restrictive interventions.



SECTION 12 – PROVIDER PARTICIPATION

Providers have the opportunity to participate in MI Health Link by joining the provider networks of the ICOs. ICOs are encouraged to contract with existing service providers for individuals eligible for and enrolling in the program to ensure continuity of care. Likewise, service providers are encouraged to participate in ICO networks to provide choice, continuity of care and high quality service. The ICO will be responsible for authorizing and paying for Medicare and Medicaid services. Additional information regarding how providers may participate in MI Health Link can be found on the MI Health Link website. (Refer to the Directory Appendix for website information.)



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SECTION 13 – MEDICAID POLICY

Current and future Medicaid policies are applicable to the Medicaid portion of the MI Health Link benefit package unless otherwise specified in this chapter or other policies or guidance.



SECTION 14 – QUALITY ASSURANCE

ICOs and PIHPs, as applicable, must comply with requirements set forth in the three-way contract, MI Health Link waiver applications approved by CMS, any other supporting documentation, and the contracts between the ICOs and PIHPs.



SECTION 15 – APPEALS

The three-way contract establishes individual notice and appeal rights that must be adhered to when any grievable or adverse action is taken by the ICO or contracted entities that would fall under the grievance or appeals processes available to individuals through Medicare and Medicaid guidelines.



SECTION 16 – OMBUDSMAN

ICOs and providers must work with the MI Health Link Ombudsman to resolve enrollment and service issues. ICOs must provide the Ombudsman contact information in their member materials.



NON-EMERGENCY MEDICAL TRANSPORTATION

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SECTION 1 – INTRODUCTION

This chapter applies to non-emergency medical transportation (NEMT) providers and authorizing parties. The Medicaid NEMT benefit is covered for Medicaid, MICHild, and Healthy Michigan Plan (HMP) beneficiaries, and for Children’s Special Health Care Services (CSHCS) beneficiaries who also have Medicaid coverage.

Federal law at 42 CFR 431.53 requires Medicaid to ensure necessary transportation for beneficiaries to and from services that Medicaid covers. The NEMT benefit must be administered to beneficiaries in an equitable and consistent manner.

Beneficiaries are assured free choice in selecting a Medicaid medical provider to render services. A beneficiary’s free choice of medical provider selection does not require the Medicaid program to cover transportation beyond the standards of coverage described in this policy in order to meet a beneficiary’s personal choice of medical provider.

Forms referenced in this chapter are accessed via the beneficiary’s case worker and are maintained on MI Bridges. The Medical Transportation Statement (MSA-4674) is also available on the Michigan Department of Health and Human Services (MDHHS) website. (Refer to the Directory Appendix for website information.)



SECTION 2 – COMMON TERMS

Authorizing Party	An affiliated entity of the Medicaid program (e.g., local MDHHS office or Medicaid-contracted transportation broker) responsible for verifying Medicaid eligibility, maintaining a network of transportation subcontractors, and scheduling the least-costly mode of appropriate transportation to medical appointments/services.
Commercial Provider	A transportation provider who uses a motor vehicle that belongs to a company or corporation to provide transportation services to a beneficiary.
Daily Long Distance Trip	A daily trip that exceeds 50 miles one-way from the beneficiary’s home.
Demand Response (Dial A Ride) Public Transportation	Public transportation characterized by the following: <ul style="list-style-type: none"> ▪ The vehicles do not operate over a fixed route or on a fixed schedule except, perhaps on a temporary basis, to satisfy a special need, and ▪ Typically, the vehicle may be dispatched to pick up several passengers at different pick-up points before taking them to their respective destinations and may even be interrupted en route to these destinations to pick up other passengers.
Fixed Route Public Transportation	Services provided on a repetitive, fixed schedule basis along a specific route with vehicles stopping to pick up and deliver passengers to specific locations.
Individual With a Vested Interest	A transportation provider who is a relative or friend of a beneficiary and who has a personal stake or interest in the livelihood of a beneficiary.
Long-Term Care Resident	A beneficiary who resides in a Medicaid-certified nursing facility, State Veterans’ Home, county medical care facility, or hospital long-term care unit.
Medi-Van	A vehicle owned by a commercial or nonprofit provider used to transport a beneficiary who is able to ambulate and transfer into and out of the vehicle, but requires door-to-door or curb-to-curb service due to their medical condition. Drivers of these vehicles are expected to assist and escort the beneficiary. This definition also includes demand response paratransit transportation services.
Medically Necessary Attendant	An individual, other than the driver of the vehicle or an individual with a vested interest, who assists a beneficiary due to their physical, mental, or developmental status on trips to and from a service or appointment that Medicaid covers.
Nonprofit Provider	A transportation provider who utilizes a motor vehicle that belongs to an entity that has been organized to carry out a charitable, educational, religious, or scientific purpose, and meets specific tax-exempt purposes to provide transportation services to a beneficiary.
Paratransit Transportation	Wheelchair-accessible, demand response services provided by public transportation agencies.
Prolonged Treatment	Medical treatment that is required to treat a medical condition which lasts more than 12 weeks.



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Public Transportation Provider	An individual employed by a public entity that provides regular or special continuing transportation available for use by the general public. This does not include school bus, charter, or intercity bus or passenger rail transportation.
Round Trip	When a beneficiary is transported from their residence, or another location, to a Medicaid-covered service and then returned to their original point of origin.
Transportation Provider	An individual (e.g., an employee of a public, commercial, or nonprofit transportation entity, volunteer driver, individual with a vested interest, or medically necessary attendant) who provides transportation services to beneficiaries.
Trip	One-way transportation of a beneficiary from their residence, or another location, to a Medicaid-covered service.
Unloaded Mileage	Mileage traveled when the beneficiary is not in the vehicle.
Volunteer Driver	A transportation provider who utilizes their personal motor vehicle to provide NEMT services to a beneficiary. Volunteer drivers do not have a personal stake or interest in the livelihood of the beneficiary.
Waiting Time	The time that a vehicle is waiting at a Medicaid-enrolled provider's facility in order to transport the beneficiary to another location during the same trip.
Wheelchair Lift Equipped Vehicle	A vehicle owned by a commercial or nonprofit provider that is equipped for a beneficiary who requires a wheelchair and that provides door-to-door service due to their inability to ambulate. Drivers of these vehicles are expected to assist and escort the beneficiary. This definition also includes demand response paratransit transportation services.



SECTION 3 – TRANSPORTATION AUTHORIZATION [CHANGES MADE 4/1/20]

Medicaid authorizes fee-for-service (FFS) NEMT services via local MDHHS offices, except in Wayne, Oakland, and Macomb counties. FFS transportation services in Wayne, Oakland, and Macomb counties are administered through a contracted transportation broker. (Refer to the Directory Appendix for transportation broker information.)

The Medicaid program contracts with Medicaid Health Plans (MHPs) and Integrated Care Organizations (ICOs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. MHPs and ICOs are responsible for providing NEMT services to their enrollees for all services covered under the managed care contract. (For additional information, refer to the Medicaid Health Plans and MI Health Link chapters of this manual.)

MHPs and ICOs may have different prior authorization and documentation requirements from those described in this chapter. Providers, beneficiaries or authorizing parties should contact the specific MHP/ICO for further information regarding NEMT. Transportation services for managed care enrollees may vary depending on the beneficiary's benefit plan. For additional information regarding benefit plans, refer to the Beneficiary Eligibility chapter of this manual.

Reimbursement for special transportation requires a completed, original Medical Verification for Transportation (DHS-5330) to serve as documentation of medical need and must be retained in the beneficiary's file. Special transportation includes medically needing a wheelchair lift-equipped vehicle, Medi-Van vehicle, attendant, prior authorization, and other special circumstances supported by medical documentation. (For prior authorization requirements, refer to the Prior Authorization (PA) section of this chapter.) The DHS-5330 must be completed annually. A local MDHHS office can authorize NEMT without a DHS-5330 for beneficiaries who do not require special transportation. Additionally, verification of medical need is not required when the transportation is to obtain medical evidence (i.e., employability, incapacity, or disability) or to meet the needs of children for protective services. **(text added per bulletin MSA 19-38)**

An initial verification of medical need for special transportation is required by the beneficiary's primary care physician (PCP). An original, completed DHS-5330 signed by the beneficiary's PCP, or a physician's assistant or nurse practitioner working under the supervision of the PCP, serves as documentation of medical need and must be retained in the beneficiary's file. In situations when a beneficiary's PCP, or a physician's assistant or nurse practitioner working under the supervision of the PCP, is unavailable and unable to complete an original DHS-5330 in a timely manner, another licensed provider may complete the form. Example providers include, but are not limited to, a physician specialist, clinical nurse specialist, certified nurse midwife, registered nurse, social worker, dentist, and other licensed providers. The licensed provider must be knowledgeable about the beneficiary's medical needs, capable of accurately completing the form, and providing direct medical, behavioral or dental services to the beneficiary. **(revised per bulletin MSA 19-38)**

In situations when a completed, original DHS-5330 cannot be secured prior to a beneficiary's scheduled Medicaid-covered appointment, authorizing parties may approve and reimburse all necessary NEMT services if the DHS-5330 is completed and returned to the authorizing party within 10 business days of the appointment. Allowable circumstances include, but are not limited to, the beneficiary's first trip to their PCP or medical appointment, or an inability by the beneficiary's physician's office to complete the form and secure the necessary signatures in a timely manner.



Authorizing parties must retain the completed, original DHS-5330 in the beneficiary's file and make it available upon request. Authorizing parties are responsible for verifying Medicaid eligibility, maintaining a network of transportation subcontractors, and scheduling the least-costly mode of appropriate transportation to medical appointments/services.

The beneficiary's need for NEMT must be evaluated before services are authorized. This includes assessing all of the following:

- The beneficiary's eligibility;
- The transportation requested is for a service Medicaid covers; and
- The beneficiary has no other means of transportation available. Availability is not dependent on whether the beneficiary previously provided their own transportation.



SECTION 4 – TRANSPORTATION PROVIDER QUALIFICATIONS

Procedures must be in place to document and verify that vehicles used by providers meet the safety needs of the beneficiary including, but not limited to:

- Seatbelts and child safety seat requirements, if appropriate; and
- Functional heating and air conditioning.

NEMT individual and agency providers must consent to required screenings to determine eligibility in order to receive Medicaid reimbursement for providing NEMT services. Individual providers are those persons who provide transportation to a Medicaid beneficiary they are not related to and include, but may not be limited to, volunteer drivers or friends, colleagues, or neighbors of a Medicaid beneficiary. Provider screening is conducted through the CHAMPS provider enrollment process. (Refer to the General Information for Providers chapter of this manual for additional information.)

Beneficiaries who transport themselves or individuals providing NEMT services to a Medicaid-enrolled family member will not be required to enroll in CHAMPS and will be exempted from mandated provider screening requirements. Self-attestation is sufficient when determining the familial relationship between the driver and the Medicaid beneficiary. Foster parents who transport their foster children are not required to enroll in CHAMPS and are exempt from mandated provider screening requirements. Demand-responsive public transit services and commercially hailed or street taxicabs are also exempt from CHAMPS enrollment and screening requirements.

4.1 BENEFICIARIES [SUBSECTION ADDED 4/1/20]

The minimum requirements for individuals who transport themselves include:

- Valid driver's license appropriate to the class of vehicle being operated;
- Compliant with Sections 304 and 319 of the Michigan Vehicle Code related to restricted driver's licenses as issued by the Michigan Secretary of State (MDHHS reserves the right to deny or revoke reimbursement of a provider due to a restricted or suspended license);
- Motor vehicle insurance; and
- Adherence to all public laws, ordinances, and regulations applicable to drivers and the vehicles that are used.

Authorizing parties must confirm a beneficiary's eligibility to receive mileage reimbursement through an established process, including but not limited to, documented verbal attestation. **(text added per bulletin MSA 19-38)**

4.2 VOLUNTEER DRIVERS [RE-NUMBERED 4/1/20]

The minimum volunteer driver requirements are:

- 18 years of age and older;
- Cannot physically reside in the same household as the beneficiary they are transporting;
- Must be able to read and communicate effectively in English;
- Valid driver's license appropriate to the class of vehicle being operated;



- Compliant with Sections 304 and 319 of the Michigan Vehicle Code related to restricted driver's licenses as issued by the Michigan Secretary of State (MDHHS reserves the right to deny or revoke enrollment of a provider due to a restricted or suspended license);
- Motor vehicle insurance;
- Adherence to all public laws, ordinances, and regulations applicable to drivers and the vehicles that are used;
- Compliant with all applicable confidentiality laws as required by the Medicaid program; and
- Compliant with all provider enrollment background and screening requirements as required by the Medicaid program. (Refer to the General Information for Providers Chapter of this manual for additional information.)

4.3 INDIVIDUALS WITH A VESTED INTEREST [RE-NUMBERED 4/1/20]

The minimum requirements for individuals with a vested interest are:

- Valid driver's license appropriate to the class of vehicle being operated;
- Compliant with Sections 304 and 319 of the Michigan Vehicle Code related to restricted driver's licenses as issued by the Michigan Secretary of State (MDHHS reserves the right to deny or revoke enrollment of a provider due to a restricted or suspended license);
- Motor vehicle insurance;
- Adherence to all public laws, ordinances, and regulations applicable to drivers and the vehicles that are used;
- Compliant with all applicable confidentiality laws as required by the Medicaid program; and
- Compliant with all provider enrollment background and screening requirements as required by the Medicaid program. (Refer to the General Information for Providers Chapter of this manual for additional information.)

4.4 COMMERCIAL AND NONPROFIT PROVIDERS [RE-NUMBERED 4/1/20]

The minimum requirements for commercial and nonprofit providers are:

- 18 years of age and older;
- Must be able to read and communicate effectively in English;
- Valid driver's license appropriate to the class of vehicle being operated;
- Compliant with Sections 304 and 319 of the Michigan Vehicle Code related to restricted drivers licenses as issued by the Michigan Secretary of State (MDHHS reserves the right to deny or revoke enrollment of a provider due to a restricted or suspended license);
- Maintenance of all necessary licensure and certification required by all transportation public laws, ordinances, and regulations applicable to the transportation provider, including any that may require liability insurance;
- Compliant with the Americans with Disabilities Act (ADA) of 1990, as amended;
- Operation of vehicles that meet the safety and medical needs of the beneficiary;



- Compliant with any state or federal statutes applicable to commercial and nonprofit transportation providers;
- Compliant with all applicable confidentiality laws as required by the Medicaid program; and
- Compliant with all provider enrollment background and screening requirements as required by the Medicaid program. (Refer to the General Information for Providers Chapter of this manual for additional information.)

4.5 PUBLIC TRANSPORTATION PROVIDERS [RE-NUMBERED 4/1/20]

The minimum requirements for public transportation providers are:

- 18 years of age and older;
- Must be able to read and communicate effectively in English;
- Commercial Driver's License (CDL) if operating a vehicle having a gross vehicle weight of 26,001 pounds or more, or designed to transport 16 or more people (including driver);
- Compliant with Michigan state statutes: Michigan Motor Bus Transportation Act of 1990, as amended; Michigan Motor Carrier Safety Act of 1963, as amended; and Michigan Vehicle Code, as amended;
- Compliant with the Americans with Disabilities Act (ADA) of 1990, as amended;
- Operation of vehicles that meet the safety and medical needs of the beneficiary;
- Compliant with all applicable confidentiality laws as required by the Medicaid program; and
- Compliant with all provider enrollment background and screening requirements as required by the Medicaid program. (Refer to the General Information for Providers Chapter of this manual for additional information.)



SECTION 5 – COVERED SERVICES

NEMT expenses, regardless of whether there is a corresponding medical claim on the date of service, may be covered for trips to and from:

- Treatment Medicaid covers (one-time or ongoing);
- Ancillary service providers (e.g., pharmacies, durable medical equipment, prosthetics, orthotics, and supplies [DMEPOS] providers) to obtain a service or item Medicaid covers;
- Medical care, treatment or services that have been prior authorized;
- Appointments to obtain medical evidence (for eligibility verification purposes only); and
- Facilities providing services Medicaid covers that do not charge for care.

Transportation from a service Medicaid covers is only covered when it is from the provider's location to the beneficiary's residence or to another service Medicaid covers. The least costly mode of transportation appropriate for the beneficiary's medical needs must be used.

Medicaid authorizes and reimburses transportation providers directly for the following NEMT services:

- Long-term lodging for approved transplant hospitals.
- Transportation to and from pregnancy-related services for Medicaid beneficiaries enrolled in the Maternity Outpatient Medical Services (MOMS) program.
- Transportation to and from day treatment provided by a Community Mental Health Services Program (CMHSP) (as part of its treatment package) for children enrolled in the Children's Waiver Program (CWP).

Transportation providers and beneficiaries may be reimbursed for mileage, tolls, parking fees, approved meals and lodging expenses, Medi-Van and wheelchair lift equipped transportation, and medically necessary attendants. The transportation provider or beneficiary must submit a complete, original MSA-4674 (Medical Transportation Statement) for all trip-associated costs to the authorizing party to receive reimbursement. NEMT reimbursement must reflect the total incurred cost to the transportation provider(s) and to the beneficiary, and must be verified with original, itemized, unaltered receipts. All receipts must be legible and attached to the MSA-4674. Transportation providers must be enrolled in CHAMPS on the date of service to receive Medicaid NEMT reimbursement unless the provider is exempt from enrollment.

In order to assure appropriate reimbursement for NEMT, MDHHS maintains a database of provider rates which is available on the MDHHS website. The database is reviewed and updated as applicable. (Refer to the Directory Appendix for website information.) NEMT providers must bill MDHHS the usual and customary fee charged to the public. Customary charge means the amount the provider charges another third party payer or the general public (except in cases where the general public receives free or reduced charges) for the same or a similar service. This definition does not include negotiated or contracted payment rates. If the provider renders a covered service to a beneficiary that the provider offers for free or for a reduced fee to the general public, the provider may only bill Medicaid up to that customary charge as long as all other Medicaid requirements are met.



5.1 MILEAGE [CHANGE MADE 10/1/20]

The Medicaid program covers the least-costly available mode of transportation suitable to the beneficiary's medical condition. The following modes of transportation are commonly utilized:

- Commercial and nonprofit transportation
- Fixed route, demand response and deviated route public transportation
- Volunteer drivers
- Individuals with a vested interest
- Beneficiaries providing their own NEMT in their personal vehicle

Volunteer drivers will not be reimbursed for driving a vehicle owned by the beneficiary or a member of the beneficiary's family.

When available, medical providers or entities that offer transportation or medical delivery services at no charge (e.g., prescription delivery services offered by the beneficiary's pharmacy) should be utilized.

Mileage is reimbursed according to transportation provider type at the appropriate rate as indicated on the MDHHS NEMT Database. Total round-trip mileage must be rounded up to the nearest mile and must be verifiable using an online mapping service or a Global Positioning System device.

(text removed per bulletin MSA 20-47)

5.2 MEALS

Authorized meals for beneficiaries, volunteer drivers, or individuals with a vested interest are reimbursed at cost or at the maximum allowable amount, whichever is less. To be entitled to meal reimbursement, meals must meet one of the following:

- For breakfast: The vehicle must depart before 6:00 AM and must return after 8:30 AM.
- For lunch: The vehicle must depart before 11:30 AM and must return after 2:00 PM.
- For dinner: The vehicle must depart before 5:30 PM and must return after 8:00 PM.

A vehicle's departure and return times cannot include non-medically related travel including, but not limited to, personal errands or business. Meals are not eligible for reimbursement if they are purchased within the requester's official city of residence.

Meal reimbursement requires original, itemized, unaltered receipts which must include the business name, address, date, time, itemized list of items purchased with cost of each item. However, if the restaurant or place of business omits any necessary items from their receipt, the information may be hand-written by the individual incurring that expense.

Bulk purchases of groceries and shared meals are not reimbursable. Meals must be purchased and consumed on the day and within the time of travel. Reimbursement for alcoholic beverages is not



permitted. If a lodging reservation or other travel includes a complimentary breakfast or other meals, Medicaid does not provide any additional reimbursement for that meal.

5.3 FEES AND TOLLS

Travel-related fees and tolls (e.g., parking, toll road, and bridge fare) are reimbursed at actual cost and require original, unaltered receipts. In situations when it is necessary for a Medicaid beneficiary to traverse the Mackinac Bridge and the original, unaltered receipt(s) is unavailable, the authorizing party may still approve reimbursement for the toll when supported by documentation on the MSA-4674. Documentation must include the origin and destination points, and a notation regarding the reason an original receipt is unavailable. This exception is not intended to eliminate the requirement that necessary Mackinac Bridge tolls require original, unaltered receipts and may be subject to post-payment review. Per leg reimbursement for passenger vehicles crossing the Mackinac Bridge will be consistent with rates included on the Mackinac Bridge Authority website.

5.4 LODGING

Medically necessary overnight stays that include meals and lodging may be authorized for a beneficiary and transportation provider for up to 14 consecutive nights. In addition, one medically necessary attendant (or individual with a vested interest) may be authorized if documented by the beneficiary's provider on the DHS-5330. Medically necessary overnight stays beyond 14 nights require prior authorization (PA) from the MDHHS Program Review Division (PRD). (Refer to the Directory Appendix for contact information.)

Medically necessary overnight stays which include meals and lodging at a Level IV Neonatal Intensive Care Unit (NICU) may be authorized for a beneficiary, a transportation provider, and if documented by the beneficiary's provider on the DHS-5330, one medically necessary attendant (or individual with a vested interest) for no more than 14 nights. Necessary overnight stays at a Level IV NICU beyond 14 nights require PA from PRD.

The least expensive, sufficiently maintained lodging available must be utilized. The availability of nonprofit accommodations (i.e., Ronald McDonald House or accommodations available through the visiting medical facility) must be explored before commercial lodging is considered. Lodging expenses are reimbursed at cost or the maximum allowable amount, whichever is less. Original, itemized, unaltered receipts are required. Reimbursement beyond an accommodation's suggested donation amount or per night rate as charged to the public will not be made.

5.5 SPECIAL ALLOWANCES

Special allowances (i.e., wheelchair lift-equipped or Medi-Van vehicles, or medically necessary attendants) are reimbursed at the rate listed on the MDHHS NEMT Database. The beneficiary's physician must document the medical necessity of all special allowances on the DHS-5330.



5.5.A. WHEELCHAIR LIFT-EQUIPPED VEHICLES

Beneficiaries may be eligible for specialized NEMT provided by wheelchair lift equipped vehicles when at least one of the following conditions is met:

- Beneficiary is wheelchair dependent; or
- Beneficiary is medically dependent on life sustaining equipment which cannot be accommodated by standard transportation.

Drivers of wheelchair lift equipped vehicles are expected to assist and escort the beneficiary.

5.5.B. MEDI-VAN VEHICLES

Beneficiaries may be eligible for specialized NEMT provided by Medi-Van vehicles when they require door-to-door or curb-to-curb assistance. Drivers of Medi-Van vehicles are expected to assist and escort the beneficiary.

5.5.C. MEDICALLY NECESSARY ATTENDANTS

Beneficiaries may be eligible to receive assistance from one attendant in addition to the driver of a wheelchair lift equipped or Medi-Van vehicle. The attendant must be medically necessary due to the beneficiary's physical, mental, or developmental status. If more than one attendant is needed, prior authorization is required. For additional information, refer to the Prior Authorization (PA) section of this chapter.

5.6 HOSPITAL FACILITY MEAL AND LODGING REIMBURSEMENT

Some hospital facilities (e.g., University of Michigan Health System [Michigan Medicine]) provide advance expenses for meals or lodging on a per diem basis to Medicaid beneficiaries securing inpatient or outpatient treatment at their facility and their medically necessary attendant (or individual with a vested interest). These facilities seek reimbursement directly from an authorizing party or local MDHHS office after the treatment's end. For these facilities to receive reimbursement of their advance expenses, they must provide to the local MDHHS office, or authorizing party, an invoice or general authorization of services documenting the name of the facility, the name of the Medicaid beneficiary, the date(s) of service, the service(s) requesting reimbursement (i.e., meals or lodging), and the cost of each service. Requests made by the facilities for reimbursement must be received by the local MDHHS office, or authorizing party, within 12 months of the incurred expense. The current maximum per-day rates for these services are indicated on the MDHHS NEMT Database.



SECTION 6 – MANAGED CARE PROGRAMS

The Medicaid program contracts with Medicaid Health Plans (MHPs) and Integrated Care Organizations (ICOs), selected through a competitive bid process, to provide services to beneficiaries. These entities are responsible for providing NEMT services to their enrollees for all services covered under their contract. (For additional information, refer to the Medicaid Health Plans and the MI Health Link chapters of this manual.)

For services provided to managed care enrollees in an FQHC, the MHP covers NEMT when:

- the service is covered under the MHP contract and the FQHC is in the MHP’s provider network; or
- the MHP has prior authorized the FQHC for the service.

MHPs and ICOs may have different prior authorization and documentation requirements from those described in this chapter. Providers, beneficiaries or authorizing parties should contact the specific MHP or ICO for further information regarding NEMT for their beneficiary. Transportation services for these enrollees may vary depending on the beneficiary’s benefit plan. For additional information regarding benefit plans, refer to the Beneficiary Eligibility chapter of this manual.

If a beneficiary was admitted to an inpatient hospital setting prior to the date of enrollment into an MHP or ICO, that entity will not be responsible for the inpatient stay or any travel-related expenses (e.g., miles, meals, or lodging) incurred by the beneficiary or transportation provider until the beneficiary’s date of discharge. This includes transportation expenses incurred as a result of the beneficiary’s return trip from the hospital to their residence or other outpatient setting. The MHP or ICO will be responsible for all care, including travel expenses, from the date of discharge forward (excluding expenses incurred as result of the beneficiary’s return trip to their residence).

For beneficiaries whose MHP or ICO enrollment status has changed, transportation may be authorized and reimbursed retroactively in the following situations:

- The beneficiary’s Medicaid eligibility was made retroactive, and the beneficiary received NEMT during the retroactive eligibility time period; or
- Transportation was authorized while enrolled in an MHP or ICO, and then the beneficiary was disenrolled retroactively by the program and enrolled into FFS.

MDHHS contracts with dental health plans (DHPs) for the administration of dental services for Healthy Kids Dental (HKD) beneficiaries. The DHP is responsible for providing, arranging, and reimbursing covered dental services to enrolled Medicaid beneficiaries. Providers must contact the DHP for specific information about covered HKD benefits. (For additional information about HKD, refer to the Dental chapter of this manual.) Local MDHHS offices, except in Wayne, Oakland, and Macomb counties, are responsible for providing NEMT services to and from DHP covered dental services. A contracted transportation broker is responsible for providing NEMT services to and from DHP covered dental services in Wayne, Oakland, and Macomb counties.



SECTION 7 – PRIOR AUTHORIZATION (PA)

Transportation may require PA in certain situations. The PA request must be submitted in writing before the service is provided unless an urgent situation exists and the circumstances are documented. Payment authorization will not be given for PA requests submitted more than 30 days after the service is provided. The PA request, along with the DHS-5330, must be submitted to the PRD for review. (Refer to the Directory Appendix for contact information.) Prior authorization may be requested for up to six months for prolonged treatment requiring multiple transports.

Reimbursement for travel expenses related to the following situations requires PA:

- All travel to and from out-of-state/beyond borderland medical providers. (Refer to the Out of State/Beyond Borderland Providers subsection of the General Information for Providers chapter of this manual for additional information.);
- Transportation reimbursement requests for medical care outside a beneficiary's community when comparable care is available locally;
- Meals and lodging for overnight stays if the medical facility is within 50 miles of the beneficiary's residence;
- Necessary meals and lodging for overnight stays beyond 14 consecutive nights;
- Requests for advance payment of travel costs; and
- Travel expenses for two or more individuals with a vested interest or medically necessary attendants.

The PA request must include:

- Beneficiary name and Medicaid identification number
- Case number
- Beneficiary address
- Explanation of medical necessity of the services requiring PA
- Travel origin and destination
- Effective travel date(s)
- Diagnosis
- Name and telephone number of the individual requesting PA
- Documentation supporting the request



Based on the documentation submitted, the PA request is either approved, denied, or returned for more information. Authorizing parties are informed of the decision in writing, and a copy of the decision must be retained in the beneficiary's file. The authorizing party must then immediately inform the transportation provider and beneficiary of the approval or denial of the PA request. Approval of a PA does not guarantee beneficiary eligibility or payment. It is the authorizing party's responsibility to verify beneficiary eligibility for the date of service prior to NEMT services being rendered.



SECTION 8 – SPECIAL SITUATIONS

8.1 UNLOADED MILEAGE

Unloaded mileage incurred by commercial and nonprofit providers is not reimbursable by the Medicaid program.

8.2 MINORS TRAVELING ALONE

The following travel circumstances apply for minor (under 18 years of age) beneficiaries:

- Children under 12 years of age must be escorted to medically necessary appointments by a parent, foster parent, caregiver or legal guardian.
- For children between the ages of 12 and 18 years, a consent letter signed by a parent, foster parent, caregiver or legal guardian is required for a child to be transported without accompaniment unless access to the service does not require parental consent by the Medicaid program.

The above policy is waived for beneficiaries who have been emancipated or are seeking transportation for health care services for which a minor is legally able to consent (i.e., pregnancy-related, sexually transmitted/venereal disease, HIV/AIDS, substance use disorder, or outpatient CMHSP care).

8.3 MEDICAL REVIEW TEAM APPOINTMENTS

Transportation is a Medicaid-covered benefit and may be authorized for beneficiaries seeking financial or medical assistance due to a disability or blindness. Transportation is limited to one trip for examination and one trip per Disability Determination Services recommendation. A completed DHS-49-F (Medical – Social Questionnaire) serves as documentation and must be retained in the beneficiary's file.



SECTION 9 – REFERRALS

An NEMT referral is not considered a denial of transportation and, as such, a DHS-301 (Medical Transportation Notice) must not be issued when an NEMT referral is made.

The following circumstances are considered referrals:

- Referring a beneficiary to their MHP (for additional information, refer to the Managed Care Programs section of this chapter);
- Referring a beneficiary to the CMHSP; and
- Referring a beneficiary to medical providers who bill Medicaid directly for services (for additional information, refer to the Covered Services section of this chapter).



SECTION 10 – DENIALS AND BENEFICIARY APPEALS

Beneficiaries who have Medicaid coverage have a right to an administrative hearing when services have been denied, reduced, changed or terminated. When a request for NEMT is denied, a beneficiary will be notified with a written denial notice (DHS-301), provided by the authorizing party, which explains the reason for the negative action and informs the beneficiary of their right to appeal. The following requirements must also be met when a beneficiary is denied transportation services:

- The DHS-301 and postage-paid return envelope must be mailed to the beneficiary within one business day of the service being denied;
- A copy of the DHS-301 must be kept in the beneficiary's file and made available upon request; and
- An employee with knowledge of the denial must be available to testify at an administrative hearing, if required.

The beneficiary or beneficiary's authorized representative may request an administrative hearing. The Michigan Office of Administrative Hearings and Rules (MOAHR) arranges and conducts the appeal process. Any questions regarding the appeal process should be directed to MOAHR. (Refer to the Directory Appendix for contact information.)



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SECTION 11 – NON-COVERED SERVICES

The following transportation services are not reimbursable:

- Waiting time;
- Trips that were provided prior to approval from the authorizing party;
- Multiple trips for a single Medicaid service;
- When a beneficiary failed to keep their appointment;
- Trips to and from services that are not covered (e.g., grocery store, non-Medicaid covered medical services);
- Routine medical care outside a beneficiary's community when comparable care is available locally, unless prior authorized;
- Transportation to and from services for individuals who have not met their spend-down;
- Expenses for services that have already occurred;
- Services for long-term care beneficiaries. Routine, non-emergency medical transportation provided for long-term care residents in a van or other non-emergency vehicle is included in the facility's per diem rate. This includes transportation for medical appointments, dialysis, therapies, or other treatments not available in the facility. (Refer to the Nursing Facility Coverages chapter of this manual for additional information regarding NEMT for long-term care beneficiaries);
- Transportation for managed care program enrollees for services covered under the program contract (refer to the Managed Care Programs section of this chapter for additional information); and
- Transportation for services provided in FQHCs.



NURSING FACILITY

This chapter is comprised of three parts:

The **COVERAGES** portion of the chapter outlines nursing facility requirements for beneficiary eligibility and admission, for providing services, and for informing beneficiaries of their rights and responsibilities.

The **CERTIFICATION, SURVEY, & ENFORCEMENT APPENDIX** includes information regarding Medicaid certification of nursing facilities, staff certification, the survey process, and enforcement remedies.

The **COST REPORTING & REIMBURSEMENT APPENDIX** contains Medicaid policy pertaining to nursing facility ownership, reimbursement, costs, and financial reporting.



NURSING FACILITY COVERAGES

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SECTION 1 – GENERAL INFORMATION

This chapter discusses Medicaid nursing facility coverage which is intended to assist beneficiaries in attaining or maintaining the highest practical physical, mental, and psychosocial well-being and maximize independence and decision-making. The chapter outlines nursing facility requirements for beneficiary eligibility and admission, for providing services, and for informing beneficiaries of their rights and responsibilities.

Nursing facilities provide services to many of the state’s most vulnerable citizens. Medicaid, as the primary payer for beneficiaries who reside in nursing facilities, adheres to all State and Federal regulations that govern care provided in these facilities. Governing regulations include, but are not limited to:

- Americans with Disabilities Act (ADA)
- 42 CFR §431, §438, §440, §441, §448, §483, §485, §488
- State Medicaid Operations Manual
- Medicare Catastrophic Coverage Act of 1988, Public Law 100-360
- Certificate of Need Commission Act 368 of 1978, as amended – Part 222
- Social Security Act
- Omnibus Reconciliation Act of 1987 (Public Law 100-203), 1988, 1989, 1990, and 1994
- Michigan Medicaid State Plan

Only those services covered by the Medicaid Program, as outlined in this chapter, are reimbursable. Included is a full description of:

- Covered Services:
 - Services covered by the facility’s per diem rate; and
 - Ancillary services that must be billed separately by the service provider.
- Non-Covered Services that the beneficiary may purchase with their patient-pay amount.

A Medicaid-certified nursing facility is defined as a nursing home, State Veterans’ Home, county medical care facility, or hospital long-term care unit with Medicaid certification. Also included are swing beds as defined in the Federal State Operations Manual (SOM) and/or State Medicaid Policy.

Beneficiary is defined as a Medicaid beneficiary, or a person legally sanctioned to make medical decisions on his behalf (i.e., guardian, conservator, activated Durable Power of Attorney).

Resident is defined as a nursing facility resident (irrespective of payer source) or a person legally sanctioned to make medical decisions on his behalf (i.e., guardian, conservator, activated Durable Power of Attorney).

Individual, as used in this chapter, means any person.



SECTION 2 – MEDICAID HEALTH PLAN

The Medicaid Health Plan (MHP) is responsible for restorative or rehabilitative care in a nursing facility up to 45 days in a rolling 12-month period. If nursing facility services will exceed this coverage, the health plan may initiate the disenrollment process by submitting the Request for Disenrollment Long Term Care form (MSA-2007). The nursing facility may bill Medicaid after the disenrollment is processed.

Beneficiaries who reside in a nursing facility are excluded from subsequent enrollment in a MHP. If a beneficiary is in a facility prior to enrollment in a health plan and the nursing facility does the admission record in CHAMPS correctly, CHAMPS will automatically remove the health plan and set the NH benefit plan.



SECTION 3 – QUALITY

MDHHS is committed to a quality long-term care system that supports people with long-term care needs, regardless of the setting in which the individual receives those services, including nursing facilities, supported living settings, and their own home. Medicaid supports a system that moves away from the traditional medical model for care to one of enhanced beneficiary participation. Nursing facilities with Medicaid certification are expected to assess and plan care with resident participation and to provide services in ways that promote and support person-centered planning and quality service delivery.

3.1 QUALITY INDICATORS

Quality is indicated by the following components:

- Regular, ongoing, and systematic monitoring and revision of individualized plans of care, progress and outcomes by the beneficiary and his support system. In order to participate, beneficiaries may require support, such as regular opportunities and assistance in reviewing key considerations. Planning results should be documented in ways that are meaningful to the beneficiary and useful to people with responsibilities for implementing the plan.
- Risk and safety concerns are considered and plans developed to minimize risk of harm while promoting independence and safety.
- Behavioral interventions and medication management are used only when necessary and are appropriately managed and monitored.
- Care coordination must support the individual's participation in his care.
- Support for personal responsibility and community relationships that avoid the unintended and detrimental consequences of organizational involvement. Facilities should minimize the disempowerment of beneficiaries or displacement of family members by professional decision-makers and/or service providers, assume the beneficiary is competent and capable of participating in his relationships and the community, and provide assistance and support only when there are unmet needs.
- Individual freedom to exercise civic rights and decision-making authority exists to the maximum extent possible.
- Individuals are free to exercise their due process and grievance rights, and are provided the information necessary to do so.
- Individuals and their support system express satisfaction and the care leads to positive outcomes.
- Diverse cultural and ethnic backgrounds are supported.
- A system of continuous quality improvement that includes input from residents and families.

Current models that utilize person-centered planning and introduce the systems/culture change to support ongoing quality in nursing facilities include, among others, The Eden Alternative™, Wellspring™, and Gentlecare™.



3.2 QUALITY OF LIFE

Nursing facilities must provide services for residents in a manner and in an environment that promotes maintenance or enhancement of the resident's quality of life. Elements of quality of life include dignity, self-determination, participation in community life and in other activities, participation in resident and family groups, and accommodation of needs through the end of life. Quality of life is defined, measured, and evaluated by residents and their support systems, and may include quality of care outcomes.

3.3 QUALITY OF CARE

Nursing facilities must meet the needs of residents in compliance with State and Federal laws, rules, codes, and established clinical guidelines and practices.

Complaints regarding the quality of care in any Michigan nursing facility can be made to the Health Facility Complaint Line. (Refer to the Nursing Facility Section of the Directory Appendix for contact information.)



SECTION 4 – BENEFICIARY RIGHTS

All nursing facility residents have the right to:

- A dignified existence;
- Self-determination; and
- Communication with, and access to, persons and services inside and outside the facility.

In accordance with Federal and State rules and regulations, nursing facilities are required to protect and promote beneficiary rights. These rights include, but are not limited to:

- The right to exercise their rights as citizens of the United States;
- The right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising their rights;
- The right to receive notice of their rights, rules and regulations, both orally and in writing, in a language that the resident understands;
- Access to their medical records and information;

(In accordance with Federal regulations, a beneficiary [or his representative] must be allowed to inspect his records within 24 hours [excluding weekends and holidays] of such request. Also, in accordance with Michigan Public Health Code, a beneficiary [or his representative] is entitled to receive and examine an explanation of his bill or an itemized statement setting forth services paid for and services rendered, regardless of the source of payment.)

- The right to be informed about their health status;
- The right to refuse treatment;
- The right to non-discrimination, including non-discrimination based on payment source;
- Notification of covered and noncovered services, and any additional costs;
- Notification of any changes in room, policies, physician, health status, and treatment;
- Protection and appropriate management of resident funds;
- The right to covered services;
- Notification of transfer or relocation;
- The right to pain and symptom management at the end of life; and
- The right to re-admission to the nursing facility and to have their bed held during an emergency hospital stay, as defined in the Holding a Bed subsection of this chapter.

In general, beneficiaries cannot be charged for Medicaid-covered services, except for patient-pay amounts, copays or deductibles. This applies to whether they are enrolled as a fee-for-service beneficiary, MDHHS is paying their Health Maintenance Organization (HMO) premium to a contracted health plan, or services are provided under Community Mental Health Services Program (CMHSP) or Pre-paid Inpatient Health Plan (PIHP) capitation. However, beneficiaries may be charged if they choose to obtain a service from an out-of-network or non-participating provider, as long as they have prior



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knowledge they will be obligated to pay the entire charge and, with that knowledge, they request the service.

Medicaid beneficiaries may not be charged the difference between the provider's charge and the Medicaid payment for a service, nor can they be charged for missed appointments.

Medicaid beneficiaries cannot be charged for the copying of medical records for the purpose of providing them to another health care provider.



SECTION 5 – BENEFICIARY ELIGIBILITY AND ADMISSION PROCESS

5.1 NURSING FACILITY ELIGIBILITY

There are five components that determine beneficiary eligibility and Medicaid nursing facility reimbursement.

- Verification of financial Medicaid eligibility
- PASARR Level I screening
- Physician-written order for nursing facility services
- A determination of medical/functional eligibility based upon a web-based version of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) prior to or the day of admission to a nursing facility. (Refer to the Nursing Facility Level of Care Determination Chapter for additional information.)
- Computer-generated Freedom of Choice (FOC) form signed and dated by the beneficiary or the beneficiary's representative as described in the Nursing Facility Level of Care Determination Chapter.

These components are defined below.

5.1.A. VERIFICATION OF MEDICAID FINANCIAL ELIGIBILITY

Medicaid reimbursement for nursing facility services for an individual requires a determination of Medicaid financial eligibility for that individual by MDHHS. When a nursing facility enters admission information for an individual who does not have active or pending Medicaid eligibility, a Medicaid Application for Health Care Coverage Patient of Nursing Facility (DHS-4574) will be automatically mailed to the individual.

Federal regulations require annual recertification that residents meet Medicaid financial eligibility requirements. The annual recertification process is performed by MDHHS.

In order for Medicaid to reimburse for nursing facility services from the date of admission of a Medicaid-eligible beneficiary, the Medicaid beneficiary must be in a Medicaid-certified bed, and the LOCD must be conducted as indicated in the Nursing Facility Level of Care Determination Chapter.



5.1.B. CORRECT/TIMELY PREADMISSION SCREENING/ANNUAL RESIDENT REVIEW (PASARR)

The Level I Preadmission Screening/Annual Resident Review (PASARR) must be performed prior to admission as described in the PASARR Process Section of this chapter.

A Level I Preadmission Screen must be performed for all individuals admitted to a Medicaid-certified nursing facility regardless of payer source. The Level I screening form (Preadmission Screening [PAS]/Annual Resident Review [ARR] (Mental Illness/Intellectual/Developmental Disability/Related Conditions Identification); DCH-3877 is available on the MDHHS website. (Refer to the Directory Appendix for website information.) The nursing facility is required to ensure that the PASARR Level I screening has been completed and passed (does not trigger a PASARR Level II) by the individual prior to admission.

Placement options for beneficiaries who were determined through Level II Preadmission screening to have a mental illness, intellectual/developmental disability or a related condition are determined through the federal PASARR screening process requirements as to whether or not they need nursing facility services, specialized services, and/or mental health services.

MDHHS performs retrospective reviews, randomly and when indicated, to determine that the nursing facility has complied with federal PASARR requirements. MDHHS reviews retrospectively to determine that the Level I screening was performed, and that the Level II evaluation was performed when indicated.

MDHHS is required to recover any payments made to nursing facilities for the period that a participant may have been admitted to a nursing facility when the PASARR screening process was not completed.

5.1.C. PHYSICIAN ORDER FOR NURSING FACILITY SERVICES

A physician-written order for nursing facility admission is required. By renewing orders, the physician certifies the need for continuous nursing facility care. The order must be signed and dated by the physician. The physician's degree must appear with the signature. A stamped signature is not acceptable.

With the exception of beneficiaries 21 years of age or under residing in a psychiatric facility, a physician (MD or DO) must approve a beneficiary's need for long-term care not more than 30 calendar days prior to the beneficiary's admission to a nursing facility.

For an individual who applies for Medicaid financial eligibility while a resident in a nursing facility, the physician must reaffirm the need for long-term care not more than 30 calendar days prior to the submission of the application for Medicaid financial eligibility.



5.1.D. APPROPRIATE PLACEMENT BASED ON MICHIGAN MEDICAID NURSING FACILITY LEVEL OF CARE DETERMINATION

5.1.D.1. MICHIGAN MEDICAID NURSING FACILITY LEVEL OF CARE DETERMINATION

Financially eligible Medicaid residents must meet medical/functional eligibility for Medicaid reimbursed nursing facility services. To verify medical/functional eligibility, the nursing facility (i.e., hospital long term care unit, county medical care facility, ventilator dependent unit, hospital swing bed, State Veterans' Home) must complete the online LOCD as described in the Nursing Facility Level of Care Determination Chapter.

CHANGE OF OWNERSHIP (CHOW)

If a new National Provider Identification (NPI) will be issued to a provider who is going through a CHOW, the provider must conduct the hard copy version of the LOCD and Freedom of Choice (FOC). Hard copies of the LOCD and FOC must be conducted in accordance with the policies in the Nursing Facility Level of Care Determination Chapter. Once the provider is given full access to CHAMPS under their new NPI, the provider must enter all of the information from the hard copy LOCD into the online version of the LOCD in CHAMPS under their new NPI. To ensure proper payments, CHAMPS will then check if the conducted date of the LOCD and enrollment date of the new NPI are within the last six months. Both conditions must be met during a CHOW for CHAMPS to process payments. If the new owner will not be issued a new NPI, the new owner must continue to conduct online LOCDs according to the policies within the Nursing Facility Level of Care Determination Chapter.

5.1.D.2. RETROSPECTIVE REVIEW AND MEDICAID RECOVERY

At random and whenever indicated, the MDHHS designee will perform retrospective reviews of a sample of residents. The purpose is to validate the medical/functional eligibility of the beneficiary. The provider must submit all medical documentation requested by the MDHHS designee. If the resident is found to be ineligible for nursing facility services, MDHHS will recover all Medicaid payments made for nursing facility services rendered during the period of ineligibility.

5.2 ADMISSION PROCESS

Prior to or upon admission, the nursing facility must provide beneficiaries and their representatives the following information. The information must be provided both orally and in a written language that the beneficiary understands. Beneficiaries must be provided copies of those items noted with an asterisk (*).

- Rights as identified in federal regulations;
- All rules and regulations governing beneficiary conduct and responsibilities during their stay in the facility; *
- Rights as a Medicaid beneficiary and a list of Medicaid-covered services (services for which the resident may not be charged) as published in the Medicaid "Know Your Rights" booklet; *



- Noncovered items and services, as well as the costs, for which the beneficiary may be charged (admission to a facility cannot be denied because the beneficiary is unable to pay in advance for noncovered items/services); *
- Facility policies regarding protection and maintenance of personal funds; *
- A description of the facility's policies to implement advance directives; *
- Facility policies regarding the availability of hospice care; *
- The name, specialty and contact information of the physician responsible for their care;
- Information about how to apply for Medicare and Medicaid; * and
- How to file a complaint.

Facilities must notify residents and their representatives (both orally and in a written language that the beneficiary understands) of any changes to the information listed above.

Receipt of the above information and any amendments must be acknowledged, in writing, by the beneficiary or his representative. Individual facilities may develop their own documentation for this process.

5.3 PREADMISSION CONTRACTS

Nursing facilities must abide by all state and federal regulations regarding preadmission contracts.

Nursing facilities are prohibited from requiring a Medicaid-eligible person or a Medicaid beneficiary, his family, or his representative to pay the private-pay rate for a specified time before accepting Medicaid payment as payment in full. Nursing facilities violating this prohibition are subject to the appropriate penalties (i.e., revocation of their Medicaid provider agreement).



SECTION 6 – MEDICAL RECORDS

Nursing facilities are required to maintain a medical record for all residents as outlined in State and Federal statutes and regulations.

Nursing facilities are required to comply with all State and Federal requirements regarding medical record confidentiality, including compliance with all Health Insurance Portability and Accountability Act (HIPAA) requirements regarding privacy.

Nursing facilities must maintain all resident assessments completed within the previous 15 months in the resident's active record. Facilities with a "paperless" system in which clinical records are electronically maintained must be able to produce a paper copy if requested for record review by State surveyors.

Nursing facilities must respect the resident's access to their medical records as required by State and Federal laws and regulations.



SECTION 7 – CARE PLANNING PROCESS

Nursing facility care planning is a continuous and ongoing process of assessment, planning, evaluation, and revision. The purpose of the care planning process is to gather information from a variety of sources, and develop a written strategy to insure that the resident receives services and supports necessary to attain or maintain the highest practical physical, mental, and psychosocial well-being. Sources of information to support care planning include the resident, his family and friends, physicians, specialists, nurses, nurse aides, dietitians, therapists and assessment tools (including the Minimum Data Set [MDS] for Nursing Facility Resident Assessment and Care Screening). A comprehensive plan identifies and addresses all aspects of the resident's health and well-being (physical/medical, emotional, mental, spiritual), not just those services that will be provided by the facility or covered by insurance. Using the principles and essential elements of person-centered planning, facilities are expected to involve residents and their designated support system throughout the entire process.

7.1 PERSON-CENTERED PLANNING

Person-centered planning is an ongoing process that recognizes the worth and dignity of each individual and his ability to choose how supports, services and/or treatment may be used to improve his life. The following principles apply:

- **Participation in planning** – Each individual has unique strengths, abilities and preferences and is able to express preferences and make choices. Each individual can participate in planning his life, with appropriate support if needed.
- **Support for planning** – People trusted by the individual and committed to supporting the individual's choices must be involved in planning for long-term care. The process is dependent on the participation of supportive relationships, such as family members and friends, and encourages their involvement, to the extent that the choices of the individual are reflected. These relationships support the individual's right to choose, even the right to take risks.
- **Outcome orientation** - Person-centered planning is outcome-oriented. The planning should lead to positive outcomes in the individual's life, i.e., helping to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The individual determines what constitutes a positive outcome. For a younger adult with a disability, this may include building a career. For an older person near the end of life, the positive outcomes may include deciding where one dies and who is present.

Evidence of person-centered planning includes:

- An assessment process that offers the opportunity for gathering information concerning each resident's preferences, personal goals, needs and abilities, health status, and other available supports. This information should be used in developing an individualized plan of care. The individual's life plans should give direction to plans with service providers, such as discharge planning from nursing facilities into community-based settings. Nursing facilities should not exclude residents in the care planning process in order to meet facility requirements for writing care plans, obtaining signatures, and so forth.
- An assessment process that includes input from professionals and others chosen by the individual. In addition to the professionals required to participate in care planning, individuals should have support for making informed choices about the additional people and professionals



they invite to their person-centered planning meetings. For example, federal guidelines require an interdisciplinary team that includes a registered nurse who has responsibility for caring for the resident and prepares care plans. In addition, the resident may choose to invite a favorite nurse aide and a former neighbor/caregiver to participate in care planning.

- A plan of care that comprehensively addresses each individual's need for health care and other services in accordance with the individual's preferences and goals.
- Services delivered in accordance with the individualized plan of care.
- Informed choice, which includes, but is not limited to, choosing among covered services and enrolled service providers, decisions about the planning process, and evaluation of the planning and its outcomes. Informed choice means knowing the options in ways that are meaningful to the individual and having information when it is useful, not only at admission, but throughout the care process.
- Support for informed choice, which requires an organizational commitment to provide information and/or experiences that sufficiently inform an individual of their options. This commitment should be met through multiple and flexible means of providing information. These might include alternative forms of communication (e.g., Braille, sign language, audio-recorded documents), hands-on experiences with options, peer support from experienced participants, and so forth.

7.2 ASSESSMENT

In collaboration with the resident and individuals identified by the resident, appropriate facility staff must assess residents regularly and as needed to identify their preferences, wishes, goals, outcomes, capabilities, and medical and psychosocial needs. Nursing facilities should use assessment tools that are accessible (e.g., large print, verbal, appropriate language, etc.) to residents and individuals identified by the resident.

Assessment tools must include, but are not limited to, the Minimum Data Set (MDS) for Nursing Facility Resident Assessment and Care Screening. Nursing facilities are expected to use assessment tools and methods that accommodate the needs and preferences of individuals (e.g., mental health assessment tools, self-assessment tools in large print, etc.).

7.3 MINIMUM DATA SET (MDS)

Nursing facilities must conduct a comprehensive, accurate, standardized, and reproducible assessment of each resident's functional capacity. The use of the current federally specified Resident Assessment Instrument (RAI), which includes the MDS, Care Area Assessment (CAA) process, and utilization guidelines, is mandatory. Michigan has made a determination not to have a state-specific Section-S, but reserves the right to develop and require its data collection as need arises.

The MDS assessment must be conducted:

- Promptly upon admission, but no later than 14 days of admission;
- Promptly after a significant change in the resident's physical or mental condition or within two weeks, whichever is sooner; and
- Not less than once every twelve months.



The facility must examine each resident once every three months, revising the assessment as appropriate to ensure its continuing accuracy.

Results of the MDS assessment must be used, in addition to other information gathered and in collaboration with the resident, for developing, reviewing, and revising the resident's plan of care. The assessment must be maintained in the resident's medical record and kept confidential.

NOTE: The Michigan Medicaid MI Choice Waiver Agencies are the designated Local Contact Agency (LCA) relative to Section Q of the MDS. (Refer to the Directory Appendix for contact information.)

Each MDS assessment must be conducted or coordinated (with the appropriate participation of other health professionals) by a licensed, registered nurse who signs and certifies the completion of the assessment. Each person who completes a portion of the assessment must sign and certify the accuracy of that portion. Data accuracy resides with the nursing facility as the source of the data.

A facility must electronically transmit to the State, at least monthly, encoded, accurate, complete MDS data for all assessments conducted since the previous transmission. A facility that fails to transmit electronic RAI data to the State is considered out of compliance and, therefore, subject to enforcement actions. (Refer to the Nursing Facility Certification, Survey and Enforcement Appendix of this chapter.)

An individual who willfully and knowingly certifies a material and false statement, or causes another individual to do so, is subject to a civil money penalty.

Questions about the Resident Assessment Instrument should be directed to the Department of Licensing and Regulatory Affairs, Bureau of Community and Health Systems (BCHS), RAI Coordinator. (Refer to the Directory Appendix for contact information.)

Federal regulations require that facilities coordinate the PASARR process and MDS. MDHHS recommends that nursing facility administrators establish mechanisms to track completion dates of PAS and ARR evaluations so that, to the maximum extent practicable, they are coordinated with resident assessments and completion of the MDS.

7.4 PREADMISSION SCREENING/ANNUAL RESIDENT REVIEW (PASARR)

The Preadmission Screening and Annual Resident Review (PASARR) must be completed for all individuals seeking to enter a nursing facility regardless of payer source. Although not federally mandated, Michigan has elected to require the Annual Resident Review (ARR) for all residents in Medicaid-certified nursing facilities regardless of payer source.

The purpose of the PASARR process is to encourage community care by supporting the placement of individuals with Mental Illness (MI) or Intellectual/Developmental Disability (I/DD) or a related condition in a nursing facility only when their medical needs clearly indicate that they require the level of care provided by a nursing facility. For individuals with mental illness or an intellectual/developmental disability or having a related condition, the PASARR process ensures the appropriate determination of the need for nursing facility services and the need for specialized services. The PASARR process also includes an appeals system for individuals who wish to dispute a PASARR determination.



Screening and evaluations performed under PASARR and all PASARR notices must be adapted to the cultural background, language, ethnic origin, and means of communication used by the individual being evaluated.

(Refer to the PASARR Process section of this chapter for additional information.)

7.5 PLAN OF CARE

Nursing facilities are required to provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident. A written individualized plan of care must be developed in the context of a person-centered planning process in order to specify services and activities, and to accommodate individual needs and preferences. The plan outlines the goals, strengths and needs of the resident and how those will be addressed. A comprehensive plan identifies and addresses all aspects of the resident's health and well being (physical/medical, emotional, mental, spiritual), not just those services that will be provided by the facility or covered by insurance. The plan also identifies the resident's wishes and capabilities regarding the potential of relocation to a lesser level of care and includes discharge planning.

The comprehensive plan of care must be developed with direct involvement of:

- The beneficiary, family and/or his/her representative;
- The attending physician;
- An RN who has assessed the beneficiary, or who is familiar with the assessment;
- Other appropriate staff disciplines; and
- Any other trusted individuals that the beneficiary might wish to include.

Medicaid requires that a nursing facility ensure that a licensed physician supervises a beneficiary's medical care. The physician must review the entire individualized plan of care on an on-going basis. The entire plan of care may include sections for:

- Nursing care;
- Rehabilitative services (if required);
- Medication;
- Treatment;
- Restorative services;
- Diet;
- Activities;
- Special plans for health and safety;
- Continuing care, measurable objectives and timetables;
- Discharge (as appropriate); and
- Mental health services.

All services rendered must be documented and consistent with the written individualized plan of care.



7.6 EVALUATION/RE-ASSESSMENT/PLAN REVISION

Care planning is a continuous and ongoing process that requires regular re-assessment and revision of the plan of care. Federal guidelines require that the facility examine each resident not less than once every three months, and revise the resident's assessment as appropriate to ensure its continuing accuracy. Re-assessment should also occur with significant changes in the resident's condition and at the request of the resident or his representative. Once the re-assessment is completed, the current plan should be evaluated and revised to meet current goals and needs.



SECTION 8 – PASARR PROCESS

Pre-admission Screening/Annual Resident Review (PASARR) in Michigan is a two-level screening and evaluation process. The Level I screening and Level II evaluation procedures and forms are the same for Pre-admission Screening (PAS) and Annual Resident Review (ARR). The forms may be obtained from the MDHHS website.

The PASARR process must be completed:

- Prior to admission to a nursing facility;
- Promptly after a significant change in a resident's physical or mental condition; and
- Not less than annually.

The PASARR process is not required in the following situations:

- When an individual is admitted to and resides in a hospital swing bed. However, the PASARR process must be completed prior to admission if the individual transfers to a nursing facility.
- When an individual is readmitted to a nursing facility after a hospital stay. If the Annual Resident Review date occurs during a period of hospitalization, the screening must be completed within 30 days of admission or readmission to the nursing facility.
- For an individual transferring from one nursing facility to another, with or without an intervening hospital stay, unless a Level I screen has not been performed previously. If a Level I screening or Level II evaluation has been completed, the screening evaluation should accompany the beneficiary to the receiving nursing facility.
- For an individual returning to the nursing facility from therapeutic leave, unless the resident's condition has changed. Therapeutic leave does not change the due date for Annual Resident Review. Advance planning may be necessary to ensure timeliness of review.
- A beneficiary receiving Medicaid hospice services (Benefit Plan ID of Hospice) entering a nursing facility for the five-day hospice respite benefit. A Level I screening must be completed if the beneficiary enters the facility for a length of time beyond the five-day respite period.

The purpose of the Level I screening is to identify individuals who may have a mental illness, intellectual/developmental disability or a related condition. If the patient is on psychotropic or antidepressant medications for purposes of pain control/symptom relief for end of life, note that information on the DCH-3877. This allows the Community Mental Health Services Program (CMHSP) to better evaluate the need for Level II screening. If the patient is on any of the above mentioned psychotropic medication groups for a related mental illness, the CMHSP will determine the need for Level II screening.

- An individual assessed by adult protective services, requiring protective services, may be granted provisional admission to a nursing facility pending further assessment due to this emergent situation. Placement in a nursing facility is not to exceed seven (7) days.



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The following table outlines screening requirements.

<p>Pre-Admission Screening (PAS)</p>	<p>A Level I screening is required for all individuals seeking to enter a nursing facility regardless of payer source, except as noted above. The Level I screening, and the Level II evaluation when indicated, must be completed prior to admission to a nursing facility.</p>
<p>Annual Resident Review (ARR)</p>	<p>All residents in Medicaid-certified nursing facilities must be reviewed at least annually to determine if the resident is in need of mental health services and/or continued nursing care. Annually means within every fourth quarter after the previous Level I screening or Level II evaluation, whether it was completed for admission, condition change, or annual review. The Level I screening must be completed for all residents, and a Level II evaluation must be performed if indicated.</p> <p>If a resident was hospitalized when an ARR was due, the Level I screening must be completed within 30 days of readmission, and any subsequent Level II evaluation must be completed within the quarter following readmission to the nursing facility.</p>
<p>Change in Condition</p>	<p>A Level I screening must be completed immediately or, at most, within 14 days when there is a significant change in the resident's mental health, or a physical change that may impact the resident's mental health needs. Federal regulations define a "significant change" as a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan or both. Changes to the Minimum Data Set (MDS), Section E (indicators of depression, anxiety, mood) would indicate a significant change for PASARR purposes. A change in condition would also be done if the consumer is in a facility in any state other than Michigan and transfers into a Michigan nursing facility. This should be done as soon as the consumer arrives at the Michigan nursing facility, no later than the 14th day after arrival. The nursing facility must notify their local CMHSP via a DCH-3877 for a Level II evaluation.</p>
<p>30-Month Rule</p>	<p>During the PASARR process, a nursing facility resident may be identified as no longer in need of nursing services but in need of specialized services. In this situation, if the resident has lived in a nursing facility for 30 continuous months, the CMHSP must advise the individual of their options, which may include community placement with specialized services or continued residence in the nursing facility with specialized services. Under these circumstances, no appeal needs to be filed in order to maintain nursing facility residency. The individual's status as a long-term resident must be evident in their nursing facility medical record.</p> <p>Individuals determined to need specialized services, who have resided in a nursing facility for less than 30 months, and who are found to no longer need nursing services must be assisted to transition to a more appropriate setting.</p>
<p>Borton vs. Califano Transfer Trauma</p>	<p>Transfer trauma protections apply to individuals with mental illness, intellectual/developmental disability or a related condition who were determined during a PASARR Level II evaluation to not need nursing facility services. Transfer Trauma is defined as any adverse psychological and/or physical effects occasioned by the transfer of a nursing facility patient that would be materially detrimental to the physical or mental health of the patient.</p>



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8.1 LEVEL I SCREENING

The purpose of the Level I Screening is to identify individuals who may have a mental illness, intellectual/developmental disability or a related condition. Level I Screening is documented on the "Preadmission Screening (PAS)/Annual Resident Review (ARR) (Mental Illness/Intellectual/Developmental Disability/Related Conditions Identification)" form (DCH-3877). (Refer to the Forms Appendix for a sample form.) The DCH-3877 must be completed and signed by a registered nurse, licensed Bachelor's or Master's Social Worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or physician.

The professional who completes the Level I Screening must provide a copy of the DCH-3877 to the prospective nursing facility resident or their legal representative. Notification must also be adapted to the cultural background, language, ethnic origin and means of communication of the person being evaluated. (For the distribution of forms and documentation, refer to the Distribution of PASARR Documentation subsection later in this section.)

The following table contains a list of psychopharmacological drugs that may indicate the presence of a mental illness. Included are examples of anti-depressant and psychotropic medications, defined as any drug that affects brain activities associated with mental processes and behavior.

The list is not meant to be all-inclusive.

Anti-Depressant Medications	
Generic Name	Brand Name
Amitriptyline Hydrochloride	Elavil
Bupropion Hydrochloride	Wellbutrin
Citalopam	Celexa
Doxepin Hydrochloride	Sinequan
Fluoxetine Hydrochloride	Prozac
Fluvoxamine	Luvox
Imipramine Hydrochloride	Tofranil
Mirtazapine	Remeron
Netazodone Hydrochloride	Serzone
Nortriptyline Hydrochloride	Aventyl, Pamelor
Paroxetine	Paxil
Sertraline Hydrochloride	Zoloft
Trazodone Hydrochloride	Desyrel
Venlafaxine Hydrochloride	Effexor

Psychotropic Medications	
Generic Name	Brand Name
Chlorpromazine Hydrochloride	Thorazine
Clozapine	Clozaril
Fluphenazine Hydrochloride	Prolixin
Haloperidol	Haldol
Loxapine Hydrochloride	Loxitane
Mesoridazine Besylate	Serentil
Olanzapine	Zyprexa
Quetiapine Fumarate	Seroquel
Risperidone	Risperdal
Thioridazine Hydrochloride	Mellaril
Thiothixene	Navane
Trifluoperazine Hydrochloride	Stelazine
Ziprasidone	Geodon



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Miscellaneous Products	
Generic Name	Brand Name
Lithium Citrate	Cibalith-S
Lithium Carbonate	Eskalith, Lithobid

8.2 LEVEL II EVALUATION

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

8.3 LEVEL II EVALUATION EXEMPTION

If the individual qualifies for an exemption to the Level II evaluation based on the criteria outlined below, the DCH-3878, "Mental Illness/Intellectual/Developmental Disability/Related Condition Exemption Criteria Certification" form must be completed. (Refer to the Forms Appendix for a sample form.) The DCH-3878 must be completed, signed, and dated by a physician's assistant, nurse practitioner, or a physician.

Exemptions to the Level II evaluation may be requested based on the following criteria:

- The individual is in a coma. If the individual is in a coma at the time the Level II evaluation is to be performed, the individual may be exempted from the Level II evaluation process. A physician must certify that the individual is in a coma. The individual may then be admitted to the nursing facility without a Level II evaluation. When the individual is no longer in a coma, the nursing facility must complete a Level I screening and refer for a Level II evaluation, if indicated.
- The individual has a primary diagnosis of dementia (such as Alzheimer's disease or another dementing illness). An exemption due to dementia cannot be claimed for any individual who is also identified as having an intellectual/developmental disability or a related condition, or for any individual with another primary psychiatric diagnosis. For example, an individual diagnosed with dementia and a primary diagnosis of depression may not be exempted. A physician's assistant, nurse practitioner or physician must certify that the individual meets the clinical criteria for dementia and does not have another primary psychiatric diagnosis, intellectual/developmental disability, or a related condition.
- The individual is convalescing after hospitalization for an acute illness and meets all of the following conditions:
 - The individual will be admitted to a nursing facility directly from a hospital after receiving acute inpatient care at the hospital. Treatment in an emergency room is not considered a hospital stay. An individual who received inpatient treatment in a



psychiatric facility cannot be admitted to a nursing facility claiming this exemption, nor can an individual who comes directly from home or any other community placement (i.e., Adult Foster Care [AFC] and assisted living).

- The individual requires nursing facility services for the condition for which they received care in the hospital.
- The attending physician, physician's assistant, or nurse practitioner has certified before admission to the nursing facility that the individual is likely to require less than 30 days nursing facility services.

Medicaid approves payment for a hospital discharge/convalescent care stay up to 30 days only. If the individual needs nursing care beyond 30 days, the nursing facility must notify the local CMHSP at least five working days before the end of the 30-day stay that a Level II evaluation is needed. The local CMHSP completes the Level II evaluation within 14 days of the date of notification and forwards the evaluation to MDHHS. The entire determination process must be completed within 40 days of the individual's admission from the hospital. If MDHHS determines that the individual no longer requires nursing facility services, Medicaid reimburses up to five days beyond the date of the determination to allow for appropriate discharge planning. It is expected that a nursing facility will begin discharge planning for residents at the time of admission from the hospital and discontinue this planning only when a determination is made that the resident will not be discharged from the nursing facility.

The person completing the Level II evaluation exemption must provide a copy of the DCH-3877 to the prospective nursing facility resident or their legal representative. Notification must also be adapted to the cultural background, language, ethnic origin and means of communication of the person being evaluated. (Refer to the Distribution of PASARR Documentation subsection of this chapter for additional information.)

8.4 LEVEL II EVALUATION COMPLETION

Individuals who are identified at the Level I screening as having a mental illness or intellectual/developmental disability or a related condition, and who do not meet exemption criteria outlined previously, must be referred to the local CMHSP for a Level II evaluation. Level II evaluations are conducted by mental health professionals through the local CMHSP under contract with MDHHS. The evaluation involves an interview with the individual, review of medical records, and consultation with nursing facility and/or hospital staff. The mental health professional must conduct the Level II evaluation in accordance with the MDHHS OBRA Operations Manual. A copy of this manual may be requested from the MDHHS OBRA Office or the local CMHSP.

When a Level II Evaluation is required, it must be completed prior to nursing facility admission.

When a Level II evaluation is indicated for an Annual Resident Review (ARR), the nursing facility must notify the local CMHSP of the need for the Level II evaluation at least 30 days prior to the due date of the ARR by sending them a new DCH-3877 (Level I screening form). For example, if the initial Level II evaluation was completed on April 15, 2004, the ARR is due April 15, 2005, and the facility must notify the local CMHSP that a new Level II is due by March 15, 2005. The local CMHSP is responsible for timely completion of Level II evaluations and for providing facilities with written documentation of PASARR determinations in a timely manner.



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Once completed, the CMHSP forwards all documentation of the Level II evaluation to MDHHS. Based on this documentation, MDHHS determines whether the individual requires nursing facility services or can be served in an alternate setting. MDHHS also determines whether specialized services or other mental health services are needed to treat the individual’s mental illness, intellectual/developmental disability or a related condition.

The MDHHS decision regarding the need for nursing facility services and the need for specialized services is forwarded to the referring CMHSP. It is the responsibility of the CMHSP to explain the evaluation and determination to the individual and his legal representative. The CMHSP must provide a copy of the evaluation and the MDHHS determination letter to the individual and his legal representative, and explain the appeal rights to the individual and their legal representative. This information must also be adapted to the cultural background, language, ethnic origin and means of communication of the individual being evaluated.

The local CMHSP notifies the attending physician, nursing facility, and discharging hospital of the results of the evaluation and the MDHHS determination in writing within five (5) days of the review. A copy of this notification must be retained in the individual’s record. (Refer to the Distribution of PASARR Documentation subsection of this chapter for additional information.)

If the facility does not receive a written determination as follow-up to a verbal determination within 30 days of an admission, the facility must send a written reminder to the CMHSP and the MDHHS OBRA Office within 45 days of the admission. (Refer to the Directory Appendix for contact information.)

The nursing facility is responsible for verifying that required PAS and ARR processes are completed and documented in the resident’s record. The nursing facility medical record must include the determinations of the level of care, the need for specialized services, the original DCH-3877 and DCH-3878 forms, and the Level II evaluation report and supporting documents.

8.5 DISTRIBUTION OF PASARR DOCUMENTATION

The following chart shows the correct distribution of copies of PASARR forms (DCH-3877, DCH-3878) and Level II evaluation documentation. All originals must be fully completed and signed.

Level I Screening Documentation (DCH-3877)		
Original	Nursing facility record	All nursing facility admissions
Copy	Individual or their legal representative	All nursing facility admissions
Copy	CMHSP	If "yes" answer(s)
Copy	MDHHS via local CMHSP	If "yes" answer(s) and no exemption criteria met

Documentation of Exemption to Level II Evaluation (DCH-3878)	
Original	Nursing facility record
Copy	Individual or their legal representative
Copy	CMHSP
Copy	MDHHS via local CMHSP



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Level II Evaluation Documentation	
Electronic Record	MDHHS OBRA Office
Copy	CMHSP
Copy	Individual or their legal representative
Copy	Nursing facility
Copy	Hospital, attending physician

MDHHS Determination	
Electronic Record	MDHHS OBRA Office
Copy	CMHSP
Copy	Individual or their legal representative
Copy	Hospital, attending physician
Copy	Nursing facility

8.6 COMPLIANCE

Failure of a nursing facility to comply with OBRA PASARR requirements will result in the loss of Medicaid reimbursement to the facility for services provided for that resident for any period during which a correct and timely screening or review was not completed for that resident. A claim should not be submitted for dates of services provided during periods for which required Pre-admission Screening or Annual Resident Review has not been completed.

The resident or parties responsible for the resident cannot be charged for the loss of reimbursement caused by the facility's failure to meet PASARR requirements.

The Level I screening is considered completed when the DCH-3877 has been filled out, signed, and distributed or, if exemption criteria are met, both the DCH-3877 and DCH-3878 have been filled out, signed, and dated with appropriate credentials noted, and distributed. The Level II evaluation process is completed when the CMHSP has completed the evaluation and the individual has been notified of the MDHHS determination.

For a screening or evaluation to be correct, the completed forms must contain information consistent with documentation in the resident's nursing facility medical record.

Compliance is monitored through the survey process, complaint investigations, and audits. Retrospective payment adjustments through interim gross adjustments and/or final settlements are made to recover funds as necessary. A nursing facility is not penalized for failures to meet PASARR provisions for which it is not responsible and/or could not prevent.

8.7 APPEALS OF PASARR DETERMINATIONS

Individuals adversely affected by PASARR determinations may appeal the determination or another person may appeal the determination on their behalf. Examples may include the determination that the individual no longer requires specialized services when they have received those services in the past and



wish to continue. An individual may decline nursing facility admission or specialized services without appeal.

Information regarding the MDHHS administrative hearing (appeal) process is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

8.8 COMPLAINTS

Complaints or concerns regarding a nursing facility's implementation of the PASARR regulations should be directed to the Health Facility Complaint Line. (Refer to the Directory Appendix for contact information.)

Complaints or concerns about local CMHSP implementation of PASARR policy should be sent to the MDHHS OBRA Office. (Refer to the Directory Appendix for contact information.)



SECTION 9 – MEDICAID COVERED AND NON-COVERED SERVICES

Determination of medical necessity and appropriateness of Medicaid services is the responsibility of the attending physician (MD or DO) and is subject to MDHHS review. Services must be within the scope of currently accepted medical practice, limitations of the Medicaid Program, and State and Federal requirements.

9.1 MEDICARE-COVERED SERVICES

For Medicare Part B covered services, MDHHS only pays up to a Medicare-enrolled beneficiary's obligation to pay (i.e., coinsurance and deductibles) or the Medicaid fee screen, whichever is less. In addition, Medicaid covers the coinsurance and deductible amounts on any Medicare-covered service not normally covered by Medicaid.

Medicaid co-insurance payments for Part A are the lower of the co-insurance charge or the current maximum co-insurance rate established under the formula stated in the Social Security Act. The facility's total payments from Medicare, Medicaid and other insurance may be up to, but cannot exceed, the amount established by Medicare as reasonable (i.e., the amount allowed by Medicare).

If the beneficiary has a Medicare benefit available, that benefit must be utilized before Medicaid pays any portion of the claim. If a beneficiary who has Medicare coverage is receiving services under CMHSP or PIHP capitation, the PIHP/CMHSP assumes the MDHHS payment liability described in this section.

For Medicare coinsurance days billed to Medicaid, the beneficiary may be in either a Medicare certified or Medicare/Medicaid dually certified bed.

Prior authorization is not required for billing the Medicare deductible and coinsurance amounts, even if the service would require prior authorization if Medicaid were the payer. However, if the facility is uncertain of Medicare coverage, prior authorization from Medicaid should still be obtained. This allows the facility to render the service, bill Medicare and then, if appropriate, bill Medicaid for its share of the service. If Medicare Part B covers an item or service that is included in the Medicaid per diem, the nursing facility is responsible for any coinsurance or deductible, even when billed by an ancillary provider.

Services for which Medicare has made a payment may not be used to offset the patient-pay amount.

If a beneficiary has Medicare Part B coverage, and Medicare does not cover a service, Medicaid considers the service to be included in the Medicaid reimbursement for routine nursing care.

9.2 MEDICARE DENIAL OF BASIC CARE

Medicare covers only skilled care. Medicaid covers both basic and skilled care. In the event a dually eligible Medicare/Medicaid beneficiary requires basic care, Medicaid will cover the service if all other admission criteria are met (e.g., physician order for nursing facility care and beneficiary meets the Medicaid Nursing Facility LOC Determination for NF care).



9.3 MEDICAID REIMBURSEMENT FOR A NURSING FACILITY BED FOLLOWING A QUALIFYING MEDICARE HOSPITAL STAY

A dually eligible beneficiary who resides in a Medicaid-only certified bed and is admitted to a hospital for acute care services may be eligible for Medicare-reimbursed Skilled Nursing Facility (SNF) benefits at the time of hospital discharge. If that beneficiary wants to return to the Medicaid NF bed he originally occupied, he may refuse his Medicare SNF benefit and Medicaid will reimburse for all medically necessary nursing facility days and other medically necessary services. The days billed to Medicaid must be included in the Medicaid census statistics.

The nursing facility must advise beneficiaries of their right to refuse their Medicare SNF benefit in order to return to their Medicaid NF bed. This notice must be in a manner that the beneficiary, family member, or beneficiary's legal representative can understand or have clearly explained to them as needed.

9.3.A. REQUIRED DOCUMENTATION

The facility must maintain, in the beneficiary's clinical and fiscal record, documentation that supports the beneficiary made the choice to forego Medicare-reimbursed services and return to his Medicaid-only certified bed. This documentation must be signed and dated by the beneficiary (or his authorized representative) and a nursing facility representative.

9.3.B. MEDICARE PART B

Required outpatient physical or occupational therapy, or outpatient speech pathology for NF beneficiaries must be provided and billed under Medicare Part B where applicable, even if no payments are made under Medicare Part A for the nursing facility stay.

9.4 OTHER INSURANCE

Many Medicaid beneficiaries have insurance coverage (either traditional health insurance or an HMO) through private and/or employer-based commercial policies. That insurance is always primary, and the rules of that insurer must be followed. This includes, but is not limited to, prior authorization requirements, qualifications of providers, and providing services through the insurer's provider network. MDHHS does not pay for services denied by the primary insurer because the primary insurer's rules were not followed.

MDHHS pays appropriate copays and deductibles up to the beneficiary's financial obligation to pay or the Medicaid fee screen, whichever is less. If the primary insurer has negotiated a rate for a service that is lower than the Medicaid fee screen, MDHHS cannot be billed more than the negotiated rate. Medicaid-covered services not included in the primary insurer's plan are reimbursed by MDHHS up to the Medicaid fee screen if all MDHHS coverage rules are followed. If a beneficiary with other insurance coverage is enrolled in a MHP or is receiving services under CMHSP or PIHP capitation, the MHP/PIHP/CMHSP assumes the MDHHS payment liabilities described in this section.



9.5 PAYMENT FOR NON-COVERED SERVICES

For necessary medical or remedial care recognized under State law but not covered by the Medicaid Program, the Medicare Catastrophic Coverage Act of 1988, Public Law 100-360, allows nursing facility beneficiaries to access their patient-pay amount to pay for these services. The services would include services rendered by providers not enrolled in the Medicaid program. The offset to the patient-pay amount must be reported for the month that services were provided. If Medicare covers the medical service, then Medicaid will continue to cover the Medicare deductible and coinsurance in the event it does not exceed the Medicaid fee screen.



SECTION 10 - MEDICAID SERVICE DESCRIPTIONS

The following table outlines those services that are included in the facility’s per diem rate or are an ancillary service that may be provided to beneficiaries in a nursing facility. Following the table is a more detailed description of each service.

The nursing facility should contact the ancillary provider or Medicaid Provider Inquiry Line to confirm Medicaid coverage of ancillary services.

All services required as a condition of licensure/certification are included in the per diem rate.

Service Description	Covered		Non-Covered
	Included in Per Diem	Ancillary Service	
Administrative Services	X		
Admission Kits (Limited to routine personal hygiene items (See Personal Hygiene Items description)	X		
Alcohol Abuse Treatment (See Substance Abuse Services and Treatment description)		X	
Ambulance Services – Emergency and non-Emergency (See Transportation description)		X	
Ancillary Services			X (some)
Beauty and Barber Services			X
Chiropractic Services		X	
Daily Oral Hygiene and Supplies (See Dental Services description)	X		
Dental Services		X	
Dietary Services and Food (including enteral tube feeding formula, supplies and equipment)	X		
Drug Dependency Treatment (See Substance Abuse Services and Treatment description)		X	
Dry Cleaning (See Laundry Services description)			X
Durable Medical Equipment – customized equipment		X	
Durable Medical Equipment – standard equipment	X		
End of Life Care	X		
Enrichment Programs	X		
Family Planning Services		X	
Food (See Dietary Services and Food description)	X		



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Service Description	Covered		Non-Covered
	Included in Per Diem	Ancillary Service	
Foot Care – Routine (See Podiatry Services description)	X		
Hearing Services		X	
Hospice Services – Nursing Facility Responsibility	X		
Hospice Services – Hospice Responsibility		X	
Hospital Services (Inpatient and Outpatient)		X	
Housekeeping and Maintenance	X		
Intravenous Therapy – nursing supplies, equipment (including all pumps)	X		
Intravenous Therapy – pharmaceuticals		X	
Laboratory Services – routine	X		
Laboratory Services Requiring Special Laboratory and Professional Laboratory Staff		X	
Laundry Services	X		
Medically-Related Social Services	X		
Medication Reviews (See Pharmacy description)	X		
Mental Health Services – facility provided	X		
Mental Health Services – local CMHSP and referrals		X	
Nurse Aide Attendance for Medical Appointments (See Transportation description)	X		
Nursing Care – routine	X		
Orthotics		X	
Oxygen - intermittent and infrequent	X		
Oxygen – daily use		X	
Personal Comfort Items			X
Personal Hygiene Items	X		
Pharmacy – Medicaid Covered Over-the-Counter Drugs		X	
Pharmacy – Routine Over-the-Counter Drugs	X		
Pharmacy— Prescription Drugs		X	
Physician Services		X	
Podiatry Services		X	
Private Duty Nursing in a Nursing Facility			X
Private Room (if medically necessary)	X		
Private Room (no medical necessity)			X



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Service Description	Covered		Non-Covered
	Included in Per Diem	Ancillary Service	
Prosthetics		X	
Radiology		X	
Supplies and Accessories	X		
Therapies – Routine maintenance	X		
Therapies – Non-routine		X	
Total Parenteral Nutritional Formula, Equipment and Supplies (See Dietary Services and Food description)		X	
Transportation Services - non-emergency	X		
Vaccines	X		
Vision Services		X	
Wound Dressings (see Supplies and Accessories)	X	X (some)	

10.1 ADMINISTRATIVE SERVICES

Nursing facilities must be administered in a manner that effectively and efficiently uses its resources to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident in compliance with all applicable State and Federal licensure and certification laws, codes and regulations. Services rendered in the general administration of the facility are included in the facility's per diem rate. Services include, but are not limited to:

- Arranging appointments;
- Building, equipment, and grounds maintenance;
- Development, adoption, and posting of patient rights;
- Development of disaster plans;
- Development of patient councils;
- Infection control;
- Insect and vermin control;
- Management of patient trust funds;
- Nursing care determinations;
- Quality control;
- Record keeping; and
- Utilization control.



10.2 ADMISSION KITS

Routine personal hygiene items in an admission kit are included in the per diem rate. Nonroutine personal hygiene items in an admission kit are not reimbursable and are not allowable costs.

10.3 ANCILLARY SERVICES

Ancillary services (i.e., services other than daily care services), excluding physician services, must be ordered and documented, in writing, by the beneficiary's attending physician, and the documentation must be retained in the beneficiary's medical record. The physician's signature on prior authorization forms, treatment plans, etc., certifies the necessity of ancillary services. The physician must review the beneficiary's progress resulting from the ancillary service not less than every 60 days and summarize the progress resulting from the ancillary service provided.

The orders must be for a specific beneficiary (no blanket orders) and prior to the service being rendered. Orders may be received by telephone but must be written in the beneficiary's medical record. Such services must be provided and billed by the appropriate enrolled provider. It is suggested that the facility contact the ancillary provider or the Medicaid Provider Inquiry Line to ascertain whether the service is covered prior to arranging for the provision of the service. (Refer to the Directory Appendix for contact information.)

The facility is responsible for arranging all ancillary and non-covered medical services. Arranging appointments and transportation for these services is included in the per diem rate.

The beneficiary or beneficiary's representative may choose to purchase non-covered services directly from an ancillary provider. The beneficiary pays the ancillary provider directly for the services provided. The nursing facility must retain, in the beneficiary's fiscal record, receipts showing that the beneficiary paid for the particular non-covered service. Medicaid post-payment reviews will be conducted to assure that the beneficiary's fiscal record contains the receipts.

Nursing facilities may not bill Medicaid for ancillary services except for therapies, oxygen, and the Medicare coinsurance or deductible for ancillary services. Otherwise, the ancillary provider must bill for the service. The Billing & Reimbursement for Institutional Providers Chapter contains the allowable nursing facility provider types that can bill for ancillary services.

Therapies may be billed by the facility regardless of coverage by Medicare. However, Medicaid remains the payer of last resort.

Ancillary services (e.g., physical therapy) provided to a beneficiary on the day of discharge may be billed to Medicaid, even if the beneficiary was admitted and discharged on the same date.

10.4 BEAUTY AND BARBER SERVICES

Any services of a professional beautician or barber are not included in the per diem rate and are not covered by the Medicaid Program. The beneficiary may purchase such services from personal funds. A beneficiary's patient-pay amount may not be used to cover these costs.



10.5 CHIROPRACTIC SERVICES (MEDICALLY-NECESSARY)

Chiropractic services, such as x-rays and treatment, are an ancillary service and are not included in the facility's per diem rate.

10.6 DENTAL SERVICES

The facility's per diem rate includes providing assistance with, and supplies for, daily oral hygiene. Dental supplies include, but are not limited to:

- Dental floss
- Mouthwash
- Mouthwash cups
- Denture adhesive
- Denture cleaner
- Denture cups
- Toothbrushes
- Toothpaste

Routine and emergency dental services are an ancillary service and are not included in the facility's per diem rate.

10.7 DIETARY SERVICES AND FOOD

Residents must be provided nourishing, palatable, well-balanced meals that meet their daily nutrition and special dietary needs. Dietary services must also meet the preferences of residents and offer substitutes of similar nutritional value.

Nutrition appropriate for each resident's condition is included in the facility's per diem rate. This includes, but is not limited to:

- Daily nutritious meals and snacks
- Reasonable food substitutes of a similar nutritive value
- Dietary supplements
- Enteral formulas, supplies, equipment, and associated nursing services
- Infant formulas
- Nursing services associated with total parenteral nutrition (TPN) *
- Special diets
- Therapeutic diets
- Water solutions

Medicaid reimburses non-profit nursing facilities that incur costs resulting from the purchase of raw food and food preparation associated with special dietary needs for religious reasons. (Refer to the Cost Reporting and Reimbursement Appendix of this chapter for more information.)

* The formula, equipment, and supplies required for the TPN feedings are an ancillary service and are not included in the facility's per diem rate.



10.8 DURABLE MEDICAL EQUIPMENT

10.8.A. STANDARD EQUIPMENT

Standard durable medical equipment is included in the facility's per diem rate. The durable medical equipment supplier and the nursing facility must make arrangements for purchasing or renting required equipment. Standard durable medical equipment includes, but is not limited to:

- Adaptive Activities of Daily Living (ADL) equipment
- Air mattresses
- Autoclaves
- Bed boards
- Bed cradles
- Bed pans
- Bed rails
- Beds (including hospital beds)
- Bedside safety rails
- Bedside stands
- Blood pressure apparatus
- Canes
- Comfortable cushioned chair
- Commodes
- Crutches
- Emesis basins
- Food pumps
- Footboards
- Footrails
- Footstools
- Freestanding trays for meals
- Geriatric chairs
- Infrared lamps
- Lap and half-lap trays
- Lifts
- Oxygen equipment and supplies
- Pads, water-circulating devices to apply heat or cold therapy (e.g., hot/cold packs, heating pads)
- Positioning pillows
- Pressure-relief positioning cushions
- Reading lights
- Sitz baths
- Splints
- Standard manual wheelchairs
- Suction machines
- Traction equipment
- Trapeze equipment
- Tub lifts
- Urinals
- Walkers
- Wash basins
- Wheelchairs for transport in or out of the facility

Such equipment must be available for all the residents demonstrating need. Previously acquired equipment should be adapted to meet the beneficiary's needs, if appropriate.



The facility is required to repair/maintain standard equipment, and this expense is included in the per diem rate. This may not be billed separately to Medicaid, the beneficiary, his family, or representative.

Replacement, repair and maintenance of standard equipment owned or rented by the beneficiary is not a Medicaid-covered benefit.

Medicaid policy has historically established that standard wheelchairs and other specified durable medical equipment are included in the Medicaid facility per diem rate in accordance with federal standards and state licensure requirements. The following describes what is meant by standard wheelchairs relative to current types of wheelchair products that are routinely prescribed and commonly available in the marketplace, and routinely prescribed and required for patient use in the long-term care environment.

In addition, nursing services include positioning and body alignment and preventive skin care. The nursing facility is responsible for proper pressure relief and positioning. The use of medical equipment as a substitute for responsible patient care is inappropriate and not covered.

Standard manual wheelchairs are included in the facility's Medicaid per diem rate. A standard manual wheelchair is any wheelchair that is routinely prescribed and required for patient use in the long-term care environment. Standard manual wheelchairs that must be available to meet health and care standards include wheelchairs and accessories that are manufactured stock items, including heavy-duty, light- or ultra-light -weight and/or -strength; hemi chairs; wheelchairs with adjustable or reclining backs; manual tilt-in-space; removable/adjustable arms; variable seat height, width or depth; anti-thrust seats; laterals, abductors, and adductors; or other non-custom positioning options. In addition, pressure-relief positioning cushions, positioning pillows, trochanter rolls, etc. required for proper beneficiary use of the wheelchair or the provision of nursing services are the responsibility of the facility.

10.8.B. CUSTOM-FABRICATED SEATING AND/OR POWER WHEELCHAIRS

Custom-fabricated seating and/or power wheelchairs for nursing facility residents may be covered when the established standards of coverage are met and the severity and intensity of the disease process requires custom-fabricated seating or a power-operated wheelchair as medically necessary and is an integral part of the facility's daily nursing plan of care.

Repairs to custom-fabricated equipment by the durable medical equipment provider are covered only when it is necessary to make the equipment serviceable. Extensive repairs and maintenance by authorized technicians are covered if the warranty has expired. The durable medical equipment provider may bill for authorized repairs. Routine periodic servicing, such as cleaning, testing, regulating, and checking of the equipment, is not separately reimbursable.



10.8.B.1. MEDICAL NECESSITY

A physician's order by itself is not sufficient documentation of medical necessity, even when it is signed by the treating physician. Clinical documentation from the medical record must support the medical necessity for the request and substantiate the physician's order. In addition, Medicaid coverage is not based solely on a physician's order; the request must also meet the standards of coverage published by MDHHS. (Refer to the Medical Necessity subsection of the Medical Supplier chapter for a complete description of medical necessity requirements.)

The nursing facility's responsibility for each resident's health care needs and other services, including patient care, transfers, safety, skin care, equipment, medical supplies, etc., are described in federal regulations and state licensure requirements. The use of medical equipment as a substitute for responsible patient care is inappropriate and not covered.

Refer to the Medical Supplier chapter for additional information regarding Medicaid definitions and standards of coverage for mobility and custom-fabricated seating systems.

10.8.B.2. NONCOVERED

Power wheelchairs and custom-fabricated seating systems, including add-on components, are not covered outside the facility per diem rate when:

- There is an appropriate economic alternative.
- The devices are not related to, or an integral part of, the nursing facility daily plan of care.
- The accessory or add-on component is deemed to be standard under the definition of a standard manual wheelchair.
- The wheelchair is used as a restraint or for the purpose of treating aberrant behaviors.
- The need for the wheelchair is a substitute for appropriate clinical nursing services, as defined in federal regulations.
- The wheelchair is inappropriate for the beneficiary's cognitive level or behavioral level.
- The beneficiary is unable to safely operate the wheelchair.
- A standard wheelchair meets functional need or outcome as defined in the plan of care.
- The device is ordered for nonstandard use (e.g., therapeutic modality or exercise).
- The device is ordered to increase sitting tolerance that exceeds acceptable medical guidelines for skin care and pressure.

10.8.C. PRIOR AUTHORIZATION

Prior authorization is required for Medicaid coverage of medically-necessary power wheelchairs, custom-fabricated seating, and manual wheelchairs with custom-fabricated seating systems outside of the facility per diem rate. The treating physician must initiate



the referral for custom-fabricated seating or a power-operated vehicle (POV) based on an identified medical need in the plan of care. Facility clinicians who are responsible for the overall nursing plan of care for, and treatment of, the resident prepare and submit prior authorization requests, medical documentation, and the Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices form (MSA-1656) within 90 days of the date the evaluation was completed. (Refer to the Prior Authorization subsection of the Medical Supplier chapter for additional information, and to the Forms Appendix for a copy of the form and form completion instructions.)

10.9 END OF LIFE CARE

Facilities are expected to have systems and policies in place to address appropriate advance care planning and end of life care. Facilities must notify residents at admission of their policies regarding the implementation of advance directives and the availability of hospice care. Residents are entitled to adequate and appropriate pain and symptom management as a basic and essential part of their medical treatment.

10.10 ENRICHMENT PROGRAMS

Facilities are required to provide or arrange for an ongoing program of activities designed to meet the interests and physical, mental and social well-being of each resident. An individualized program may be developed as part of the person-centered care planning process. Programs designed to maintain the resident's quality of life are included in the facility's per diem rate. Such services include, but are not limited to:

- Social services;
- Books;
- Current periodicals (e.g., newspapers, magazines) [If the beneficiary personally subscribes to a periodical (e.g., newspaper, magazine) for his own use, he is responsible for payment of that subscription.];
- Diversional programs;
- Motivational programs;
- Reality-oriented programs; and
- Recreational programs.

10.11 FAMILY PLANNING SERVICES

Family planning services are an ancillary service and are not included in the facility's per diem rate.

10.12 HEARING SERVICES

Hearing evaluations are an ancillary service and are not included in the facility's per diem rate.

A Medicaid copayment is not required for nursing facility beneficiaries.



10.13 HOSPICE SERVICES

Upon admission to a nursing facility, residents must be advised of the facility's policies regarding the availability of hospice care.

Nursing facility beneficiaries (including Medicaid-approved complex care cases) are eligible for Medicaid hospice services if determined by a hospice provider to meet hospice level of care. Additionally, in certain situations (such as lack of a caregiver in the home), a hospice beneficiary, in consultation with the hospice provider, may elect to enter a nursing facility to receive end of life care. Medicare beneficiaries receiving or eligible for the 100-day skilled nursing benefit have the right to choose hospice instead. This decision should not be influenced by differences between hospice and Medicare skilled nursing facility reimbursement rates.

If the beneficiary is enrolled in a MHP and is admitted to the nursing facility with the hospice benefit, the MHP is responsible for reimbursement of hospice services.

For nursing facilities that elect to contract with hospice providers, a written contract is required between the hospice provider and the nursing facility that specifically outlines the responsibilities of each. Additionally, the contract must specify how the hospice provider will reimburse the nursing facility for room and board.

Nursing facilities **cannot** bill Medicaid directly for room and board or any other services for hospice beneficiaries. A hospice is responsible for all costs for a person receiving hospice care. The hospice bills Medicaid for room and board, then reimburses the nursing facility at the rate specified in the contract between the providers.

MDHHS reimburses the hospice for its daily rate, for room and board, and QAS for beneficiaries in Medicaid or Medicaid/Medicare dually certified beds. The room and board rate is 95% of the facility's Medicaid per diem rate, plus 100% of the QAS amount. Although the rate paid to the hospice by Medicaid is set, it is not necessarily the rate that the hospice must pay the facility. It is expected that some services may be purchased or traded between the facility and the hospice, so the negotiated room and board rate must be stipulated in the contract.

Hospice services are reimbursable for day of discharge if services were rendered, regardless of the setting in which the services were provided. This includes the transfer of the beneficiary from one hospice provider to another as long as services were provided by both agencies. (This will be randomly verified by post payment audit and as indicated.) If the beneficiary has hospice as of 12:01 a.m., the hospice is responsible for the payment of services provided to the beneficiary until midnight. The hospice will continue, for payment purposes, as the primary provider for the full day of discharge.

Room and board for a hospice/nursing facility (NF) resident is reimbursable on the day of discharge only if the discharge is due to resident death. Room and board reimbursement for the day of discharge from the NF for any other reason is not covered as the resident is not there at the midnight census to be counted as a resident.

Because Medicaid is making a payment for room and board (even though it is paid to the hospice), beneficiaries must be treated as all other Medicaid beneficiaries. For example, the facility cannot seek or accept additional or supplemental payment from the beneficiary, his family, or representative in addition to the amount paid for the covered service, even when a beneficiary has signed an agreement to do so.



10.13.A. NURSING FACILITY RESPONSIBILITIES

Nursing facilities must adhere to all State licensure requirements, even though some of the components of care are provided by the hospice rather than the nursing facility. An example of a licensure component completed by the hospice is that, upon admission, the hospice provides the facility with copies of the beneficiary's history and physical, interdisciplinary assessment, and plan of care. For purposes of licensure, these copies are accepted as appropriate.

If a beneficiary is already receiving hospice services and elects admission to a nursing facility, it is the responsibility of the hospice provider to update the beneficiary's location of service in CHAMPS. To update the beneficiary's location of service in CHAMPS, the hospice provider must discharge the beneficiary and complete an admission with the updated location of service in CHAMPS. (Refer to the Beneficiary Admission and the Beneficiary Discharge sections of the Hospice chapter for additional information.) The new admission will result in real-time changes to the beneficiary's Program Enrollment Type (e.g., HOS-NFAC) and the National Provider Identification (NPI).

Hospice staff cannot be utilized to meet staffing patterns required for licensure (i.e., the facility cannot include hospice staff on staffing reports).

Although the hospice is responsible for developing the coordinated plan of care, the nursing facility, as well as the beneficiary, must be an active participant in its development.

If the hospice beneficiary in a nursing facility has a patient-pay amount, it is the hospice's responsibility to collect that amount from the beneficiary. The nursing facility cannot collect the patient-pay amount from a hospice beneficiary unless the contract with the hospice specifically delegates that responsibility to the facility.

Services that must be provided by the nursing facility include:

- Room and board;
- Laundry (including facility items as well as personal items); and
- All other non-terminal illness-related services afforded other Medicaid beneficiaries (e.g., services included in the per diem rate).

Hospice covered beneficiaries residing in the nursing facility must not experience any lack of nursing facility services or personal care due to their status as a hospice beneficiary. Facilities must offer the same drugs, services, medical supplies and equipment to all beneficiaries who have elected the hospice benefit in the same manner that services are provided to other beneficiaries in the facility who have not elected hospice care. If a service is normally furnished as part of the facility's per diem rate, the service must also be provided to hospice beneficiaries. If services are provided for needs associated with a non-terminal illness and are normally furnished and billed by another provider, that practice would continue.



10.13.B. HOSPICE RESPONSIBILITIES

Hospice must certify/re-certify the beneficiary's need for hospice care.

If a beneficiary already living in a nursing facility elects the hospice benefit, it is the responsibility of the hospice to admit the beneficiary for hospice services, indicating the nursing facility NPI in the Admission Information Section in CHAMPS. A completed admission will result in real-time changes to the National Provider Identification (NPI) and the beneficiary's PET code. (Refer to the Beneficiary Eligibility chapter for additional information.)

The hospice, in collaboration with the beneficiary and/or family and nursing facility, will establish a coordinated plan of care for the beneficiary. The plan must specify the overall care to be provided and indicate, in detail, which services will be provided by the hospice and which will be provided by the facility.

If the hospice beneficiary has a patient-pay amount, it is the hospice's responsibility to collect that amount from the beneficiary. The nursing facility cannot collect the patient-pay amount from a hospice beneficiary unless the contract with the hospice specifically delegates that responsibility to the facility.

10.13.C. SERVICE PROVISION

The following is intended for use as a guideline only. It identifies services for which the hospice is responsible, services that the hospice may arrange, and services that are "negotiable."

10.13.C.1. SERVICES THAT HOSPICE MUST PROVIDE (RELATED TO THE TERMINAL ILLNESS)

- A coordinated plan of care outlining the responsibilities of each provider;
- Intermittent (i.e., less than eight hours per day) nursing care of the hospice beneficiary;
- Counseling (defined as bereavement, nutritional, and spiritual); and
- Social work services.

10.13.C.2. SERVICES THAT HOSPICE MAY ARRANGE (RELATED TO THE TERMINAL ILLNESS)

- Spiritual care; and
- Home health aide/homemaker services. This applies only for services not provided during the facility's normal provision of care. For example, if the facility normally provides baths five times a week but the hospice plan of care calls for a bath each day, the hospice aide would provide baths on the days the facility does not.



10.13.C.3. NEGOTIABLE SERVICES

Services that must be available for hospice beneficiaries but appropriate contracted providers may render, as related to the terminal illness and as included in the patient plan of care, include the following. These services are the responsibility of the hospice, and **cannot** be billed to Medicaid by the contracted provider.

- Inpatient care for acute episodes of pain and symptom control;
- Inpatient respite care (not available for beneficiaries residing in a nursing facility);
- Laboratory;
- Pharmacy;
- Durable medical equipment, medical devices, and supplies;
- Radiology;
- Medical;
- Up to 24 hours of continuous care (at least eight hours of which must be nursing care) during periods of crisis;
- Physical therapy;
- Occupational therapy;
- Speech/language pathology; and
- Emergency ambulance transportation (if the service is included as part of the hospice plan of care).

10.14 HOSPITAL SERVICES

A nursing facility must have in effect a transfer agreement with one or more hospitals.

10.14.A. PLANNED INPATIENT HOSPITAL ADMISSION

When a hospital admission is planned, the beneficiary must be discharged from the nursing facility. The nursing facility must not count the day of discharge as reimbursable by Medicaid. This day is included on the hospital's claim when billing. The facility may not bill Medicaid for hospital leave days for a planned admission. (Refer to Holding a Bed [Hospital Leave and Therapeutic Leave] subsection of this chapter for more information.)

10.14.B. EMERGENCY INPATIENT HOSPITAL ADMISSION

When a resident is admitted to the hospital on an emergency basis, the nursing facility may receive Medicaid reimbursement for holding their bed. (Refer to Holding a Bed [Hospital Leave and Therapeutic Leave] subsection of this chapter for more information.)

10.14.C. OUTPATIENT AND EMERGENCY ROOM

Outpatient and emergency room services are an ancillary service and are not included in the facility's per diem rate.



A beneficiary who goes to the hospital for outpatient or emergency room services is not discharged from the nursing facility because the beneficiary is not admitted to the inpatient hospital. The beneficiary should be included in the census of the nursing facility, and this day may be billed to Medicaid even if the beneficiary was being treated at midnight in the hospital outpatient or emergency room.

10.15 HOUSEKEEPING AND MAINTENANCE

Facility and room/bed maintenance necessary to maintain a sanitary, orderly, and comfortable environment are a required service and included in the nursing facility's per diem rate.

10.16 INTRAVENOUS THERAPY

Intravenous therapy nursing services, supplies and equipment (including all pumps) are included in the facility's per diem rate.

Pharmaceuticals used in IV therapy are an ancillary service and are not included in the facility's per diem rate.

10.17 LABORATORY SERVICES

Any nursing facility that performs laboratory services must be certified/accredited under the Clinical Laboratory Improvement Amendments (CLIA).

Laboratory tests that are listed as waived tests under CLIA are included in the facility's per diem rate (e.g., Testrip). A list of these tests and the instrumentation needed to perform them can be found on the CMS website. (Refer to Clinical Laboratory Improvement Amendments under Provider Resources in the Directory Appendix for website information.)

Laboratory services that can only be performed with special laboratory equipment by professional laboratory staff may be provided and billed by the appropriate enrolled ancillary provider (e.g., independent laboratory, outpatient hospital). Such services are not included in the facility's per diem rate.

Drawing, collecting and delivery of laboratory specimens are routine nursing services. As such, they are included in the facility's per diem rate regardless of who actually performs the service (i.e., nursing facility or ancillary provider).

10.18 LAUNDRY SERVICES

Facilities are responsible for general laundry services (e.g., bedding) and the beneficiary's personal laundry (e.g., clothing). Such services are included in the facility's per diem rate.

Dry cleaning services may be billed to the beneficiary if the beneficiary requests the service in writing, he has prior knowledge that the service is not covered by Medicaid, and he agrees to accept the cost. A beneficiary's patient-pay amount may not be used to cover these costs.



10.19 MEDICALLY-RELATED SOCIAL SERVICES

Nursing facilities must provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. These services may include, for example, information and referral, resident and family support, discharge planning, and are included in the facility's per diem rate.

10.20 MENTAL HEALTH SERVICES

Nursing facilities are required to have a written agreement with the local CMHSP outlining their working relationship to provide screening, evaluation and specialized services to nursing facility residents. The agreement must include a description of the process to be used to ensure the annual review of residents previously identified as having a mental illness, intellectual/developmental disability or a related condition. The agreement must also specify the means through which the facility and the CMHSP will deliver mental health services for nursing facility residents.

Completion of required Pre-admission Screening and Annual Resident Review is included in the facility's per diem rate. Prior to admission to a nursing facility, all individuals, regardless of payment source, must receive the Level I Pre-admission Screening (PAS) to identify the need for mental health and specialized services. Additional screening for mental health and specialized services is done as an Annual Resident Review (ARR), or more frequently in response to a change in a beneficiary's condition. (Refer to the PASARR Process section of this chapter for more information.)

Mental health services provided by the nursing facility staff, as specified in the resident's plan of care, are included in the facility's per diem rate. Nursing facilities must provide mental health, intellectual/developmental disability or related condition services that are of lesser intensity than specialized services to all residents who need such services.

10.20.A. SPECIALIZED SERVICES

Specialized services are those identified by the PASARR Level II and are provided or arranged by the CMHSP. These services must be available to nursing facility individuals regardless of whether they are identified and required by the PASARR process, or whether the individual is determined to require additional services to be provided or arranged for by the State as specialized services. Individuals with a primary diagnosis of dementia are also covered by this requirement, even though the PASARR process exempts individuals with a primary diagnosis of dementia.

The PASARR Level II evaluation may provide recommendations regarding the specialized services and programs needed by the resident. Recommendations are based on evaluation of the resident's impairment in functional skills and the severity of those deficits. Nursing facilities must meet the responsibilities as outlined in this section for providing specialized services.

"Specialized Services" are defined as those mental health services for residents who have a mental illness, intellectual/developmental disability or a related condition which are:

- Of greater intensity than those normally required from a nursing facility;
- Provided in conjunction with usual nursing facility services;



- Determined through the PASARR process;
- Provided or arranged for by the local CMHSP acting on behalf of the State; or
- Result in the continuous and aggressive implementation of an individualized plan of care.

Specialized services for residents with **mental illness** may include, for example, individual, group and family psychotherapy, crisis intervention services, and formal behavior modification programs.

Specialized services for residents with a **intellectual/developmental disability or related condition** include specialized professional involvement because the service need is related to the resident's intellectual/developmental disability or related condition. Evaluators must carefully distinguish between those service needs that require the involvement of an intellectual/developmental disability professional and those which are "generic" and do not require specifically-trained professionals. For example, administering medication is a "generic" service, while teaching a resident to self-administer may be a "specialized service" because it requires the involvement of an intellectual/developmental disability professional to design and monitor the program.

For residents with **multiple diagnoses**, such as intellectual disability and mental illness or intellectual disability and dementia, evaluators may recommend either specialized services or other mental health services, depending on the interrelationship of the two diagnoses.

10.20.B. NURSING FACILITY RESPONSIBILITIES

Responsibilities of the nursing facility include:

- Providing all of the usual and customary services (refer to the Medicaid Covered Services subsection) and as required by licensing and certification. This includes specialized mental health rehabilitation services as defined in 42 CFR 483.120.
- Monitoring the need for PASARR evaluations and ensuring that they are completed on time (refer to the PASARR Process section). The nursing facility must notify the CMHSP when a Level II evaluation is indicated.
- Collaborating with the resident or his legal representative and the CMHSP to develop an individualized plan of care for specialized services based on the needs identified during the PASARR Level II evaluation. The plan of care must outline the responsibilities of each provider for the specialized services.
- Coordinating the identified services (which may be obtained from the local CMHSP) and implementing and monitoring the services recommended in the individualized plan of care. Nursing facilities must also provide interventions which complement, reinforce and are consistent with any specialized services the individual is receiving or is required to receive by the State through the CMHSP. The individualized plan of care must specify how the facility will integrate relevant activities throughout all hours of the day at the facility to achieve consistency and enhancement of the goals identified in the individualized plan of care.



10.20.C. CMHSP RESPONSIBILITIES

Responsibilities of the CMHSP include:

- Performing the comprehensive evaluation (Level II evaluation) when required by the PASARR Screening.
- Collaborating with the resident or his legal representative and the nursing facility to develop an individualized plan of care for specialized services based on the needs identified during the PASARR Level II evaluation. The plan of care must outline the responsibilities of each provider for the specialized services.
- Providing specialized services to nursing facility residents who have been determined to need them through the PASARR process. MDHHS has allocated funds to local CMHSPs for this purpose.
- Providing training to nursing facility direct care staff to implement and monitor the programs as designed, and participating in the evaluation and modification of the plan of care as needed.
- Providing services to nursing facility residents on the same basis as to all other persons in the region. A nursing facility may use the local CMHSP as a mental health service provider in order to fulfill the nursing facility's obligation to provide specialized mental health rehabilitation services. Services for residents with a primary diagnosis of dementia are also available from a local CMHSP on the same basis.

In 1991, funds were made available to local CMHSPs to provide specialized services and other mental health services to individuals residing in nursing facilities. Priority for use of these funds is for individuals with the most severe mental health problems who need specialized services. To the extent there are funds remaining after this priority group is served, MDHHS has given local CMHSPs authorization to serve individuals who need mental health services other than specialized services.

Ancillary providers of mental health services may bill Medicaid directly.

10.21 NURSING CARE

Nursing facilities must have nursing staff sufficient to provide nursing and other related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Nursing care includes the responsibility for development, implementation and oversight of a plan of care that remains consistent with on-going observation, assessment and intervention by licensed nurses. The following are examples of custodial and rehabilitative nursing care that may be performed by, or under the supervision of, licensed nurses and are included in the per diem rate. Nursing services include, but are not limited to:

- Observing vital signs and recording the findings in the beneficiary's medical record
- Administration of topical, oral, or injectable medications, including monitoring for proper dosage, frequency, or method of administration, including observation for adverse reactions



- Treatment of skin irritations or small superficial or deep skin lesions requiring application of medication, irrigation, or sterile dressings
- Routine changing of dressings in chronic, non-infected skin conditions and uncomplicated postoperative incisions
- Nursing observation and care of beneficiaries with unstable or complex medical conditions which can only be provided by, or under the immediate direction of, licensed nursing personnel
- Proper positioning in bed, wheelchair, or other accommodation to prevent deformity and pressure sores
- Provision of bed baths
- Routine prophylactic and palliative skin care (e.g., application of creams and lotions) for the prevention of skin irritation and pressure sores
- Administration of intravenous solutions on a regular and continuing basis
- Administration of tube feedings
- Nasopharyngeal aspiration required for maintenance of a clear airway
- Care of a colostomy or ileostomy during early postoperative period, on an on-going basis, and conducting colostomy training
- Use of protective restraints, bed rails, binders, and supports (if ordered by a physician and in compliance with state and federal regulations) provided in accordance with written patient-care policies and procedures
- Use of intermittent positive pressure breathing equipment and nebulizers
- Care of catheters
- Care of tracheostomies, gastrostomies, and other indwelling tubes
- Administration of oxygen or other medicinal gases on a regular and continuing basis in the presence of an unstable medical condition or when nursing assessment is required to determine frequency and necessity of administration
- Identifying the need for, and insuring arrangements for, prompt and convenient clinical, laboratory, x-ray, and other diagnostic services
- Use of heat as a palliative and comfort measure, such as whirlpool and hydrocolator
- Training and assistance in transfer techniques (bed to wheelchair, wheelchair to commode, etc.)
- Training, assistance, and encouragement of self-care as required for feeding, grooming, toileting activities (including toilet routine to encourage continence), and other activities of daily living
- Normal range-of-motion exercises as part of routine maintenance nursing care
- Pain assessment and management

10.22 ORTHOTICS

Orthotics are an ancillary service and are not included in the facility's per diem rate.



10.23 OXYGEN

The administration of oxygen and the related nursing services are included in the per diem rate.

Oxygen gas, equipment, and supplies for intermittent and infrequent use are included in the facility's per diem rate.

If a beneficiary requires frequent or prolonged oxygen on a daily basis (i.e., at least 8 hours per day):

- As a resident in the Nursing Facility, the oxygen gas, equipment, and supplies must be billed by an enrolled medical supplier, not the nursing facility.
- As a resident in a County Medical Care Facility or a Hospital Long Term Care Unit, the oxygen gas, equipment, and supplies must be billed by the facility. A DME provider cannot bill for oxygen gas, equipment, and supplies for these residents.

NOTE: The rental of a concentrator **is** billable by a Medical Supplier and should not be confused as needing to be billed by the facility.

(Refer to the Billing & Reimbursement for Institutional Providers Chapter in this manual for billing instructions.)

Oxygen services (i.e., gas, equipment, and supplies) are not covered by Medicaid if Medicare is paying for the stay. Medicare's per diem reimbursement rate includes the oxygen services.

10.24 PERSONAL COMFORT ITEMS

Medicaid does not cover individual personal comfort items (e.g., telephone, television, radio, guest trays). Such services are not included in the facility's per diem rate. Beneficiaries may purchase individualized services with personal funds. A beneficiary's patient-pay amount may not be used to cover these services.

If the facility provides personal comfort items to all its beneficiaries (e.g., a television in the recreation room), the service is included in the facility's per diem rate.

10.25 PERSONAL HYGIENE ITEMS

Items needed for personal hygiene are included in the facility's per diem rate. Such items include, but are not limited to, the following:

- Bacteriostatic soaps
- Body lotions
- Combs and brushes
- Cotton swabs
- Deodorant/ antiperspirant
- Facial tissues
- Hair conditioners (as appropriate)
- Incontinence supplies
- Medicine cups
- Oral hygiene supplies
- Patient gowns
- Personal hygiene preparations
- Safety razors
- Sanitary napkins
- Shampoo
- Shaving cream
- Soaps



10.26 PHARMACY

Nursing facilities must provide pharmaceutical services to meet the needs of each resident.

Prescriptions must be ordered and documented, in writing, in the beneficiary's medical record by the attending physician. These prescriptions comply with the federally mandated tamper resistant prescription pad policy as long as the beneficiary does not have the opportunity to handle the medical record. Additional information on the tamper resistant prescription pad policy can be found in the Pharmacy Chapter of this manual.

A Medicaid copayment is not required for prescription pharmaceuticals for nursing facility beneficiaries.

The Michigan Pharmaceutical Product List (MPPL) contains the over-the-counter and prescription pharmaceutical products covered by Medicaid and any restrictions placed on those products, including when prior authorization is required. The prior authorization process is outlined in the MPPL and may be obtained by the physician or their designee. The Michigan Pharmaceutical Products List is available online. (Refer to the Directory Appendix for website information.)

Pharmaceuticals dispensed in nursing facilities must be billed through a pharmacy (unless pharmacy is included in the per diem rate, i.e., ICF/IID).

10.26.A. OVER-THE-COUNTER PRODUCTS (OTC's)

- The MPPL designates when an OTC drug is included in the facility's per diem rate. It is the responsibility of the facility to provide these products. Examples of OTCs in the per diem include mouthwash, topical antiseptics, analgesics, cough and cold preparations, ointments (both generic and brand name [e.g., Vaseline, Gold Bond]), and vitamins and minerals. The pharmacy or supplier must make arrangements with the nursing facility for reimbursement.
- OTCs not included in the per diem rate that may be billed to Medicaid, as outlined in the MPPL, are reimbursable to the pharmacy for nursing facility beneficiaries. Examples include Diphenhydramine and Insulin.

10.26.B. MEDICATION REVIEWS

Medication reviews, as required by federal regulations, are the responsibility of the facility and are included in the per diem rate. The pharmacist must make arrangements with the facility for reimbursement of such services.

10.26.C. RETURN OF UNUSED DRUGS

Nursing facilities must, with a few exceptions for drugs such as controlled substances that are prohibited from being reused, properly credit Medicaid by returning unused prescription medications to the pharmacy. This policy applies to Medicaid beneficiaries where Medicaid is paying for the prescription medication. This does not apply to residents who have Medicare Part D.



The nursing facility must maintain documentation of:

- The quantity of medications dispensed and consumed by a beneficiary; and
- The return of all unused medications to the pharmacy so the pharmacy can credit Medicaid.

The nursing facility is required to return all prescription drugs that can be appropriately returned to the pharmacy due to the following reasons:

- Discontinuation in use by the prescriber
- Transfer to another facility (e.g., hospital or nursing facility)
- Discharge from nursing facility
- Death of beneficiary

The nursing facility and pharmacy may be subject to post-payment review to ensure the unused prescription drugs (as allowed by Federal and State law) are being returned by the nursing facility, and Michigan Medicaid is properly credited for the returned unused prescription drugs.

The nursing facility provider must not return prescription drugs to the pharmacy which are unsuitable for return according to State and Federal law.

The returned prescription drugs must:

- Have been properly stored
- Be returned unopened
- Not be a compounded product
- Be dispensed in the original packaging
- Be a non-controlled substance

The nursing facility should contact its contracted pharmacist consultant for assistance regarding which prescription drugs are not appropriate for return.

10.26.D. BENEFICIARY PHARMACY INSURANCE DEDUCTIBLE, COINSURANCE, COPAYS AND PREMIUMS

10.26.D.1. BENEFICIARY LIABILITY UNDER MEDICARE PART D

Beneficiaries who are enrolled in Medicaid and Medicare are considered dual eligibles. Dual eligibles who reside in nursing facilities do not have to pay premiums, coinsurance, deductibles and copays for prescription drugs if they are enrolled in a Medicare Part D plan. However, the Medicare Part D benefit requires that Medicaid make a payment(s) for nursing facility care for one full calendar month before the dual eligible is exempt from prescription drug copays.



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Under either Medicare or Medicaid, a nursing facility is not responsible for paying the pharmacy for a beneficiary's liability (copays, deductibles, and/or coinsurance) unless the facility has assumed this obligation by contract or such payment is required by state law.

10.26.D.2. COORDINATION WITH MEDICARE PART D

Medicaid does not coordinate benefits with the Medicare Part D benefit. Medicaid does not reimburse a pharmacy for the beneficiary's liability for prescription drugs if the beneficiary is:

- Enrolled in a Medicare Part D plan and the prescription drugs are covered under the Medicare Part D benefit.
- Eligible to join a Medicare Part D plan but chooses to retain his commercial insurance in place of joining a Medicare Part D plan.

If a beneficiary joins a Medicare Part D plan that has a premium more than the Medicare standard premium established for Michigan, the beneficiary must pay the difference in the cost that Medicare does not pay.

10.26.D.3. CONDITIONS WHEN NURSING FACILITIES CAN OFFSET THE PATIENT-PAY AMOUNT

The following table gives conditions on when a nursing facility can offset the patient-pay amount for the beneficiary's liability for prescription drugs.

If	Then
Beneficiary recently enters a nursing facility and his liability is not exempt under the Medicare Part D benefit until Medicaid has made a payment for one month, and it is established that the beneficiary will reside in the nursing facility for one month or more.	Nursing facility can offset the patient-pay amount for the beneficiary's liability during the initial month of the nursing facility stay.
Beneficiary is retroactively enrolled in Medicaid and his liability exemption under the Medicare Part D benefit has not yet taken effect.	The offsetting of the patient-pay amount for the beneficiary's liability can only occur for the first month if the retroactive enrollment in Medicaid is more than one month. The beneficiary's liability for subsequent months must be billed to the Medicare Part D plan by the pharmacy.
Beneficiary is prescribed drugs not covered by Medicare Part D, Medicaid or commercial insurance.	Nursing facility can offset the patient-pay amount.
Beneficiary has pharmacy copays, coinsurance, and deductibles from his commercial/private insurance.	Nursing facility can offset the patient-pay amount.

Nursing facilities cannot offset the patient-pay amount for insurance premiums.



Instructions for offsetting the patient-pay amount are contained in the Offset to Patient-Pay Amount for Noncovered Services section in the Billing & Reimbursement for Institutional Providers chapter.

10.26.D.4. RETROACTIVE MEDICAID AND MEDICARE PART D ENROLLMENT

If a beneficiary becomes retroactively enrolled in Medicaid and a Medicare Part D plan, a pharmacy can bill the Medicare Part D plan for the beneficiary's liability during the retroactive period in which the drugs were dispensed. However, in order for the pharmacy to bill Medicare Part D retroactively, the pharmacy must receive proof that Medicare Part D was made retroactive. The nursing facility can assist in getting the appropriate information to the pharmacy by obtaining the proof of retroactive eligibility from the beneficiary or the beneficiary's representative (this could be the facility). The pharmacy cannot make the decision of retroactive eligibility on its own. Hence, it is important that the nursing facility communicate with the pharmacy about the retroactive information so that the pharmacy can bill the Medicare Part D plan.

10.26.D.5. BENEFICIARIES INELIGIBLE FOR MEDICARE PART D

For beneficiaries who are not eligible for the Medicare Part D benefit, Medicaid will continue to coordinate benefits with their commercial/private insurance.

10.26.D.6. QUESTIONS ON MEDICARE PART D

Questions regarding a beneficiary's eligibility for Medicare Part D, specific Medicare Part D drug coverage, or retroactive enrollment in Medicare Part D must be directed to Medicare. Also, the Michigan Medicare/Medicaid Assistance Program (MMAP) provides free education and personalized assistance to people with Medicare and Medicaid, their families, and caregivers (including the nursing facility). (Refer to the Directory Appendix for contact information.)

Beneficiaries must contact their/their spouse's employer human resources department for questions concerning the coordination of their commercial/private insurance and Medicare Part D.

10.27 PHYSICIAN SERVICES

Physician services must be provided and are an ancillary service. Such services are not included in the facility's per diem rate. In accordance with federal requirements, residents have the right to choose an attending physician.

A physician must initially examine a resident within 48 hours of admission to the nursing facility, unless the resident has been examined by a licensed physician within five days before admission and a copy of that examination is available in the facility at the time of the resident's admission. If the admission occurs on a Friday, the exam must be completed within 72 hours.

A physician must evaluate a beneficiary every 30 days for the first 90 days after admission. The resident must then be evaluated every 60 days unless otherwise justified and documented by the physician. At a minimum, the resident must be evaluated at least once every 90 days on an ongoing basis.



A physician visit is considered timely if it occurs no later than ten days after the required visit. After the initial visit, the physician may alternate personal visits between the physician and a physician assistant, clinical nurse specialist or nurse practitioner.

10.28 PODIATRY SERVICES

Palliative treatment and routine foot care (e.g., trimming of the nails, removal of corns and calluses) are included in the facility's per diem rate.

Medically necessary podiatry physician services are an ancillary service and are not included in the facility's per diem rate.

10.29 PRIVATE DUTY NURSING

Private duty nurses are not covered in a nursing facility by the Medicaid Program nor are they included in the facility's per diem rate. The beneficiary may use personal funds to purchase private duty nursing services. A beneficiary's patient-pay amount may not be used to cover the cost of private duty nursing.

10.30 PRIVATE ROOM

When a Medicaid beneficiary requires a private room due to medical necessity, the nursing facility is reimbursed at the usual per diem rate. Private rooms required for medical necessity are included in the facility's per diem rate. Written documentation of medical necessity must be part of the beneficiary's medical record.

Medical necessity is defined as a documented medical condition that creates the need to isolate the resident for his safety and/or the safety of others (i.e., infection control). This also includes behavioral conditions related to a medical condition (i.e., aggression related to dementia). The medical necessity must be documented, as well as addressed, in care planning and treatment.

If a beneficiary requests a private room and there is no medical necessity, the beneficiary may elect to pay privately. The nursing facility must advise the beneficiary that a private room is not a Medicaid-covered service unless it is medically necessary, and that the beneficiary or family is responsible for paying the difference between the cost of a semi-private and private room. The facility may only charge the difference between what it would normally charge a private-pay resident for a semi-private and a private room. Facilities may not charge beneficiaries the difference between the Medicaid per diem rate and the rate charged a private-pay resident for a private room. For example, if the facility charges \$98.00/day for a semi-private room and \$112.00/day for a standard private room, the charge is \$14.00/day. The beneficiary's patient-pay amount may not be used for this purpose.

If the beneficiary agrees to pay the difference between the semi-private and private room rate, the beneficiary or family member must request permission, in writing, from MDHHS. The Request for Authorization of Private Room Supplemental Payment for Nursing Facility form (MSA-1580) is used to obtain the permission. The MSA-1580 is completed by the beneficiary or family member. (Refer to the Forms Appendix for a copy of MSA-1580.) Requests to supplement the cost of a private room are reviewed for cost and reason for request on a case-by-case basis. A response will be sent to the requestor, the beneficiary (if different), and the facility within ten working days.



This response must be retained as part of the beneficiary's medical record. Subsequently, these charges are subject to audit by MDHHS, CMS or designated representatives of either of those entities. These charges must be reported by the nursing facility as revenue received. This response, however, does not guarantee that the beneficiary will be provided a private room. The agreement to provide a private room is given by the nursing facility.

If a Medicaid beneficiary is in a private room (either Medicaid-certified or dually-certified) because the private room is the only bed available, the facility cannot request the beneficiary or beneficiary's family pay the difference between the semi-private and the private room rate, nor can the facility transfer or discharge the beneficiary due to non-payment of the difference.

10.31 PROSTHETICS

Prosthetic services are an ancillary service and are not included in the facility's per diem rate.

10.32 RADIOLOGY

Radiology services are an ancillary service and are not included in the facility's per diem rate.

10.33 SUBSTANCE ABUSE SERVICES AND TREATMENT

Services rendered for the treatment of alcohol and drug abuse are an ancillary service and are not included in the facility's per diem rate.

10.34 SUPPLIES, ACCESSORIES AND EQUIPMENT

Supplies, accessories, and equipment necessary to achieve the goals of the beneficiary's plan of care are included in the facility's per diem rate and must be available to the beneficiary. Medical supplies, accessories, and equipment include, but are not limited to:

- Atomizers
- Bandage products
- Bed linens
- Bib or protective cover
- Catheters/accessories and irrigation solution
- Cloth diapers
- Cotton balls
- Cotton swabs
- Deodorizers
- Diagnostic agents (e.g., Testape, Kyotest)
- Disposable diapers
- Disposable gloves



- Dressings (e.g., surgical pads, cellulose wadding, tape)
Note: Some supplies for complex wound care are not included in the per diem rate and must be obtained through a medical supplier or pharmacy. Supplies that must be billed by a medical supplier, including information for interpreting the list of supplies, are on the MDHHS website. (Refer to the Directory Appendix for additional information.)
- Elastic hose
- Enema kits
- Finger cots
- First aid trays
- Flameproof cubicle curtains
- Foot soaks
- Hot water bottles
- Hypodermic needles/syringes
- Ice bags
- Incontinence pads, pants, and liners
- IV supplies and equipment; related supplies (including IV infusion pump)
- Minor medical/surgical supplies
- Miscellaneous applicators
- Nebulizers (hand-held or used with a compressor)
- Ostomy supplies
- Plastic waste bags
- Recreational/therapeutic equipment and supplies to conduct ongoing activities
- Safety pins
- Sheepskin, devices and solutions for preventing/treating decubiti
- Slings
- Stethoscopes
- Straws
- Syringes/needles
- Thermometers
- Tongue blades (depressors)
- Towels/washcloths
- Tracheostomy care kits and cleaning supplies
- Trochanter rolls
- Water carafes/glasses



Note: This list is not complete. Generic equivalents and products in the same family (i.e., same general use) are also included in the facility's per diem rate.

10.35 TELEMEDICINE

A nursing facility can be either an originating or distant site for telemedicine. Refer to the Billing & Reimbursement for Institutional Providers Chapter for information regarding billing the originating site facility fee. Refer to the Telemedicine Section of the Practitioner Chapter for additional information regarding telemedicine services.

Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

10.36 THERAPIES [CHANGE MADE 4/1/20]

Routine maintenance therapy consists of the repetitive services required to maintain function. The development of the therapy and treatment are included in the per diem rate. Such therapy does not require the therapist to perform the service, nor does it require complex and sophisticated procedures.

Nursing facilities must provide or obtain specialized rehabilitative services if required by the beneficiary's plan of care. Non-routine occupational therapy (OT), physical therapy (PT) and speech therapy (ST) are ancillary services that are covered separately from the per diem rate if prior authorization is obtained and the following conditions are met:

- The therapy must be billed by the facility;
- There must be a written order by the attending physician/licensed physician's assistant for each calendar month of therapy; and
- The written orders must be signed by the attending physician/licensed physician's assistant and retained in the beneficiary's medical record.

Refer to the Therapy Services Chapter of this manual for additional information.

Non-routine OT, PT and SLP services are included in the Patient Driven Payment Model (PDPM) (revised per bulletin MSA 19-24) rates paid to State Veterans' Homes. State Veterans' Home providers are to bill for non-routine therapies on the same claims as daily care. All therapy services require prior authorization.

10.37 TRANSPORTATION

10.37.A. NON-EMERGENCY NON-AMBULANCE TRANSPORTATION

The nursing facility is responsible for non-emergency non-ambulance transportation for all Medicaid beneficiaries, including Medicare/Medicaid beneficiaries when Medicare is covering the cost of the care. This transportation includes transport to medical appointments/treatment not available in the facility (e.g., dialysis treatment), as well as when the facility arranges for services to be provided at the facility (e.g., hearing aid dealer; transportation costs of portable x-ray equipment and personnel). The facility must either arrange or provide transportation. Reimbursement for non-emergency non-ambulance transportation, whether the beneficiary is transported to the appointment or



the services are provided at the facility, is included in the facility per diem rate. The per diem rate also includes transportation for newly-admitted beneficiaries from a hospital or another residence.

Travel to out-of-state medical providers (other than Michigan Medicaid-enrolled "borderland" providers as defined in the General Information for Providers chapter of this manual) is not the responsibility of the facility and must be prior authorized by MDHHS.

The facility must select the most appropriate, cost-effective mode of transportation. Whenever possible, a facility-owned vehicle should be used. This vehicle must comply with the Americans with Disabilities Act (ADA).

In rare situations, the condition of a beneficiary needing non-emergency transport requires an attendant in addition to the driver. In such cases, it is appropriate for a nurse aide to accompany the beneficiary and this cost should be reflected in the annual cost report as "staffing costs associated with providing needed medical care." Sending a nurse aide or other staff member with the beneficiary being transported must not negatively impact the care of residents remaining in the facility.

The need for a nurse aide to accompany a beneficiary must not be confused with the responsibility of the family or legal guardian "to attend the beneficiary if escort is needed to sign consent forms, decide treatment options, sign insurance forms, provide histories, etc." A nurse aide is not to be responsible for these legal and medical decisions and knowledge.

10.37.B. EMERGENCY AMBULANCE

Nursing facilities must have contractual arrangements for ambulance services for emergencies. When there is an emergency, an ambulance provider renders the service and bills Medicaid.

10.37.C. NON-EMERGENCY AMBULANCE

When a physician issues a written order for non-emergency ambulance transportation, usually due to the need for a stretcher or other emergency equipment, the ambulance provider may only bill Medicaid directly and must maintain the physician's order as documentation of medical necessity. The written order must contain, at a minimum, the following information:

- Beneficiary's name and Medicaid identification (ID) number;
- Attending physician's NPI number and attending physician or provider signature;
- Type of transport necessary;
- Explanation of the medical necessity for ambulance transport (i.e., why other means of transport could not be used);
- Origin and destination;
- Diagnosis;



- Frequency of needed transports (required for ongoing, planned treatment); and
- Type of ongoing treatment (required for ongoing, planned treatment).

A separate physician's order is required for each individual transport, unless a beneficiary has a chronic medical condition that requires planned treatment. For chronic conditions, a physician may order non-emergency transportation for a maximum time period of up to 60 days in a single order. The physician's order for ongoing treatment must state the frequency of the transport and the type of ongoing treatment necessary. If non-emergency ambulance transport is not ordered by the beneficiary's physician, arrangements for payment must be between the facility and the ambulance provider, and cannot be charged to the beneficiary, beneficiary's family or used to offset the patient-pay amount. The cost of non-emergency ambulance transports not ordered by the beneficiary's physician must be identified and removed on Worksheet 1-B by the nursing facility.

10.38 VACCINES

Reimbursement for any vaccination ordered by the attending physician and administered in the nursing facility is included in the per diem rate. The invoiced purchase cost of the vaccine should be included as an allowable medical supply expense on the facility's cost report.

10.39 VISION

Vision services (examinations and glasses) are ancillary services and are not included in the facility's per diem.

A Medicaid copayment is not required for nursing facility beneficiaries.



SECTION 11 – SPECIAL PLACEMENTS AND AGREEMENTS

11.1 DEMENTIA UNITS

A nursing facility may elect to designate beds or units to address the special needs of beneficiaries with Alzheimer’s disease or other dementing illnesses. Care for Medicaid beneficiaries in dementia specialty beds is reimbursed as defined for any other nursing facility bed.

11.2 HOLDING A BED (HOSPITAL LEAVE AND THERAPEUTIC LEAVE)

Medicaid reimburses the nursing facility for holding a bed while the beneficiary is admitted to a hospital for emergency medical treatment (hospital leave) or takes a therapeutic leave from the facility for non-medical reasons.

Prior to therapeutic leave or transfer to a hospital, providers must give written notice of the facility’s bed hold and readmission policy to the beneficiary and a family member or legal representative. This must include information about Medicaid coverage for therapeutic and hospital leave. In an emergency, notice must be given to the beneficiary and family or legal representative within 24 hours. If the beneficiary refuses to have a family member notified, this must be documented in the beneficiary’s record.

The hospital leave portion of this policy only applies when Medicaid is the primary payer for room and board for the nursing facility stay at the time of the emergency hospital admission. For beneficiaries who are dually eligible for Medicare/Medicaid or have other insurance, Medicaid will not reimburse for holding a bed if Medicare or the other insurance is the primary payer for room and board for the nursing facility stay at the time of hospital admission. Medicaid will reimburse for the bed, however, if the resident who was Medicaid at the time of the hospitalization returns to the facility within the ten-day period with Medicare or other insurance coverage for the subsequent stay.

The written notice must specify:

- The Medicaid bed hold policy under which the beneficiary is permitted to return and resume residence in the facility; and
- The facility’s written policy under which a beneficiary is readmitted to the facility when their absence is in excess of the Medicaid-reimbursed leave days.

The beneficiary must be readmitted immediately to the first available bed if the beneficiary still requires nursing facility services and is still Medicaid eligible.

NOTE: This readmission policy also applies to Medicaid residents admitted before the effective date of the Denial of Payment for New Admissions (DPNA) who take temporary leave before, on, or after the effective date of the DPNA and are not considered new admissions upon return and, therefore, are not subject to the denial of payment.



11.2.A. HOSPITAL LEAVE DAYS

Medicaid reimburses a nursing facility to hold a bed for up to ten days during a beneficiary’s temporary absence from the facility due to admission to the hospital for emergency medical treatment only when the facility’s total available bed occupancy* is at 98 percent or more on the day the beneficiary leaves the facility. "On the day" is defined as the facility’s census at midnight (i.e., 12:01 a.m. – the first minute of the day).

Facilities at 97.50 percent occupancy or more may round up to 98 percent. Facilities may not round up 97.45 percent – 97.49 percent to 98 percent.

Occupancy includes all licensed beds (e.g., Medicaid-certified, dual Medicare/Medicaid certified, licensed only). The 98 percent or more occupancy does not include beds held open for hospital or therapeutic leave day(s).

In cases where a facility’s available bed occupancy is below 98 percent on the day the beneficiary leaves for an emergency admission to the hospital, but rises to 98 percent or more during his hospital stay, no hospital leave days can be billed for the beneficiary. Hospital leave days are only billable for a beneficiary if the occupancy rate is 98 percent or more on the day the beneficiary leaves the hospital.

In cases where the available bed occupancy is at 98 percent on the day the beneficiary leaves and drops below 98 percent during his hospital stay, the facility may bill up to 10 hospital leave days.

In instances where a facility is enrolled with Medicaid and has more than one provider NPI number, the available bed occupancy must be calculated separately for each provider NPI number.

Examples of Worksheet for Determining % of Occupancy

		Example 1	Example 2
A.	Total Licensed Beds (excluding beds in an approved non-available bed plan and/or beds disapproved by LARA for occupancy)	179	140
B.	Number of Total Licensed Beds Not Occupied (unoccupied beds available for a new resident)	2	7
C.	Beds for Residents on Hospital Leave (Medicaid or private pay is paying to hold the bed)	6	8
D.	Beds for Residents on Overnight Therapeutic Leave	0	10
E.	Total Residents on Leave (C + D = E)	6	18
F.	Adjusted Licensed Beds (A – E = F)	173	122
G.	Number of Residents Physically in Facility (total occupancy minus total residents on leave) (A – B – E = G)	171	115

* Calculation of available bed occupancy for purposes of Medicaid reimbursement for hospital leave days is different than calculation of occupancy for cost reporting purposes.



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Examples of Worksheet for Determining % of Occupancy

		Example 1	Example 2
H.	Occupancy (number of residents physically in facility divided by adjusted bed capacity) (G / F = H)	171 / 173 = 99%	115 / 122 = 94%

Facilities billing for Hospital Leave Days must document in the beneficiary's medical (clinical) record what the facility's census was at the time the beneficiary left the facility for a hospital leave.

The facility must hold the bed and may bill Medicaid if there is reasonable expectation by the attending physician at the point of admission to the hospital that the beneficiary will return to the nursing facility by the end of the tenth day. The hospital admission must be for emergency medical treatment, as documented by the attending physician in the beneficiary's medical record.

An "emergency medical condition" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the beneficiary (or, with respect to pregnant women, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

The beneficiary must return to the nursing facility in ten or fewer days in order for the nursing facility to bill Medicaid for hospital leave days.

If the beneficiary is in the hospital for more than ten days, the nursing facility is released from its obligation to hold the bed and cannot bill Medicaid for any hospital leave days. The resident may be charged to hold the bed for those days if they agree in advance. (See Medicaid Non-Covered Leave Days subsection.) The facility is encouraged to monitor the resident during the hospital stay to determine the likely length of hospitalization.

If the resident is expected to be in the hospital for ten days or fewer and dies while in the hospital, the nursing facility may bill Medicaid for the hospital leave days up to the day before the resident died.

If the resident returns to the nursing facility under Medicare coverage, and was Medicaid eligible prior to the emergency admission, the facility may bill Medicaid for the hospital leave days if the emergency hospitalization was for ten days or fewer.

A resident is counted in the facility census if they are in the facility at midnight. If the resident is out of the facility on hospital leave at midnight, that day must be counted as a hospital leave day. If the resident returns to the nursing facility from the hospital, then is re-admitted to the hospital for the same condition that they were hospitalized for previously, the 10-day period of Medicaid reimbursed hospital leave days continues if the



resident was not counted in the facility census for that day. If, given the circumstances above, the resident was counted in the facility census, a new 10-day period of Medicaid reimbursed hospital leave days may begin.

The resident need not be shown on the Medicaid claim as discharged from the nursing facility unless the hospital admission was a planned admission (not an emergency) or was longer than 10 days. NOTE: If the claim does show discharged, the facility is reminded of Medicaid's readmission policy. The beneficiary must be readmitted immediately to the first available bed if the beneficiary still requires nursing facility services and is still Medicaid eligible. This readmission policy also applies to Medicaid residents admitted before the effective date of the Denial of Payment for New Admissions (DPNA) who take temporary leave before, on, or after the effective date of the DPNA and are not considered new admissions upon return and, therefore, are not subject to the denial of payment.

Patient-pay amounts and billing methods are not affected by this hospital leave day policy. The nursing facility should continue to collect any patient-pay amount, typically on the first day of the month, and indicate the amount collected on the Medicaid claim. CHAMPS automatically deducts the patient-pay amount and reimburses the provider for the balance. If the facility bills Medicaid for hospital leave days that occur at the beginning of the month, then the nursing home should collect the patient-pay amounts as usual. The facility should charge the amount against the patient-pay that Medicaid will pay for that day. For example, if a resident has a patient-pay of \$200 and is in the hospital for an emergency condition for the first five days of the month (the stay is 10 days or fewer), the nursing facility should collect the patient-pay amount from the resident, then submit a Medicaid claim. Medicaid would reimburse the facility the hospital leave day per diem rate, minus the patient-pay amount. Using 2002 figures, the facility reimbursement would be \$150.30 [(\$70.06 x 5)-\$200].

There is no limit to the number of hospital leave days per resident that may be billed to Medicaid annually as long as there are no more than 10 consecutive leave days per hospital stay.

Medicaid hospital leave days are not included in the Medicaid census statistics. Leave days reimbursed by other payer sources must be included in the census statistics.

11.2.B. THERAPEUTIC LEAVE DAYS

If the beneficiary has a temporary absence from the nursing facility for therapeutic reasons as approved by a physician, Medicaid reimburses the facility to hold the bed open for up to a total of 18 days during a 365-day period. Therapeutic leave is for non-medical reasons, such as overnight stays with friends or relatives. A resident is counted in the facility census if they are in the facility at midnight. If the beneficiary is out of the facility on therapeutic leave at midnight, that day must be counted as a therapeutic leave day.



The Medicaid Program covers up to 18 therapeutic leave days in a 365-day period for each beneficiary if:

- The facility reserves the bed for the beneficiary during his absence; and
- The beneficiary's written plan of care provides for out-of-facility visits; and
- The beneficiary returns to the facility.

There is no limit to the number of therapeutic leave days that may be reimbursed at one time as long as the total does not exceed 18 days in a 365-day period (not the calendar year). For example, if a resident goes on a 5-day family vacation beginning April 10, 2003, that resident has 13 therapeutic leave days remaining until April 9, 2004.

If a beneficiary does not return from a therapeutic leave, the beneficiary must be discharged on the date he left the facility. The date of admission and the date of discharge may not be billed as therapeutic leave days.

Therapeutic leave days must be included in the Medicaid census statistics if the therapeutic leave day is being paid by the beneficiary or Medicaid.

11.2.C. MEDICAID NON-COVERED LEAVE DAYS

Medicaid does not reimburse providers to hold a bed for reasons other than emergency transfer to a hospital (10-day maximum per hospital admission), or therapeutic leave (18-day maximum per 365-day period). However, the facility may hold the beneficiary's bed for other reasons and for leave days not covered by Medicaid, and bill the beneficiary if the beneficiary:

- Has prior knowledge that the service is not a Medicaid benefit; and
- Desires to have the bed reserved; and
- Agrees, in writing, to pay the facility to hold the bed at a specified rate. (The beneficiary's patient-pay amount may not be used for this purpose.)

If the beneficiary elects to not pay privately, the beneficiary has the option to return to the next available, equivalent bed. A beneficiary cannot be involuntarily transferred/discharged after a temporary absence, including discharge to obtain acute care in an inpatient hospital, unless the appropriate criteria are met and the appropriate regulations, policies, and procedures are followed.



Except for Medicaid-covered leave days and when beneficiaries have paid to hold a bed, the beneficiary must be discharged from the facility and then readmitted upon return to the first available bed.

All paid bed hold days (excluding Medicaid hospital leave days) must be included in the Medicaid cost report census statistics.

11.3 INVOLUNTARY TRANSFER OR DISCHARGE

11.3.A. CONDITIONS

A nursing facility must not involuntarily transfer or discharge a beneficiary unless:

- It is necessary for the welfare of the beneficiary, and the beneficiary's needs cannot be met in the facility; *
- The beneficiary's health has improved sufficiently so the beneficiary no longer needs the services provided by the facility; *
- It is necessary to protect the safety of individuals in the facility;
- It is necessary to protect the health of individuals in the facility; *
- The beneficiary has failed, after reasonable and appropriate notice, to pay (or to initiate payment under Medicaid) for a stay at the facility; or
- The facility ceases to operate.

The facility must include documentation in the beneficiary's clinical record for any of the above circumstances.

11.3.B. TRANSFER TRAUMA

For certain residents (defined below), transfer trauma must be considered when that resident may be moved due to a change in the level of nursing need.

Transfer trauma is defined as "any adverse psychological and/or physical effects occasioned by the transfer of a nursing home patient that would be materially detrimental to the physical or mental health of the patient."

Residents for whom transfer trauma must be considered include all those who have resided in the current nursing facility for at least one year, or who have been involuntarily transferred within the previous year. (A discharge to obtain acute care in an inpatient hospital, followed by an immediate readmission within three weeks to the same nursing facility, does not interrupt the continuity of a resident's stay.)

The SSA evaluates transfer trauma. This evaluation considers the social, mental and emotional adjustment of the resident, including the length of time that the resident has

* Items require documentation of medical necessity by the attending physician.



been in the nursing facility and the relationships that the resident has formed in the facility. This evaluation may also consider the resident's age, history and success of previous placements, and history of adapting to change. Consideration must also be given to the opinion of the attending physician regarding the resident's social and emotional adjustment and the physical effects of the proposed transfer.

Transfer trauma must be considered before the resident is notified of a nursing level of care change. When Medicaid is the payer source, Medicaid payment at the current level continues while transfer trauma is being considered.

If Medicaid was not the payer source immediately prior to the transfer trauma issue being raised, then Medicaid payment is not made until a decision is reached.

If the transfer trauma decision upholds the beneficiary's medical need to remain in a bed not certified for his present level of care, then the beneficiary's prior level of care will be retained to provide for continued Medicaid coverage.

If it is determined that there is no issue of transfer trauma, the beneficiary must be transferred to a bed or setting appropriate for the new level of care. MDHHS will change the Benefit Plan Assignment, which can be appealed by the beneficiary or their designated representative.

Concerns about involuntary transfer and/or transfer trauma should be reported to the Health Facility Complaint Line. (Refer to the Directory Appendix for contact information.)

11.3.C. BENEFICIARY NOTIFICATION

Nursing facilities must give beneficiaries a 30-day written notice regarding transfer unless:

- The transfer or discharge is a health care emergency;
- The safety or health of beneficiaries or staff is endangered;
- The beneficiary agrees to the transfer/discharge;
- The beneficiary's health has improved sufficiently so the beneficiary no longer needs the services provided by the facility; or
- The facility ceases to operate.

The notice must include:

- The reason for the transfer or discharge;
- The effective date of the transfer or discharge;
- The location to which the beneficiary will be transferred or discharged;
- The name, address, and (toll-free) telephone number of the State Long Term Care Ombudsman;



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- For beneficiaries with developmental disabilities (DD), the mailing address and telephone number of the agency responsible for the protection and advocacy of DD individuals, established under the Developmental Disabilities Assistance and Bill of Rights Act;
- For nursing facility beneficiaries with mental illness (MI), the mailing address and telephone number of the agency responsible for the protection and advocacy of MI individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act; and
- Appeal rights.

The facility must also provide:

- Sufficient preparation and orientation to beneficiaries to ensure safe and orderly transfer or discharge from the facility, as required by state and federal regulations; and
- Notice of the facility's bed-hold and re-admission policy, including the Medicaid bed-hold policy.

If a nursing facility elects to discontinue operations (voluntary closure) or withdraw from the Medicaid program, the facility must provide notice to the beneficiary as outlined above not less than 30 days before the closure or withdrawal. The notice must be sufficient to allow for suitable relocation arrangements.

11.4 MARRIED COUPLES

When married beneficiaries or blood relatives live in the same Medicaid nursing facility, they may share a room if both spouses or their relatives consent. (This policy applies only to beneficiaries who both require nursing facility services. It does not apply when one beneficiary does not require nursing facility services. For example, if both spouses wish to share a room in a nursing facility, in order for Medicaid to cover both of them in the facility, they must both require nursing facility services. If only one of them requires nursing facility services, Medicaid only covers services for that person.)

11.5 COMPLEX CARE

The Complex Care Prior Approval-Request/Authorization for Nursing Facilities form (MSA-1576) is used to request prior approval (PA) for the placement of a Medicaid beneficiary for whom placement from a hospital has been, or could be, hindered due to the cost and/or complexity of nursing care or special needs. The authorization covers an individually negotiated reimbursement rate for the placement. Special individualized placement requests and payment arrangements are based on medical necessity and/or service/supply needs exceeding those covered by Medicaid reimbursement for routine nursing facility care.

Examples include, but are not limited to:

- Ventilator dependent care (for nursing facilities not contracted with MDHHS to provide ventilator dependent care)
- Multiple skin decubiti utilizing several treatment modalities



- Tracheostomy with frequent suctioning needs
- Beneficiaries who require intensive nursing care or treatment.

Program requirements:

- Referrals must come from the nursing facility.
- Hospitals must document that at least ten (10) Medicaid certified nursing facilities within a 50 mile radius of the hospital refused to admit the beneficiary due to the complexity of the patient's care needs.
- Nursing facilities may request approval after admitting a beneficiary if the hospital failed to accurately document the beneficiary's condition and needs prior to transfer to the nursing facility. The nursing facility must request approval within 30 days from the date of admission to the nursing facility.

The following information must be submitted:

- A completed MSA-1576, including any requests for additional nursing, CENA, supplies or equipment. **NOTE:** The only supplies or equipment that will be considered are those not included in the facility's per diem rate or not separately billable by a Medicaid-enrolled medical supplier. An electronic copy of the form is available on the MDHHS website. (Refer to the Directory Appendix for website information.) (Refer to the Medicaid Service Descriptions Section of this chapter for information regarding what services are to be provided by the NF as part of the daily per diem reimbursement.)
- The beneficiary's medical background, including:
 - current medical status;
 - admitting history and physical;
 - a copy of all consultations;
 - most recent three-day physician progress notes;
 - treatment/nursing care plan; and
 - justification for any additional nursing hours and/or special equipment requested.

(This information should be included on the MSA-1576.)

- Recent (within the past 30 days) lab, x-ray, and diagnostic or therapeutic test results or reports.
- A list of 10 nursing facilities (as documented by the hospital) within a 50-mile radius that have denied admission, including:
 - Name, address, and telephone number of the nursing facility
 - Contact person's name and title
 - Date of contact
 - Reason for denial
- Documentation of the financial resources available to the beneficiary, including:
 - Medicaid coverage



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- Medicare Parts A and B
- Other commercial insurance coverage.
- Name and telephone number of a contact person at the nursing facility seeking the additional reimbursement for complex care.

It may take up to 15 business days for the MSA-1576 to be processed. If it appears that a beneficiary, upon discharge, will require intensive nursing care, the hospital's discharge planning coordinator should initiate the MSA-1576 as early in the beneficiary's hospital stay as possible to ensure a smooth transition to the nursing facility.

MDHHS will make a determination and return to the provider a letter indicating approved, denied, insufficient data, no action, or approved as amended. If approved, the approval letter will contain a PA number with start and end dates. To renew a request, the facility must submit another MSA-1576 at least 15 business days prior to the expiration/end date.

A beneficiary residing in a nursing facility with an active complex care prior authorization for vent care for two consecutive years must receive a pulmonary evaluation at the beginning of the third year and annually thereafter. A beneficiary may be exempt from the annual pulmonary evaluation if, at the time the scheduled evaluation is due, the beneficiary elects not to have the evaluation, the physician documents a medical reason to not perform it, or the beneficiary received a pulmonary evaluation within the current year, such as during a hospital stay. If the beneficiary chooses not to have the evaluation, the nursing facility must notify the beneficiary's physician of that decision. Documentation of the decision to decline the evaluation by either the beneficiary or the physician must be in the beneficiary's medical record.

11.6 ONE-DAY STAY

A nursing facility is reimbursed for a one-day stay if a Medicaid beneficiary is admitted to the facility and, the same day, is discharged from the facility due to death, return home, or transfer to another institution that is not a Medicaid-enrolled provider. The one-day stay does not apply to a beneficiary admitted to a nursing facility if, later that day, the beneficiary is discharged and transferred to another nursing facility or an inpatient hospital and, at midnight, the second facility or hospital claims the beneficiary in its daily census.

A one-day stay must be included in the Medicaid census statistics.



11.7 RELIGIOUS NON-MEDICAL HEALTH CARE CENTER

Religious Non-medical Health Care Centers may be licensed as nursing facilities and certified for Medicaid. Beneficiaries in Medicaid-certified facilities, under the care of a practitioner, may be determined to be in need of nursing care and, therefore, covered by Medicaid.



SECTION 12 – SPECIAL PROVIDER TYPE COVERAGES AND LIMITATIONS

12.1 HOSPITAL SWING BEDS

In order to address the shortage of rural nursing facility beds, federal requirements allow rural hospitals to provide post-hospital extended care services. Such a hospital, known as a swing bed hospital, can "swing" beds between hospital and nursing facility levels of care on an as-needed basis. In order to receive Medicaid reimbursement, hospital swing beds must meet all applicable state and federal requirements and provide all required services.

Providers of hospital swing bed services may bill Medicaid for hospital swing bed days only when the combined length of stay in the acute care bed and swing bed exceeds the average length of stay for the Medicaid inpatient diagnosis related group (DRG) of the admission. Hospitals that are exempt from the DRG reimbursement system may bill for Medicaid-covered swing bed days beginning the day of admission to the swing bed.

The total number of Medicaid-reimbursed hospital swing bed days is limited to 100 days per beneficiary per calendar year.

A hospital swing bed provider must not provide extended care services if the hospital owns or operates a hospital long-term care unit that has beds available at the time a patient requires admission for extended care services.

Medicaid does not require the MDS for clinical assessment purposes or reimbursement for beneficiaries in hospital swing beds. The PASARR process must be completed, as outlined earlier in this chapter, prior to placement in a nursing facility.

(Refer to the Billing & Reimbursement for Institutional Providers Chapter of this manual for additional swing bed billing instructions.)

12.2 VENTILATOR-DEPENDENT CARE UNITS

There may be occasions when a beneficiary no longer requires acute hospital care but requires specialized care in a Ventilator Dependent Care Unit (VDCU). Medicaid authorizes admission of ventilator dependent Medicaid beneficiaries to hospital and nursing facility ventilator units with which it has agreements to provide VDCU services, and for which there is an enhanced Medicaid reimbursement.

12.2.A. PLACEMENT CRITERIA

A request for placement must show that the:

- Beneficiary is dependent on life-supporting mechanical ventilating equipment for at least six hours per day.
- Beneficiary stay normally meets or exceeds the hospital high-day outlier threshold for DRG 207.



Approval for admission to a VDCU will not be given for a beneficiary who is only on CPAP or BIPAP. If a beneficiary has weaning potential or requires other rehabilitative services (in addition to the respiratory care) and is enrolled in a Medicaid Health Plan (MHP), the MHP is responsible for the first 45 days reimbursement in the post-acute setting. If there is no weaning potential and the beneficiary does not require rehabilitative services, disenrollment from the MHP may occur at the time the beneficiary is discharged from the hospital.

The MHP is responsible for initiating disenrollment of a beneficiary by submitting the Request for Disenrollment Long Term Care form (MSA-2007) to MDHHS.

In situations where a beneficiary cannot immediately be placed in a nursing facility or hospital VDCU, Medicaid will cover nursing days in the inpatient hospital. When the beneficiary is in a hospital setting because a nursing facility placement is not available, Medicaid will cover the ancillary services provided by the hospital.

The hospital cannot charge a beneficiary the difference between the hospital's charge and the MDHHS payment for nursing days.

If a beneficiary refuses an appropriate placement to a VDCU, the beneficiary is responsible for all hospital charges incurred after the date of referral.

12.2.B. AUTHORIZATION FOR VDCU PLACEMENT

To begin the prior authorization process once a VDCU has agreed to accept the beneficiary, the VDCU must contact (by telephone) the MDHHS Medicaid Prior Authorization Contractor for authorization. The MDHHS Medicaid Prior Authorization Contractor will consider the request for ventilator-dependent unit care based on current Medicaid policy. The request will be approved or denied immediately during the telephone call. (Refer to the Directory Appendix for contact information.)

Note: If the PA request is approved, the MDHHS Medicaid Prior Authorization Contractor will:

- request the VDCU's National Provider Identifier (NPI) for inclusion in the prior authorization record; and
- provide the VDCU with a prior authorization number for billing purposes.

The nursing facility must report any change of condition, such as weans from ventilators, transfers, discharges, re-hospitalizations and deaths of these complex care residents to the MDHHS Medicaid Prior Authorization Contractor.

Residents who are weaned from their ventilators will be allowed a 14-day stay in the VDCU from the date they are removed from the ventilator, at the allotted VDCU reimbursement rate, in order to assure complete wean is maintained. Once the 14 days of successful wean has been maintained, it is then the responsibility of the VDCU to



transfer the resident to a Medicaid LTC bed within the facility, transfer the resident to another nursing facility, or discharge the resident home with appropriate care planning involving family, responsible party, and community resources. Once successful wean has been maintained, the PA number will be retired.

If a beneficiary is in need of therapy, prior authorization for the therapy must be obtained under the VDCU's NPI. (Refer to the Nursing Facility Claim Completion section of the Billing & Reimbursement for Institutional Providers chapter for additional information.)

12.2.C. NON-AUTHORIZATION OF NEW ADMISSIONS TO A MEDICAID APPROVED VDCU IF FACILITY HAS A SURVEY CITATION OF ACTUAL HARM

New admissions to a VDCU will not be approved from the date a nursing facility receives the CMS-2567 (written survey report) containing the survey citation at a level of actual harm or higher on the scope and severity grid (G, H, I, J, K or L) pertaining to a resident or residents of the VDCU. Authorizations of new admissions will resume when the Department of Licensing and Regulatory Affairs, State Survey Agency notifies the State Medicaid Agency that all deficiencies have been corrected and the facility has been found to be in substantial compliance. This policy does not apply to the renewal of authorizations for Medicaid beneficiaries residing in a VDCU prior to the survey citation of actual harm.



CERTIFICATION, SURVEY & ENFORCEMENT APPENDIX

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SECTION 1 – INTRODUCTION

Michigan Department of Health and Human Services (MDHHS), under an approved State Plan as required by the Social Security Act, is responsible for annual Medicaid certification of all nursing facilities (other than State-owned facilities, such as a State Veterans' Home). Michigan Department of Licensing and Regulatory Affairs (LARA) is responsible for ensuring all Medicaid-certified nursing facilities are in compliance with Health Survey and Life Safety Code Survey requirements.

As required by federal law, the State Medicaid Agency (MDHHS, Medical Services Administration) has entered into an interagency agreement with the State Survey Agency (Michigan Department of Licensing and Regulatory Affairs [LARA], Bureau of Community and Health Systems [BCHS]) to conduct surveys of Medicaid providers and applicants. The State Medicaid Agency (SMA) accepts State Survey Agency (SSA) certification decisions as final, but exercises its own determination whether to enter into agreements with providers.

For the purposes of this appendix, a Medicaid-certified nursing facility (NF) is defined as a non-state-owned nursing home, county medical care facility, or hospital long term care unit with Medicaid certification. This appendix includes information regarding Medicaid certification of nursing facilities, staff certification, the survey process, and enforcement remedies when facilities are not in compliance with applicable requirements.



SECTION 2 - MEDICAID CERTIFICATION AND DE-CERTIFICATION OF NURSING FACILITY BEDS AND MEDICAID PROVIDER ENROLLMENT

This Section describes Medicaid certification requirements for nursing facilities, certification and de-certification of nursing facility beds, and how nursing facility providers enroll in Medicaid.

The SMA is responsible for initial certification and annual certification of beds for nursing facilities seeking Medicaid reimbursement. In order for a provider to receive Medicaid reimbursement for nursing care, the nursing facility beds must be Medicaid certified by the SMA and the provider must be enrolled with Medicaid. The SSA is responsible for conducting any required certification surveys for the SMA.

2.1 DUAL CERTIFICATION [CHANGES MADE 4/1/20]

MDHHS requires all new Medicaid-certified nursing facility beds to also be certified for Medicare. Applications for certification of new Medicaid beds that are not Medicare-certified will be denied. Applications for initial Medicare certification may be made to the LARA-BCHS. Facilities must meet state and federal regulations for certification.

Providers may seek annual certification of nursing facility beds currently certified as Medicaid-only. Beds that were certified as Medicaid-only as of August 1, 2004 are not required to become Medicare-certified. This exception also applies to Medicaid-only certified beds that were designated as unavailable for occupancy on August 1, 2004. However, MDHHS strongly encourages Medicare and Medicaid (dual) certification of all nursing facility beds in order to maximize access for beneficiaries.

A nursing facility that has certified beds that were granted an exception under this policy, and that is subsequently involved in circumstances that would require it to enroll with Medicaid (such as a change in ownership), must secure Medicare certification for Medicaid beds within one year. A provider's failure to secure dual certification for all Medicaid-certified beds will result in denial of Medicaid certification and termination of Medicaid enrollment.

A provider that applies for new Medicaid certification for some beds in a nursing facility must dually certify all Medicaid beds in the facility before any new Medicaid bed certifications will be approved for the facility, even if the existing Medicaid-certified beds were granted an exception under this policy. For example, a nursing facility has a distinct part or unit that is certified as Medicaid-only and is granted an exception under this policy. The provider adds a new wing and applies for Medicaid certification for the new beds. The new beds will be approved for Medicaid certification only if all Medicaid beds in the nursing facility are also certified for Medicare, including the beds in the historically Medicaid-only unit.

A licensed nursing facility entity that becomes a provider as a result of the purchase of a previously closed or currently operating Medicaid-only nursing facility must receive Medicare certification for all Medicaid-certified beds in that nursing facility within one year from the date of purchase of an operating nursing facility or the date of reopening of a previously closed nursing facility. The provider will receive a provisional Medicaid provider agreement while pursuing Medicare certification of the Medicaid-certified beds. This provisional agreement is time limited and holds the provider to the loss of Medicaid certification and disenrollment without appeal if Medicare certification is denied. If warranted, the SMA may grant an additional grace period contingent upon evidence that substantial progress has been made toward Medicare certification. Failure to meet this requirement will result in de-certification of the Medicaid beds and termination of Medicaid enrollment.



A nursing facility that currently has Medicare certification of its Medicaid beds must maintain the dual certification. A nursing facility that voluntarily disenrolls or decertifies beds from Medicare will lose Medicaid certification of those beds. A nursing facility that loses its Medicare certification through the Centers for Medicare & Medicaid Services (CMS) regulatory enforcement actions will automatically lose its Medicaid certification. An exception or exemption to this dual certification may be made pursuant to the provisions contained in Section 21718 of P.A. 368 of 1978 (MCLA 333.21718). Any exception or exemption granted to a nursing facility under Section 21718 of P.A. 368 of 1978 prior to August 1, 2004 will be recognized.

Facilities granted a Certificate of Need (CON) for special population beds, as defined in the Certificate of Need Review Standards for Nursing Home and Hospital Long-Term Care Unit (HLTCU) beds, are also required to dually certify these special population beds (e.g., ventilator dependent care beds, behavioral, traumatic brain injury/spinal cord injury [TBI/SCI]). (revised 4/1/20) ICF/IID or MI beds need not be dually certified.

A provider must apply for and receive dual Medicaid and Medicare certification for new Medicaid beds acquired through the CON process, e.g. new construction or the redistribution of certified beds.

All beds approved pursuant to CON Review Standards for nursing home and HLTCU beds must be dually certified for Medicare and Medicaid. Beds approved under this subsection shall not be converted to or utilized as general nursing home use without a CON for nursing home and hospital long-term care unit beds; and shall not be offered to individuals other than the special populations they were initially approved for. (text added 4/1/20)

2.2 MEDICAID BED CERTIFICATION LIMITS

Individual facilities seeking to enroll in the Medicaid program or seeking to increase the number of Medicaid-certified beds must apply as outlined in the Medicaid Nursing Facility Bed Certification Process subsection of this appendix. Applications to the SMA will be reviewed in date order and must be received 45 days before the first of the month beginning the next quarter of the provider's cost reporting year. MDHHS will authorize Medicaid-certified beds, limited by the aggregate Upper Bed Limit (set in 1996 at 47,542), based on the criteria outlined in the Criteria for Evaluation of Medicaid Bed Certification Applications subsection. Preference will be given to facilities that are applying for Medicaid certification in order to dually certify beds, to facilities that are creating innovative living environments for beneficiaries who choose nursing facility care, and to facilities in geographic areas with limited Medicaid accessibility. Changes in bed certifications will take place after approval is granted effective on the first of the month beginning the next quarter of the provider's cost reporting year. Changes in bed certifications will not be approved on a retroactive basis.

2.3 CRITERIA FOR EVALUATION OF MEDICAID BED CERTIFICATION APPLICATIONS [CHANGES MADE 4/1/20]

The SMA (MDHHS-MSA) will collaborate with the SSA (LARA-BCHS) when making a determination regarding the approval or denial of any application for Medicaid bed certification and provider enrollment. Approval or denial of an application to MDHHS for Medicaid bed certifications will be based on the following criteria:

- Verification from the SSA that the beds are also Medicare-certified.
- The nursing facility's historical and current survey performance demonstrates no regulatory deficiencies or only deficiencies with minimal impact on residents. The nursing facility has not



been subject to one of the following actions or concerns within **(text deleted 4/1/20)** the preceding eight full quarters (or as noted) of the filing of an application for Medicaid bed certification:

- A state enforcement action involving license revocation, a limited or total Ban on Admissions, reduced license capacity, selective transfer of residents, receivership, or appointment of a clinical/administrative advisor or temporary manager.
- Termination of Medicaid enrollment initiated by MDHHS.
- A state rule violation showing failure to comply with state minimum staffing requirements and/or a federal citation documenting potentially harmful resident care deficits resulting from insufficient staff.
- A state or federal finding of Immediate Jeopardy.
- Repeat citations at the harm or substandard quality of care level. "Repeat citation" is defined as two citations of the same federal deficiency, or two or more citations within the same regulatory grouping, at the substandard quality of care, harm, or Immediate Jeopardy levels, issued within the last preceding eight full quarters or two standard survey cycles. (The time frame for this criterion may exceed eight quarters.) This criterion considers deficiencies resulting from both standard and abbreviated surveys.
- A number of citations at Level Two or above on the scope and severity grid on two consecutive standard surveys that exceeds twice the statewide average number of citations. (The time frame for this criterion may exceed eight quarters.)
- A number of citations at Level Two or above on the scope and severity grid resulting from abbreviated surveys during the preceding full eight quarters that exceeds twice the statewide average number of citations. **(revised 4/1/20)**
- A federal or state termination or decertification action.
- A federal or state action to deny payment for new or all admissions.
- A filing of bankruptcy or failure to meet financial obligations that threatens the ability of the nursing facility to achieve or maintain compliance with state and federal requirements.
- An outstanding debt to MDHHS (i.e., cost settlement, civil money penalty [CMP] fine, provider Quality Assurance Assessment Program (QAAP) tax, licensing fees). This does not include financial issues that are in the appeal process.

NOTE: When a provider sells a nursing facility, the provider is responsible for all QAAP assessments billed and incurred prior to the date of the sale. The purchaser(s) must assure escrow of any outstanding QAAP amounts owed, or the purchaser(s) becomes responsible for payment of the QAAP and penalty amounts owed before Medicaid participation is granted.

- Failure to comply with a state correction notice order.
- Enforcement action against the administrator's license in current or previously administered nursing facilities.



- Any other concerns reasonably related to the ability of the nursing facility to maintain compliance with Medicare and Medicaid Requirements for Long Term Care Facilities or to provide appropriate care to residents.
- If currently enrolled as a Medicaid provider, in addition to the criteria above, must be a provider in good standing, defined as:
 - The nursing facility, owner(s), administrator, or other staff are not sanctioned or excluded by Medicare or Medicaid;
 - The nursing facility is in compliance with the Medicare and Medicaid Requirements for Long Term Care Facilities.

Medicaid may enter into a provisional enrollment with a provider (or the owner or management company) that does not meet the above criteria if:

- The applicant and the owner or management company take actions acceptable to MDHHS to correct, improve or remedy any conditions or concerns that would result in denial of the application; and
- The applicant and the owner or management company attains and maintains compliance with the criteria above during the period of the provisional Medicaid enrollment. Failure of the provider to comply with the terms of the conditional agreement will result in termination without appeal of the provisional Medicaid enrollment.

2.4 MEDICAID NURSING FACILITY BED CERTIFICATION PROCESS

Current providers who wish to change their Medicaid-certified beds (increase, decrease, relocate) and providers who wish to enroll in the Medicaid Program may do so as outlined in this subsection. A written application to change Medicaid-certified beds must contain the following:

- Number and location of facility beds.
- Current certification designation of all facility beds by unit or wing.
- Requested number and proposed location of increased, decreased, or relocated Medicaid beds, with an attached layout of the facility showing the current and proposed distribution of beds.

A provider may apply for a change in Medicaid bed certifications any time throughout the year up to once per quarter.

The change in bed certifications will take place after approval is granted effective on the first of the month beginning the next quarter of the provider's cost reporting year. Changes in bed certifications will not be approved on a retroactive basis.

In addition to the process outlined below, nursing facilities must abide by the procedures outlined in the State Operations Manual, Chapter 3, Section 3202, Change in Size or Location of Participating SNF and/or NF.

MDHHS will respond to Medicaid bed certification applications with a determination within 45 days of receipt of all requested information.



2.4.A. BED CERTIFICATION PROCESS FOR MEDICAID ENROLLED PROVIDERS

Nursing facilities that are currently enrolled with Medicaid and want to change their number of Medicaid-certified beds must file a written application to both LARA (BCHS) and MDHHS (SMA). (Refer to the Directory Appendix for application mailing instructions related to Medicaid bed certification changes.) The SMA and the SSA will collaborate regarding the consideration and disposition of applications for additional Medicaid beds. The SSA will conduct surveys as needed. Medicaid approval or denial of the application will be based on the considerations outlined in the Criteria for Evaluation of Medicaid Bed Certification Applications and the Dual Certification subsections of this appendix.

Once the SMA makes a determination regarding the application for additional Medicaid bed certifications, the provider, the SSA, MDHHS Provider Enrollment, and the MDHHS LTC Reimbursement and Rate Setting Section (RARSS) will be notified, in writing, by the SMA. If the application is denied, the provider will be notified of their appeal rights in writing. If the application is approved, the SSA will be notified by the SMA of the change. The SSA will also notify the provider of the change.

2.4.B. BED CERTIFICATION PROCESS FOR NURSING FACILITIES NOT ENROLLED IN MEDICAID

This subsection applies to providers operating existing facilities that have not previously participated in the Medicaid Program, or providers seeking to certify Medicaid beds following the loss of certification due to a regulatory action.

Non-Medicaid providers seeking to receive Medicaid certification for nursing facility beds and receive Medicaid payment must file a written application with both the SSA and with the SMA. The SMA and the SSA will collaborate regarding the consideration and disposition of the application for Medicaid bed certifications. The SSA will conduct surveys as needed. Medicaid approval or denial of the application will be based on the considerations outlined in the Criteria for Evaluation of Medicaid Bed Certification Applications subsection of this appendix.

Once the SMA makes a determination regarding the application for Medicaid bed certifications, the provider, the SSA, MDHHS Provider Enrollment, and RARSS will be notified, in writing, by the SMA. If the application is denied, the SMA will notify the provider of their appeal rights in writing. If the application is approved, the SMA will notify the provider and the SSA of the change. The SSA will also notify the provider of the change.

The provider must also enroll in Medicaid as outlined in the Medicaid Provider Enrollment subsection of this appendix.

2.4.C. BED CERTIFICATION PROCESS DURING A CHANGE IN OWNERSHIP (CHOW)

A provider seeking a change in ownership of a nursing facility must first receive approval through the CON process within MDHHS. The new provider can avoid a delay in payment and address any potential certification issues by submitting a written 90-day advance notice, plus a copy of the sale and/or lease agreement, to the SSA, the



SMA/LTC Services Section and RARSS. (Refer to the Directory Appendix for contact information.)

The following are changes in ownership that must be reported to the SMA and the SSA, regardless of whether a CON is required:

- A change from sole proprietorship to partnership or corporation,
- A change from partnership to sole proprietorship or corporation,
- A change from corporation to sole proprietorship, partnership or corporation,
- Sale or lease of a nursing facility,
- Transfer or sale of stock resulting in a change of the controlling interest in a privately held company,
- Consolidation or merger of two or more corporations that results in the creation of a new corporation.

If the new owner does not want to make any changes in bed certifications, no additional action regarding certifications is required and the certifications continue as they were under the previous owner. However, if the facility has beds designated as Medicaid-only, the new owner must dually certify all Medicaid beds within one year as outlined in the Dual Certification subsection. As part of the CHOW approval process, the SMA may deny bed certifications and recommend against Medicaid enrollment based on the criteria in the Criteria for Evaluation of Medicaid Bed Certification Applications subsection. In addition, dual certification requirements apply as outlined in the Dual Certification subsection.

If the new owner wants to change the bed certifications, a written application must be filed with the SSA and with the SMA Long Term Care Services Section. The SMA and the SSA will collaborate regarding the consideration and disposition of the application for changes in the Medicaid bed certifications. The SSA will conduct surveys as needed. Medicaid approval or denial of the application will be based on the considerations outlined in the Criteria for Evaluation of Medicaid Bed Certification Applications subsection.

Once the SMA makes a determination regarding the application for changes in the Medicaid bed certifications, the provider, the SSA, MDHHS Provider Enrollment, and the RARSS will be notified, in writing, by the SMA. If the application is denied, the SMA will notify the provider of appeal rights in writing. If the application is approved, the SMA will notify the SSA of the change. The SSA will also notify the provider of the change.

A new owner is considered a new provider and must enroll in Medicaid as outlined in the Medicaid Provider Enrollment subsection, regardless of whether any bed certification changes are made.



Under a change of ownership (CHOW), a nursing facility must not notify the local MDHHS office if there is a change in the facility's NPI/Medicaid Provider ID number. Rather, the change of ownership submission completed by the facility in the CHAMPS Provider Enrollment subsystem will automatically update the admission or discharge data for these beneficiaries in CHAMPS by moving them to the new NPI once the change of ownership is approved by MDHHS staff. Nursing facilities will not be required to update the admission or discharge data in CHAMPS for these beneficiaries when a change in ownership occurs.

2.4.D. BED CERTIFICATION PROCESS FOR A NEW NURSING FACILITY OR NEWLY LICENSED NURSING FACILITY BEDS

A provider seeking to build a new nursing facility, build a new section of a nursing facility, significantly remodel, or newly license nursing facility beds must first receive approval through the CON process within MDHHS.

Providers seeking to receive Medicaid certification for new nursing facility beds and receive Medicaid payment must file a written application with both the SMA and the SSA. The SMA and the SSA will collaborate regarding the consideration and disposition of the application for Medicaid bed certifications. Medicaid approval or denial of the application for additional bed certifications will be based on the Criteria for Evaluation of Medicaid Bed Certification Applications.

Once the SMA makes a determination regarding the application for new or additional Medicaid bed certifications, the provider, the SSA, MDHHS Provider Enrollment, and RARSS will be notified in writing. If the application is denied, the SMA will notify the provider of appeal rights in writing. If the application is approved, the SMA will notify the SSA of the change. The SSA will also notify the provider of the change.

If not already enrolled, the provider must enroll in Medicaid as outlined in the Medicaid Provider Enrollment subsection.

2.5 MEDICAID ENROLLMENT AS A VENTILATOR DEPENDENT CARE UNIT (VDCU) AND ADDITIONAL VDCU BEDS

Medicaid approval or denial of Medicaid enrollment as a VDCU and applications to increase the number of VDCU beds is based on Medicaid policies in the Dual Certification and the Criteria for Evaluation of Medicaid Bed Certification Applications sections of this appendix. In addition, VDCU applications will be coordinated with LARA-BCHS, Health Facility Licensing, Permits and Support Division.

2.6 MEDICAID PROVIDER ENROLLMENT

To enroll with Medicaid, a nursing facility must:

- Receive CON approval of the beds (new providers and CHOW).
- Receive written notice from the SMA approving the Medicaid bed certifications.



- Complete a New Provider Information Packet to establish data with the RARSS. (A New Provider Information Packet may be obtained from RARSS or the MDHHS website. Refer to the Directory Appendix for contact and website information.)
- Complete the on-line CHAMPS Provider Enrollment application process. (Refer to the Provider Enrollment Section of the General Information for Providers Chapter for additional information.)

A provider will not be enrolled with Medicaid until all of the above requirements are met.

NOTE: The provider's employer identification or tax identification number (EIN/TIN) registered with the Vendor Registration System must agree with the EIN/TIN on file with the RARSS and in the nursing facility enrollment information in the CHAMPS Provider Enrollment system.

2.7 NOTIFICATION PROCESS FOR REGULATORY ACTIONS

MDHHS or CMS may make decisions that result in the loss or reduction of a provider's Medicaid-certified beds. Loss of certification, or de-certification, means that Medicaid will no longer pay for any service in the nursing facility related to the de-certified beds.

MDHHS or its designee notifies the following entities, in writing, of the loss of Medicaid certification at least 30 days prior to the effective date of payment termination:

- The affected nursing facility,
- The local MDHHS office, and
- The public by means of public notice in a local newspaper.

This notification of the nursing facility's loss of certification will state that residents must either:

- Make other arrangements for payment to the nursing facility; or
- Relocate to a setting that is Medicaid certified.

The provider may request assistance from MDHHS to coordinate relocation for those beneficiaries who wish to transfer. MDHHS may choose to apply the Nursing Facility Closure Protocol described in the Nursing Facility Closure Protocol subsection to protect the best interests of residents faced with transfer.

2.8 NURSING FACILITY CLOSURE PROTOCOL

An interagency agreement exists, including the SMA, the Aging and Adult Services Agency (AASA), the SSA, and MDHHS, to delineate the roles and responsibilities of the respective agencies when residents of licensed/certified nursing facilities must be relocated due to nursing facility involuntary or voluntary closure. The agreement applies to all nursing facilities, including those that are county medical care facilities or hospital long-term care units. At the time of a closure, the nursing facility will be provided with a copy of this agreement and contact information for the agency representatives who will be involved in the closure.



2.9 VOLUNTARY WITHDRAWAL FROM PARTICIPATION IN THE MEDICAID PROGRAM OR VOLUNTARY NURSING FACILITY CLOSURE

A provider may choose to close voluntarily, not as a result of regulatory action. A provider may also choose to continue operating as a nursing facility, but withdraw from participation in the Medicaid Program. In both situations, the nursing facility must follow established guidelines to assure safe and appropriate care of residents.

When a provider decides to close voluntarily, the administrator of the nursing facility must provide written notification prior to the impending closure to the:

- State Survey Agency (SSA),
- State Medicaid Agency (SMA) /Long Term Care (LTC) Services Section,
- LTC Ombudsman,
- Residents of the nursing facility, and
- Legal representatives of such residents or other responsible parties.

Written notice must be provided at least 60 days before the date of closure. Note: In cases where the Secretary of the U.S. Department of Health & Human Services (HHS) terminates the facility's participation in either the Medicare and/or Medicaid programs, notice must be provided no later than the date that the Secretary of the U.S. Department of Health & Human Services (HHS) determines appropriate for such notification.

This 60-day notice requirement begins before any attempt to transfer a resident out of the facility in anticipation of a facility closure/withdrawal. The provider must ensure that no new residents are admitted on or after the date on which such written notification is submitted.

The written notice of a voluntary closure must include the plan for closure. The plan must be approved by the SSA and the SMA/LTC Services Section prior to notification of residents of the closure. The plan must outline the transfer and adequate relocation of residents that assures placement in the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.

Upon approval of the plan by the SSA and the SMA/LTC Services Section, actual notice of closure must be given, which means that the notice must be given to the resident and a family member or legal representative in a form that they can understand and must be explained to them as needed. The notice must include the plan as approved by the State for the transfer and adequate relocation of the residents by the date specified by the State prior to closure. It must also include assurances that the residents would be transferred to the most appropriate facility or other setting in terms of quality, services, and location, including home or community-based settings, taking into consideration the needs, choice, and best interests of each resident. The notice must include contact information for the LTC Ombudsman and the Area Agency on Aging.

In the event of a voluntary closure, the nursing facility remains Medicaid-certified until all residents are relocated.



If the nursing facility chooses to withdraw from Medicaid but remain open as a licensed nursing facility, residents who are Medicaid eligible at the time of facility disenrollment may remain in the facility and receive Medicaid payment. The nursing facility's Medicaid enrollment will continue for purposes of payment for state plan services as long as Medicaid residents remain in the facility.

The interagency agreement referenced in the Nursing Facility Closure Protocol subsection of this appendix addresses voluntary closures as well as regulatory closures, and outlines the responsibilities of the state agencies involved. The SSA monitors the withdrawal or closure of a nursing facility. The provider may request MDHHS assistance with resident relocation if needed.

If the provider does not fulfill their responsibilities for the safe and appropriate relocation of residents, as reported by the SSA, the State Closure Team may change the closure into a regulatory action. At that point, the closure becomes non-voluntary and the State Closure Team may request the assistance of a closure agent or take other measures to insure a safe and orderly transfer of residents. The interagency agreement referenced in the Nursing Facility Closure Protocol subsection of this appendix would apply.

2.10 NURSING FACILITY FILING OF BANKRUPTCY

Medicaid-enrolled providers are required to notify the MDHHS Long Term Care Services Section Manager and the RARSS Manager immediately upon filing for bankruptcy. (Refer to the Directory Appendix for contact information.)

2.11 RE-ENTRY AFTER DE-CERTIFICATION

A nursing facility may re-enter the Medicaid Program after decertification (whether voluntary or involuntary) if the following conditions are met:

- Submission of a request to the SSA for re-entry, including documentation indicating that the factors leading to a regulatory termination no longer exist.
- Evidence that all of the applicable statutory and regulatory requirements have been met.
- There is reasonable assurance that the deficiencies that caused the regulatory termination will not reoccur.
- The facility is concurrently pursuing Medicare certification.
- The facility meets all enrollment criteria outlined in this section.

Upon re-entry into the Medicaid Program, all Medicaid beds must also be Medicare certified.

The process for re-entering the Medicaid Program includes:

ACTION	DESCRIPTION OF PROCESS
Application	The nursing facility must make application for program re-entry to the SSA. The SSA forwards the completed application and evidentiary confirmation to CMS and the SMA for review and processing. A nursing facility may apply for re-certification at any time; however, the Criteria for Evaluation of Medicaid Bed Certification Applications apply as outlined in this section.



ACTION	DESCRIPTION OF PROCESS
<p>Departmental Review</p>	<p>The SMA makes a formal review of the nursing facility's financial status and requests confirmation of compliance with all civil rights requirements from the Office of Civil Rights (OCR). If financial responsibility and compliance with the civil rights requirements are confirmed, a reasonable assurance period (not subject to appeal) is set and the SSA is asked to conduct an initial survey.</p>
<p>Survey Activity</p>	<p>There will be at least two surveys during the reasonable assurance period.</p> <ul style="list-style-type: none"> ▪ Initial Survey - A survey is conducted at the beginning of the reasonable assurance period to document compliance with previously cited deficiencies. The initial survey may be a partial or full survey at the discretion of LARA. A finding of substantial compliance at this survey will allow the nursing facility to begin the reasonable assurance period. If the nursing facility is found to not be in substantial compliance, then it must re-apply. ▪ Second Survey - A full survey must be conducted and the nursing facility must be in substantial compliance in order for the reasonable assurance period to end. The SSA will schedule the survey to coincide with the end of the established reasonable assurance period. If the nursing facility has maintained compliance during the reasonable assurance period, it may be approved for Medicaid enrollment. If the nursing facility is not in substantial compliance at the second survey, it must enter another reasonable assurance period if it continues to seek re-entry into Medicaid. ▪ General Survey Protocol - Facilities are afforded the same rights for challenging survey results as in the standard certification process, which is through the administrative review process within the SSA. During the reasonable assurance period, the SSA may conduct as many surveys as approved by Medicaid to document compliance with state and federal requirements. Surveys are unannounced; therefore, the nursing facility will only receive acknowledgement of receipt of the approved application and that Medicaid enrollment is based on the outcomes of the surveys conducted. All survey reports (CMS-2567L) are forwarded to the SMA within 10 working days to determine the significance of any findings and the resultant action plan. The results of each survey are evaluated to ensure that the reasons for the termination no longer exist or are at the level of substantial compliance (Level One – Cells A, B or C). Facilities are notified of the determination, in writing, by the SMA. If the SSA determines that the conditions for re-entry are met, Medicaid enrollment will be approved. If the SSA determines that the conditions for re-entry have not been met, the SSA will send the provider a denial letter. The nursing facility may correct the deficiencies and re-apply for certification, resulting in another reasonable assurance period.



ACTION	DESCRIPTION OF PROCESS
<p>Reasonable Assurance Period</p>	<p>The reasonable assurance period is designed to assure that a nursing facility can operate for a certain period of time without the re-occurrence of the deficiencies that led to termination from participation in the program(s). The SMA contacts the SSA to conduct surveys during the reasonable assurance period.</p> <p>The reasonable assurance period begins when the initial survey is completed, which assures LARA that the nursing facility is complying with requirements for which they were originally de-certified. The SMA will establish a reasonable assurance period, typically from one to six months duration. The length of the reasonable assurance period is not subject to appeal. The time frame for reasonable assurance is based upon criteria, which may include:</p> <ul style="list-style-type: none"> ▪ A history of maintaining compliance ▪ Absence of a pattern of repeat citations ▪ Timely submission of plans of correction and implementation of approved plans of correction when needed ▪ Number of adverse actions initiated in the past three years ▪ History of termination and re-admission to the program ▪ Current compliance status ▪ Existence of other factors that may affect compliance, e.g., staffing concerns, turnover of key personnel, pay scale <p>The SMA will not approve Medicaid enrollment until the reasonable assurance period has been satisfied.</p> <p>During the reasonable assurance period, the nursing facility must:</p> <ul style="list-style-type: none"> ▪ Employ adequate management and care staff to provide care in accordance with all applicable federal, state and local regulations. ▪ Limit admissions to two residents per day or four residents in a seven-day period, regardless of payment source. ▪ Develop an admissions informed consent document that is acceptable to the SMA and that explains the re-entry process. The document should further explain to the resident (or authorized representative) that his residency in the nursing facility could be temporary and a transfer to another setting may be necessary if the nursing facility fails to meet all of the requirements for certification. This notice must be explained to, and signed by, the resident or his authorized representative. A signed copy of this document must be placed in the resident's record.
<p>Appeals Procedure</p>	<p>An applicant may appeal a denial of Medicaid enrollment by submitting a written request within 60 days of the date of the denial decision. The appeal should be addressed to the Michigan Office of Administrative Hearings and Rules (MOAHR). (Refer to the Directory Appendix for contact information.) The written appeal must include documentation to support the appeal. If the applicant fails to submit documentation within the 60 days, then the denial decision remains in effect.</p>



ACTION	DESCRIPTION OF PROCESS
Payment	Providers are eligible for Medicaid reimbursement when the nursing facility has been found to meet the conditions for re-entry and is an enrolled Medicaid provider. Under extraordinary circumstances, the SMA may elect to enter into a provisional Medicaid provider agreement during the reasonable assurance period. In most cases, Medicaid reimbursement is not available until the facility has met all required conditions.

2.12 NON-AVAILABLE BEDS

Any nursing facility bed is considered available for occupancy if the bed is licensed and Medicaid certified, unless it is removed from service due to a regulatory ban on admissions or removed voluntarily using the SMA's non-available bed policy.

The SMA allows nursing facilities to designate beds as non-available, thereby removing them from the occupancy and rate setting calculations. For more information on this policy, refer to the Cost Reporting & Reimbursement Appendix of this chapter.



SECTION 3 - STAFF CERTIFICATION

All health care professionals performing duties within Medicaid-certified nursing facilities must possess the licensure and certification credentials required for their individual disciplines.

3.1 NURSE AIDE CERTIFICATION AND TRAINING

A nurse aide employed in a Medicaid-certified nursing facility must be a Certified Nurse Aide (CNA). Medicaid reimburses facilities through the annual cost settlement process for the Medicaid share of documented costs directly related to meeting the nurse aide training and testing requirements. Training programs and testing sites must be approved by the SSA in order for those costs to be reimbursed by Medicaid. A nursing facility may not charge its employed aides for training, testing, and registry costs related to meeting these requirements. (Refer to the Cost Reporting & Reimbursement Appendix of this chapter for additional information.)

The SSA is responsible for approval of programs that train and certify nurse aides for employment in all Medicaid-certified nursing facilities.

- For information about training requirements, programs or facilities, or concerns regarding the testing program or information placed on the Nurse Aide Registry, contact the LARA Bureau of Community and Health Systems.
- For testing registration information or assistance, or test site concerns, contact the LARA BCHS Nurse Aide Section or refer to their website.
- To inquire about a nurse aide's listing on the Registry, name and good standing, contact the LARA BCHS Nurse Aide Section or refer to their website.

(Refer to the Directory Appendix for contact information.)

3.2 EMPLOYEE SCREENING (CRIMINAL BACKGROUND CHECKS)

Nursing facilities are prohibited from employing, independently contracting with, or granting clinical privileges to any individual making application or being offered privileges who has been convicted of certain crimes. Michigan Public Act 28 of 2006 requires nursing facilities to facilitate and bear the cost of criminal background checks, either through the Michigan State Police or the Federal Bureau of Investigation (depending on defined criteria), on all individuals seeking to perform direct services to residents. The law also provides for the sharing of criminal background information with other member agencies of the provider community for the purpose of applicant screening.

An overview of Michigan Public Act 28 of 2006 and template forms for use by nursing facilities conducting criminal history checks on applicants are available on the MDHHS website. (Refer to the Directory Appendix for website information.)



SECTION 4 - NURSING FACILITY SURVEY

The purpose of surveying nursing facilities in the State of Michigan is to ensure quality of life and quality of care for residents. In order to fully comply with the applicable federal and state statutes, the SMA has contracted with the SSA to conduct nursing facility certification surveys. This contract represents the intent and purpose of both agencies to promote high quality health care and services for beneficiaries under the Medicaid Program to:

- comply with state and federal statutes, regulations and guidelines requiring the proper expenditure of public funds for the administration of the Medicaid Program and certification of health care providers;
- assure that the services provided under Title XIX and Title V of the Social Security Act are consistent with the needs of beneficiaries and the programs' objectives and requirements.

Reports generated as a function of this process are used by MDHHS to assure proper payment of claims submitted, to facilitate enforcement actions, and to assess continued certification under the current Medicaid enrollment.

4.1 SURVEY PROCESS

The basic survey protocol, including criteria and procedures, is the same for participation in both the Medicaid and Medicare Programs. The SSA:

- At appropriate intervals as prescribed by federal and state regulations, conducts on-site surveys, re-surveys and other necessary monitoring of the providers applying to or already participating in the Medicaid Program to determine compliance with program requirements.
- Recommends to the SMA certification of those providers that meet applicable federal and state statutes and regulations. The methodology of survey, evaluation and certification complies with applicable statutes, regulations, the provisions of the intra-agency agreement and is subject to review and comment by the SMA.
- Notifies the SMA and the individual provider within five working days of a certification determination and 30 calendar days prior to the expiration or automatic cancellation date of a time limited certification. Such notifications shall be made by a document process mutually agreed upon by both agencies and shall include information sufficient in detail to allow Medicaid to carry out appropriate provider agreement action. This document process shall also allow for extensions of existing certifications as provided for in federal regulations.
- Annually provides to Medicaid a complete listing of all certifications in effect on January 1st of that year.
- Determines and authorizes any waiver of provider requirements granted, the conditions of the waiver, and the time period such waiver will be in effect.



4.2 SURVEY REVIEW

The SSA sends all survey reports with enforcement recommendations to the SMA for review. Reports and subsequent enforcement recommendations include information sufficient in detail to allow the SMA to carry out appropriate provider agreement action. Following review and authorization by the SMA, the SSA may be designated to generate any or all of the necessary certification and enforcement documentation pertaining to a participating provider.



SECTION 5 - NURSING FACILITY ENFORCEMENT

This enforcement policy applies when the State Survey Agency (SSA) or the Centers for Medicare & Medicaid Services (CMS) determines, on the basis of a standard, abbreviated, extended, or partial extended survey, that a provider is or was out of compliance with the federal certification requirements as stated in 42 CFR Part 488, Survey, Certification and Enforcement Procedures. In Michigan, the LARA Bureau of Community and Health Systems (BCHS) functions as the SSA.

5.1 AUTHORITY

The Omnibus Budget Reconciliation Act (OBRA) of 1987, as amended, incorporated specific provisions for nursing home reform into the Social Security Act, including revised requirements for survey, certification, and enforcement of providers participating in the Medicare and Medicaid programs. Applicable regulations are found at 42 CFR Part 488.

5.2 GUIDING PRINCIPLES OF ENFORCEMENT

5.2.A. PHILOSOPHY

- All long term care providers have the **responsibility** to provide person-centered quality care and services appropriate to the needs of the residents they serve.
- Long term care providers are an essential **resource** for communities, providing health care services, education, and employment.
- LARA, as the licensing and certification authority, must insure that all Michigan long term care providers fulfill their responsibility to provide **quality** services.

5.2.B. PURPOSE

To develop, implement, and support an enforcement system that:

- **Promotes** continuous provision of quality care and the highest practicable physical, mental and psychosocial functioning of each resident.
- **Protects** the health, welfare, rights, and choices of long term care residents, as defined by law and regulation, without infringing upon the rights of the resident.
- **Promptly corrects** noncompliance through effective application of appropriate regulatory remedies.

5.3 ENFORCEMENT PRINCIPLES

- The enforcement system must reflect a philosophy of serving resident needs by providing quality care.



- The SSA and the SMA must both strive for consistency in identifying deficiencies and in decision-making for selection and application of remedies. This enforcement principle is consistent with the intent of federal enforcement regulations, the State Operations Manual, and the CMS evaluation process for SSA performance.
- The SMA's enforcement plan contains a range of remedies. This allows an appropriate remedy scheme tailored to the facility and the cited deficiencies.
- Repeat noncompliance or failure to obtain compliance will result in the application of progressively stronger remedies.
- Remedies that displace residents from their homes will only be used as a last resort; such remedies include facility closure, termination of Medicaid or Medicare provider agreements, or transfer of residents. These remedies will not be used unless the health, safety and/or welfare of the residents is seriously affected, other remedies have not resulted in the facility's ability to achieve and maintain substantial compliance, and/or the physical plant is not a viable setting for quality care and services.
- State enforcement remedies for nursing facilities must include, at a minimum, statutorily specified remedies for skilled nursing facilities and may include additional or alternative remedies approved by CMS.

5.4 FACILITY COMPLIANCE AND DEFICIENT PRACTICE

The SSA or CMS, on the basis of a standard, abbreviated, extended or partial extended survey, will determine whether a participating provider is in compliance with the federal regulations governing Medicaid certification. Based on this determination, one or more remedies (corrective actions) may be selected based on the seriousness of the deficiency, facility history, welfare of the residents, and the likelihood that the remedy will promote prompt and sustained compliance. Enforcement remedies include both federal and state enforcement options. Criteria have been designed to minimize the time between identification of the deficiencies and application of remedies. Repeated or uncorrected deficiencies will be assessed progressively stronger remedies. If the SSA finds that a provider currently meets the requirements, but previously was noncompliant, the SSA may impose a remedy for the days it finds that the facility was not in compliance. Nothing in this paragraph shall be construed as restricting the remedies available to the LARA to address a nursing facility's deficiencies.

5.5 DETERMINING THE SERIOUSNESS OF DEFICIENCIES

To determine the seriousness of deficiencies for the purpose of selecting enforcement remedies, LARA will consider the factors of scope and severity. Scope represents how much of the facility, or how many residents, are or may be affected by a specific deficient practice. Severity represents the potential for harm, or the level of harm that has occurred. Scope and severity are assigned an alphabetic and numeric level on the remedy determination grid. The most serious deficiency cited (based on level of scope and severity) determines the category or categories of remedies to be applied. Other factors in the selection of remedies include:

- whether the deficiencies immediately jeopardize the health, safety, or welfare of the facility's residents
- the relationship of one deficiency to other deficiencies
- the facility's compliance history



- the likelihood that the selected remedy will promote correction and continued compliance
- the provider’s culpability, i.e., whether noncompliance is the result of neglect, indifference or disregard
- the relationship of one remedy to other remedies

5.5.A. SEVERITY

LEVEL OF SEVERITY	DEFINITION
No actual harm with a potential for minimal harm	The deficiency has the potential for causing no more than a minor negative impact on the resident(s).
No actual harm with a potential for more than minimal harm, but not Immediate Jeopardy	Noncompliance that results in minimal physical, mental, and/or psychosocial discomfort to the resident and/or has the potential (not yet realized) to compromise the resident's ability to maintain and/or reach his highest practicable physical, mental and psychosocial well being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.
Actual harm that is not Immediate Jeopardy	Noncompliance that results in a negative outcome that has compromised the resident's ability to maintain and/or reach his highest practicable physical, mental, and psychosocial well being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.
Immediate jeopardy to resident health or safety	A situation in which immediate corrective action is necessary because the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, serious harm, impairment, or death to a resident receiving care in the facility.

5.5.B. SCOPE

SCOPE OF IMPACT	DEFINITION
Isolated	Scope is isolated when one or a very limited number of residents are affected and/or one or a very limited number of staff are involved, and/or the situation has occurred only occasionally or in a very limited number of locations.
Pattern	Scope is a pattern when more than a very limited number of residents are affected, and/or more than a very limited number of staff are involved, and/or the situation has occurred in several locations, and/or the same resident(s) has been affected by repeated occurrences of the same deficient practice. The effect of the deficient practice is not found to be pervasive throughout the facility.
Widespread	Scope is widespread when the problems causing the deficiencies are pervasive in the facility or represent systemic failure.

5.6 ENFORCEMENT REMEDIES

A remedy is a corrective action. Remedies available to LARA are specified in federal and state law. When the scope and severity increase, the deficiencies repeat, or the facility fails to maintain substantial compliance, selected remedies may also increase.



5.6.A. FEDERAL ENFORCEMENT REMEDIES

Each federal remedy listed below is described in rules as stated in 42 CFR Part 488 et. seq., and further discussed in the CMS State Operations Manual for Medicaid and/or Medicare certified facilities. Federal remedies available to LARA or CMS include, but are not limited to:

- Denial of payment for new Medicare and/or Medicaid admissions
- State monitoring
- Temporary management
- Directed plan of correction
- Directed inservice training
- Civil money penalties
- Transfer of residents
- Closure of facility with transfer of residents
- Termination of Medicaid enrollment
- Denial of payment for all Medicare and/or Medicaid residents imposed by CMS
- Alternative or specified state remedies approved by CMS
- Administrative/Clinical Advisor

5.6.B. STATE ENFORCEMENT REMEDIES

The SSA has the option of imposing any state or federal remedy based on the facility's failure to maintain compliance, deficiencies cited within the same regulatory grouping that repeat within the last 24 months (or two standard survey cycles), and the degree of culpability of the facility. In addition to federal remedies, the SMA may accept one or more of the following enforcement actions taken by the SSA under state licensure authority. Also see Michigan Enforcement Rules for Long Term Care Facilities at R 330.11001-330.11017.

- Emergency Order Limiting, Suspending or Revoking a License
- Notice of Intent to Revoke Licensure
- Correction Notice to Ban Admissions or Readmissions
- Transfer Selected Patients; Reduce Licensed Capacity; or Comply with Specific Requirements
- Appointment of a Temporary Manager or Clinical/Administrative Advisor
- State Patient Rights Penalties, if applicable



5.7 DENIAL OF PAYMENT FOR NEW ADMISSIONS (DPNA)

Denial of payment for new admissions may be imposed at any time a provider is not in substantial compliance and must be imposed when a provider is not in substantial compliance within three months of being found out of compliance.

The DPNA enforcement remedy stops Medicaid payment for any new residents admitted to the facility after the effective date of the DPNA. The resident's status on the effective date of the denial of payment is the controlling factor in determining whether readmitted residents are subject to the denial of payment.

Guidelines for the definition of new admission are:

- Medicaid residents admitted to the facility on or after the effective date of the denial of payment for new admissions are considered new admissions. If Medicaid residents are discharged and readmitted to the facility, they continue to be considered new admissions, and are subject to the denial of payment.
- Medicaid residents admitted to the facility and discharged before the effective date of the DPNA are considered new admissions if they are readmitted to the facility on or after the effective date of the DPNA. Therefore, they are subject to the denial of payment.
- Medicaid residents admitted before the DPNA and discharged on or after the effective date of the DPNA are not considered new admissions if subsequently readmitted. Therefore, they are not subject to the denial of payment.
- Medicaid residents admitted before the effective date of the DPNA who take temporary leave before, on, or after the effective date of the DPNA are not considered new admissions upon return and, therefore, are not subject to the denial of payment.
- Medicaid residents admitted on or after the effective date of the DPNA who take temporary leave (e.g., hospital or therapeutic leave) are not considered new admissions when they return. If they were subject to the DPNA before their leave, they continue to be subject to it after their return.
- Private pay residents admitted to the facility after the effective date of the DPNA who then become eligible for Medicaid are subject to the denial of payment.
- Private pay residents in the facility prior to the effective date of the DPNA who then become eligible for Medicaid after the effective date of the DPNA are not subject to the denial of payment.

5.8 RECOVERY OF MEDICAID FUNDS FOR ADMISSIONS DURING DPNA

Under federal regulations, no federal funds will be paid to a nursing facility or to a state for any resident admitted when the facility is under a Denial of Payment for New Admissions sanction. Nursing facilities will be subject to Medicaid post-payment review to determine if any new residents were admitted during a period of time when the facility was under a DPNA sanction and, if so, Medicaid funds will be recovered from the facility. Facilities will be notified in advance of any recovery action and given the opportunity to produce documentation indicating that the admission was not a new resident and/or to appeal the MDHHS determination.



5.9 MINIMUM DATA SET - RESIDENT ASSESSMENT INSTRUMENT

A nursing facility is required to submit resident assessments to the QIES ASAP system using the Medicare Data Communication Network (MDCN). Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2). All other MDS assessments must be submitted within 14 days of the MDS Completion Date (Z0500B). Failure to comply will result in citations and imposition of remedies, including requirement of a plan of correction. Continued failure to comply will result in increasingly severe remedies up to and including termination of Medicaid enrollment.

An individual who willfully and knowingly certifies a material and false statement in a resident assessment will be subject to civil money penalty fines as outlined in 42 CFR § 483.20(f)(5)(j)(1).

5.10 TERMINATION

This remedy may be imposed at any time when appropriate, but must be imposed when a provider has been out of substantial compliance for six months.

5.11 PURPOSE OF REMEDIES

TYPE OF REMEDY	PURPOSE
Directed Plan of Correction	The purpose of the directed plan of correction is to achieve correction and continued compliance with federal requirements. It is used when specific corrective action is required or the corrective action must be accomplished within a specified time, e.g., when a facility's heating system fails and specific repairs or replacement must be made within a specific period of time; when a provider has had difficulty attaining compliance after a revisit; or when assistance with a plan of correction is needed to ensure an effective revisit prior to imposition of a denial of payment or termination of provider status.
Directed In-Service Training	The purpose of directed in-service training is to provide basic knowledge to achieve compliance and remain in compliance with federal requirements. Directed in-service training is used when education is likely to correct deficiencies and help the provider achieve substantial compliance.
State Monitoring	The purpose of state monitoring is to oversee correction of cited deficiencies as a safeguard against further harm to residents when harm or a situation with a potential for harm has occurred. State monitoring is appropriate if the provider has had three consecutive standard surveys with substandard quality of care; poor compliance history, pattern of poor quality of care, and/or many complaints; immediate jeopardy without a temporary manager appointment; concern that conditions in a facility have potential to worsen; the provider refuses to accept appointment of a temporary manager; the provider is unwilling or unable to take corrective action for cited substandard quality of care. LARA may impose state monitoring without notice.
Denial of Payment for New Admissions	The purpose of Denial of Payment for New Admissions (DPNA) is to encourage prompt and sustained compliance. DPNA may be imposed any time the provider is found out of substantial compliance and must be imposed when a provider is out of compliance three months after a determination of noncompliance. DPNA may be imposed alone or in combination with other remedies.



TYPE OF REMEDY	PURPOSE
Denial of Payment for All Medicare and Medicaid Residents	The purpose of Denial of Payment for All Medicare and Medicaid Residents is to encourage prompt and sustained compliance. This remedy may be imposed any time the provider is out of substantial compliance, but only by CMS. Factors considered in imposing this remedy include the seriousness of current survey findings, noncompliance history of the facility, and failure of other remedies to achieve or sustain compliance.
Temporary Management	The purpose of a temporary manager is to oversee correction of deficiencies and ensure the health and safety of the facility’s residents while corrections are being made. A temporary manager may be imposed as a federal remedy any time a provider is not in substantial compliance; when a facility’s deficiencies constitute immediate jeopardy or widespread actual harm and is imposed as an alternative to termination; or to oversee the orderly closure of a facility. The authority and qualifications of the temporary manager are described in the State Operations Manual at Section 7550.
Temporary Administrative and/or Clinical Advisor	The purpose of a Temporary Administrative and/or Clinical Advisor is to monitor and mentor the facility administrative and/or clinical staff through the period of corrective action. This is an additional federal Category 2 enforcement remedy defined in the State Plan and MDHHS Rule 330.11007(6). Authority for this remedy is found at §488.303(e) and §488.406(a)(8)&(9).

5.12 REVISIT POLICY

Revisits are not assured and, depending on the circumstances of any given situation, termination can occur any time for any level of facility noncompliance without regard to revisits. Facilities have the responsibility to correct their deficiencies and notify the SSA when corrections will be completed. It is expected that revisit requests will be made prudently so that the likelihood of additional revisits is reduced. If correction is not achieved at the expected time, the facility should notify the SSA that correction has been delayed so that the revisit can be delayed. LARA’s expectation is that the facility has achieved compliance status as alleged in the Plan of Correction. Revisits may be conducted for any level of noncompliance. Remedies may be imposed for any level of noncompliance. Revisits are not assured before imposition of denial of payment for new admissions or termination.

The SSA is authorized, at its discretion, to perform up to three revisits to verify compliance. A fourth revisit may be conducted by the SSA only with the authorization of the SMA. An approved Plan of Correction must be received by the SSA with each revisit request. A fourth revisit requires justification.

5.13 CHOOSING THE COMPLIANCE DATE

LARA follows CMS policy related to revisits. On a first revisit, the compliance date is the accepted Plan of Correction completion date if it is determined at the time of the revisit that the deficiencies were corrected and the facility is in substantial compliance. If a revisit survey identifies that the facility had a deficiency after the completion date that was corrected before the revisit date, the actual correction date is used.

On the second revisit, the compliance date is the revisit date, unless there is specific evidence of earlier compliance. In this case, observation of compliance is relevant, as is evidence indicating a specific date of correction.



On third or subsequent revisits, the compliance date is the revisit date, without exception.

5.14 EVIDENCE OF COMPLIANCE IN LIEU OF A REVISIT

Revisits may be conducted at any time for any level of noncompliance. Revisits are required whenever a survey finds noncompliance at Level F (Substandard Quality of Care), Harm, or Immediate Jeopardy (IJ) and must continue for all citations at that level until compliance is achieved with F (SQC), Harm, or IJ citations. In other cases, appropriate to the type of deficiency, acceptable evidence of compliance may be allowed in lieu of a revisit at the SSA’s discretion. Evidence of compliance is not acceptable after a second revisit has been conducted within an enforcement cycle. When a facility is allowed to present acceptable evidence in lieu of a revisit, the compliance date is the date the evidence indicates the facility was in substantial compliance.

5.15 SETTING THE MANDATORY THREE- AND SIX-MONTH REMEDY TIME FRAMES

The three-month mandatory denial of payment for new admissions and the six-month mandatory termination dates will be set based on full months rather than on a number of days. With few exceptions, these dates will coincide with the same numerical date of the month of survey exit that identified the noncompliance. For example, if a survey ended on 1/15, the three-month effective date for mandatory denial of payment for new admissions is 4/15, and the six-month termination date is 7/15. Exceptions involve those cases for which a three-month or six-month numerical date is not on the calendar. In these cases, the effective date of the remedy will be the next calendar day.

Immediate Jeopardy situations generally have 23-day termination cycles.

5.16 FAILURE TO READMIT A QUALIFIED MEDICAID RESIDENT

A daily civil money penalty (CMP) of \$400 will be imposed when an enrolled Medicaid facility refuses to readmit a qualified Medicaid resident (as defined by CMS) following hospitalization. An opportunity to correct will not be provided. This daily CMP will start on the date validated by LARA that nursing home readmission should have occurred. The daily \$400 CMP continues until the resident is offered the next qualifying available Medicaid bed at the refusing facility, or the resident is placed in another suitable facility. The refusing facility will be notified by the SSA when an allegation of failure to readmit a qualified Medicaid resident is being investigated.

5.17 DEFINITIONS

TERM	DEFINITION
Administrative and/or Clinical Advisor	An alternative federal Category 2 remedy imposed upon a facility for the purpose of mentoring facility administrative and/or clinical staff through the period of corrective action.
Ban on Admissions	Admissions to the facility are suspended on the date specified in the LARA Correction Notice Order. Includes readmissions if stated in the order.
CMS	The Centers for Medicare & Medicaid Services.



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TERM	DEFINITION
Culpability	The extent to which the facility is responsible for the cited deficient practice. This is often related to occasions when the noncompliance is determined by the SSA to be intentional, or a product of neglect, indifference, or disregard.
Deficiency	A facility's failure to meet any participation requirement specified in the Social Security Act or in 42 CFR, Subpart B, 483.5 - 485.75.
Failure to Maintain Compliance	Inability of the facility to maintain substantial compliance for at least three months, or a facility having three or more survey cycles in a 12-consecutive month period.
Immediate Jeopardy	Immediate Jeopardy to resident health or safety means a situation in which immediate corrective action is necessary because the nursing facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, serious harm, impairment, or death to a resident receiving care in the facility. Such a finding is made in accordance with the criteria and definitions in the CMS State Operations Manual Appendix Q - Guidelines For Determining Immediate Jeopardy.
Noncompliance	Any deficiency that causes a facility to not be in substantial compliance.
No Opportunity to Correct	The facility will have remedies imposed immediately after a determination of noncompliance has been made.
Opportunity to Correct	The facility is allowed an opportunity to correct identified deficiencies before remedies are imposed.
Past Noncompliance	Past noncompliance is noncompliance that occurred between two certifications of compliance, against which a civil money penalty is imposed. If past noncompliance is cited, a civil money penalty must be imposed.
Plan of Correction (POC)	Mandatory for all deficiencies of scope and severity levels B through L on the remedy determination grid. A POC must be provided to the SSA within 10 days of the receipt of the survey report (CMS-2567). The POC must be approved by the SSA; if disapproved, remedies may be imposed immediately.
Remedy	A corrective action. Some remedies are specified in federal law; others are specified in state law.
Repeat Deficiency	When deficiencies in the same regulatory grouping of requirements are found more than once within 24 months or two standard survey cycles.
Repeated Noncompliance	For purposes of enforcement action, this term refers to findings of Substandard Quality of Care on three (3) consecutive standard surveys, but does not refer to citations in which the substance of a deficiency or the exact tag number of a deficiency is repeated.
Substandard Quality of Care	Deficiencies at 42 CFR 483.13 (Resident Behavior and Facility Practices, F tags 221-226); 483.15 (Quality of Life, F tags 240-258); or 483.25 (Quality of Care, F tags 309-333) on the remedy determination grid in cells F, H, I, J, K, or L.
Substantial Compliance	Survey findings or acceptable evidence of compliance in lieu of revisit indicate that no actual harm has occurred and there is a potential for no more than minimal harm.



5.18 SUBSTANDARD QUALITY OF CARE (SQC)

When a standard or abbreviated survey identifies substandard quality of care (SQC), an extended or partial extended survey is conducted. In addition to the imposition of remedies, the SSA takes the following actions:

- Notifies the attending physicians of residents identified during the survey process as having been affected by the substandard quality of care.
- Notifies the state licensure board responsible for licensing the facility's administrator of all findings of substandard quality of care.
- Prohibits the facility from providing nurse aide training and competency evaluation programs for two years.

If a facility has been found to have provided SQC on the last three (3) consecutive standard surveys, along with other remedies, LARA will impose:

- Mandatory denial of payment for new admissions;
- State monitoring.

5.19 IMMEDIATE JEOPARDY

When the SSA identifies that Immediate Jeopardy to resident health or safety exists, the provider is notified and directed to submit as soon as possible an allegation that the Immediate Jeopardy has been removed. Within two calendar days of the last day of the survey during which Immediate Jeopardy was identified, the SSA will notify the provider that the SMA must terminate Medicaid enrollment within 23 calendar days of the last day of survey if the Immediate Jeopardy has not been removed. At its discretion, the SMA may appoint a temporary manager who must remove the Immediate Jeopardy within 23 days to avoid termination.

In order for a 23-day termination timeclock to be stopped, the provider must submit an acceptable Plan of Correction to the SSA. A subsequent revisit must then be conducted to verify removal of the Immediate Jeopardy, even if the underlying deficiencies have not been fully corrected.

Civil Money Penalties (CMP) of \$3,050 to \$10,000 per day will be imposed for each day an Immediate Jeopardy was identified before removal. Following removal of the Immediate Jeopardy, CMPs will continue until the facility is found to be in substantial compliance, but will be selected from a lower fine range of \$50 to \$3,000 per day. The upper range of CMPs will apply for a minimum of one day, even if the Immediate Jeopardy is removed immediately after identification and notification. No CMP will apply on the day the facility is determined to be in substantial compliance.

The SSA may consider using a Per Instance Civil Money Penalty of \$1,000 to \$10,000 when the beginning date of the deficiency cannot be determined, or when a Civil Money Penalty is combined with other enforcement actions, e.g., a discretionary denial of payment for new admissions, directed plan of correction, or directed in-service training.



5.20 NO OPPORTUNITY TO CORRECT

Providers will not be given an opportunity to correct deficiencies before remedies are imposed when they have deficiencies of actual harm (or higher) on the current survey event, as well as on the previous standard survey or any intervening survey. The previous harm (or higher) level deficiency must have been in a completed survey cycle with compliance verified. LARA will impose either a Civil Money Penalty or Denial of Payment for New Admissions, or both. LARA may impose other optional federal remedies.

5.21 OPPORTUNITY TO CORRECT

An opportunity to correct deficiencies before remedies are imposed is not assured. The SSA has no obligation to give a provider an opportunity to correct deficiencies prior to imposing remedies and must only meet the minimum notice requirements that are applicable to the imposition of remedies. At the SSA's discretion, it may provide facilities an opportunity to correct deficiencies before remedies are imposed when they do not meet the criteria for "No Opportunity to Correct."

When an opportunity to correct deficiencies before remedies are imposed is offered, the SSA will request an acceptable plan of correction, provide initial notice of possible enforcement action, conduct a revisit (if applicable), and provide formal notice of other remedies if noncompliance continues at revisit. While formal notice of denial of payment for new admissions is generally provided in the first revisit letter, the SSA may provide it to the facility in the initial deficiency notice.

LARA must impose DPNA no later than three months after the last day of the survey that identified the noncompliance if substantial compliance is not achieved.

LARA may impose either a per day or per instance Civil Money Penalty for past noncompliance, for days of noncompliance after the finding is made, or a combination thereof. Amounts will be determined by LARA based on facility history, repeating deficiencies, high numbers of deficiencies, culpability of the provider, failure to achieve or maintain substantial compliance, and for increasing noncompliance.

5.22 PROHIBITION OF APPROVAL OF NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS

Federal law, as specified in the Social Security Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a Section 1819(b)(4)(C)(ii)(II) or Section 1919(b)(4)(C)(ii) waiver; has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$5,000; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities. Exceptions to this, as specified in Public Law 105-15, Permitting Waiver of Prohibition of Offering Nurse Aide Training and Competency Evaluation Programs in Certain Facilities, will apply.

5.23 NEW OWNER

A new owner may apply to the SSA to have approval of the facility's nurse aide training and competency evaluation program restored before a two-year lockout period has expired.



5.24 NOTICE OF CMP ASSESSMENT

Prior notice is not required before the imposition of CMPs. A penalty equivalent to a one-day penalty will apply in all circumstances even if the violation(s) is immediately corrected. The daily penalty will end on the day prior to the determination of substantial compliance, or on the day prior to the determination that a civil money penalty is no longer warranted. The SSA determines compliance. CMP amounts may be increased to reflect changes in levels of noncompliance at revisit. CMP amounts may increase for repeat deficiencies.

The SSA has developed a CMP schedule for Immediate Jeopardy and Harm or Potential Harm occurrences to promote a consistent application of penalties. The CMP schedule conforms to 42 CFR 488.408 and is intended to cover the majority of cases of CMP imposition. Situations may occur that justify exception to the guidelines. The CMP schedule is subject to change without notice. For further information, contact LARA Bureau of Community and Health Systems (BCHS). (Refer to the Directory Appendix for contact information.)

Accrual of CMPs ceases when one of the following situations occurs:

- the facility is determined by the SSA to have achieved substantial compliance
- the appointment of a receiver by a circuit court
- closure of a facility
- appointment of a temporary manager for the purpose of overseeing the orderly closure of the facility
- termination of a provider agreement

5.25 USE OF CMP FUNDS

Money collected by the SMA as a result of civil money penalties is held in a special fund to be applied to the protection of the health or property of residents of any nursing facility that LARA finds deficient. Money recovered by the SMA from funds due a facility (because of lack of payment of civil money penalties by the facility) is also deposited into this fund.

5.26 COST REPORTING FOR REMEDIATION EXPENSES

Temporary manager and (limited) other remediation expenses incurred by the provider as a result of an enforcement action are a Medicaid allowable routine nursing care cost as part of the owner/administrator cost classification. Total owner/administrator compensation is subject to established program cost limitations and allowable cost principles. Civil money penalties are not allowable Medicaid costs. (Refer to the Cost Reporting & Reimbursement Appendix of this chapter for additional information.)

5.27 APPEAL RIGHTS

The provider is notified of appeal rights at the time of remedy imposition. Providers may only appeal the existence of a deficiency and/or the number of days considered in violation. The established daily amount of the CMP is not subject to appeal. Appeals are through MDHHS. (Refer to the Directory Appendix for contact information.)



MDHHS has developed an informal review process for resolution of disputes regarding deficiencies cited by surveyors. Information regarding this process can be found on the MDHHS website. (Refer to the Directory Appendix for website information.)

The provider is also notified of waiver rights at the time of remedy imposition. Within 60 calendar days of the notice of appeal rights, the provider may elect to waive the right to appeal. The waiver must be in writing and be received by the SSA Enforcement Unit and by MOAHR within 60 days of the notice of appeal rights. Waiver of the right to appeal will reduce the total CMP amount by 35%.

5.28 PENALTY COLLECTION

Collection of civil money penalties will be made by voluntary transmittal, in a check payable to the State of Michigan, within 30 calendar days of notice of penalty amount due or within 15 days of issuance of appeal results. If voluntary transmittal does not occur, the CMP will be recovered by gross adjustment against the next available Medicaid warrant or as a component of final cost settlement in a change of ownership. No repayment schedules will be allowed for any penalty assessments. Civil money penalties are not allowable Medicaid costs.



COST REPORTING & REIMBURSEMENT APPENDIX

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SECTION 1 – INTRODUCTION

This appendix outlines Medicaid policy pertaining to nursing facility ownership, nursing facility reimbursement, nursing facility costs, and nursing facility financial reporting. Cost reporting, rate determination, financial settlement, audit, and appeal processes are addressed in this appendix. Costs classifications (such as plant, variable, allowable and non-allowable, add-ons) used to determine nursing facility reimbursement are defined.

Throughout the appendix references will be made to the State Medicaid Agency (SMA) and the State Survey Agency (SSA). The Michigan Department of Health and Human Services (MDHHS), Medical Services Administration, is the designated SMA, and is responsible for administration of the Medicaid program. The Michigan Department of Licensing and Regulatory Affairs (LARA), Bureau of Community and Health Systems (BCHS) is the designated SSA.

1.1 REIMBURSEMENT RATE METHODOLOGY – GENERAL

The Medicaid nursing facility reimbursement rate is prospectively determined based on the nursing facility's historical or acquisition costs, which are subject to limitations put forth in policy. Participating Medicaid providers' nursing facility resident days and cost information are reported to the SMA on an annual cost report submitted by the nursing facility. The nursing facility industry aggregate cost data is used to analyze and determine facility class reimbursement limits and related cost levels necessary for calculating nursing facility per diem rates and other analysis. The facility's routine nursing care per diem rate includes plant and variable cost based on the facility's audited allowable costs, measured against class wide rate limitations. Additional reimbursement for specific services outside of the routine nursing care per diem rate are also analyzed and determined from the facility's annual cost report and included in the Medicaid annual reimbursement settlement.

The intent of the Medicaid nursing facility reimbursement system is to:

- Assure high quality services at reasonable costs.
- Encourage the efficient use of nursing care resources.
- Provide reimbursement for allowable costs incurred by prudent, cost-conscious facility managers.
- Provide a review and appeal mechanism to assure that nursing facility providers receive fair and equitable treatment.

Reductions may be implemented to the variable cost portion of the NF rate due to Executive Order, legislative mandate, or cost savings initiatives. Notice of a reduction, or continuation of a reduction, will be issued via a policy bulletin. A record of recent NF variable rate reductions will be maintained on the MDHHS website. (Refer to the Directory Appendix for website information.)

1.2 MEDICARE PRINCIPLES OF REIMBURSEMENT

Unless stated otherwise in this appendix, Medicaid reimbursement rates are determined for nursing facilities in accordance with the federal Principles of Reimbursement established for the Medicare Program. Nursing facility providers are expected to comply with applicable provisions in these Principles, with policies published by the SMA, and with all relevant federal and state statutes, rules and regulations.



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When reviewing the Principles of Reimbursement, any references to "intermediary" should be interpreted as referring to the SMA.

Medicare Principles of Reimbursement appear in the Code of Federal Regulations (CFR), at Title 42, Part 413, and in manuals published by the federal Centers for Medicare & Medicaid Services (CMS). The Provider Reimbursement Manual, also referred to as PRM-15 and Pub. 15, may be obtained from CMS electronically or by contacting CMS. (Refer to the Directory Appendix for website and contact information.)



SECTION 2 – DEFINITIONS [CHANGES MADE 4/1/20]

General definitions are provided in this section. More detailed explanations are provided in relevant sections related to cost, audit or rate setting.

Abuse	Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
Acceptable Cost Report	A complete and accurate accounting of the financial and statistical activities of a nursing facility provider prepared in accordance with Medicaid policy and cost reporting instructions on the electronic format required by the SMA. The cost report must include the certification statement signed by an authorized representative of the nursing facility certifying the cost report as a true, correct and complete statement of facility financial and statistical activities prepared from the nursing facility provider's books and records.
Administrator	A nursing facility administrator is a person(s) who is on site and responsible for the professional administration, supervision and management of the nursing facility and operations as they relate to resident care. The nursing facility administrator must be licensed in accordance with the law in Michigan.
Allowable Costs	Costs incurred in the provision of nursing facility services subject to guidelines and limitations set forth in Medicare Principles of Reimbursement, as they appear in federal regulations and in manuals published by the federal Centers for Medicare & Medicaid Services, unless stated to the contrary in policies and procedures issued by the SMA.
Ancillary Services	Services for which charges are customarily made in addition to routine service charges. Services are defined in the Coverages portion of this chapter.
Asset Acquisition Cost	<p>The cost or value for a nursing facility asset determined in accordance with Medicare Principles of Reimbursement. Medicaid further defines acquisition cost as the cost incurred by the present owner in acquiring the asset.</p> <p><u>For Class I, II, III and IV Nursing Facilities</u></p> <p>For depreciable assets acquired after July 31, 1970, the historical cost may not exceed the lower of current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of purchase, or the fair market value of the asset at the time of its purchase.</p> <p><u>For Class III and IV Nursing Facilities</u></p> <p>For depreciable assets acquired on or after December 1, 1997, the allowable historical cost of the asset may not exceed the historical cost less depreciation allowed to the owner of record as of August 5, 1997 or, if the asset did not exist as of August 5, 1997, the first owner of record after August 5, 1997.</p>
Audit	Review of the financial records used to complete a Medicaid cost report for compliance with allowable cost principles and other policy contained in the Medicaid Provider Manual. An audit includes, but is not limited to, a limited-scope audit or an on-site audit. (text added per bulletin MSA 19-28)



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Audit Adjustment	An adjustment to the cost report after an audit to correct items that are noncompliant with allowable cost principles or other policy contained in the Medicaid Provider Manual. Adjustments can be a direct adjustment (i.e., an adjustment only for the noncompliant item[s]), an extrapolation adjustment, or a combination of the two adjustment methods. (text added per bulletin MSA 19-28)
Audit Disallowance	See Audit Adjustment definition. (text added per bulletin MSA 19-28)
Authorized Representative	An individual who has legal authority to obligate the nursing facility entity. The individual may be an officer, senior or majority partner, possess controlling ownership interest or an appropriate management employee of the licensed nursing home business entity. For purpose of signatures required for cost reporting and reimbursement request actions, individuals not included in these positions must have designated legal right to act on behalf of the subject business entity.
Available Bed	A bed considered available for occupancy. Beds are considered available except in the following situations: <ul style="list-style-type: none"> ▪ Unoccupied beds when the facility is under a regulatory Ban on Admissions (does not include beds unoccupied when the facility is under a Denial of Payment for New Admissions action). ▪ Beds covered under a SMA-approved Non-Available Bed Plan. ▪ Beds temporarily unoccupied due to renovation or construction where the SSA has deemed the beds unacceptable for occupancy, for example beds which are a part of a Building Program Agreement.
Available Bed Days	The number of available bed days for a facility is the number of available beds in the facility multiplied by the number of days in the cost reporting period that they are available.
Average of Variable Costs	See Class Average of Variable Costs.
Ban on Admissions	A regulatory/enforcement sanction, imposed by the SSA, prohibiting the admission of any new resident(s) into the nursing facility, regardless of payment type, while the prohibition is in effect. Readmissions are allowed during this period on an individual case basis at the discretion of the SSA. A modified ban on admissions is a regulatory/enforcement sanction, imposed by the SSA, which may be imposed for a period of time after a ban on admissions has ended. The length of the modified ban on admissions is at the discretion of the SSA and may limit the number of new admissions for a designated period of time. Note: A Ban on Admissions is different from a Denial of Payment for New Admissions.
Base Costs	Costs that cover activities associated with direct patient care. Major items under these categories are payroll and payroll-related costs (salaries, wages, related payroll taxes, fringe benefits) for departments of nursing, nursing administration, dietary, laundry, diversional therapy, and social services; food; linen (does not include mattress and mattress support unit); workers compensation; utility costs; consultant costs from related party organizations for services relating to base cost activity, nursing pool agency contract service for direct patient care nursing staff, and medical and nursing supply costs included in the base cost departments. With the exception of nursing pool services, purchased services and contract labor from unrelated parties or from related organizations, incurred in lieu of base costs as previously defined, are separated into base and support costs using the industry-wide average base-to-variable cost ratio.



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Base Costs Per Day	Facility base costs divided by the total number of resident days for the same period.
Base Cost Component, Indexed	See Indexed Base Cost Component.
Base Period	An interval of time for which cost data is obtained and used in the calculation of a prospective reimbursement rate.
Capital Expenditure	Expenditure not limited to cost of construction, engineering, and equipment, which, under Generally Accepted Accounting Principles, is not properly chargeable as an expense of operation.
Case-Mix Category	System that categorizes residents based on their clinical conditions and resource consumption into different groupings. Residents with similar clinical conditions and resource consumption are grouped into the same case-mix category. (text added per bulletin MSA 19-24)
Census	See Resident Days/Occupancy.
Census Day	<p>A census day is counted when a resident is occupying a nursing facility bed at midnight. A census day is counted if:</p> <ul style="list-style-type: none"> ▪ the resident is away from the facility for therapeutic leave and the facility is paid by any payer source to hold the bed; ▪ the resident is on a one-day stay and the nursing facility is paid for the day; ▪ the resident is discharged due to death and the nursing facility is paid for the day; ▪ the leave days (bed holds) are paid for by non-Medicaid sources; or ▪ it is a resident's day of discharge that qualifies as a late discharge by the Medicare program. <p>A resident is counted for census purposes if the resident is admitted to the hospital, except when the facility may be reimbursed by Medicaid to hold the bed or when a Medicaid beneficiary is hospitalized and the facility is ineligible for reimbursement because it is not at 98% occupancy (unless the facility is reimbursed by another payer source to hold the bed). If a resident is hospitalized and the facility is not paid by any source to hold the bed, the day is not included in the census. A resident is counted for census purposes on the day of admission, but not on the day of discharge except as noted above.</p>
Chain Organization	A group of two or more nursing care facilities, or at least one nursing care facility and another business or entity, that is owned, leased, or through any other device controlled or operated by one organization. Chain nursing facility organizations include, but are not limited to proprietary organizations and various religious, charitable, and governmental organizations, any of which may be engaged in other activities not directly related to health care.
Change of Ownership	The exchange of real property, e.g., a sale of stock or real estate, including a sale of a building housing a nursing facility provider as a lessee; a change in corporate structure for a nursing facility, e.g., a change from a sole proprietorship to a corporation; or any other ownership change that affects the provider/licensed operator of a nursing facility.
Class I Facilities	Proprietary and nonprofit nursing facilities that do not fall under the Class II, Class III, Class IV or Class V definitions.
Class II Facilities	Proprietary nursing facilities for the mentally ill or developmentally disabled (intellectual disability), with a different variable cost limit than Class I facilities.



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Class III Facilities	Proprietary nursing facilities, hospital long term care units, and nonprofit nursing facilities that are county-operated medical care facilities.
Class IV Facilities	State-owned and operated institutions for individuals with intellectual disabilities (developmentally disabled), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and nonprofit nursing facilities for individuals with intellectual disabilities.
Class V Facilities	A distinct part of a special nursing facility for the care of ventilator-dependent residents.
Class VI Facilities	Hospitals that provide a program of short-term nursing care (Swing Beds) not exceeding 100 days per stay.
Class VII Facilities	State-owned and-operated veterans' homes as established under Michigan Public Act 152 of 1885.
Class Average of Variable Costs (AVC)	The total indexed variable costs for all facilities in a class divided by the total resident days for all facilities in the class. An AVC is calculated for each nursing facility class. For example, the AVC for October 1, 2018, which is used for rate year October 1, 2018 to September 30, 2019, is based on variable costs reported in cost reports for facility fiscal years ending in 2017, indexed to October 1, 2017.
Class Variable Cost Limit (VCL)	A limit set at the 80th percentile of the Indexed Variable Costs (IVC) for facilities in a particular class during the current calendar year. The 80th percentile is determined by rank ordering facilities from the lowest to the highest IVC, then accumulating Medicaid resident days of the rank-ordered facilities, beginning with the lowest, until 80% of the total Medicaid resident days for the class are reached. The Variable Cost Limit for the class of facilities equals the IVC of the nursing facility in which the 80th percentile of accumulated Medicaid resident days occurs. A VCL is calculated for Class I and Class III nursing facilities. For example, the VCL for October 1, 2018, which is used for rate year October 1, 2018 through September 30, 2019, is based on variable costs reported in cost reports for facility fiscal years ending in 2017, indexed to October 1, 2017.
Common Ownership	A situation in which more than one individual possesses significant (5% or greater) ownership or equity in a nursing facility or an organization serving the nursing facility provider.
Compensation	The total monetary, fringe, and/or benefits received by an employee or owner for services rendered to the nursing facility.
Completed Audit	Issuance of the Preliminary Summary of Adjustment Notice. Completed audit includes the Exit Meeting with the nursing facility provider unless the Exit Meeting is waived. (text added per bulletin MSA 19-28)
Control	A situation where an individual or organization has the power, directly or indirectly, to significantly influence and/or direct the actions or policies of a nursing facility or an organization serving the nursing facility provider.
Corporate Official or Employee	An individual representing an organization with the authority to exercise control over a nursing facility.
Cost Center	A division, department, or subdivision thereof; a group of services; or any other unit or type of activity into which functions of an organization or nursing facility are divided for purposes of cost assignment and allocation.



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Cost Index	An indicator used to adjust nursing facility cost levels. The cost index used by Medicaid is Global Insight's Skilled Nursing Facility Market Basket Without Capital Index, which is published quarterly in the Global Insight DRI-WEFA Health Care Cost Review. The cost index is used to adjust reported costs from the facility's cost report period end date to October 1 of the year that is one year prior to the rate year being calculated. For example, cost report data used to set rates for the October 1, 2018 to September 30, 2019 nursing facility rate year are indexed to October 1, 2017.
Cost Report	Reports submitted annually by a nursing facility that is participating in the Medicaid program at a utilization rate on average of at least six Medicaid residents must be on MDHHS cost reporting forms. A nursing facility provider with fewer than six Medicaid residents per day must file a "less than complete cost report" and is not subject to audit or rate setting purposes. (revised per bulletin MSA 19-28)
Current Provider	The provider that operated the nursing facility during the period of the last cost report on which normal rate setting would occur. Also see Provider.
DEFRA	Deficit Reduction Act of 1984
Denial of Payment for New Admissions (DPNA)	A regulatory/enforcement action, imposed by the CMS or the SMA, prohibiting payment for new Medicare and/or Medicaid admissions. Medicaid will not pay for services provided to a resident admitted during a DPNA. Note: A Denial of Payment for New Admissions is different from a Ban on Admissions.
Economic Inflation Rate	The annual economic inflation percentage for Class I and Class III nursing facilities established by the state legislature through the appropriations process.
Economic Inflation Update	The Economic Inflation Rate (EIR) for the facility class applied to the lesser of the Variable Rate Base for the facility or the class Variable Cost Limit.
Extrapolation	An audit adjustment methodology that projects an error rate (using valid statistical procedures) for expenses reported on the cost report through the audit of statistically sampled items. The error rate will solely or partially determine the provider's audit adjustments. (text added per bulletin MSA 19-28)
Facility	An entire nursing facility or a distinct part thereof being considered for rate setting. The entire building may be considered a distinct part unit for rate setting purposes. A unit smaller than the entire building may also be considered a distinct part unit for rate setting purposes if the identified facility space area meets required certification requirements.
Fair Market Value	The price that an asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition, generally comparable to the price at which other sales have been consummated for assets of like type, quality and quantity in a particular market at the time of acquisition.



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<p>Filed Cost Report</p>	<p>A cost report package is only considered filed when all the following conditions are met:</p> <ul style="list-style-type: none"> ▪ the package is complete; ▪ the cost report calculations are mathematically accurate, reasonable, and consistent; ▪ the completed electronic cost report (ECR) data uses the required software and specified format; ▪ MDHHS audit staff can generate a full cost report applicable to the cost year from the ECR file; ▪ an electronic copy of the Certification Statement is completed and signed, and agrees with the submitted ECR file; ▪ the data meets a set of validation checks contained within the ECR, plus the appropriate bed size and certification reporting requirements; ▪ the submitted ECR file includes proper reporting of costs and related cost report allocations in accordance with prior year(s) audit adjustment determinations for like costs or cost reporting issues; and ▪ the cost report preparation complies with Medicaid policy and cost reporting instructions. (text added per bulletin MSA 19-28)
<p>Fiscal Year - Facility</p>	<p>For purposes of cost reporting, a nursing facility provider's financial reporting year for tax purposes, normally a 12-month period unless approved for exception. Exceptions include, but are not limited to, a change in provider ownership, fiscal period end date change, or facility relocation to a replacement facility. (revised per bulletin MSA 19-28)</p>
<p>Fiscal Year – State</p>	<p>October 1 through September 30.</p>
<p>Fixed Equipment (Major)</p>	<p>Equipment that is affixed to or constitutes a structural component of the nursing facility as defined by the current version of the American Hospital Association Chart of Accounts.</p>
<p>Hold A Bed Day</p>	<p>See Leave Day.</p>
<p>Home Office</p>	<p>The central office of a chain organization. (see Chain Organization)</p>
<p>Hospital Long Term Care Unit (HLTCU) (revised 4/1/20)</p>	<p>A distinct part of a general hospital licensed as a nursing facility.</p>
<p>Hospital Leave Day</p>	<p>See Leave Day - Hospital.</p>
<p>Indexed Base Cost Component</p>	<p>A facility's total per resident day allowable base costs indexed to October 1 of the year that is one year prior to the rate year being calculated.</p>
<p>Indexed Support Cost Component</p>	<p>A facility's indexed base cost component multiplied by the lesser of the facility's support-to-base ratio or the support-to-base ratio limit for that facility's bed-size group.</p>
<p>Indexed Variable Costs</p>	<p>The sum of a facility's allowable base and support costs per resident day indexed to October 1 of the year that is one year prior to the rate year being calculated.</p>



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Leave Day – Hospital	A day for which a facility may be reimbursed by Medicaid to hold a resident's bed for his/her return. (Medicaid policy pertaining to reimbursement is contained in the Coverages portion of this chapter.) Leave days reimbursed by other payer sources must be included in the facility census for cost reporting purposes.
Leave Day – Therapeutic	A day where a facility may be reimbursed by any payer source to hold a resident's bed for his/her return. Medicaid policy pertaining to reimbursement is contained in the Coverages portion of this chapter. The day is counted as a census day of care for resident occupancy on the nursing facility's cost report.
Management Company	An entity contracted by a licensed and Medicaid-enrolled nursing facility provider to manage one or more of the daily operations of the facility.
Medical Care Facility (MCF)	A county-operated nursing facility.
Minimum Data Set (MDS) Assessment	Clinical assessment tool required for all Medicaid-or-Medicare certified long-term care facilities. The federally required Omnibus Budget Reconciliation Act (OBRA) MDS assessments listed in A0310A of the MDS 3.0 Resident Assessment Instrument (RAI) Manual are the only assessments that may be used to determine rates for Class VII facilities.
Net Quality Assurance Supplement (Net QAS)	The QAS minus the non-Quality Measure Initiative share of the Medicaid Quality Assurance Assessment Program tax.
Net Quality Measure Initiative Amount (Net QMI Amount)	The Quality Measure Initiative payment amount minus the Quality Measure Initiative share of the Medicaid Quality Assurance Assessment Program tax.
New Facility (for rate-setting purposes)	A nursing facility provider that does not have a current Medicaid historical cost, including a newly constructed facility, an existing facility that has never before participated in the Medicaid program, a facility that has participated in Medicaid in a different provider class, or an existing facility that qualified as a "No Medicaid" or "Low Medicaid" activity cost reporting provider for two consecutive fiscal years. The consecutive fiscal years must cover a period of at least 24 months in total and may only cover dates in which the facility was enrolled in Medicaid and averaged six or more Medicaid residents per day. A nursing facility that has made physical plant additions or (revised per bulletin MSA 19-28) renovations, including a total replacement or a facility that has been sold or resold is not considered a new facility.
New Provider in a Medicaid-Enrolled Facility	A person or business entity that has purchased or is purchasing a nursing facility that previously had Medicaid participation and whose new ownership individual(s) or business entity are not related through family or business ties to the owner's business entity of the previous owner. Under certain circumstances, a sale between family members may be approved by the SMA and the new owner may be considered a new provider.
Non-Medicare Nursing Facility Days	Nursing Facility days for which Medicare (Part A [Fee for Service] and Part C [Medicare Advantage, including MI Health Link days where Medicare is the primary payer]) is not the primary source of reimbursement.
Non-statistical Sampling	An audit sampling method that does not meet the definition of statistical sampling. Under an audit using solely non-statistical sampling methods, extrapolation methods may not be used to determine audit adjustments. (text added per bulletin MSA 19-28)



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Nursing Facility or Nursing Home	A facility (or distinct part of a facility) that is licensed and certified by the State of Michigan or certified by CMS to provide nursing care and related medical services for residents who require such care above the level of room and board.
OBRA	The federal Omnibus Budget Reconciliation Act, initially passed in 1987 as Public Law 100-203, with amendments in 1988, 1989, 1990 and 1994. This law incorporated specific provisions for nursing facility reform, including revised requirements for the survey and certification process and for the enforcement process.
Occupancy	See Resident Days/Occupancy.
Occupancy Rate	The total number of resident days in a given period divided by the number of available bed days in the facility for the same period.
Owner/Administrator	A person who is employed and functions as the administrator, assistant administrator, business manager, or in any other administrative capacity in the nursing facility, and who is also part or full owner of the nursing facility operating entity, i.e., the provider and/or the nursing facility's real property. If a Director of Nursing is an owner and acts occasionally in an administrator capacity, the time acting in an administrative capacity is allocated to the owner/administrator salary.
Ownership/Corporate Interest	<p>A person, partnership, or corporation that:</p> <ul style="list-style-type: none"> ▪ Has ownership interest totaling 5% or more in a nursing facility, i.e., in the disclosing entity, or in the corporate entity owning the facility; or ▪ Has an indirect ownership interest equal to 5% or more in a nursing facility, i.e., in the disclosing entity, or in the corporate entity owning the facility; or ▪ Has a combination of direct and indirect ownership interests equal to 5% or more in a nursing facility, i.e., in the disclosing entity, or in the corporate entity owning the facility; or ▪ Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by a nursing facility, i.e., in the disclosing entity, or in the corporate entity owning the facility, if that interest equals at least 5% of the value of the property or assets of the facility/disclosing entity; or ▪ Is an officer or director of a nursing facility, i.e., in the disclosing entity, that is organized as a corporation; or ▪ Is a partner in a nursing facility, i.e., in the disclosing entity, which is organized as a partnership. <p>Examples:</p> <ul style="list-style-type: none"> ▪ If Ms. C owns 10% of a note secured by 60% of the nursing facility provider's assets, Ms. C's interest in the provider's assets equates to 6% and must be reported. Conversely, if Mr. S owns 40% of a note secured by 10% of the provider's assets, Mr. S's interest in the provider's assets equates to 4% and need not be reported. ▪ If Mr. F owns 10% of the stock in a corporation that owns 80% of the nursing facility, Mr. F's interest equates to an 8% indirect ownership interest and must be reported. Conversely, if Ms. N owns 80% of the stock of a corporation that owns 5% of the stock of the nursing facility, Ms. N's interest equates to 4% indirect ownership interest and need not be reported.
Patient	See Resident.



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Patient Driven Payment Model (PDPM)	Classification system used to place nursing facility (NF) residents into different case-mix categories as determined by the Minimum Data Set (MDS) and used to set payment rates for Class VII facilities. PDPM consists of four case-mix categories and six rate components. The physical therapy (PT) and occupational therapy (OT) component, the speech-language pathology (SLP) component, the non-therapy ancillary (NTA) component, and the nursing component represent the four case-mix categories. PDPM rates are comprised of a PT component, OT component, a SLP component, an NTA component, a Nursing component and a Non-Case-Mix component. (text added per bulletin MSA 19-24)
Per Resident Day Cost	The total cost for a cost component divided by the total number of resident days. The number of resident days used is the greater of the number of resident days listed in the facility's cost report or 85% of the total number of available bed days for the cost reporting period.
Plant Costs	Plant costs include depreciation, interest expense (incurred for either working capital or capital indebtedness, mortgage discount points), property taxes, amortization costs associated with loan financing costs (e.g., letters of credit), letter of credit application or commitment fees, amortization of legal fees pertaining to acquisition, recording fees or other fees relating to the capital asset acquisition, and specific lease expenses.
Property Owner	A person, partnership, corporation, organization, or entity, other than the nursing facility provider, having the property rights to the building in which a nursing facility operates or to the land on which a nursing facility sits.
Proprietary Provider	A provider or organization that is organized and operated with the expectation of earning profit for its owner[s], as distinguished from providers organized and operated on a nonprofit basis. Proprietary providers may be sole proprietorships, partnerships, or corporations.
Provider	A legal entity (person, partnership, corporation, or organization) that has been approved to participate in the Michigan Medicaid Program. Some conditions of provider participation continue after enrollment in Medicaid has ended, e.g., record retention.
Purchase Allowance	A deduction granted for damage, delay, shortage, imperfection, or other causes, excluding discount and return.
Purchase Discount	A reduction (off the original price for property, goods or services) granted for the settlement of debts (e.g., 5/10 days which means a 5% discount if paid within 10 days).
Purchase Price	The total price agreed upon between a buyer and a seller for property, goods or services.
Quality Assurance Assessment Factor (QAAF)	The percentage increase determined and implemented by Medicaid for a class of nursing facilities.
Quality Assurance Supplement (QAS)	The product of the QAAF for the class times the lesser of the Variable Rate Base for the facility or the class Variable Cost Limit. Class III publicly-owned facilities basis is the lesser of the Class III VCC or the Class I VCL.
Quality Measure Initiative (QMI)	Quality Assurance Assessment Program funded payments to nursing facilities based on their average quality measure domain rating on the Nursing Home Compare (NHC) website, along with a resident satisfaction survey factor.



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Related Entity or Organization	An entity having a business relationship with a nursing facility provider that has 5% or greater beneficial interest or common ownership in or has control of the facility or the facility owner, whether such control has legal standing or is utilized. Also see Chain Organization and Ownership/Corporate Interest.															
Related Party	An individual, group of individuals, or business entity that meets criteria similar to that defining a related entity or organization.															
Resident	An individual who has been admitted to the provider's facility and has not been discharged.															
Resident Days/Occupancy	Resident days or occupancy for nursing facility Medicaid cost reporting is the sum of the census days in a specified period of time. To calculate the resident days for a particular day, total the census days for that day. (Medicaid residents who are hospitalized are not counted in the census). Example: <table style="margin-left: 40px;"> <tr> <td>Residents occupying beds in facility</td> <td>=</td> <td>100</td> </tr> <tr> <td>Residents on therapeutic leave</td> <td>=</td> <td>5</td> </tr> <tr> <td>Hospitalized Medicaid residents</td> <td>=</td> <td>3</td> </tr> <tr> <td>Paid bed hold days</td> <td>=</td> <td>1</td> </tr> <tr> <td>Total resident days</td> <td>=</td> <td>106</td> </tr> </table>	Residents occupying beds in facility	=	100	Residents on therapeutic leave	=	5	Hospitalized Medicaid residents	=	3	Paid bed hold days	=	1	Total resident days	=	106
Residents occupying beds in facility	=	100														
Residents on therapeutic leave	=	5														
Hospitalized Medicaid residents	=	3														
Paid bed hold days	=	1														
Total resident days	=	106														
(text deleted per bulletin MSA 19-24)																
Restricted Revenue	Revenue that is designated or earmarked, by law, to finance some specific activity or group of related activities.															
Routine Nursing Costs	Costs including, but not limited to, necessary medical, nursing, and mental health services, and all items of expense that nursing facility providers incur in the provision of routine nursing services. Costs must be included in the nursing facility provider's Medicaid cost reporting in accordance with established cost classifications.															
Routine Nursing Services	Organized nursing care and activities for the resident, under the observation and assessment of licensed nurses, who enable the resident to attain or to maintain the highest practicable physical, mental, and psychosocial well being in accordance with a written plan of care.															
Settlement	The process of reconciling a nursing facility's interim rates based on filed cost report data to audited cost report data. A final settlement is computed after the cost report has been audited, a final rate based on audited data is issued, and all appeals have been adjudicated. (text added per bulletin MSA 19-28)															
State Medicaid Agency (SMA)	The Michigan Department of Health and Human Services (MDHHS). The work unit within MDHHS with administrative responsibility for the Medical Assistance (Medicaid) Program is the Medical Services Administration.															
State Survey Agency (SSA)	The Michigan Department of Licensing and Regulatory Affairs (LARA). The work unit within LARA with administrative responsibility for nursing facility survey and certification is the Bureau of Community and Health Systems (BCHS).															



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Statistical Sampling	<p>An audit sampling method that has the following characteristics:</p> <ul style="list-style-type: none"> ▪ random selection of the sampled items; ▪ the use of probability theory to evaluate sample results; and ▪ the use of valid statistical procedures. <p>Under an audit that solely or partially uses the statistical sampling method, extrapolation methods may be used to determine audit adjustments. (text added per bulletin MSA 19-28)</p>
Support Costs	<p>Costs that are payroll and benefit-related (salaries, wages, related payroll taxes, fringe benefits) for the departments of housekeeping, maintenance of plant operations, medical records, medical director, and administration; administrative costs; all consultant costs not specifically identified as base; all equipment maintenance and repair costs; purchased services; and contract labor not specified as base costs.</p>
Support Costs Per Day	<p>A facility's support costs divided by the total number of resident days for the same period.</p>
Support Cost Component, Indexed	<p>See Indexed Support Cost Component.</p>
Support-to-Base Ratio	<p>A facility's allowable support costs divided by allowable base costs. A facility's support-to-base ratio is limited to the 80th percentile support-to-base ratio for the facility's bed-size group. The bed-size groups are defined as 0-50, 51-100, 101-150, and 151+ nursing care beds in the facility. Group bed size is based on the number of licensed beds in a facility regardless of bed type or whether the bed is available. This includes all types of licensed nursing beds, Home for the Aged beds, or any other type of licensed bed where nursing care is provided. A facility's support-to-base ratio is rebased annually from the most recent audited base period, regardless of ownership.</p>
Support-to-Base Ratio Limit for Bed Size Group	<p>The support-to-base ratio limit for a bed-size group is set at the 80th percentile of the support-to-base ratios for facilities in the same bed-size group. The bed-size groups are defined as 0-50, 51-100, 101-150, and 151+ nursing care beds in the facility. The 80th percentile is determined by rank-ordering facilities within the same bed-size group from the lowest to the highest support-to-base ratio, then accumulating Medicaid resident days of the rank-ordered facilities, beginning with the lowest, until 80% of the total Medicaid resident days for the group are reached. The support-to-base ratio limit for the bed-size group equals the support-to-base ratio of the nursing facility in which the 80th percentile of accumulated Medicaid resident days occurs.</p>
Swing Beds	<p>A program of short-term nursing care not exceeding 100 days, provided to patients in a hospital as defined in federal law and Michigan statute.</p>
Therapeutic Leave Day	<p>See Leave Day – Therapeutic.</p>
Variable Costs	<p>A facility's total allowable base and support costs for providing routine nursing services to residents, as determined in the Allowable Costs Section of this appendix. Also see definitions for Base Costs and Support Costs.</p>
Variable Cost Component	<p>The lesser of a facility's Variable Rate Base or the Class Variable Cost Limit, plus the Economic Inflation Update.</p>
Variable Cost Limit	<p>See Class Variable Cost Limit.</p>
Variable Costs Per Day	<p>A facility's variable costs (total base and support costs) divided by the total number of resident days for the same period.</p>



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Variable Costs, Indexed	See Indexed Variable Costs.
Variable Rate Base	The sum of a facility's indexed base cost component and indexed support cost component. For rate setting purposes, the figure used as the facility's Variable Rate Base is the lesser of the facility's calculated Variable Rate Base or the Class Variable Cost Limit.



SECTION 3 - OWNERSHIP CHANGES AND MEDICAID TERMINATION

3.1 PREREQUISITE

When an ownership change is anticipated, the Certificate of Need (CON) requirement must be satisfied before Medicaid enrollment can occur. MDHHS administers the CON Program. Contact information and subject matters pertaining to the CON may be found on-line on the MDHHS website. (Refer to the Directory Appendix for website information.)

3.2 OWNERSHIP CHANGES

When an ownership change is anticipated, the proposed Seller(s) and the proposed Purchaser(s) must provide written notice to both the State Medicaid Agency (SMA) and the State Survey Agency (SSA) at least 90 calendar days prior to the anticipated ownership change. The written notice to the SMA must be sent to the MDHHS LTC Reimbursement and Rate Setting Section (RARSS) and to the Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.) The written notice to the SSA must be sent to the nursing facility's team manager. Failure to provide written notice to either agency could result in payment and settlement delays.

Prior to the ownership change date, the new ownership must complete a New Provider Information Packet to provide RARSS with the necessary information for the rate setting and reimbursement process. Failure to provide this information prior to or immediately upon completion of the purchase will delay the rate setting and reimbursement processing for the new ownership. For New Facility/Owner Requirements, refer to the Cost Reporting Section of this appendix.

If a facility changes ownership, the facility must register the NPI for the new owner through the on-line CHAMPS Provider Enrollment (PE) subsystem. If the provider tax identification number (TIN) did not change, the NPI can be reported through the CHAMPS PE maintenance function. If the change involves a new TIN, the provider must complete a new enrollment application. The new owner must not use the prior owner's NPI for reporting and billing Medicaid services. Failure of the new ownership to register the new provider NPI number for billing subjects the new owner to financial responsibility for the prior owner's claim liability. Refer to the Provider Enrollment Section of the General Information for Providers Chapter for additional information.

The Seller(s) and the Purchaser(s) will be notified by RARSS and advised of any requirements related to cost reporting and rate setting, including final settlement for the former owner. For information regarding reimbursement settlement, refer to the Cost Report Reimbursement Settlement Section of this appendix.

3.3 NURSING FACILITY SALE BETWEEN FAMILY MEMBERS

The sale of a family owned nursing facility between family members is allowable and recognized as a transfer of ownership and a recognized sale transaction for Medicaid reimbursement within allowable cost and reimbursement limits if all of the following requirements are met. However, if it is subsequently determined control is not relinquished by the prior entity or interested parties, asset values will revert back to the values prior to the recognized sale and any additional reimbursement paid will be recovered.

- A purchase contract or agreement must be present. The transaction must terminate the seller's interest in the business. The seller must not have any recourse or ownership protection to retain



or have a security interest in obtaining future ownership of that nursing facility in the event of the termination of the new ownership (purchaser) at a later date.

- Borrowing or financing for the sale transaction must be between the purchaser and a non-related third party (i.e., a financial institution). Financial loans from the family-related seller individual or entity to the family-related purchaser are not allowable for reimbursement. The finance instrument must not be a land contract from the seller.
- Total dollar amount of allowable borrowings cannot exceed the purchase price (allowable asset value). The Capital Asset Value (CAV) limit applicable to the nursing facility immediately prior to the sale, appropriately adjusted for nursing facility asset items that are excluded from the sale transaction, is the maximum reimbursable borrowing balance applicable to the asset transaction.
- The nursing facility property appraisal must be obtained. The facility appraisal value must support the purchase price negotiated between the sales parties. Refer to the Appraisal Guidelines Section of this appendix for additional information.
- The new ownership operation must be a different legal entity in which the family-related seller is not an officer or board member exercising control over the new operation. The nursing facility entity may remain as an ongoing business entity in a situation where the real estate sale does not involve the licensed nursing facility operator. This occurs where a related party lease exists between the nursing facility entity prior to the real estate transaction, and the real estate transaction of the leased nursing facility is between the family-related parties. The requirement that the family-related lessor/seller cannot exercise active interest or control in the management of the nursing facility after the sale must be met.

The following will be applied to a change in ownership as a result of a sale between family members:

- The allowable asset value to the purchaser is limited to the allowable historical capital asset cost of the seller party (or nursing facility entity owned by the family member) minus the dollar amount of depreciation expense allowed and reimbursed under the Medicaid Program. There is no increase in nursing facility asset values. MDHHS considers Medicaid reimbursement to the nursing facility for depreciation expense was zero dollars during the period that the seller provider was reimbursed by Medicaid for plant cost based upon capital asset value tenure reimbursement rate.
- The tenure factor for the nursing facility following the sale will revert to zero due to the capital asset transaction affecting a plant cost increase.
- The Medicaid program plant cost reimbursement limitations of the Deficit Reduction Act (DEFRA) of 1984 will not apply to the transaction as a result of the purchase limitation to the historical asset cost base of the seller.
- The seller may be subject to depreciation recapture dependent on the sale price of the assets and the depreciation reimbursement made to the seller during the period in which the seller was reimbursed a plant cost component under the depreciation cost method. The reimbursement period of depreciation recapture is limited to Medicaid services reimbursed during the period from October 1, 1984 through the date in which the nursing facility transferred to the tenure plant cost component reimbursement. The dollar amount of depreciation recapture may impact the asset acquisition allowable dollar amount for the purchaser.



3.4 FACILITY ASSET CHANGE OF OWNERSHIP

In the event of a binding agreement and/or sale occurring on or after July 18, 1984, the Plant Cost Component for the nursing facility, attributable to the agreement and/or sale, is limited to the Medicaid Program policy provisions applying federal reimbursement limits of the DEFRA. Refer to the plant cost component rate determination provisions in the Rate Determination Section of this appendix for additional information.

At the time of the facility asset ownership change, the Provider must complete a Plant Cost Certification and submit a copy of the purchase and/or lease agreement, along with plant cost information, to the MDHHS LTC Reimbursement and Rate Setting Section (RARSS). The information is necessary to establish the reimbursement rate for the Plant Cost Component due to the asset ownership change. For Plant Cost Certification requirements and timeframes for filing the data, refer to the Plant Cost Certification Section of this appendix.

For an explanation of the effect of the sale of assets on the Tenure Factor, refer to the Rate Determination Section of this appendix.

In the event of a sale after March 31, 1985, Medicaid will recapture from the selling provider any reimbursement received in the form of depreciation expense, through the date of either the sale and transfer of assets or, for a Class I facility, that provider's conversion to a "Return on Current Asset Value Component" reimbursement, whichever is earlier. This reimbursement provision does not apply to Class I nursing facility providers whose ownership began after March 31, 1985. For information regarding depreciation reimbursement adjustment, refer to the Cost Report Reimbursement Settlements Section of this appendix.

3.5 TERMINATION OF MEDICAID PARTICIPATION

A nursing facility that loses its Medicaid certification as a result of regulatory action, irrespective of whether that action requires facility closure, or a nursing facility that chooses to terminate its participation in the Medicaid program without closing must comply with notice and cost reporting requirements. Refer to the Cost Reporting Section in this appendix and to the Notification Process for Regulatory Actions, Nursing Facility Closure Protocol, or Voluntary Withdrawal From Participation in the Medicaid Program or Voluntary Nursing Facility Closure subsections in the Certification, Survey & Enforcement Appendix of this chapter for relevant information.

When Medicaid participation is terminated voluntarily or involuntarily, payment for at least one month of services rendered is retained for Final Settlement.



SECTION 4 - COST REPORTING

A nursing facility participating in the Medicaid program must submit a Medicaid cost report to MDHHS annually as a condition of participation. An electronic copy of the cost report, the cost report completion instructions, completion and submission checklists, and related information are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

4.1 EXCEPTIONS

4.1.A. EXCEPTION FOR HOSPICE PROVIDER OWNED NURSING FACILITY

A hospice provider that owns and operates a nursing facility is not required to file an annual cost report to Medicaid. The nursing facility industry aggregate cost data is used in place of individual facility cost data to establish a Medicaid reimbursement rate for this type of nursing facility. Rate determination procedures are addressed in the Rate Determination Section of this appendix.

4.1.B. EXCEPTION FOR SWING BEDS

Hospitals providing short term nursing services (swing beds) are not required to submit a Medicaid nursing facility cost report. Costs associated with swing beds are combined with those of the hospital and submitted on the hospital cost report. Refer to the Hospital Chapter of this manual for information regarding cost reporting requirements related to swing beds.

4.1.C. STATE VETERANS' HOMES

A State Veterans' Home is not required to submit a Medicaid NF cost report. The Medicare SNF cost report is used in place of the Medicaid cost report. The Medicare cost report is to be submitted electronically to the MDHHS Reimbursement and Rate Setting Section (RARSS) through the MDHHS File Transfer application. The Medicare Principles of Reimbursement apply for cost reporting purposes rather than the allowable cost principles described in the Allowable and Non-Allowable Costs section of this Appendix. The cost reporting requirements in the Less Than Complete Cost Report, Cost Report Due Date, New Facility/Owner Requirements, Changing a Cost Reporting Period, and Cost Report Delinquency subsections of this Appendix are still applicable.

4.2 NURSING FACILITY COST REPORT

An annual cost report is required for the cost reporting period which is based on the nursing facility's fiscal reporting year end. Each cost report must include an itemized list of all expenses as recorded in the formal and permanent accounting records of the facility. These records must be maintained in a manner consistent with the Medicare Principles of Reimbursement, except where modified by Medicaid policy. Records must also be kept in a manner consistent with previous cost reporting periods. The accrual method of accounting is mandated for all providers. For any cost situation that is not covered by the Medicare Principles of Reimbursement guidelines or Medicaid policy, Generally Accepted Accounting Principles (GAAP) should be applied.



Related organizations and costs to related organizations, as defined in federal policies and regulations, must be disclosed on the nursing facility cost report. Related organization costs claimed for Medicaid reimbursement through the nursing facility's rate determination process must be documented to RARSS on a completed home office cost report or on alternative cost reporting schedules as defined in the Home Office, Chain Organization, or Related Party Cost Reporting subsection of this appendix.

RARSS retains the filed nursing facility cost reports for a minimum of three years from the date of receipt. Nursing facilities are required to retain documentation supporting filed cost reports for a minimum of seven years from the end of the applicable cost reporting period, or beyond the seven year period if audit determinations have not been resolved.

4.3 COST REPORT REQUIREMENTS [CHANGES MADE 4/1/20]

The RARSS will send a notice electronically through the File Transfer application to the facility or business office as designated by the provider soon after the end date of the nursing facility's cost reporting period on record. The notice specifies the nursing facility's county and license number coding, fiscal reporting period end date, cost report due date, and other pertinent data necessary for the completion of the cost report. The provider will have access to the specific information required to file an acceptable Medicaid Cost Report package in File Transfer. File Transfer has the applicable electronic cost report template, completion instructions, construction cost index for asset acquisitions, and other pertinent information in downloadable form.

The completed cost report package submitted to RARSS must include:

- The standardized electronic cost report (ECR) data in accordance with specified formatting and software.
- An electronic copy of the Certification Statement (Worksheet A), which has been prepared and printed from the completed ECR file, and physically signed by an authorized representative of the nursing facility certifying to the accuracy of the prepared cost report.
- A copy of the nursing facility's detailed general ledger and complete (no grouping or summary) trial balance of revenues and expenses. **Both documents must be submitted as electronic Excel files. (text added per bulletin MSA 19-28)**
- A completed cost report submission checklist.
- Copies of supporting workpapers for all Worksheet 1-A and Worksheet 1-B adjustments as electronic Word or Excel files (invoices may be submitted as PDF files). **(text added per bulletin MSA 19-28)**

The completed cost report package must be delivered electronically through File Transfer to RARSS as indicated in the notice.

4.4 COST REPORT ACCEPTANCE [CHANGE MADE 4/1/20]

Each cost report submitted to RARSS is verified prior to its acceptance. The cost report package will only be accepted if all of the following conditions are met:

- The package is complete.
- The cost report calculations are mathematically accurate, reasonable and consistent.



- The completed electronic cost report (ECR) data uses the required software and specified format.
- MDHHS audit staff can generate a full cost report applicable to the cost year from the ECR file.
- An electronic copy of the Certification Statement is completed and signed, and agrees with the submitted ECR file.
- The data meets a set of validation checks contained within the ECR plus the appropriate bed size and certification reporting requirements.
- The submitted ECR file includes proper reporting of costs and related cost report allocations in accordance with prior year(s) audit adjustment determinations for like costs or cost reporting issues.
- The cost report preparation complies with Medicaid policy and cost reporting instructions.

Prior to acceptance of the submitted cost report, RARSS may adjust inaccurate data reported on the cost report if correct data is available to RARSS and the adjustment would not impact the computation of the per diem reimbursement rate. For example, RARSS may adjust the Title XIX Routine Nursing Days reported on the cost report if there is large discrepancy between the reported days and actual billed Medicaid days from the reporting period.

A cost report is considered not filed until it is accepted by RARSS. If the submitted cost report is determined to be unacceptable, RARSS will return the cost report to the nursing facility for correction and provide notice of the date the corrected cost report is due. The returned cost report will include information that indicates the reason(s) for the unacceptable report.

A corrected cost report – a revision of the most recently submitted cost report – may be submitted to RARSS for acceptance upon approval by RARSS. The provider should contact RARSS to obtain the acceptance status of that reporting period's most recent cost report ECR file prior to submission of a corrected cost report. A corrected cost report that is accepted by RARSS defaults as the original cost report.

MDHHS shall accept a non-delinquent cost report no more than 60 calendar days after the cost report is filed. **(text added per bulletin MSA 19-28)**

4.5 LESS THAN COMPLETE COST REPORT

With written approval from the RARSS, a nursing facility may submit a less than complete cost report.

4.5.A. NO MEDICAID UTILIZATION [CHANGE MADE 4/1/20]

A nursing facility with no Medicaid utilization during a cost reporting period is required to submit a less than complete cost report. **(revised per bulletin MSA 19-28)**

4.5.B. LOW MEDICAID UTILIZATION [CHANGE MADE 4/1/20]

A nursing facility with low Medicaid utilization during a cost reporting period is required to submit a less than complete cost report. "Low utilization" is defined as an average of less than six **(revised per bulletin MSA 19-28)** Medicaid residents per day in the facility for the cost year, i.e., fewer than 1,825 Medicaid nursing days. The nursing facility must submit a written request to RARSS for approval to file a less than complete cost report



for the specific cost reporting period. The request must be signed by an authorized representative of the nursing facility, identify the reporting period the request applies to, include the facility's name and provider NPI number, and:

- Indicate the reason(s) for the request.
- Indicate Medicaid utilization and the approximate Medicaid dollar amount of payments received for the year.

The written request must be submitted to the RARSS within 30 calendar days following the date of the nursing facility cost report filing notice.

After RARSS reviews the filed utilization and payment information, RARSS will send a written response to approve or deny the facility's request to submit a less than complete cost report. If approved, the facility will be required to furnish the following information using the required formats (ECR file worksheets):

- Information and Certification page.
- Statistical and Fiscal Data page.
- Ownership Information and Questionnaire.

In addition, the facility must prepare and submit the following information for the cost reporting period:

- Balance Sheet, and
- Prepared Financial Statements.

The nursing facility must submit the data within the same period required for complete cost reports. Medicaid reserves the right to require the facility to file a complete cost report.

4.6 COST REPORT DUE DATE

The RARSS will notify the nursing facility of the cost report due date by letter mailed to the nursing facility or designated business office. An acceptable cost report must be received by RARSS within five months following the nursing facility's cost reporting period end date. Subsequent notice of the cost report due date is addressed in the Cost Report Delinquency subsection of this appendix.

A cost report is considered filed timely if the acceptable cost report is submitted to the RARSS on or before the last day of the fifth month following the cost report period end date. Late submission of an acceptable cost report may cause a delay in determination of the provider's annual reimbursement rate and the rate notice to the provider. Refer to the Rate Determination subsection of this appendix for additional information.

4.6.A. CORRECTED COST REPORT DUE DATE [CHANGE MADE 4/1/20]

If a cost report is returned to the provider as unacceptable by the LTC Reimbursement and Rate Setting Section (RARSS), the provider is given five business days from the date of the RARSS cost report return letter to submit a corrected cost report via File Transfer.



(revised per bulletin MSA 19-28) A written request for an extension may be made to RARSS for additional days (not to exceed 30 calendar days from the return date). The RARSS will notify the provider in writing of the extension decision. If a corrected cost report is not received by the correction due date, the nursing facility is subject to cost report delinquency and payment termination notification. Refer to the Cost Report Delinquency subsection of this appendix for additional information.

4.6.B. COST REPORT FOR FACILITY CLOSURE OR CHANGE OF OWNERSHIP

A nursing facility that has terminated its Medicaid program participation, either voluntarily or as the result of regulatory action, is required to submit a final cost report within five months following termination date.

The former owner of a nursing facility that has undergone a change of ownership is required to submit a final cost report within five months following the effective date of the ownership change.

4.7 NEW FACILITY/OWNER REQUIREMENTS

A new Medicaid provider (either a new owner or a new Medicaid participating provider) must notify RARSS of its fiscal year, cost reporting period, and other pertinent information regarding the nursing facility. In order for RARSS to establish the facility's Medicaid reimbursement rate, this notice must be submitted to MDHHS at least 30 calendar days prior to the begin date of Medicaid participation. Untimely submission of the data will result in delaying Medicaid payment to the nursing facility.

The new provider information packet is available by request to the RARSS. An electronic copy of the packet may also be accessed on the MDHHS website. (Refer to the Directory Appendix for contact and website information.)

The new provider information data must include the following items:

- Medicaid operations begin date.
- Fiscal year reporting period.
- Federal employer identification number.
- Facility business name.
- Corporate name (if different from business name).
- Facility address.
- Business mail address (if different from facility address).
- Affiliation to a home office chain or related nursing facility group, including corporate organization, address, fiscal reporting period, federal employer identification number and contact person information.
- Nursing facility Medicare Program status.

The new provider information data packet must be signed and submitted by an authorized representative of the nursing facility.



4.8 CHANGING A COST REPORTING PERIOD

An annual cost report is required for the reporting period based on the nursing facility's fiscal reporting year. A nursing facility must file an annual cost report in accordance with the cost reporting period established with RARSS. However, under certain circumstances, RARSS may authorize a change in the nursing facility cost reporting period. The new cost reporting period must concur with the period of the nursing facility financial reporting year.

4.8.A. NEW FACILITY/NEW OWNERSHIP INITIAL COST REPORT

A new Medicaid provider (either a new owner or a new Medicaid participating provider) must notify RARSS of its fiscal year and cost reporting period, and other pertinent information regarding the nursing facility. The initial cost report must cover a period of at least two months but may not exceed 13 months.

4.8.B. WRITTEN REQUEST FOR COST REPORTING PERIOD CHANGE

A nursing facility owner interested in changing a cost reporting period must submit a written request to RARSS. The request for such a change must be filed at least two months prior to the first day of the new fiscal reporting period being requested. The request must include documentation supporting the change, such as a copy of an approval of Medicare Program reporting change or Internal Revenue Service reporting year change notice. If the reporting year change is not yet approved by these agencies, a copy of notice to Internal Revenue Service reporting or application for Medicare Program reporting change may be submitted. The request must also include a copy of the nursing facility director or governing board approval resolution or minutes adopting the fiscal reporting revision.

RARSS will notify the provider in writing of the approval or denial of the request and cost report period requirements resulting from the request.

4.8.C. APPROVAL FOR TRANSITION PERIOD COST REPORTING

If the change is approved, the nursing facility will be required to file a cost report for the period between the end date of the original cost reporting period and the beginning date of the new cost reporting period. This cost report must cover a period not less than two months and not more than 13 months. Cost report periods that cover a period less than seven months may be used for Medicaid reimbursement for retrospective cost settlement determination for specific cost items, but are not used for prospective rate setting determinations affecting a subsequent rate setting year.

4.8.D. EXTENDED PERIOD COST REPORT

A provider may submit a request for a cost reporting period of more than 12 months but not greater than 13 months if:

- the provider is terminating Medicaid Program participation; or
- the facility is closing.



Written request must be made to the RARSS and must outline the exceptional circumstances. The provider will be notified in writing of approval or denial.

The RARSS may approve such requests if the Medicaid program or the nursing facility is not significantly adversely affected. Examples include requests in which:

- the request is not made for purpose to gain access to higher ceiling rates or economic inflation adjustors;
- the cost report data will have limited use for reimbursement determinations, i.e., not used for annual rate setting;
- the report is not used for subsequent period rate determination; and
- it is used solely for retrospective settlement items.

4.9 COST REPORT DELINQUENCY [CHANGE MADE 4/1/20]

The nursing facility cost report is considered delinquent if:

- The cost report is not received by RARSS within five business days of the date on the Delinquency and Medicaid Payment Termination Notice. **(revised per bulletin MSA 19-28)**
- A corrected cost report has not been received by RARSS by the cost report due date or correction period due date and the cost report remains not filed with RARSS.

If the nursing facility cost report is delinquent, RARSS will share a delinquency and Medicaid payment termination notice with the nursing facility or the provider's designated business office through File Transfer. The notice will indicate the date (not less than ten business days from the notice date) on which Medicaid payment will be terminated unless a cost report is received by the RARSS.

If an acceptable cost report is received after payment termination, payments will be reinstated through the normal pay cycle(s) process. Medicaid will remove the payment termination entry pertaining to the cost report delinquency action allowing the release of all payments withheld for the cost report delinquency action.

4.10 AMENDED COST REPORT [CHANGE MADE 4/1/20]

An amended cost report to adjust a previously accepted cost report may be permitted or required by Medicaid.

An amended cost report is accepted by Medicaid to:

- Correct material errors detected subsequent to the filing of the original cost report.
- Comply with health insurance policies or regulations.
- Reflect the settlement of a contested liability.

Before completing and submitting an amended cost report, the nursing facility should contact the RARSS by verbal or written communication to determine the appropriate mode for making the necessary amendment(s). Amended cost report data will be effective for reimbursement rate determination and



payment for nursing facility services rendered beginning in the month following the receipt of the provider's notice to RARSS of the need to amend the cost report.

The provider must include a disclosure letter with the amended cost report identifying the reason for the amended report and citing the cost report Worksheet(s) and the data input cell(s) within the Worksheet(s) that have been revised.

Providers cannot amend an audited cost report or amend a filed cost report after the reimbursement rate period has ended (i.e., a 2017 year-end cost report cannot be amended after it is audited or after September 30, 2019, whichever comes first). **(revised per bulletin MSA 19-28)** Amended cost reports will not be accepted by RARSS after the completion of an audit except in cases where the filed and audited cost report continues to be the basis for the nursing facility's current reimbursement rate. An amended cost report must properly reflect any audit adjustments made to the original cost report. Amended data will be used, as appropriate, to compute future rates but will not be used to retroactively change a previously paid prospective rate. Use of amended cost report data for retroactive application to prior services will only be made in cases related to fraud or failure to disclose required information in the cost reporting. Situations where retroactive changes are permissible are described in the Cost Report Reimbursement Settlements Section of this appendix.

4.11 HOME OFFICE, CHAIN ORGANIZATION, OR RELATED PARTY COST REPORTING

Nursing facilities that have costs applicable to services, facilities, and supplies furnished to the provider by organizations or entities related to the nursing facility by common ownership or control may include the costs in the nursing facility cost report. These costs may arise from arrangements involving a home office of a chain organization or services provided to the nursing facility or purchased by the nursing facility from related party businesses.

For facilities that are operated as part of a chain organization, home office costs claimed on the individual nursing facility's cost report must be reported using the Medicaid Nursing Facility Home Office Cost Statement (MSA-1578).

For nursing facilities reporting costs of services provided by a related party organization, the MSA-1578 must be used for reporting costs. An electronic copy of MSA-1578 will be available to providers in File Transfer. Alternative cost reporting worksheets or accounting schedules may be substituted for the Home Office Cost Statement if RARSS agrees that the alternative format provides supporting documentation to adequately identify expenses and the allocation of costs to the nursing facility. RARSS will approve the format as submitted, require additional data or revisions to the reporting format, or disapprove the alternative reporting.

When the fiscal year for the home office or related organization coincides with the nursing facility's fiscal year, the due date for the home office or related party organization cost report must coincide with the nursing facility's annual cost report due date. In cases where the fiscal years do not coincide, the nursing facility must submit the cost report of the home office or related party organization for the most recently completed fiscal year of that entity. If the report was previously submitted to RARSS, it must be resubmitted by the same due date as the nursing facility's cost report. Exception: Participation in the cost allocation option (as outlined in the Related or Chain Organization Cost Allocation subsection of this chapter) supersedes this requirement. (Refer to the Related or Chain Organization Cost Allocation subsection in this appendix for additional information.)



4.11.A. HOME OFFICE COSTS - CHAIN ORGANIZATION

For Medicaid purposes, a chain organization consists of a group of two or more nursing facilities, or at least one nursing facility and any other business or entity owned or operated and controlled by one organization.

For Medicaid policy regarding allowable costs, refer to the Cost Classification and Cost Finding Section of this appendix.

4.11.B. RELATED PARTY BUSINESS TRANSACTIONS

The operating costs of a related ownership organization are allocated to the individual nursing facility as a purchased service. This cost must be identified within the appropriate cost center in the Medicaid cost report. Identification of the type of service determines if the costs qualify to be apportioned between base and support cost using the industry-wide base and support cost percentages. If the service does not qualify to be apportioned by this method, the allocated costs are classified as support costs in the individual nursing facility.

The related party organization cost reporting is required for the specific related party organization business entity in the following cases:

- If the dollar amount of routine nursing care costs to the individual nursing facility exceeds \$25,000 in aggregate, regardless of the number or type of services provided.
- If the sum (total dollar amount) of routine nursing care costs to multiple nursing facilities exceeds \$125,000 in aggregate, regardless of the number or type of services provided and number of nursing facilities served.

These dollar limits apply to related party business transactions whether they are routine or ancillary nursing services. The dollar thresholds only apply to costs allocated to a Medicaid routine care unit, either directly or through the stepdown process (i.e., if \$25,000 in costs are allocated to a nursing facility from a related party, but none of the costs are allocated to the Medicaid routine care unit, then no home office cost report is required). Beginning October 1, 2018 and biennially thereafter, these amounts are updated based on the Centers for Medicare & Medicaid Services (CMS) Skilled Nursing Facility (SNF) Market Basket. Amounts are posted on the Long-Term Care Reimbursement and Rate Setting Section (RARSS) website. (Refer to the Directory Appendix for website information.)

Facility lease arrangements between related parties must be separately reported in the cost report as described in the Allowable and Non-Allowable Cost Section of this appendix.

Related party expenses must remain on the individual nursing facility cost report for the proper allocation of overhead costs regardless of whether they are ancillary or routine. This provision applies even if a home office cost report is not required.



4.11.B.1. EXCEPTION PROCESS

An exception to the related party home office cost reporting requirements may be granted if all or part of the expenses are directly allocated to the nursing facility or facilities. If only part of the expenses are directly allocated, the sum of all other expenses allocated to a facility or facilities must be less than the dollar thresholds established in policy. Exceptions must be approved by RARSS prior to or on the due date of the home office cost report. Examples of expenses that would qualify for an exception include, but are not limited to, health insurance benefits, administrator and other staff salaries, retirement benefits, payroll taxes, other fringe benefits, contracted health services, medical supplies, office supplies, utilities, legal fees, etc.

4.12 COST REPORT FILED UNDER PROTEST

As part of the cost settlement and cost report audit process, a nursing facility provider may dispute a Medicaid regulatory or policy interpretation. (Refer to the Appeal Process Section of this appendix for additional information.) If the provider has a dispute regarding the annual cost report, the nursing facility must submit a separate cost report, referred to as a "protest cost report" to establish their reporting of the dispute issue. In order to preserve the nursing facility cost report claim, this separate cost report must be identified as under protest for the disputed issues that remain under appeal or are subject to an appeal. The protest cost report filing must include an accompanying letter, signed by the nursing facility authorized representative, listing the disputed issue(s) and respective dollar amount(s) for the basis of the protest cost report filing. Protest cost reporting issues will be addressed in the cost report audit process dependent upon resolution of the disputed issues. The cost report filed under protest will not be used for rate determination, but will provide information for audit consideration relative to disputed issues. The auditor will address necessary audit adjustments to the accepted cost report to reflect the appeal resolution.

Protest cost report filing is not for general disagreement with promulgated Medicaid policy. The RARSS will not accept protest cost reports filings that include items considered as disagreement or dissatisfaction with promulgated policy.



SECTION 5 - PLANT COST CERTIFICATION

Medicaid reimburses nursing facilities for costs associated with capital asset ownership. The costs are referred to as plant costs and are reimbursed as the Plant Cost Component of the per diem reimbursement rate. The Plant Cost Component is based on the cost report data submitted by the nursing facility for the previous calendar year. The Plant Cost Component includes costs associated with capital asset acquisition, depreciation, interest expense (either working capital or capital indebtedness), property taxes, amortization costs associated with loan financing costs (letters of credit, asset acquisition legal fees) and specific lease expenses. The Plant Cost Component of the reimbursement rate determined for a nursing facility remains consistent throughout the State's fiscal year period (October through September), unless the facility qualifies for an interim reimbursement rate.

Example: Plant cost data from cost report year-end December 31, 2017 is the basis for the Plant Cost Component for the October 2018 through September 2019 rate period. Refer to the Cost Classification and Cost Finding, and the Rate Determination sections of this appendix for additional information.

The process used to determine if a facility qualifies for an interim reimbursement rate is called Plant Cost Certification. Special rate setting provisions qualify facilities to use current year costs associated with capital ownership instead of the prior year's cost report data to determine the Plant Cost Component of the reimbursement rate. Rate setting provisions are available for facilities incurring exceptional changes in the facility's plant costs during the current year. Qualifying situations such as new construction or renovation, new asset acquisition, new ownership, or changes in the nursing facility's bed size or the type of resident services are considered to determine eligibility for Plant Cost Certification.

5.1 PLANT COST CERTIFICATION ELIGIBILITY CRITERIA [CHANGES MADE 4/1/20 AND 10/1/20]

A facility may plant cost certify when there is no plant cost data available or when the plant cost data inadequately reflects the current rate period plant costs. Plant Cost Certification is available in the following situations:

- The nursing facility provider is constructing a new building or incurring physical plant improvements with Certificate of Need (CON) approval, or the asset costs are, on average, \$5,000 or more per licensed bed for a Class I or Class V (text added 10/1/20) facility or \$3,000 or more per licensed bed for a Class III facility in capital expenditures in a single cost reporting period. Medicaid will update the capital expenditure per licensed bed amounts effective October 1, 2020 and biennially thereafter based on a construction cost index for steel frame buildings and rounded to the nearest \$500 (i.e., \$5,150 would round to \$5,000, \$5,250 would round to \$5,500, etc.). (revised per bulletin MSA 19-28)
- There is an approved CON ownership change for an existing facility, or the nursing facility assets have changed ownership in a manner that requires CON review.
- The SSA has changed the class level of the facility, change in Medicaid certified beds, or the type of nursing or resident care services provided in the nursing facility.
- The nursing facility has an approved non-available bed plan in the cost report period.
- The nursing facility is in the first full cost report year following the termination of an approved non-available bed plan.



5.2 PLANT COST CERTIFICATION SUBMISSION [CHANGES MADE 4/1/20]

The provider must complete the Plant Cost Certification process and qualify in order to receive an interim reimbursement rate. The RARSS must receive a compilation of the nursing facility's expected allowable plant costs and a statement signed by the nursing facility's authorized representative attesting to the data's accuracy and adherence to the Plant Cost Certification policy. The provider must use the MDHHS required format for document preparation. A provider having a nursing facility license and leasing the facility must report facility costs of the lessor in accordance with Medicaid's reimbursement policy. Refer to the Allowable Cost and Non-Allowable Cost, and Cost Classification and Cost Finding sections in this appendix for additional information.

A provider requesting an interim reimbursement rate must provide the information in the Medicaid Long Term Care Plant Cost Certification format and submit copies of supporting documentation. A copy of the format is available on the MDHHS website. (Refer to the Directory Appendix for website information.) The Plant Cost Certification packet of accepted sample formats is available by request to RARSS. An electronic copy of the packet can also be accessed on the MDHHS website.

Supporting documentation must include the following items for a transfer of ownership of a license, acquisition, or lease that requires CON approval:

- **(text deleted per bulletin MSA 19-28)**
- Purchase Agreement
- Mortgage and Loan Agreements
- At least 36 months of Interest Amortization Schedules for Financing prepared by the lender
- Property Tax Statements
- Capital Asset Cost Appraisal
- Purchase Closing Statement or Recording

Supporting documentation must include the following items, where applicable, for a renovation, addition, or new construction:

- **(text deleted per bulletin MSA 19-28)**
- Licensed Bed Notice issued by the State Survey Agency (SSA)
- Mortgage and Loan Agreements, if applicable
- At least 36 months of Interest Amortization Schedules for Financing prepared by the lender
- Property Tax Statements
- Construction Contract Statement or Summary

RARSS must receive the provider's completed Plant Cost Certification prior to the cost reporting period filing deadline, and providers must meet the qualifications to receive an interim reimbursement rate. **(text added per bulletin MSA 19-28)** The completed information and supporting documentation may be sent to RARSS by mail, delivery, or File Transfer. Inquiries relating to the submission of the data should be directed to the RARSS office. (Refer to the Directory Appendix for contact information.)



If RARSS determines that the plant certification eligibility criteria are met, the submitted cost data will be desk reviewed, adjusted if necessary, and used to calculate the nursing facility's Plant Cost Component. If the fiscal year cost report filing and subsequent cost report audit determine the data used to calculate the reimbursement for the Plant Cost Component resulted in an overpayment or underpayment to the provider, the Medicaid recovery or additional reimbursement due the provider is included in the cost report reimbursement settlement. (Refer to the Cost Report Reimbursement Settlement section of this appendix for additional information.)

5.2.A. PLANT COST CERTIFICATION REQUIREMENT FOR REIMBURSEMENT – BUILDING AND EQUIPMENT CHANGES

A new or existing provider or business entity operating a nursing facility that is incurring a change involving the nursing facility's building and equipment must complete a Plant Cost Certification. A provider that obtains ownership of the nursing facility building and equipment or enters a lease agreement for the facility must submit a completed Plant Cost Certification. In the instance that a lease change is the result of a facility ownership change where the provider has a different landlord, a plant cost certification is required if any terms of the lease agreement changes, such as lease amount, duration, etc.

The Plant Cost Component of the reimbursement rate will be zero until the Plant Cost Certification is received by the RARSS. In order to be eligible for retroactive reimbursement, the provider must submit a completed Plant Cost Certification on or before the date of the initial filing of cost report for the year in which the ownership change or asset transaction occurred. The effective date of the Plant Cost Certification will be the month that new ownership becomes the licensed entity or the asset transaction. Plant Cost Certification requests received by RARSS subsequent to the cost report filing will not be eligible for retroactive reimbursement, and future plant cost reimbursement rates will be effective as outlined under the effective period policy.

5.2.B. PLANT COST CERTIFICATION SUBMISSION WAIVER

If the provider qualifies for Plant Cost Certification under the approved non-available bed plan or because it is the first cost report year after the non-available bed plan termination, the data submission requirement is waived. The provider has the option to file during the rate year or to defer the plant cost rate revision until the cost report reimbursement settlement. Settlement adjustments for plant costs for the cost reporting period will automatically apply to non-available bed plan periods. If a Plant Cost Certification is not filed, the nursing facility's interim Plant Cost Component will continue to be based on the previous year's cost report, and the cost report reimbursement settlement will be adjusted to the allowable plant cost level for the cost report period. Refer to the Cost Report Reimbursement Settlement section of this appendix for additional information.

5.3 PLANT COST CERTIFICATION EFFECTIVE PERIOD [CHANGES MADE 4/1/20 & 7/1/20]

The effective period of the plant cost certification will be determined by the RARSS. A completed Medicaid Long Term Care Plant Cost Certification request in required format, with documentation, received by the RARSS prior to the 16th of the month is effective and included in the reimbursement rate



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as of the first day of the following month (e.g., a request received between September 16 and October 16 will be reflected for days of care beginning November 1).

The effective date of the plant cost certification cannot be prior to the month in which the facility experienced the change of ownership or the qualifying asset change. The rate is not revised for partial months. For interim rate setting, the revised reimbursement rate due to the Plant Cost Certification will not be applied to prior service dates except in instances where a provider meets certification eligibility under the nursing facility ownership change or lease provisions. If a plant cost certification is filed prior to the provider's cost report year end, an interim reimbursement rate is effective on a prospective basis for service dates after filing date. Retroactive reimbursement due to the plant cost change for that cost report year services will be addressed in the initial and final settlement determination of the cost report. Refer to the Cost Report Reimbursement Section of this appendix for additional information.

If a Plant Cost Certification is filed after the provider's cost report year end filing deadline but prior to the rate year beginning immediately after the filing deadline, the plant cost reimbursement rate change is only effective on a prospective basis in accordance with the period established by the Plant Cost Certification request receipt date. Plant Cost Certifications filed on or after the rate year beginning after the applicable cost report filing deadline will not be accepted (i.e., if a provider has a December 31, 2018 cost report year end and made a qualifying capital change in 2018, then the provider would need to submit a Plant Cost Certification prior to October 1, 2019 for it to be accepted). **(revised per bulletin MSA 19-28)**

The Plant Cost Certification interim reimbursement ends when the nursing facility's prospective Plant Cost Component is based on the first complete cost report year that reflects the plant costs which qualified the nursing facility for Plant Cost Certification.

Example: A nursing facility with a cost report period of January 1, 2019 through December 31, 2019 completes an eligible renovation project in June 2019, and submits a Plant Cost Certification before June 16, 2019 to be effective July 1, 2019. (Note: Rate Year refers to a period coinciding with the state fiscal year rate period. The periods listed below the Rate Year identify the period during which the rate will be paid and the cost report year on which the rate is based.)

Nursing Facility Initial Period Interim Rates for Plant Cost Reimbursement

Rate Year: October 2018 – September 2019	October 2018 – June 2019: Plant cost for the cost year end December 2017	July 2019 – September 2019: Plant cost based on plant cost certification reflecting expected cost for the cost report year end December 2019
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Nursing Facility Final Rates for Plant Cost Reimbursement

Rate Year: October 2018 – September 2019	October 2018 – December 2018: Plant cost for the cost report year end December 2017	January 2019 – September 2019: Plant cost for the cost report year end December 2019 (corrected 7/1/20)
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Rate Year: October 2019 – September 2020	October 2019 – December 2019: Plant cost for the cost report year end December 2019	January 2020 – September 2020: Plant cost for the cost report year end December 2020
Rate Year: October 2020 – September 2021	October 2020 – December 2020: Plant cost for cost report year end December 2020	January 2021 – September 2021: Plant cost for the cost report year end December 2021
Rate Year: October 2021 – September 2022	October 2021 – September 2022: Plant cost for cost report year end December 2020	

5.4 PLANT COST CERTIFICATION UPDATES AND REVISIONS

The nursing facility's initial Plant Cost Certification will continue to be used for the interim Plant Cost Component unless the nursing facility submits a revision to the Plant Cost Certification.

Following the initial submission of the Plant Cost Certification, the nursing facility is responsible to submit an updated or revised Plant Cost Certification to assure the interim Plant Cost Component reimbursement is representative of the current rate period plant costs.

The nursing facility provider may revise its submitted Plant Cost Certification at the beginning of subsequent fiscal year rate periods or the beginning of a calendar quarter, but not more than two times per year. The effective timeframes for payment based on the updated information are the same as noted above.

The overpayment penalty provisions, if applicable, remain in effect regardless of payment based on initial submission or revised data.

5.5 PLANT COST CERTIFICATION OVERPAYMENT PENALTY

At the time of the MDHHS audit of the provider's fiscal year cost report, if the interim reimbursement payments resulting from Plant Cost Certification exceed cost report settlement plant cost reimbursement, all excess funds paid as a result of the Plant Cost Certification request will be recovered by Medicaid. The provider will be assessed a penalty for overpayments resulting from Plant Cost Certification. The penalty will be 10 percent of the aggregate dollar amount difference between the interim reimbursement payments resulting from the Plant Cost Certification and the cost report settlement plant cost reimbursement. The penalty will be waived if the aggregate dollar amount difference is equal to or less than 10 percent of the provider's aggregate Plant Cost Component reimbursement amount for the cost settlement period. Overpayment recovery and penalty determination are included in the Cost Report Reimbursement Settlements Section.



SECTION 6 – AUDIT

The goal of the cost report audit is to provide the MDHHS assurances that the cost report information is accurate for the determination of Medicaid reimbursement rates, and includes the following objectives:

- To review, analyze, and test the nursing facility's Statement of Reimbursable Cost and underlying financial records to confirm that only reasonable and allowable costs have been included.
- To confirm that the methods used to calculate the required statistical information are adequate and that the statistical data is recorded accurately.
- To confirm that the cost finding and cost apportionment have been accurately and fairly computed.
- To confirm the accuracy of the costs allocated to Medicaid by independently applying the method approved for the provider's use in computing reimbursable cost.
- To confirm that, in all material aspects, the nursing facility provider is in compliance with the reimbursement policies and regulations.
- To review, analyze and test the nursing facility's revenue and billings to determine the propriety of billing practices and identify potential errors and financial risk to Medicaid.
- To identify the underlying causes of significant errors or problems noted during the audit and to suggest improvements.
- To follow up on significant problem areas identified in previous audits.
- To confirm consistent and uniform application of federal and state laws, rules, and regulations for reimbursable costs.

The audit process described in this section is not applicable to State Veterans' Homes.

6.1 AUDIT PROCESS

The annual audit process may include a desk audit/review, a computer check, and/or an onsite audit. This process may be performed by MDHHS audit staff or by a qualified designee.

Onsite audits will be conducted no less than once every four years. An audit of either limited or full scope will be performed on the records of each participating nursing facility provider to ensure that the expenses attributable to allowable cost items are accurately reported in accordance with established principles and guidelines.

A Preliminary Summary of Audit Adjustments Notice is issued to the facility upon completion of the audit.

6.1.A. REQUIRED INFORMATION

Each provider must allow access or arrange for access by MDHHS staff, or their designees, to required financial records and statistical data including:

- Records required by the Medicare Principles of Reimbursement
- Complete financial records of related organizations



- Complete records of lessors necessary to determine underlying costs of leasing facilities and items of equipment

These records include, but are not limited to, the following:

- Census records and numbers and types of leave days for each Medicaid beneficiary/resident (i.e., hospital, therapeutic)
- Resident medical records, with details of medical services received by each resident
- Resident service charge schedules
- Resident trust fund account records, with evidence of quarterly reporting to each resident
- Medicaid Cost Report with supporting documentation for cost finding statistics utilized on the report
- Supporting documentation for Nurse Aide Training and Competency Evaluation Program activity and cost data
- Documentation to support the cost and activity level for special Medicaid reimbursement provisions beyond the scope of services included in routine nursing care
- Total and Medicaid ancillary charge summaries and logs
- Medicare Cost Report, if applicable
- Medicare and other health insurance billing and payment records for each resident
- Books of original entry, including standard/special journals, payroll journals, disbursement journals, etc.
- Employee records, including detailed payroll records, personnel files, employee wage scales, shift schedules, union contracts, agreements, fringe benefits (e.g., deferred compensation, pension plans, insurance, personal use of assets, special allowances), individual accounts of leave days, job descriptions, and payroll tax returns.
- Facility policy and procedure manuals and related materials
- Plans for internal control
- Minutes of meetings of the governing body
- General and subsidiary ledgers, including stock ledgers, cash receipts, etc.
- Purchase requisitions and orders
- Vouchers and invoices in detail to support services and goods purchased
- Records related to management fees, executive services or personal services contracts, and contracts for services under arrangement
- Charts of accounts
- Checking account registers, canceled checks, and bank statements
- Vehicle mileage and use logs
- Fixed asset records
- Capital expenditure records and depreciation lapse schedules



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- Copies of long-term debt obligations, mortgages, notes payable/receivable, amortization schedules, year-end statements, and loan histories
- Tax returns, or federal informational returns for tax-exempt facilities
- Provider organization ownership disclosure records, e.g., Articles of Incorporation, Partnership Agreement, and other similar documentation
- Records regarding chain organizations, including corporate home office costs
- Work papers and records regarding the preparation of cost reports
- Audit reports of financial statements
- Work papers of internal and external accountants used in the preparation of the cost report(s)
- Records regarding working capital. Analysis of source and use of funds, which includes working capital loan principle payments
- Leases and all related records
- Accounts receivable Aging Schedule
- Accounts payable Aging Schedule

6.1.B. AUDIT TIMELINE [SUBSECTION ADDED 4/1/20]

MDHHS shall ensure that an audit of a cost report is completed no later than 21 months after the final acceptance of a cost report, and that the 21-month period does not include any time associated with any appeal or a charge of fraud filed against the provider. A cost report not audited within the 21 months will be accepted as filed and move to settlement. (text added per bulletin MSA 19-28)

6.1.C. ON-SITE AUDIT [SUBSECTION ADDED 4/1/20]

MDHHS shall complete an on-site audit on an as-needed basis. The on-site audit shall not last more than 30 calendar days per cost report year for an individual nursing facility, and not more than 30 calendar days per cost report year per nursing facility for two or more commonly owned or controlled facilities up to a maximum of 180 calendar days per cost report year (i.e., the on-site audit could last 60 days per cost report year for two facilities, 90 days for three facilities, etc. up to a maximum of 180 days for six or more facilities), unless MDHHS and the nursing facility agree in writing to extend the timeline. An on-site audit will occur where the nursing facility's records are located, regardless of whether those records are located on the nursing facility's premises or elsewhere. A limited-scope audit shall be performed for cost reports in which an on-site audit is not performed. (text added per bulletin MSA 19-28)

6.1.D. AUDIT SAMPLING [SUBSECTION ADDED 4/1/20]

MDHHS shall use statistical sampling, non-statistical sampling, or a combination of sampling methods for selecting items to audit. If a combination of sampling methods is used, then the items that could be selected under the statistical sample cannot be included in the non-statistical sample and vice versa (i.e., if 29 items are selected



through a statistical sample out of a possible 500 items, then the other 471 items cannot be included in a non-statistical sample). **(text added per bulletin MSA 19-28)**

6.1.E. SCHEDULING AN AUDIT [SUBSECTION ADDED 4/1/20]

MDHHS will submit an Intent to Audit – Scheduling Notice at least 30 calendar days prior to the intended audit start date. The audit start date may take place no more than 10 business days after the intended audit start date or on a date prior to the intended audit start date. The provider must provide a response to the notice within five business days, otherwise the audit will begin on the intended audit start date. If the intended audit start date does not work for the provider, then they must notify MDHHS within five business days of the notice and provide alternative dates for the audit. If a mutually agreed upon audit start date cannot be selected, then the audit will commence on the intended audit start date. **(text added per bulletin MSA 19-28)**

6.1.F. AVAILABILITY OF INFORMATION [RE-NUMBERED & CHANGE MADE 4/1/20]

The nursing facility must have an accounting and records maintenance system to provide accurate cost, revenue and statistical data, and other information that can be verified by MDHHS Bureau of Audit staff or their designees. Documentation must be provided to support the actual expenditure of costs; non-actuarial estimates are not allowable supporting documentation.

Prior to the audit start date, MDHHS staff will submit an Audit Engagement Notice to the provider via File Transfer. This notice will include a list of the required documentation and the consequences for unavailable documentation. The documentation required by the Audit Engagement Notice must be available to MDHHS within 15 business days. If none of the documentation requested in the notice is available within 15 business days, then MDHHS will move to schedule an Exit Meeting. If some of the documentation is available, then the provider will have two or five business days to submit the unavailable documentation; two business days for an individual facility and five business days for two or more commonly owned or controlled facilities. If documentation is not released within the timeframes described in this paragraph, then the costs in question will be preliminarily disallowed and the provider may not submit the unavailable documentation until the Exit Meeting.

While reviewing available documentation, MDHHS may determine that additional documentation is necessary to support an expense. MDHHS will submit a written request to the provider, and the provider will have two or five business days to submit the additional documentation; two business days for an individual facility and five business days for two or more commonly owned or controlled facilities. If the documentation is not released within the timeframes described in this paragraph, then the costs associated with the item in question will be preliminarily disallowed and the provider may not submit the unavailable documentation until the Exit Meeting.

MDHHS will move to schedule an Exit Meeting or audit other expenses after the timeframes described in this subsection have passed, even if requested documentation is not made available. **(revised per bulletin MSA 19-28)** (Refer to the Appeal Process Section of this appendix for additional information.)



6.1.G. EXTRAPOLATION [SUBSECTION ADDED 4/1/20]

MDHHS may use extrapolation methods to determine audit adjustments for expenses included in the sampling universe (i.e., all items that have a chance to be sampled in a random sampling process) in a statistical sample. The provider will be notified if extrapolation methods were used in the Exit Meeting Summary of Audit Adjustments Notice, the Preliminary Summary of Audit Adjustments Notice, and the Final Summary of Audit Adjustments Notice. The notice will include the sampling selection methodology, the sample size, the disallowed expenses, and the extrapolation formulas and calculations. The Preliminary Summary of Audit Adjustments Notice will also include the provider's appeal rights, which include the ability to appeal the extrapolation methods used to determine the audit adjustment. **(text added per bulletin MSA 19-28)**

6.1.H. EXIT MEETING [SUBSECTION ADDED 4/1/20]

An Exit Meeting is a meeting offered to the provider to be held within five business days after the completion of the audit work to communicate the audit results to the provider and to obtain the provider's comments on the proposed findings of the audit prior to the issuance of the Preliminary Summary of Audit Adjustments Notice. The offer to schedule an Exit Meeting will be sent to the provider in the Exit Meeting Summary of Audit Adjustments Notice. To schedule an Exit Meeting, a provider must specify dates and times for the meeting to take place that are within five business days of the written offer to schedule a meeting. An Exit Meeting may be scheduled prior to the issuance of the Exit Meeting Summary of Audit Adjustment Notice, but if the scheduled Exit Meeting does not occur within five business days of the issuance of the Exit Meeting Summary of Audit Adjustments Notice, then the meeting date must change to occur within five business days of the notice. An Exit Meeting may be held in person, via telephone, or via electronic correspondence (i.e., email, video chat, etc.). If a provider does not attend a scheduled Exit Meeting, then the provider forfeits their right to an Exit Meeting. The provider may designate an authorized representative to attend the Exit Meeting (e.g., their cost report preparer, etc.).

In addition to the offer to schedule an Exit Meeting, the Exit Meeting Summary of Audit Adjustments Notice will contain a summary of MDHHS' proposed audit adjustments. The provider may submit additional information related to a proposed audit adjustment at the Exit Meeting and for up to two business days after the Exit Meeting (or within five business days of the Exit Meeting Summary of Audit Adjustments Notice if an Exit Meeting is not held). MDHHS will not consider any additional information related to a proposed audit adjustment after two business days have passed from the date of the Exit Meeting (or five business days from the issuance of the Exit Meeting Summary of Audit Adjustments Notice if an Exit Meeting is not held). **(text added per bulletin MSA 19-28)**

6.1.I. COMPLETED AUDIT [SUBSECTION ADDED 4/1/20]

A completed audit is represented by the issuance of the Preliminary Summary of Audit Adjustments Notice. The Preliminary Summary of Audit Adjustments Notice will be issued after the Exit Meeting is held or waived. **(text added per bulletin MSA 19-28)**



6.1.J. RETROACTIVE RATE CHANGES [RE-NUMBERED 4/1/20]

A retroactive change in a nursing facility's rate and reimbursement may be made after completion of an audit in the following situations:

- For those providers that are retrospectively settled.
- For those providers that had an interim rate set prior to completion of the cost report audit.
- For those providers that were retrospectively settled because they were granted Rate Relief.
- For audit adjustments required as a result of a hearing decision.

Refer to the Reimbursement Rate Determination section of this appendix for detailed information regarding retroactive effective periods for rate determination and reimbursement actions.

6.1.K. REOPENING AUDIT DETERMINATIONS [RE-NUMBERED & CHANGE MADE 4/1/20]

MDHHS may elect to reopen an audit determination following completion and closing of the audit of a nursing facility cost report. MDHHS will provide notice to the nursing facility of the audit reopening and the issues for which the audit is under review. Results of the audit reopening will be submitted to the provider, who will be given the opportunity to review the findings and appeal in accordance with Medicaid policy. If it is determined that the audited cost report contains incorrect data, MDHHS will use corrected data to compute future rates. The audit revisions will be effective for reimbursement rate determination and payment for nursing facility services rendered beginning the month following notice to the provider that the subject audit is being reopened.

The results of audit reopening actions will only be effective for retroactive reimbursement revision in cases of fraud or when the provider's failure to disclose required information was pertinent to the determination of allowable cost.

MDHHS will not reopen an audit determination for any reason other than fraud beyond the 21-month period described in the Audit Timeline subsection of this appendix. **(revised per bulletin MSA 19-28)**

6.1.L. RECORD RETENTION [RE-NUMBERED 4/1/20]

Each nursing facility's accounting and related records must be kept for a period of not less than seven years. This obligation does not end if a provider closes or sells a facility. All records, source documents, contractual agreements, and corporate minutes must be available onsite, or at a readily accessible location, for verification and inspection by MDHHS staff or their designees. When accounting personnel, books and records are located out of state, the provider is required to pay auditor travel expenses if MDHHS staff or their designees deem it necessary to access documentation during the course of an audit.



6.2 FINANCIAL FRAUD AND ABUSE

Federal Medicaid law and regulations require the Medicaid program to establish and maintain methods and criteria for the identification, investigation, and referral of potential fraud and abuse. In accordance with federal and state requirements, MDHHS will authorize the suspension of Medicaid payments (in whole or in part) to a nursing facility provider on receipt of reliable evidence that the provider committed fraud or willful misrepresentation while enrolled as a Medicaid provider. The provider will receive written notice of such suspension and may request an administrative review. (Refer to the Appeal Process Section of this appendix for additional information.)

A MDHHS auditor or designee who observes potential fraud or financial abuse will prepare a separate report of observations. Observations of potential fraud or abuse include, but are not limited to, the following:

- Recording of personal expenses
- Overutilization of services to inflate charges
- Unauthorized use of resident trust funds
- Payroll entries of personnel who provide no services
- Concealment of business activities
- Falsifying records
- Charging Medicaid for costs not incurred
- Duplicate billing
- Billing beneficiaries inappropriately for Medicaid services
- Soliciting, offering, or receiving a kickback, bribe, or rebate
- Knowingly failing to disclose required information in the Medicaid cost report

Reports of observations will be reviewed by MDHHS staff and appropriate actions taken. This may include forwarding a copy of the report and supporting documentation to the state Attorney General's Health Care Fraud Division.



SECTION 7 - COST REPORT REIMBURSEMENT SETTLEMENTS

The nursing facility reimbursement rate is determined in accordance with the policy provisions outlined in the Rate Determination Section of this appendix. The reimbursement rate may include routine nursing care services and various rate add-on amounts depending on the Medicaid reimbursement policy effective at the time. The facility rate is a per diem amount. Rate determination may be based on filed cost report data, audited cost report data, cost data submissions and projections for specific reimbursement activity, or interim reimbursement provisions in accordance with Medicaid policies. The reimbursement rate is determined at the beginning of the rate year and the nursing facility is provided notice of the rate determination prior to implementation of the rate. The reimbursement rate may be revised any time during the rate year in accordance with rate determination policies. Rate revisions can result from the following actions as detailed in the Rate Determination Section:

- More recent Fiscal Year filed cost report
- Audited cost report
- Plant Cost Certification
- Nurse Aide Training and Competency Evaluation Program
- Special Dietary Cost Allowance
- Special Reimbursement policy actions

Reimbursement for ancillary services provided to Medicaid-eligible residents will be made in accordance with policies identified in the Coverage portion of this chapter and in the Billing & Reimbursement for Institutional Providers Chapter.

7.1 INTERIM REIMBURSEMENT AND RATE REVISIONS

The Rate Determination Section in this appendix outlines the process for determining the nursing facility's annual reimbursement rate. If RARSS determines that a reimbursement rate must be revised, the rate change may affect payment for future and/or previous dates of service. RARSS will notify the provider of the rate change and the rate's applicable period.

If a rate revision applies to future dates of service, RARSS will send written notice to the provider's designated address specifying the revised rate and the applicable period for the rate.

If a rate revision must be applied to previous dates of service in the current cost report year, RARSS will notify the provider of the applicable period and the reimbursement rate. If the rate revision applies to previous dates of service in the current cost report year, RARSS will make the determination of an underpayment or overpayment amount, and RARSS will notify the provider of the process for implementing the payment adjustment(s).

If the rate revision applies to a prior cost report year's dates of service, the payment adjustment process is addressed in the Initial Settlement Section of this appendix.



7.2 INITIAL SETTLEMENT

The SMA may determine that a retroactive adjustment to the nursing facility reimbursement rate and payments is needed after the end of the provider's rate year. The retroactive adjustment may be due to a previous interim rate revision or to implement a rate based on actual cost report data. After the filing and acceptance of the cost report, the RARSS will determine if an Initial Settlement adjustment is necessary to make a retroactive payment adjustment for the rate period covered by the cost report. The Initial Settlement uses the most recent accepted cost report data to calculate the retroactive reimbursement and paid Medicaid claims and other payment data. (Refer to the Rate Determination Section of this appendix for additional information.)

The RARSS will consider provider requests for Initial Settlements on an exception basis in the following situations:

- The provider anticipates a significant amount due them by Medicaid and requests an Initial Settlement in writing. The provider may make the request with the filing of the cost report.
- A payment adjustment is necessary for several months of the cost report period, and the current date is beyond the cost report period end date.
- The review of a filed cost report identifies that the interim rate add-on amount, plant cost certification amount, or other special reimbursement interim amount included in the interim rate exceeds the amounts filed in the cost report.
- The provider has terminated Medicaid participation and has failed to file an acceptable cost report. An overpayment determination will be made for the payments to the provider during the period that cost report data is required for determining final reimbursement.

If the RARSS determines that the Initial Settlement is an underpayment amount to the nursing facility, additional payment will be made to the provider for not less than 70 percent and not more than 80 percent of the determined settlement amount due the provider based on a review of the provider's financial situation and the effect of the filed cost report data on the reimbursement settlement determination. Although the provider may request a review of the Initial Settlement amount, the Initial Settlement payment level percentage is not subject to appeal.

If RARSS determines there is an overpayment to the nursing facility, the SMA will recover the overpayment amount as outlined in the Medicaid Recovery of Overpayments subsection.

Before making any payment adjustment, the RARSS will notify the provider in advance using a Notice of Program Reimbursement letter. The provider is given 15 calendar days for review of the settlement determination. After the period afforded the provider to review the Notice of Program Reimbursement, a notice stating the payment adjustment date(s) is shared with the provider through File Transfer. A provider may request up to an additional 30 days to review an Initial Settlement. The provider must submit a written request stating the reason and the amount of the additional time needed (up to 30 days) for review. RARSS will review the request and notify the provider in writing of the approval or denial for additional time.

If the settlement action requires correction following the review, a new notification and review period will apply to the corrected settlement. After the period afforded the provider to review the Notice of Program Reimbursement, a notice stating the recovery payment date(s) is shared with the provider through File Transfer.



The RARSS may process a Revised Initial Settlement for the cost report period if it determines that additional payment adjustment is necessary after processing an original Initial Settlement and before completing a final settlement. A Revised Initial Settlement will be completed when there are significantly more approved claims, rate revisions or errors in the prior determination and a final settlement action cannot yet be completed. The notification and payment processing actions identified with the original Initial Settlement procedures also apply to the Revised Initial Settlement process. The payment criteria will be applicable to the aggregate dollar amount of the Initial and Revised Settlements for the reimbursement period.

7.3 FINAL SETTLEMENT

The RARSS may determine that withholding of payment is necessary or that a retroactive adjustment to the nursing facility reimbursement rate and payments is needed after the end of the provider's rate year. A retroactive adjustment may be due to a previous interim rate revision or to implement a rate based on actual cost report data. After a cost report is audited, RARSS will determine if a Final Settlement adjustment is necessary to make a retroactive payment adjustment for the rate period covered by the cost report. The Final Settlement uses the audited cost report data to calculate the retroactive reimbursement and paid Medicaid claims and other payment data. Final Settlements determine if additional payment is due to the nursing facility or Medicaid.

When Medicaid participation is terminated voluntarily or involuntarily, payment for at least one month of services rendered is retained for Final Settlement.

RARSS shares a Notice of Program Reimbursement with the provider through File Transfer. The notice explains the:

- Settlement adjustment(s) and the process prior to RARSS taking the payment action.
- Provider's appeal rights.

The provider is allowed 15 calendar days for review of the settlement determination. After the period afforded the provider to review the Notice of Program Reimbursement, a notice stating the payment adjustment date(s) is shared with the provider through File Transfer.

To obtain an extension, RARSS will review written requests from the provider stating the exceptional reason and the amount of additional time needed for the review (up to 30 calendar days). RARSS will review the exceptional circumstances stated in the request and notify the provider in writing of the approval or denial for additional time. If approved, an extended period of up to an additional 30 calendar days may be granted to the provider for review. After the period afforded the provider to review the Notice of Program Reimbursement, a notice stating the recovery payment date(s) is shared with the provider through File Transfer.

If the settlement action is corrected following a review, a new notification and review period will apply to the revised determination. After the period afforded the provider to review the Notice of Program Reimbursement, a notice stating the payment adjustment date(s) is shared with the provider through File Transfer.



RARSS may process a Revised Final Settlement for the cost report period if RARSS determines that additional adjustments are necessary subsequent to processing the Final Settlement. The adjustment(s) will be processed if significant adjustments or errors exist in the prior settlement calculation. Notification and payment processes outlined in the Final Settlement process also apply to the Revised Final Settlement process.

7.3.A. FINAL SETTLEMENT TIMELINE [SUBSECTION ADDED 4/1/20]

MDHHS shall issue a Notice of Program Reimbursement for a final settlement not more than 60 calendar days after the issuance of the Final Summary of Audit Adjustments Notice or no more than 60 calendar days after the Preliminary Summary of Audit Adjustments Notice becomes the Final Summary of Audit Adjustments Notice. (text added per bulletin MSA 19-28)

7.4 DEPRECIATION RECAPTURE REIMBURSEMENT ADJUSTMENT

If a provider has been reimbursed for asset depreciation expense in the Plant Cost Component and has sold the nursing facility assets, the sold assets may be subject to a depreciation recapture reimbursement adjustment in the reimbursement settlement for the cost report period in which the nursing facility assets are sold. The depreciation reimbursement adjustment uses reimbursement rates paid for services between October 1, 1984 and the date the facility was sold, or the date the Plant Cost Component of the per diem rate was converted to the tenure plant cost reimbursement method. (Refer to the Rate Determination Section of this appendix for additional information.)

The depreciation recapture adjustment is only applicable to the reimbursement rate periods the provider was paid a rate that specifically included depreciation expense in the Plant Cost Component of the Medicaid per diem rate. If the provider has never received Plant Cost Component reimbursement that specifically includes depreciation expense as a cost element of the rate calculations, the provider is not subject to the depreciation recapture reimbursement adjustment and is not required to complete the Medicaid Program Depreciation Recapture reporting.

A nursing facility provider that was reimbursed for depreciation in the Plant Cost Component and sells the nursing facility's assets must complete the Medicaid Program Depreciation Recapture reporting schedules for each applicable cost reporting year where depreciation was reimbursed. The Medicaid Program Depreciation Recapture schedule must be submitted with the cost report for the year that the asset sale occurs. Reporting schedules and instructions will be provided to the provider with the final period cost reporting request or may be requested from RARSS. The reporting schedules (Excel file) and completion instructions (Word file) are available in electronic format or hard copy format.

If the Medicaid Program Depreciation Recapture is not applicable, the schedules must indicate N/A (not applicable) and be submitted with the cost report filing. If RARSS does not receive completed reporting schedules, RARSS will apply a 100 percent depreciation expense reduction rate to calculations for each cost report period used to calculate the settlement.

The net depreciation reimbursement adjustment for each cost report year the provider was reimbursed by Medicaid will be included in the settlement calculation. The depreciation adjustment will be limited to the amount Medicaid reimbursed for depreciation expense in each cost report year. Plant cost reimbursement allowances will be included in the calculation of the depreciation adjustment, and may result in reducing the net depreciation adjustment if the provider had not previously qualified for the



incentive allowances prior to the depreciation reduction. The cost report reimbursement settlement notice will include the determination of depreciation recapture reimbursement adjustment.

7.5 MEDICAID RECOVERY OF OVERPAYMENTS

Overpayment(s) due from a participating provider will first be offset against other settlements, payment adjustments, claims processing or any amounts due to the provider through lump sum or sequential installments until the overpayment amount is satisfied. If the provider is not participating in Medicaid, the overpayment amount must be paid to the State of Michigan for the Medicaid program immediately upon notification.

7.5.A. REQUEST FOR SETTLEMENT EXTENDED PAYMENT OF SCHEDULE

If a participating provider alleges inability to repay the total overpayment amount in a lump sum or in sequential offset(s), the provider may request consideration for an extended repayment schedule. Extension requests for Settlement repayments must be received by RARSS within 15 calendar days of the Notice of Program Reimbursement date sent to the provider from RARSS. RARSS will notify the provider in writing of the decision. Requests received after 15 calendar days will be considered at the discretion of RARSS.

7.5.B. CRITERIA FOR DETERMINING EXTENDED PAYMENT ARRANGEMENTS

Extended settlement repayment schedules will only be considered if the net dollar amount of the current settlement notice reflects an overpayment amount of more than 10 percent of the provider's normal monthly Medicaid reimbursement payment(s). The provider's request must demonstrate that lump-sum recovery will create extraordinary financial hardship on the provider, and that the cash flow need of the nursing facility prevents the immediate repayment of the overpayment amount. Other factors that must not be present in creating financial hardship to the provider are significant expenditures for unallowable costs, ownership and management compensation exceeding Medicaid allowable cost limits, or significant dollar amounts for unallowable related party business transactions.

RARSS will share the notification of the provider's repayment schedule and the repayment recovery dates and dollar amounts through File Transfer. Requests for longer than three months will only be considered under exceptional circumstances, e.g., the monthly recovery schedule amount would be greater than 50 percent of the provider's normal monthly Medicaid reimbursement payment.



SECTION 8 - ALLOWABLE AND NON-ALLOWABLE COSTS

Unless stated to the contrary in this section, Medicaid allowable costs for nursing facilities are determined in accordance with provisions in the federal Principles of Reimbursement established for the Medicare program. This section does not propose to set reimbursement standards or reimbursement methodology. The focus here is the determination of allowable costs. Reasonable costs associated with nursing facility services included in the provider's per diem rate, as identified in the Coverages portion of this chapter, are allowable costs within the parameters of the Principles.

NOTE: Definitions for the principal terms used in this section may be found in the Definitions Section of this appendix. A copy of the cost report referenced in this section, completion instructions for the report and related information are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

8.1 ADVERTISING

Allowable advertising costs are considered those costs incurred by the nursing facility for an informational objective to inform the public about its services. Costs incurred for a promotional objective to increase patient utilization are not properly related to patient care and are not allowable. Examples of advertising costs incurred for a promotional objective include, but are not limited to, television ads, radio ads, restaurant placemats, billboards, and placing a facility's name on items without contact information. Advertising in the Yellow Pages is an allowable cost, except that Medicaid limits the cost to that associated with a black ink Yellow Pages ad listing not to exceed 2" x 2" in size.

8.2 APPRAISALS

Appraisal expenses incurred by providers may be allowable costs (administrative and general) if the appraisal is of assets related to resident care and if it meets the Medicaid Appraisal Guidelines. Expense for an appraisal of assets not related to resident care is not an allowable expense. Refer to the Appraisal Guidelines Section of this appendix for additional information.

8.3 ATTORNEY AND LEGAL FEES

The provider must maintain documentation and evidence of expenses incurred for legal fees and related costs as being related to the nursing facility's furnishing of patient care in order for such expenses to be allowable costs. Attorney fees are considered allowable costs incurred in the course of providing patient care, except as noted below.

Where MDHHS or the Centers for Medicare & Medicaid Services (CMS) takes action against the provider by initiating an enforcement action or issuing an audit finding, then the legal costs of responding to the action are allowable only in the following circumstances.

8.3.A. AUDIT FINDINGS AND RATE ACTIONS

- The provider prevails and the action is reversed.
Example: The audit finding is not upheld and the audit adjustment or rate action is reversed.



- The provider prevails as defined by reduction of the contested audit finding by 50 percent or more.
Example: An audit finding for an adjustment of \$50,000 is reduced to \$25,000.

8.3.B. ENFORCEMENT ACTIONS

- The provider prevails and the action is reversed.
Example: A DPNA is rescinded and does not go into effect, or when a provider is not in compliance before the effective date of the DPNA but succeeds in disputing the imposition and the DPNA is rescinded with no interruption in payment for the covered service.
- The period of imposition of a DPNA is reduced by 50 percent or more due to a change in the date that a nursing facility is determined to have been in compliance.
Example: The length of a DPNA is reduced from 20 days to 10 days.
- The provider prevails as defined by reduction of a fine by 50 percent or more.
Example: A Civil Money Penalty fine is reduced from \$5,000 to \$2,500.
- A federal enforcement action (F tag) is reduced in scope or severity.
Example: An H-level citation reduced to a G-level citation, an F (SQOC)-level citation reduced to an E-level citation, or an Informal Dispute Resolution decision results in a reduction from an E-level citation to a D-level citation. Abatement of an Immediate Jeopardy or correction of a deficiency does not constitute a reduction.
- A state enforcement action is eliminated.
- A settlement agreement is reached between the provider and the state and federal government prior to a Hearing.

8.3.C. GENERAL ADMINISTRATION OF THE FACILITY

- Attorney fees incurred in connection with facility acquisition, mortgage or finance transactions are allowable if Medicaid determines the fees reasonable. The fees must be reported under plant cost and capital asset cost reporting. Legal expenses incurred relative to a nursing facility or capital asset acquisition are considered allowable if they are capitalized and amortized over the loan for up to a five-year period.
- Legal fees incurred in the process of securing financing or refinancing of facility loans must be amortized over the life of the mortgage.
- Attorney fees relating to employer activities, labor negotiation, or in response to employment related issues or allegations, to the extent that the engaged services or actions are not prohibited under federal principles of allowable cost.
- Legal and attorney fees associated with a legal settlement negotiated by the provider or court-ordered damages are allowable, provided the fees are not covered by any of the provider's liability insurance (examples of liability insurance include, but are not limited to, auto liability insurance, general liability insurance, professional liability insurance, etc.). The fees must also meet all other Medicaid and federal allowable cost principles and policies.



8.4 BAD DEBTS, CHARITY AND COURTESY ALLOWANCES

Bad debts, charity, and courtesy allowances, as defined in the Medicare Principles, are deductions from revenue and are not allowable costs.

Bad debts are amounts considered to be uncollectable from accounts and notes receivable that were created or acquired in providing services. Charity allowances are reductions in charges made by the nursing facility provider due to the indigence of a resident. Courtesy allowances indicate a reduction in charges in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the nursing facility, for services received by the provider.

Uncollected revenue for Medicare coinsurance and deductible billing amounts and patient payments for Medicaid eligible residents, and for non-covered services for Medicaid are not allowable costs.

8.5 CIVIL MONEY PENALTIES

Costs incurred for fines or money penalties for violation of federal, state, or local laws are not allowable.

8.6 EDUCATIONAL ACTIVITIES AND IN-SERVICE TRAINING

Medicaid has established credentials/requirements for educational activities to be recognized as allowable costs. Educational activities outside the continental United States are not allowable.

Approved educational activities are formally organized or planned programs of study engaged in by nursing facility providers in order to enhance the quality of resident care in a facility. These activities must be licensed where required by state law. Where licensing is not required, those presenting the educational activity must be recognized as a professional for the particular activity. Examples of allowable educational activities costs are:

- Part-time education for a facility's employee at properly accredited academic or technical institutions (including other providers) devoted to undergraduate or graduate work to enhance the quality of medical care or the operating efficiency of the nursing facility.
- Costs, including associated travel expense within the continental United States, for employees to participate in educational seminars and workshops to enhance the quality of medical care or the operating efficiency of the nursing facility that does not lead to the ability to practice and begin employment in a nursing or allied health specialty.

The costs of the following in-service training activities are recognized as routine nursing care costs and are allowable costs:

- Orientation and on-the-job-training.
- Mandatory in-service education for Medicaid and Medicare certification.
- Maintenance of a medical library.
- Training of a resident or resident's family in the use of medical appliances.

Costs incurred for activities related to an approved Nurse Aide Training and Competency Evaluation Program (NATCEP) are not allowed under routine nursing care, except as provided in the Medicaid



allowable cost and reimbursement policy outlined in the Cost Classifications and Cost Finding Section of this appendix.

8.7 FACILITY VEHICLES AND TRAVEL

The cost of operating a facility-owned or leased vehicle must be adequately documented and differentiated between resident care use, business use or personal use. Only the costs for resident care and costs related to the conducting of facility business are allowable vehicle and travel costs. Use of a facility vehicle by facility personnel to commute from home to the facility and to return home at the end of the daily work period or other personal travel activity is considered personal use. Cost related to personal use travel activity is not allowable. Vehicle personal use is only allowable if the costs are reported employee compensation and satisfies Internal Revenue Service individual compensation tax reporting requirements.

The minimum documentation that must be retained and be available to auditors for all vehicles is:

- A Mileage log for each vehicle.
 - The log must contain at least the date, total miles for business use, name of driver, origination and destination, and the reason(s) for the vehicle use.
 - The log must report the monthly beginning and ending odometer reading.
- Business mileage and total mileage use of the vehicle to support the dollar allocation for determining allowable cost.
- Charge slips or invoices for fuel, maintenance, and other similar items.

If the reason for a trip is to transport a resident for medical care or treatment, the medical condition necessitating the trip must be documented. If the reason is to attend a seminar, convention, or meeting is related to nursing facility operation, invoices must document proof of attendance and mileage logs must be documented to identify the reason for the trip. Vehicle use for general business travel or other activity must include the reason in the mileage log.

Medicaid considers mileage that is not logged as not related to resident care or facility operation. The cost relating to unrecorded or non-supported as business use mileage is not allowable.

Travel by nursing facility personnel via personal vehicle use is an allowable expense if the travel is consistent with the aforementioned purpose criteria. Medicaid will allow such documented mileage at the State of Michigan, Department of Technology, Management & Budget (DTMB), approved private vehicle rate. The mileage rate includes all vehicle costs and is treated as a variable support cost. The approved private vehicle mileage rate information can be accessed on the DTMB website. (Refer to the Directory Appendix for website information.)

8.8 INTEREST [CHANGE MADE 4/1/20]

Interest is the cost incurred for the use of borrowed funds. Necessary and proper interest on both current and capital indebtedness is an allowable cost in accordance with Medicare Principles of Reimbursement. The allowance for interest expense is determined using one of the following principles:

- Allowable interest expense is determined in accordance with current Medicare Principles. Medicaid applies the following guidelines, although not fully inclusive, in determining allowable



interest expense. Interest expense must be reduced by all investment income, except where such income is from:

- Gifts, grants, and endowments held separately or pooled with other funds.
- Qualifying deferred compensation and/or self-insurance trust funds.
- Income from a provider's qualified pension fund.
- The rate of interest on a loan must not be in excess of what a prudent borrower would have had to pay in the marketplace at the time the loan was made.
- Interest expense, to be allowable, must be paid to a lender not related through control, ownership, or personal relationship to the borrowing organization. Interest paid by the provider to partners, stockholders, or related organizations of the provider is, therefore, not allowable.

Exception: A nursing facility operated by a religious order is allowed to borrow funds from the order and claim necessary interest expense for those funds.

- Interest on loans in excess of asset value acquisitions (after July 1970) is not an allowable cost. In a situation where the purchase price exceeds the historical cost or the cost basis, the interest expense on that portion of the loan used to finance the excess is not allowable.
- Interest expense applicable to borrowings principle balance for a nursing facility acquisition must be separately identified and reported from interest expense applicable to working capital or miscellaneous capital asset acquisitions (assets that are not part of or related to a facility acquisition). See Cost Finding and Cost Classifications for borrowing principle balance descriptions.
- Working capital borrowings are considered funds borrowed for 12 months or less to meet current normal operating expenses. For lines of credit, the borrowing shall be compliant with the 12 month requirement if the provider repays the entire amount withdrawn within 12 months of the date of the first draw. If the entire amount of the working capital borrowing is not repaid within 12 months, then all the interest expense associated with the borrowing is unallowable.
 - The loan must meet allowable cost principles. The rules on working capital borrowings do not apply to loans on capitalized assets. Interest on current indebtedness meeting the 12 month requirement and other program working capital criteria is allowable, whereas interest expense for long-term working capital indebtedness is not considered allowable.
 - The nursing facility must document the need and due date for the working capital loan. The need must be to meet normal operating expenses and must be supported by an application of funds analysis demonstrating the use of loan proceeds for nursing facility expenses.
 - For the application of funds analysis, the provider must show that current cash receipts are not sufficient to meet the accounts payable, payroll, and other financial obligations. The provider must also demonstrate that the loan proceeds went directly into the appropriate cash account. The provider must document when each withdrawal was used, how each withdrawal was used, and how the funds are being applied to a purpose related to patient care. If the Home Office is the recipient of funds and intends to transfer funds to a provider under the Home Office, the provider must demonstrate the financial need for the funds, how the money was used, and how the use is related to patient care.



- The loan must include/require repayment of the principal balance within a prescribed period, including regular scheduled repayment amounts applying to the principal borrowings amount. The provider may repay the principal balance of the loan on a monthly, quarterly, or annual basis. If the provider repays the entire principal balance before the expiration of the loan term, the interest expense on that loan is considered allowable. If the provider has a line of credit, the provider must repay the entire amount withdrawn within 12 months of the date of the first draw for the interest expense to be considered allowable.
- Interest income is applied first as a reduction to mortgage related borrowing allowable interest expense, and then to other borrowings allowable interest expense.
- Interest expense is distinguished from penalty or finance late fees by the existence of a lender and borrower relationship pertaining to the financed amount. Penalty and finance fee assessments relating to late payment of liabilities are not considered borrowing costs and are not allowable.
- Interest expense includes the cost of finance charges associated with borrowed funds. If the interest expense on borrowed funds is allowable or unallowable, this would include any applicable finance charges. Finance charges include, but are not limited to, expenses related to the maintenance of records, account maintenance fees, related transaction fees, administration, etc.
- For loans issued on or after November 1, 2019, interest on loans, to be allowable, must reflect a principal balance payment on at least an annual basis if the loan is greater than four years old. For loans issued prior to November 1, 2019, interest on loans, to be allowable, must reflect a principal balance payment on at least an annual basis starting on November 1, 2023. Refinancing of a loan or refinancing of multiple loans is not considered a principal balance payment, nor is a refinanced loan considered a new loan for purposes of this section. **(text added per bulletin MSA 19-28)**

8.8.A. INTEREST CLASS I AND CLASS II NURSING FACILITIES

For the Class I and Class II facility, interest on borrowed funds related to the facility acquisition allowable interest expense is determined in accordance with the Principles in effect on July 17, 1984, prior to the changes associated with the mandates of the DEFRA of 1984 and its limitations on the revaluation of assets.

- The dollar amount of facility acquisition financing is limited to the lesser of:
 - the purchase price of the nursing facility,
 - the current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of purchase, or
 - fair market value at the time of purchase; minus the purchase down payment.
- Interest expense on the dollar amount of a facility acquisition loan principle in excess of the financing limit is not allowable.
- Depreciated replacement cost is defined as the current reproduction cost adjusted for straight-line depreciation over the life of the asset.



- Depreciated replacement cost must be determined by an independent appraiser, chosen and paid for by the nursing facility provider, in accordance with the "Appraisal Guidelines" in the Principles.

Note: For Class I and Class II facilities that choose to forego increased reimbursement for interest expense, they must adopt the prior owner's financing and acquisition costs, interest expense schedule of borrowings, principal amortization, and interest expense recognized for reimbursement by the Medicaid program prior to the sale. Annual cost reporting must continue to be based on the prior owners.

8.9 LEASE COSTS

The Medicaid allowable cost provisions for asset lease transactions depend on the type of asset. Generally, asset lease transactions require that the lease expense be removed from cost and replaced by the underlying ownership cost of the property owner. Lease or long-term rental agreement (more than twelve months duration) transactions must be reported in the Medicaid cost report Statement of Leased Capital Assets. Cost reporting disclosure of lease costs is required to properly classify ownership costs for determining Medicaid reimbursement. There are also specific asset lease transactions that must be reported in the cost report statement but are an exception to the underlying ownership disclosure requirement. Specific types of lease expenses are discussed in the following sections.

Maintenance costs for leased capital assets, other than lease situations qualifying under "pass-through lease" criteria, are classified as variable costs. The nursing facility must determine and report these costs in the appropriate cost center or department. This requirement may necessitate the breakout of the maintenance costs for the lease contract.

Lease costs are differentiated from incidental or non-recurring rental expenses incurred to address a limited need of the facility. Rental expense incurred for incidental or limited time rental items, or non-recurring rental transactions, are allowable operating costs in the applicable cost center or department requiring the rental action. Limited time rental is considered as not longer than twelve months, non-recurring, and prohibits several/numerous sequential transactions for the same or similar rental items.

Exception: An extended period up to 24 months may be approved by RARSS in instances related to construction or renovation. The provider must submit an extension request to RARSS in writing at least 45 calendar days prior to the effective date of the extension. The request requires disclosure of item, duration, and action that precipitated the need to extend the project. RARSS will respond in writing.

8.9.A. FACILITY LEASE

Cost reporting and reimbursement for capital assets relating to the nursing facility premises are under the same methods whether the items are owned or leased. For items to be considered allowable costs, the acquisition dates and asset costs, interest expense and other applicable ownership costs must be reported. Allowable lease costs are determined using one of the following principles:

- A nursing facility provider that entered into an acceptable, arm's-length lease prior to September 1, 1973, where the lessor has refused to open its books, is allowed an actual lease cost up to a maximum of \$2.50 per resident day. This limit was developed from the average lease/rental costs for facilities leased prior to September 1, 1973, at which



time the current method of calculation was effected. The pre-September 1, 1973, lessee has the right of appeal of an acceptable, arm's-length lease agreement for costs that exceed the \$2.50 limit.

- A nursing facility provider that entered into, or amended, an acceptable, arm's-length lease agreement on or after September 1, 1973, is allowed a plant cost component determined in accordance with the Rate Determination section of this appendix, as applicable to an owner-provider, if the lessee discloses the allowable cost information required for rate setting. Leased assets are treated as though the lessor and the lessee are one and the same. Without full disclosure, lease expenses are not an allowable cost.

Interest expense allowed in the case of the lessor is also limited by Medicare Principles of Reimbursement. Further, interest income of the provider (lessee) is offset against all interest expense, including interest expense allowed on rental properties.

8.9.B. PLANT COST LEASE OTHER THAN FACILITY SPACE

Lease expense for nursing facility equipment or other activity that does not qualify for pass through lease expense is not allowable and must be reported utilizing the ownership underlying cost reporting requirement. If a lease is a virtual purchase and the lessee becomes the property owner at the termination of the lease, or for a nominal buyout amount, ownership cost reporting must be applied. The definition criteria of a virtual purchase are addressed in the federal Principles of Reimbursement.

Office space costs incurred in a home office or related party administrative service transaction are allowable under application of allowable depreciation, interest and property tax underlying ownership cost principles. Reasonable and necessary lease expenses incurred by a home office or related party for administrative services office space are allowable. Ownership underlying cost reporting is not required for leased business office space or similar leased space except in rental transactions involving a related party landlord. Related party transactions for office space are limited to ownership underlying costs applicable to allowable depreciation cost principles. The cost of office space is included in the cost of the home office or related party administrative services space cost and must be reported in accordance with Medicaid policy identified in the Cost Classification and Cost Finding Section of this appendix.

8.9.C. PLANT COST PASS THROUGH LEASES

A select group of rental and lease situations are exceptions to the requirement for disclosure of the underlying ownership costs. The lease or rental cost of qualifying items is allowed as plant cost in the lease rental cost classification to the extent that the asset use and cost is related to patient care. The pass through lease allowance applies to the following:

- Vehicle lease to a maximum of \$425/month or \$5,100/year, per vehicle
- Photocopiers
- Postage meters
- Telecommunications systems (including fax machines)



- Desktop or notebook computers and printers
- Parking lots and off-site record storage for rental from an unrelated party ownership and arm's length transaction

8.10 LIFE INSURANCE PREMIUMS

Life insurance premiums are allowable when the premium is a fringe benefit for the insured employee when the beneficiary of the employee's insurance is not the provider. The cost of life insurance premiums for insurance on the lives of officers and employees, including provider-based physicians, is an allowable cost only within the provisions of Medicare Principles of Reimbursement.

8.11 LIQUIDATION OF SHORT-TERM LIABILITIES

A short-term liability must be liquidated within one year after the end of the cost reporting period in which the liability is incurred. The liquidation of liabilities requirement for Medicaid applies the federal Principles of Reimbursement for the determination of allowable costs. In instances where a nursing facility provider does not liquidate a short-term liability within the period specified in the federal requirements, the costs for the related goods and services are not allowed in the cost reporting period in which the liability was incurred, but are allowable in the cost report period when the liability is paid.

Exception to the one-year time limit to liquidate a short-term liability will be considered in accordance with the federal Principles of Reimbursement. A provider may request an extension for good cause to liquidate short-term liability. The provider must submit a written request at the time of submission of the Medicaid cost report to RARSS identifying the liability amount(s) and an explanation for the nonpayment of the liabilities and expected payments to liquidate the liability. RARSS will review the request and notify the Provider of the approval of an extension, not to exceed three years after the end of the cost report period that the request is filed, or of the denial of the request.

8.12 LOBBYING AND POLITICAL ACTIVITY COSTS

A provider's costs incurred to support or oppose decisions of the federal Congress or state Legislature, costs related to campaigns for particular candidates or issues, and contributions to political action committees involving partisan elections are not allowable. Costs incurred, whether directly or indirectly through organization membership dues, fees or assessments, for these activities or to influence legislation are not allowable. Contacts with federal or state agencies in the course of business operations of the nursing facility and general comment on proposed policies are not considered lobbying activity.

8.13 MAINTENANCE OF EFFORT CONTRIBUTIONS BY COUNTY GOVERNMENT

In accordance with Public Act 408 of 1984, as amended, county governments that own and operate a nursing facility are responsible for maintenance of effort funding levels for the operation of that facility. The county government contributions to the nursing facility operations specifically due to the provisions of the Act, as amended, are not allowable costs of the county medical care facility Medicaid cost reporting.



8.14 MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT (DME), ORTHOTICS, AND PROSTHETICS [CHANGE MADE 4/1/20]

The cost of medical supplies or DME are generally considered an allowable cost. However, the following items are not allowable and must be billed by the medical supplier:

- Air-fluidized beds
- Bariatric beds
- Bilevel positive airway pressure (BiPAP) device
- **(text deleted 4/1/20)**
- Custom-fabricated seating systems may be covered outside of the nursing facility per diem rate when a standard item will not meet the medical and functional needs of the user and standards of coverage are met.
- Negative pressure wound therapy pump and accessories (wound VAC)
- Orthotics and Prosthetics
- Parenteral nutrition, including all supplies, equipment, and solutions
- Powered air flotation bed (low air loss therapy)
- Selected surgical dressings
- Shoes and additional components

The Nursing Facility Coverages chapter further describes the services included in the Medicaid per diem rate.

8.15 MEMBERSHIP FEES

Reasonable costs of memberships in professional, technical, or business-related organizations are allowable if the organization's mission or objectives are primarily related to resident care and/or long term care services activities. Costs of memberships in civic organizations for the purpose of implementing civic objectives are also allowable for Medicaid purposes (e.g., Chamber of Commerce). Any portion of membership fees used for lobbying, supporting political candidates and campaigning, or in social, fraternal, and other such organizations are not allowable. Awareness of an organization's ongoing lobbying and political activities requires identification of the portion of the organization's fees, dues, assessments or other allocations of costs to members or associated nursing facility providers. If an amount of non-allowable cost is not identified relating to this purpose, all costs associated with the fees or dues are non-allowable, unless the provider can document the appropriate unallowable portion.

8.16 MEDICAL DIRECTOR/PHYSICIAN SERVICES

The nursing facility must have a designated medical director that maintains responsibility for the implementation of resident care policies, for coordinating medical care, and is directly accountable to nursing facility management. The cost(s) applicable to the provision of the duties and responsibilities of the medical director is allowable routine nursing care. The nursing facility must maintain adequate records to document the level and type of services rendered by the medical director as a facility employee, or under a service contract or some other designated capacity. The cost(s) relating to the medical director duties and responsibilities must be distinguished from physician services activities that



are not allowable routine nursing care. Refer to the Practitioner Chapter for discussion regarding physician services.

8.17 NON-PAID WORKERS/VOLUNTEERS

The value of services of non-paid workers is an allowable cost. The services must be performed on a regular, scheduled basis. The services must be of the type customarily performed by full-time employees and necessary to enable the nursing facility provider to carry out the functions of normal resident care and the operation of the facility. The value of services of a type for which providers generally do not remunerate individuals performing such services is not an allowable cost.

Example: Donated services of individuals in distributing books and magazines to residents, administering a provider canteen or cafeteria or a provider gift shop are not allowable/reimbursable.

8.18 OWNER AND ADMINISTRATOR COMPENSATION

The cost for compensation to nursing facility owners is determined in accordance with Medicare Principles of Reimbursement, except the compensation to administrators, owner/administrators, or owners who function as administrators or assistant administrators, and corporate office executive management compensation is subject to specific dollar amount cost limits. Allowable cost limits are applied to nursing facilities based upon the bed size of the facility. Allowable cost limits are applied to individuals based upon the aggregate number of beds in nursing facilities being served or within the corporate organization. Compensation is remuneration to the individual for job performance and includes the costs of salary and wages, fringe benefits, director fees, and costs of services or items provided to the individual.

The compensation limit schedule is available on the MDHHS website. MDHHS annually adjusts the Owner/Administrator Compensation Limits to include cost-of-living changes as reflected by the United States Department of Labor Consumer Price Index for the metropolitan Detroit area. (Refer to the Directory Appendix for the website address.) Owner/Administrator Compensation Limits are expressed as facility annual compensation amounts and must be pro-rated on a monthly basis in situations where the cost reporting period is not 12 months.

8.18.A. COMPENSATION LIMIT FOR INDIVIDUAL NURSING FACILITY

The allowable cost limit for compensation to nursing facility administrators, owner/administrators, or owners who function as administrators or assistant administrators is determined according to the following criteria.

- Facility bed size includes licensed beds for nursing home, home for the aged and hospital services beds. Other categories of resident beds or housing arrangement beds are not included in determining the facility bed size for determining the appropriate compensation limit.
- The owner/administrator compensation limit used must coincide with the number of beds available for occupancy. The measurement criteria for determining the facility bed size is the number of beds available for resident or patient care at the beginning of the cost reporting period.



- Each nursing facility having 50 licensed beds or more must have a full-time licensed facility administrator. As required under State law, this individual is expected to be in the facility directing, conducting, or participating in activities directly related to the nursing facility during the normal 40-hour business week. A current position description that adequately defines the duties and responsibilities for the administrator position must be retained at the facility.
- The total compensation amount claimed for allowable costs for the facility administrator and related positions must not exceed amounts established by the SMA. These amounts are established by facility bed size: 1-49 beds, 50-99 beds, 100-149 beds and 150 beds or more.

The owner/administrator compensation limits apply to the costs for the positions of administrator, assistant administrator, and/or other administrative employees performing functions or having work responsibilities normally considered nursing facility administrator work activity. If an individual is functioning in a position that requires a nursing facility administrator's license, that person's compensation must be subjected to the limit. However, if a person does not have a license, but is performing the job functions and work activity of an administrator, that individual's compensation must also be included in the amount subjected to the limit. Inclusion of an individual's compensation in the total amount subjected to the limit is not only based on the individual having a license, it is also based on the job functions and work activity. Compensation paid by a related party or central office and charged directly to the nursing facility for individuals performing these activities must be included in the individual nursing facility compensation amount subject to the limit.

The compensation limit schedule does not apply to the salary of owners employed in capacities other than administration of the nursing facility provider's operation. The allowable salary level of an owner employed in a non-administration position cannot exceed the market value salary for that position, e.g., director of nursing, social services director. The allowable salary level must be commensurate with the amount of time the owner spends working in the non-administration position. If the owner also participates in facility administration, the portion of the payroll costs attributed to the administrative work must be included in the owner/administrator salary compensation and subject to the appropriate salary limits. The individual's administrative work must be appropriately documented with a position description and job responsibilities, and the allowable salary level for the administrative work must not exceed salary levels for similar administrative positions.

8.18.B. COMPENSATION LIMIT FOR OWNER AND/OR ADMINISTRATOR SERVING MULTIPLE NURSING FACILITIES

Where an individual is involved in the administration of more than one nursing facility, the maximum compensation allowed for allocation per facility and the allowable facility compensation is computed as follows:

- Total the number of beds, as defined in the individual nursing facility section, in all facilities served by the owner and/or administrator.



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- Determine the appropriate compensation limit from the published schedule for the total number of beds.
- Compare the appropriate compensation limit with the actual allowable total salary and fringe benefits paid to the individual. The compensation limit is expressed as an annual amount (12-month period) and applicable to a full time position defined as a minimum of 40 hours per week committed to nursing home related management and administrative activity. Adequate work activity records must be available for verification of time expended for nursing facility related activity. Time commitment for less than full time requires the compensation limit be prorated to reflect the portion of time committed to this activity. Example, if 30 hours per week during an annual period is attributed to this activity, the adjusted limit for the individual is 75 percent of the appropriate compensation limit.
- The lesser of total allowable compensation or the compensation limit per the schedule is then allocated to all the facilities served by the owner and/or administrator based on a ratio of the number of beds in the individual facility to the total number of beds in all facilities served. The hours directly devoted to individual homes may be used as the allocation basis if verified by auditable records.
- Combine the allocated owner and/or administrator compensation with the allowable compensation of the facility's administrator/assistant administrator/co-administrator.
- Compare the combined compensation amount to the compensation limit schedule maximum allowable for the number of beds for that particular sized facility. The lesser of the facility's combined compensation or the facility's compensation limit is the allowable compensation to be used in the determination of allowable cost related to resident care.

The following illustrates an example of the allowable owner/administration compensation limit application for a group of four facilities of varying sizes with a total of 400 beds, and the allowable facility compensation. The owner and/or administrator total compensation is \$250,000 for full time nursing facility related activity for a cost reporting period ending December 31, 2017. The compensation is \$31,354 greater than the limit (\$250,000 minus \$218,646 equals \$31,354).

Total number of beds in all facilities served	400
Compensation Cost Limit for 150+ bed facility as of 12/31/2017	\$218,646
Owner and/or Administrator Total Compensation	\$250,000
Amount allowed for allocation to individual facilities (lesser of bed size limit or actual compensation)	\$218,646
Amount of compensation not allowed	\$31,354



Nursing Facility Bed Sizes	1-49 Beds	50-99 Beds	100-149 Beds	150+ Beds
Facility Compensation Limit 12/31/2017	\$72,883	\$121,471	\$145,766	\$218,646
Example Facilities	Facility 1	Facility 2	Facility 3	Facility 4
Total Facility Beds	40	70	100	190
Allocation of Owner and/or Administrator Compensation ¹	\$21,865	\$38,263	\$54,662	\$103,857
Compensation of Facility Administrator	\$40,000	\$85,000	\$95,000	\$115,000
Facility Total Compensation to be compared to Limit ²	\$61,865	\$123,263	\$149,662	\$218,857
Disallowed Compensation per Facility	\$0	\$1,792	\$3,896	\$211

- ¹ The percentage of the facility's beds of the total across all four facilities is multiplied by the compensation limit, e.g., 40/400 x \$218,646.
- ² Total compensation equals the sum of the allocation amount and the individual nursing facility administrator compensation.

8.18.C. COMPENSATION LIMITATION FOR HOME OFFICE EXECUTIVE/MANAGEMENT

Salary and wages, fringe benefits and other related compensation costs for home office executive and management staff are included in the provider's home office cost report, and costs are allocated to the individual nursing homes and other business activities conducted by the organization. The allocation of the compensation costs is made to the operating entities of the corporation through the home office cost statement, and these costs are not included in the limit imposed on the individual nursing facility owner/administrator compensation.

The compensation limit for high-level management employees at the corporate home office level is enhanced to acknowledge increased scope of the business activity and corporate responsibility. The enhanced compensation limit is applicable in chain organization or related party management services situations where home office cost statement reporting exists, and full management oversight and administrative services are being provided to the nursing facilities and other business activities of the organization. Compensation costs for corporate office individuals under the enhanced compensation limit must be documented by a current position description, employment contract or other verifiable documentation that adequately defines the position, duties and responsibilities for the individual, and demonstrates the presence of services provided to the organization. Compensation to an individual employee of the corporate or central office, regardless of employment position or job activity function, is subject to the enhanced compensation limit to determine allowable cost. The enhanced



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compensation limit is expressed as an annual amount (12-month period) and is applicable to a full time position.

Employees paid by the corporate or central office but charged directly to the individual nursing facility for administrator or assistant administrator work functions at that facility are not eligible for the enhanced compensation limit. Allowable cost limits for such employees are addressed under individual nursing facility compensation limit.

The enhanced Medicaid allowable compensation for individual corporate office official and executive management employee personnel is applicable only to organizations greater than 150 beds. The enhanced compensation limit is based on the total number of beds owned and operated by and under full management control of the corporate organization and determined in accordance with the following schedule:

Number of Beds in the Chain Organization	Enhanced Compensation Limit
151 to 500 beds	100% of the 150+ bed facility limit
501 to 1,000 beds	120% of the 150+ bed facility limit
1,001 to 2,000 beds	130% of the 150+ bed facility limit
Over 2,000 beds	150% of the 150+ bed facility limit

The total number of beds includes all types of nursing home, home for the aged, hospital services, resident and other housing arrangement beds. If the business activity for the beds is not included in the allocation of the home office costs, the beds must not be counted for determining the number of beds in the chain organization. The 150+ bed facility limit used to determine the enhanced compensation limit amount is the MDHHS published limit for the year end corresponding to the reporting period end date of the home office cost statement.

8.19 OXYGEN

Medicaid coverage of oxygen services for residents in nursing facilities is addressed in the Medicaid Services Descriptions Section of the Coverages portion of this chapter. The costs of oxygen gas, equipment, and supplies for intermittent and infrequent use are allowable in the routine nursing care cost and are included in the per diem reimbursement rate. Oxygen equipment rental costs for a limited period for purposes of providing this service are allowable in accordance with the incidental rental cost provisions addressed in the Lease Cost subsection of this appendix.

The costs of oxygen related services for frequent or prolonged use on a daily basis (i.e., at least 8 hours per day), regardless of payer source, is an ancillary services cost and is not an allowable routine nursing care cost. For residents requiring frequent and prolonged oxygen use who are in a nursing facility, the oxygen gas, equipment, and supplies must be billed by an enrolled medical supplier, not the nursing facility. For residents requiring frequent and prolonged oxygen use in a County Medical Care Facility or a Hospital Long Term Care Unit, the oxygen gas, equipment, and supplies must be billed by the nursing facility, not the medical supplier. These costs must be separately identified in the facility's accounting records or adequately compiled and verifiable for audit and excluded from Medicaid cost report routine nursing care unit cost.



8.20 PATIENT TRANSPORTATION

The Transportation Section of the Coverages portion of this chapter addresses the nursing facility's responsibility to arrange or provide for non-emergency patient transportation. The cost for this transportation is a routine nursing care cost included in the nursing facility's annual cost report, and any reimbursement for the services is included in the routine nursing care per diem rate. Patient transportation costs are classified as support costs for Medicaid cost reporting.

The nursing facility must select the most efficient and cost effective mode of transportation for resident care which may include utilizing a facility owned vehicle or contracted outside service. Whenever possible, a facility-owned vehicle should be used. Costs relating to the nursing facility vehicle operation are addressed under the Facility Vehicles and Capital Asset Cost subsections of this appendix.

Costs incurred for contracted outside service for patient transportation must be included in the Medicaid cost reporting under the following reporting procedures:

- Administration and General Transportation – when the expense is not directly identified for specific residents or the care unit in which the resident resides in the facility; or
- Routine Nursing Care, Miscellaneous Support Cost
 - when there is only one routine nursing care unit in the facility and all resident transportation is for residents in that unit, or
 - when there are multiple nursing or residential care units in the facility, and the expense is directly identified by individual resident and location unit where the individual resides in the facility. Costs must be allocated to the corresponding nursing unit cost center identified in the Medicaid cost report.

8.20.A. NON-EMERGENCY AMBULANCE

When a physician issues a written order for non-emergency ambulance transportation, usually due to the need for a stretcher or other emergency equipment, the ambulance provider may bill Medicaid directly and must maintain the physician's order as documentation of medical necessity. If non-emergency ambulance transport is not ordered by the beneficiary's physician, arrangements for payment must be between the facility and the ambulance provider and cannot be charged to the beneficiary, beneficiary's family, or used to offset the patient-pay amount. The cost of non-emergency ambulance transports not ordered by the beneficiary's physician must be identified and removed on Worksheet 1-B by the nursing facility.

8.21 PERSONAL COMFORT ITEMS

The costs of services and items that do not contribute primarily to the resident's treatment of an illness or the resident's ability to function are not allowable. Direct costs, and the appropriate share of indirect costs, relating to such items as telephones, televisions and/or radios that are located in the patient's accommodations and furnished solely for the personal comfort of the resident, are not allowable. The cost of television and radio services furnished to residents generally is allowable if furnished in common use areas of the facility such as day rooms, recreation rooms or similar purpose area of the facility for the common benefit of facility residents. The cost of nurse-patient communications system that has no capability other than nurse and patient communication is allowable.



The costs of systems, including nurse-patient communications, television and telephone services, and similar items, may have the capability of providing residents with outside entertainment and providing nurse-patient communications. Only the cost of the component for nurse-patient communication is allowable routine nursing care. Direct distinction of cost related to the nurse-patient communication must be made for proper cost reporting, or an appropriate allocation must be established for Medicaid approval for the purpose of identifying the patient related and personal comfort related cost portions of combined systems.

8.22 PRIVATE DUTY NURSES

Costs for nursing staff services provided by or under the supervision of a registered professional nurse are allowable; however, the costs of services of a private-duty nurse or other private-duty attendant are not allowable routine nursing care. Private-duty nurses or private-duty attendants are registered professional nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular patient under arrangement between the patient and the private-duty nurse or attendant.

A patient, or someone acting on their behalf, may arrange and pay for a private-duty nurse, or the nursing facility that initially incurs the requested costs may look to the patient for payment of the non-covered nursing facility service. Where the nursing facility acts on behalf of the resident, the services of the private-duty nurse or other attendant(s) under this arrangement are not allowable routine nursing care services regardless of the payment process to the private duty or other personnel or the control which the nursing facility may exercise with respect to the services rendered by the private-duty nurse or attendant.

8.23 PROVIDER DONATIONS FOR OUTSTATIONED STATE STAFF

For cost reporting periods beginning prior to April 1, 2019, provider donations and administrative costs and incidental costs (workspace and telephone), incurred by the provider for outstationed staff are allowable costs. Costs are allowable to the amount contractually determined with the State.

For cost reporting periods beginning on or after April 1, 2019, provider donations for outstationed state staff and any associated costs paid to the State of Michigan for outstationed state staff are non-allowable costs. These costs must be reported on the provider's cost report and then adjusted from the cost report to be excluded from the rate setting process. A provider that utilizes an outstationed state worker(s) must submit a copy of their contract(s) for the use of that worker with their cost report.

8.24 PURCHASE DISCOUNTS

All discounts, allowances, and refunds of expenses are reductions in the cost of goods or services purchased and are not income. When they are received in the same accounting period in which the purchases were made or expenses were incurred, they will reduce the purchases or expenses of that period. However, when they are received in a later accounting period, they will reduce the comparable purchases or expenses in the period in which they are received.

Purchase discounts have been classified as cash, trade, or quantity. Cash discounts are reductions granted for the settlement of debts before they are due. Trade discounts are reductions from list prices granted to a class of customers before consideration of credit terms. Quantity discounts are reductions



from list prices granted because of the size of individual or aggregate purchase transactions. Whatever the classification of purchase discounts, like treatment in reducing allowable costs is required.

As with discounts, allowances and rebates received from purchases of goods or services and refunds of previous expense payments are clearly reductions in costs and must be reflected in the determination of allowable costs. In addition, late charges on purchases are not an allowable expense. These would be in addition to regular costs authorized.

8.25 REBATES LARGER THAN ONE YEAR'S EXPENSE AND EXTRAORDINARY EXPENSE

Normal refund or rebate amounts are reported as a reduction offset to current operating costs in accordance with federal Principles of Reimbursement. A refund or rebate amount of previous years' allowable expenses must not be reported in total in the current fiscal year-end cost report where the refund or rebate amount pertains to more than one prior year reported expense. Likewise, extraordinary expense pertaining to more than one prior year must not be reported in total in the current fiscal year-end cost report. Refund or rebate and the extraordinary expense amounts pertaining to more than one prior year must be equally spread over as many subsequent years as the number of years represented by the refund or rebate or the extraordinary expense amount not to exceed three years. In the instance of a sale, the selling provider must include 100 percent of the remaining rebate balance in the final cost report. The apportionment will start in the cost-reporting year in which the refund amount is received or the extraordinary expense is discovered. These provisions are limited to Medicaid cost reporting requirements and do not change the applicable accounting principles for financial reporting.

8.26 RESEARCH ACTIVITIES

The cost of research activities is allowable in accordance with Medicare Principles. If research is conducted in conjunction with, and as a part of, the care of residents, the costs of usual resident care are allowable to the extent that such costs are not met by funds provided for the research.

8.27 ROUTINE NURSING SERVICES

A provider's costs associated with the provision of necessary medical, nursing and mental health services, within the provisions of Medicare Principles of Reimbursement and requirements specified in the Coverages portion of this chapter, are allowable expenses. This includes costs incurred for meeting state federal requirements associated with specialized mental health rehabilitation services, e.g., monitoring the necessity for Annual Resident Reviews and coordinating or providing required services. The medical supply costs associated with routine nursing services and reimbursed by Medicare Part B are not allowable routine costs for Medicaid if the provider is reimbursed by Medicare.

8.28 SICK LEAVE

The reasonable cost of sick leave taken (or payment in lieu of sick leave taken) by an employee is recognized as a fringe benefit and is included in allowable costs in the cost reporting period when paid. If the sick leave is vested and refunded, contributions to the fund are allowed under applicable provisions of the Medicare Principles. However, where the nursing facility provider's sick pay plan grants employees the right to demand cash payment for unused sick leave at the end of each year, the pertinent accruals are includable, without funding, in the cost reporting period when earned.



8.29 TAXES AND FEES

Taxes, including employee payroll taxes, sales taxes, and state imposed sales and use taxes, are allowable variable costs. The Michigan Business Tax and the Michigan Corporate Income Tax are allowable variable support costs.

8.29.A. GENERAL TAXES

Real and personal property taxes are allowable plant costs.

8.29.B. QUALITY ASSURANCE ASSESSMENT PROGRAM (QAAP) TAX

A nursing facility's QAAP tax, including the Quality Measure Initiative (QMI) share of the tax, is an allowable cost and must be reported in the nursing facility Medicaid annual cost report. The tax must be reported on the provider's cost report as assessed and accounted for on the accrual basis. The QAAP tax cost is adjusted through the cost reporting process to be segregated from use in rate setting. The QMI share of the QAAP tax must be reported on a separate account on the provider's cost report than the rest of the QAAP tax.

8.29.C. FEES AND ASSESSMENTS

Costs incurred for late payments, or for violation of federal, state, or local laws, are not allowable.

8.29.D. PENALTY TAXES UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

Penalty taxes that may be assessed on employers under the employer-shared responsibility provisions in the Patient Protection and Affordable Care Act (PPACA) are not allowable costs used to calculate the Medicaid room and board rate. As such, the facility must remove these penalty taxes from allowable costs via a Worksheet 1-B adjustment.

8.30 THERAPY AND PATHOLOGY SERVICES

A nursing facility provider must establish accounting procedures to reflect individual cost centers for reimbursable ancillary services, including physical therapy, occupational therapy, speech pathology and other services not classified as routine nursing care. Whether the therapist/pathologist is salaried, under contract, or an independent provider, a nursing facility provider must record Medicaid program payments as income and all expenditures for therapist/pathologist supportive personnel, equipment and its maintenance, supplies, and other costs directly attributable to rendering services in these cost centers.

The service is considered ancillary if the complexity of the service prescribed for the resident is such that it can be performed safely and/or effectively only under the general supervision of skilled rehabilitation personnel. Ancillary therapy services are evidenced by the presence of the following conditions:

- A written physician order.
- The skills of qualified technical or professional health personnel, such as physical therapists, occupational therapists, speech pathologists or audiologists, are required.



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- Services are provided directly by, or under the general supervision of, the skilled personnel to assure the safety of the patient and to achieve medically desired results. General supervision requires that initial direction and periodic inspection of the actual activity is necessary.
- Services are rendered as part of an active treatment for a specific condition that has resulted in a loss or restriction of mobility or function.

Therapy services considered routine nursing care are services rendered under circumstances where the general supervision of exercises, which have been taught to the patient, can be performed repetitiously without skilled rehabilitation personnel. This includes maintenance programs where the performances of repetitive exercises, which may be required to maintain functions, do not require the involvement and services of skilled rehabilitation personnel, but may require the assistance of a trained nurse aide. Routine nursing care may include repetitive exercises to improve gait, maintain strength or endurance, passive exercises to maintain range of motion in paralyzed extremities, and assistive walking.

The cost of the development of the maintenance plan when prepared by a licensed therapist is allowable. A provider must maintain documentation, which includes the amount of time required by the therapist to develop the maintenance plan. Medicaid considers maintenance plan development as routine nursing care included in the per diem rate.

The cost of the MDS assessment is allowable. A provider must maintain documentation, which includes the amount of time required by the therapist to complete the MDS assessment. Medicaid considers the MDS assessment as routine nursing care included in the per diem rate.

Depreciation for equipment and facility space assigned to these services must be included as an expense in the ancillary cost centers and computed in accordance with Medicaid guidelines for allowable depreciation. A uniform charge structure must be applied to the entire facility population receiving the services.



SECTION 9 - COST CLASSIFICATIONS AND COST FINDING

Medicaid-enrolled providers must develop and adopt a uniform Chart of Accounts that meets the minimum requirements established by Medicaid for classifying and reporting costs incurred in providing care to nursing facility residents. A nursing facility's accounting system will normally include more detailed accounts for recording facility costs. However, for cost reporting purposes, the detailed accounts are compiled into aggregate cost classification centers in accordance with program policies.

The following cost descriptions are guidelines to provide consistency in nursing facility provider cost reporting. Reimbursement classifications are identified for individual cost elements in examples available on the MDHHS website. (Refer to the Directory Appendix for website information.) More detailed discussions of cost categories are in the Allowable and Non-Allowable Costs section of this appendix.

9.1 NURSING FACILITY BED DAYS AND RESIDENT OCCUPANCY

A provider must report nursing facility bed days and resident occupancy statistics in the annual cost report. Policy related to facility census is presented in the Definitions section of this appendix. Specific attention should be directed to the following definitions: available bed, available bed days, ban on admissions, census, census day, denial of payment for new admissions, hold a bed day, leave day – hospital, leave day – therapeutic, occupancy, occupancy rate, per resident day cost, resident, resident days/occupancy, therapeutic leave day.

The nursing facility's resident occupancy statistics and cost reporting requirements will be significantly affected in cases where the provider requests, and is granted, approval for designating non-available beds as outlined in the Non-Available Beds subsection of this appendix.

9.2 VARIABLE COSTS – BASE AND SUPPORT

Variable costs include the total allowable base and support costs in a facility's routine nursing service units. A provider must allocate variable costs (support or base) depending on the activity for which the cost was incurred. The provider must also report direct costs for ancillary service costs and other non-reimbursable service costs. The direct costs incurred or attributed to these activities will not specifically be identified as base or support costs, however, the cost report cost finding process will allocate general services cost activities as base or support costs depending on the activity for which the cost was incurred.

9.2.A. BASE COSTS

Base costs cover activities associated with direct patient care. Major activities under these categories are payroll and payroll-related costs for departments of nursing, nursing administration, dietary, laundry, diversional therapy and social services, food, linen (excluding mattress and mattress support unit), workers compensation, utility costs, consultant costs from related party organizations for services relating to base cost activity, nursing pool agency contract service for direct patient care nursing staff, and medical and nursing supply costs included in the base cost departments.



9.2.B. SUPPORT COSTS

Support costs cover allowable activities not associated with direct patient care. Major items under these categories are payroll and payroll-related costs for the departments of housekeeping, maintenance of plant operations, medical records, medical director, and administration, administrative costs, all consultant costs not specifically identified as base, all equipment maintenance and repair costs, purchased services, and contract labor not specified as base costs. Contract services costs for these departments are also support costs.

9.2.C. BASE/SUPPORT COSTS – PAYROLL RELATED

Nursing facility expenses related to payroll taxes and employee health and welfare are classified as base/support costs. These costs include fringe benefits such as employer contributions to FICA, FUTA, MESC, employee life and health insurance, retirement, physicals and all other insurance provided to employees as fringe benefits. If a nursing facility's accounting records do not separately reflect the payroll taxes and employee health and welfare expenses for "base" and "support" personnel by cost center identification, the total amount of these costs must be reported in the appropriate "base/support" cost category. Workers compensation is a base cost and not divided between base and support.

If the nursing facility's accounting system allows the allocation of costs to specific personnel or activities, the specified costs must be used on the cost report. If the nursing facility accounting system does not allow for this specificity, then a reclassification of costs must be made to the appropriate service areas. In these cases, it will be necessary to reclassify such costs on the basis of salary and wage costs distribution.

9.2.D. BASE/SUPPORT COSTS – CONTRACT SERVICES FOR DIRECT PATIENT CARE

A provider that purchases direct care services as an alternative to employing personnel may apportion the contract services costs between base and support cost by applying the industry-wide average base-to-variable cost ratio. The nursing facility must appropriately report these costs in the annual cost report. Medicaid reviews the industry-wide average base-to-variable cost ratio annually and revises it if a difference of two percent or greater exists between the current calendar year cost report aggregate average industry data and the previously promulgated industry-wide base-to-variable cost ratio. If a revision is applicable, the revised cost ratio will be effective for subsequent year cost reporting.

9.3 PLANT COSTS

Plant costs include depreciation, interest expense (either working capital or capital indebtedness), real estate and personal property taxes, amortization costs associated with loan financing costs (amortization of legal fees, recording fees or other fees relating to the capital asset acquisition points, letters of credit), and specific lease expenses.



9.4 CAPITAL ASSET EXPENDITURE

Medicaid limitations on capital expenditure costs are determined in accordance with Medicare Principles except as modified by Medicaid policy.

A nursing facility provider anticipating capital expenditures should contact the CON Evaluation Section to make application for a CON. (Refer to the Directory Appendix for contact information.)

If a CON is approved, the provider may be eligible for increased reimbursement, subject to Plant Cost Component limits. If a new capital expenditure required CON review and was denied, the provider's reimbursement rate must exclude the costs of the denied capital expenditure. The provider's cost report must identify capital expenditures approved and denied by CON.

The nursing facility must have written policies and procedures that establish dollar level thresholds beyond which an asset acquisition is considered a capital asset. Medicaid sets the thresholds at having an estimated useful life of at least two years and a historical cost of at least \$5,000. The nursing facility capital asset policy may have lower dollar level threshold than the Medicaid limit, but may not have a higher limit. If the provider's capitalization policy sets lower thresholds than Medicaid, then the provider's established policy must be followed for cost reporting. A provider may not have separate capitalization policies for Medicaid cost reporting and for other financial statements and reports.

Assets that are acquired as part of an integrated system must be considered as a single asset for capitalization purposes. Assets that have a stand-alone functional capability may be considered on a single item basis. Individual asset items that do not meet the dollar and useful life threshold are classified as minor equipment and will be reported as minor equipment expense in the cost report of the year of acquisition.

Example: An office workspace with connecting portions dependent upon other portions for support and stability; a communication system installed in the facility and in resident rooms to allow the full functioning of two-way communication system.

Repair and improvement costs related to assets that result in extending useful life or increased productivity must be capitalized for Medicaid if they are capitalized under Generally Accepted Accounting Principles. Providers must demonstrate consistency in financial reporting.

Providers must follow Generally Accepted Accounting Principles (GAAP) in reporting repairs to capital assets. Repairs that should be capitalized under GAAP must not be an expense item on the cost report.

9.4.A. CAPITAL ASSET COST DATA FOR CLASS I FACILITIES

9.4.A.1. CAPITALIZED ASSET ACQUISITION COSTS

Capitalized asset acquisition costs are used to determine the Current Asset Value for the Plant Cost Component in the Class I nursing facility reimbursement rate. The Medicare Principles of Reimbursement are used to determine the acquisition costs allowable to the original provider/owner of the asset. The SMA uses only the acquisition cost incurred by the original owner to determine the capital asset value cost data. Asset acquisition costs are allowed for related party transactions in accordance with Medicare's interpretation for costs to related organizations.



The cost basis for capital assets is the CAV value determination of the original owner's audited historical acquisition cost. It is the responsibility of the current owner to provide the audited historical cost and purchase year of the original owner; otherwise, the assets are assumed obsolete for payment determination purposes, i.e., of no current asset value. The current provider must annually report the cost and the applicable year's depreciation for newly purchased assets and value changes to previously acquired assets. Cost reporting for asset acquisition costs related to a capital asset that is traded-in for a new replacement item must also report the value of the capital assets.

Capital costs related to assets that are no longer used in the facility operation and assets that are not necessary for resident care, e.g., excessive land not allowed under the Principles, are not allowable in the nursing facility capital asset value cost data.

To ensure that Medicaid does not pay for assets that are no longer being used to provide resident care, the original acquisition costs, or an estimate thereof, are removed from the current capital asset cost data. The costs of retirement or replacement of buildings, building improvements, building additions, fixed building equipment, land improvements, or movable equipment are removed from the capital asset cost data for the corresponding year of the original acquisition of that retired or replaced asset.

When the original value can be ascertained through such methods as component part depreciation records, the provider must remove the original costs of the retired or replaced assets from the year of the original acquisition, and report the new asset item cost for the year purchased.

Building components, building services equipment or other fixed equipment assets or land improvements may have historically been included within the asset price of the building to which they are attached and, as a result, are not separable for purposes of calculating depreciation or the capital asset cost data. However, in the determination of the Current Asset Value, an asset must exist in the nursing facility for it to have a value. Therefore, if a fixed asset has been retired or replaced and the asset cost cannot be determined from the provider's Medicaid/Medicare asset cost schedule, construction records, or tax records, the provider must determine and report the original asset cost based on the cost of a similar asset.

If a nursing facility provider is unable to report the original asset cost by either individual asset cost or component basis, the new asset will be assumed as a replacement of a similar asset for determining the necessary revisions to the capital asset cost data using the asset trade-in provisions.

When a capital asset is traded-in for a new replacement item, either the original owner's cost or a derived value of the item traded in is removed from the capital asset cost data. The purchase price of the new asset, prior to consideration of the value of any trade-in, is added into the capital asset cost data for the current year of purchase. If the original cost of the item is unknown, the provider must derive a value by backdating the purchase price amount for the new replacement asset. If the asset being replaced is of a different quality or type than the new asset, the amount to be backdated may be based on the expected current cost of a similar asset of like quality and type. The derived value calculation is made by applying a construction cost index (exclusive of the annual obsolescence adjustment) to the value of the new asset item cost, then subtracting the



derived value from the previous capital asset cost data historical cost for that original acquisition year. An electronic copy of the annual economic index compilation and the derived application process used for nursing facility cost reporting can be accessed on the MDHHS website. (Refer to the Directory Appendix for website information.)

Capital assets that are leased or rented are treated as obsolete assets for rate determination purposes when the underlying historical acquisition cost to the original owner has not been disclosed, or when the underlying information cannot be verified through audit.

Capital assets recorded in the central office, home office, or related organization financial records that are identifiable to a specific nursing facility are included in that facility's capital asset cost data determination process. The asset values, interest, and property taxes identified with these assets must be charged directly to the nursing facility and will be reimbursed in accordance with the applicable policy.

Costs of capital assets associated with the operation of related organizations are not included in the capital asset cost data determination for a specific nursing facility. The plant and variable costs of such organizations are treated as purchased services. (Refer to the Variable Costs – Base and Support subsections for discussion regarding purchase and contract services.)

9.4.A.2. EXCEPTIONS TO ASSET ACQUISITION COST CAPITALIZATION

Exceptions to the acquisition cost basis for assets may be allowed in the following situations:

- For the occasional purchase of used, movable equipment for ongoing nursing facility operations when the purchase is not related to a change in facility ownership. For the purchase of used replacement equipment, e.g., re-manufactured beds, a used lawn tractor, or used vehicles, the asset acquisition is treated as if new items were purchased. The allowable cost of acquisition is included in the year the asset is put into service by the current purchaser.
- For the nursing facility land value. The land value to be included in the Current Asset Value is based on the current owner's allowable acquisition cost determined in accordance with Medicare Principles, and not to exceed the amount reported to the Internal Revenue Service for federal tax purposes. The cost of the prior owner's land improvement asset, which is an integral part of the nursing facility land component and is included in the new or current owner's land acquisition cost, must be excluded from the historical capital asset cost data. The current facility ownership capital asset cost data cannot include both the land purchase price and the original owner's land improvement cost data.
- When equipment is purchased as "used" equipment as part of a facility change of ownership, or only a change of ownership of the facility equipment has occurred, the prior owner's (seller) computation of value at the time of sale is continued to the new owner.



9.4.B. CAPITAL ASSET CATEGORIES (FIXED ASSETS)

Capital asset classifications and asset useful life for depreciation purposes are determined in accordance with the American Hospital Association (AHA) guidelines in effect at the time of the asset acquisition.

General descriptions of the asset cost categories for cost reporting are:

Land – includes the land owned and used in the provider operations and includes off-site sewer and water lines, public utility costs necessary to service the land, government assessments for street paving and sewers, cost of permanent roadways and grading of a non-depreciable nature, cost of curbs and sidewalks where the replacement is not the responsibility of the nursing facility, and other land expenditure of a non-depreciable nature.

Land Improvement – improvements of a depreciable nature including paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc. where replacement is the responsibility of the nursing facility.

Building – includes the basic building structure, shell or frame, and additions thereto, building components, exterior walls, interior framing, walls, floors and ceiling, architectural, consulting, and interest expense associated with new construction or acquisition.

Building Improvement – includes building equipment attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating and air conditioning systems, etc. The general characteristics of fixed equipment are: (a) attached to or installed in the building structure, and (b) fairly long life but may be less than the building.

Leasehold Improvement – includes betterments and additions made by the lessee to the leased property, whereby the improvements become the property of the lessor after expiration of the lease. These items generally meet the requirements of building improvement assets.

Department Equipment – includes assets generally assigned to a specific department within the nursing facility with relatively fixed location but capable of being moved; as distinguished from building equipment. (Refer to Building Improvement.)

Furniture and Fixtures – includes assets similar in characteristic to department equipment, however, normally with no fixed location or used by various departments within the facility.

Transportation Equipment – includes vehicles used in conducting nursing facility operations relative to resident transportation, plant operations and maintenance, or general means of transport.

Capital asset costs incurred by a landlord who is leasing facility assets to a provider must be disclosed and reported in the provider's annual cost report. Capital asset cost reporting and allowable cost policies are applicable to the reporting of the leased assets in the same manner as if the assets were owned by the provider.



9.4.C. DEPRECIATION

Class I and Class II nursing facilities are under the tenure plant cost reimbursement methodology, and potential reimbursement is not based on depreciation expense for the nursing facility capital assets. The costs of services provided from home office or related party transactions, other than for capital assets related to the nursing facility physical plant, may include depreciation expense for asset costs applicable to the operations of the home office or related party business. Allowable depreciation costs for the home office or related party will be determined in accordance with Medicare Principles. These costs will be included in the home office or related party administrative services space costs and must be reported in accordance with Medicaid policy identified in the Related or Chain Organization Cost Allocation subsection of this appendix. Class III and Class IV nursing facilities reimbursed under the depreciation plant cost reimbursement methodology will have depreciation costs determined in accordance with allowable cost principles defined in this policy. The allowance for depreciation is determined in accordance with Medicare Principles except that only the straight-line method of depreciation may be used. The historical asset cost basis and the depreciation basis for nursing facility sales is subject to the limitation on the valuation of assets mandated by the Medicare Principles.

In addition to the depreciation standards in the Medicare Principles, Medicaid also requires adherence to the following standards:

- Consistent use of either component or composite asset depreciation schedules. Component depreciation is permitted in the case of a newly constructed facility and for recognized building improvements where the costs can be separated and acceptable useful lives determined. Composite depreciation must be used in the case of a newly purchased, existing facility.
- All abandonment losses are considered as a depreciation expense item.

9.4.D. DISPOSAL OF DEPRECIABLE ASSETS

9.4.D.1. CLASS I NURSING FACILITIES

Class I nursing facilities will account for asset acquisition and disposal in accordance with the Capital Asset Cost Data for Class I Facilities subsection of this appendix.

A Class I nursing facility purchased on or after March 31, 1985 is not subject to depreciation adjustment. In the event of a sale, the assets of Class I facilities whose ownership began prior to March 31, 1985, amounts included in the Medicaid per diem rate as an explicit depreciation expense item are subject to recapture in the event of a gain on the disposal of assets. The selling Provider must complete Medicaid Program Depreciation Recapture reporting schedules along with the applicable fiscal year cost report. Refer to the Cost Report Reimbursement Settlement, Depreciation Recapture Reimbursement Adjustment subsection of this appendix for additional information.



9.4.D.2. CLASS III NURSING FACILITIES

Class III providers whose Medicaid rate includes depreciation expense must adhere to the Medicare Principles of Reimbursement to account for the disposal of depreciable assets. If the disposal of depreciable assets in the reporting year results in a gain or aggregate loss below \$5,000, the adjustment will be made in the nursing facility provider's current year cost reporting allowable cost. The allowable gain is limited to the amount of depreciation previously included in the provider's allowable costs for the disposed assets.

In the event of a sale of the entire nursing facility and the termination of Provider participation in the Medicaid program, the terminating Provider must complete Medicaid Program Depreciation Recapture reporting schedules along with the applicable fiscal period cost report. Refer to the Cost Report Reimbursement Settlement, Depreciation Recapture Reimbursement Adjustment section of this appendix for additional information.

9.5 LOANS/BORROWINGS BALANCE REPORTING

Necessary and proper interest on current and capital debt is a Medicaid allowable cost. All interest expense, whether on current or long term debt, is classified as a plant cost. Determination of allowable interest expense will be in accordance with Medicare allowable cost principles. However, there are reimbursement limits for determining the Plant Cost Component specific to Medicaid which are addressed in the Rate Determination section of this appendix.

Medicaid requires nursing facilities to report the loans and borrowings balance in the annual cost report. The cost report instructions identify the schedules that must be used to report borrowing principle balances. The nursing facility must report the beginning balance and monthly end balance of outstanding allowable loans and borrowings for the period corresponding to the cost report year. The loans and borrowings in the borrowing balance report must only include the outstanding loans or other liability obligations for which the nursing facility is claiming interest expense related to that borrowing principle. If the nursing facility is filing a cost report claim for interest expense as an allowable cost, the nursing facility must document the corresponding borrowing obligation related to the interest expense. The outstanding borrowing balance is defined as the allowable borrowing principle amount on which the interest rate, normally expressed as an "interest rate percentage", is applied for the purpose of calculating the interest expense applicable to the specific cost report period.

Loans from related parties or unallowable borrowings must be excluded from the cost report borrowing balance schedule. The interest incurred on excluded borrowings must be removed from incurred interest costs in a like manner. Interest income or investment income which is required to be offset to interest expense in the cost report period must not be considered a reduction in the outstanding borrowing balance principle.

Mortgage principle balances or similar finance arrangements for the purpose of nursing facility or business acquisition must be separately identified from other loan balances in the cost report borrowing balance schedule. Examples of other loan balances include working capital and miscellaneous asset acquisition purpose loans. In the event of refinancing and co-mingling of separate loan balances into a single finance arrangement, the nursing facility must identify the appropriate portions of the combined financed amount used for different purposes and maintain the separation for cost reporting. Likewise, multiple loans for the same purpose must be combined for the appropriate category for cost reporting.



Borrowing principle obligations incurred by a home office must be reported on the individual nursing facility cost report borrowing balance worksheet only for loans directly associated with financing the individual nursing facility asset purchases or facility acquisition costs. The interest expense applicable to such loans must also be identified, directly charged to the individual nursing facility, and reported as interest expense for the nursing facility. Working capital and other loans incurred directly under the home office operation and not related to nursing facility acquisition are considered general administrative costs and are included, to the extent determined necessary and reasonable, in the home office cost allocation to the individual nursing facilities and other business operations of the corporate chain.

Allowable outstanding loan balances of landlord entities that are leasing nursing home facility assets to a provider must be disclosed and reported in the provider's annual cost report. Borrowings balance cost reporting and allowable cost policies are applicable to the reporting of the underlying cost of the landlord entity in the same manner had the borrowings been recorded on the financial records of the provider.

9.6 COST FINDING

Cost finding is the process of recasting the data from the accounts kept by a provider to determine the cost of services rendered, allocating direct costs, and prorating indirect costs in accordance with Medicare Principles of Reimbursement, except where modified by Medicaid policy. Medicaid determines reimbursement rates for nursing facility providers based on specific categories of cost, as addressed in other sections of this appendix.

9.6.A. COST ALLOCATION BASIS

The Medicaid cost reporting process establishes the cost finding process. Indirect and non-revenue producing cost centers are allocated using a statistical basis that reflects an equitable measurement of the services provided to, or benefits derived by, a revenue producing or non-reimbursable activity. The nursing facility must develop and maintain adequate statistical data to corroborate the basis of the cost allocation. Adequacy requires that the data be accurate and include sufficient detail to accomplish the purpose for which it is intended. When completing the allocation of the general service cost centers, the nursing facility provider should first allocate those cost centers that render the most services to, and receive the least services from, other cost centers.

9.6.A.1. FACILITY SQUARE FOOTAGE AND SPACE REPORTING

A facility space cost allocation is based on square footage identified with specific service areas or activities occupying and using that space. Square footage is an allocation base that may be applicable for multiple indirect cost center activities. However, for cost centers where the basis is the same (e.g., square feet), the total statistical basis over which the costs are to be allocated will differ because of the prior elimination of cost centers that have been allocated.

A consistent and uniform process must be used by the nursing facility for compiling and charging the square footage to each service activity that is primarily benefiting from or using that space. Facility space that is used for multiple activities must be documented and connected to each applicable activity based upon current data that reflects actual use and is available for audit verification. Hallway space located within a specific department or service area is considered usable space for that department. Areas of the



facility for general use, such as connecting hallways, reception areas, lobby, and elevator, used or benefiting all service activities are considered common space. Identifying and counting common space must be consistent for all service areas of the facility.

For example, common space in one service department cannot be excluded from space allocated to that service activity, while similar common space located in other service departments is included in the space allocation of other service activities. The allocation basis must apply either the gross method, where all common area is included and charged to the specific services activity, or the net method, where common space located within the identified service area is not charged to the service activity. The nursing facility's handling of common space area in the cost report allocation must result in equitable distribution of costs associated with the common space to appropriate activities. A change in the process or methodology that the nursing facility uses for allocating space is a change in allocation basis, so appropriate notice and a request must be made to the SMA.

9.6.A.2. ANCILLARY/THERAPY SERVICES SPACE REPORTING

Facility space used for ancillary services delivery must be identified and charged to the appropriate ancillary services cost center. For example, space used for skilled rehabilitation services provided based on a physician's order must be allocated to the appropriate ancillary cost center.

Accounting procedures must be established and implemented to reflect individual cost centers for reimbursable therapy and pathology services. Irrespective of the therapist or pathologist's status as an employee, contractor or independent provider, the nursing facility must record all charges as income and all expenditures for supportive personnel, equipment and its maintenance, supplies and other costs directly attributable to reimbursable expenses in these cost centers.

9.6.A.3. ANCILLARY/THERAPY SERVICES ADMINISTRATIVE OVERHEAD

Medicaid requires that administrative overhead associated with ancillary services be allocated to the ancillary services cost center. The required basis for distribution of administrative costs to the benefiting activities of the nursing facility is accumulated costs. The accumulated costs base generally includes all service activities of the nursing facility.

In specific situations, the nursing facility may request exclusion of certain ancillary service groups from the administrative cost overhead allocation in the Medicaid cost report. The determination applies only to those service items where the billing to the third party only allows for the recovery of the direct cost of the service. The provider must demonstrate considerable inequity of the overhead cost allocation to these service activities that have been identified as excluded groups under the Medicare Principles of Reimbursement and that it is not incurring additional costs beyond the activity for arranging for the services. The incidental costs for inclusion of the ancillary service bill preparation must be as follows:



- The facility representatives arrange for the services to be performed by an agency or entity that is not part of the nursing facility operation.
- The nursing facility is not directly involved in providing the ancillary service.
- The nursing facility does not incur any costs for supplies and equipment necessary to perform the service.
- The ancillary service is being recorded through the accounting records and billing system of the nursing facility for the consolidated billing of the services provided to the nursing facility resident.
- The nursing facility does not have physical space dedicated for the purpose of delivery or rendering of the ancillary service. Dedicated space is considered space that is used predominantly for the purpose of the ancillary service delivery.
- The nursing facility is not charging a mark-up related to the billing of the service.

If the nursing facility is allowed to bill for, or recover revenue in excess of, the direct cost of the services, the statistical and fiscal worksheet of the cost report may be adjusted to reflect the revenue received. The amount of revenue exceeding the direct cost will be considered the overhead amount that must be reflected as an adjustment to the "miscellaneous expense" in the Administrative and General cost center, in addition to the direct cost adjustment to exclude the ancillary service cost from the cost allocation step-down. The nursing facility must demonstrate that the excess revenue is a fair representation of the overhead cost or activity associated with providing the service. If this requirement is not met, the ancillary services activity must be included in the administrative cost allocation basis for the apportionment of overhead to the activity.

9.6.A.4. ANCILLARY GROUP EXCLUSION

A provider may request an ancillary group exclusion. The exclusion request must be approved by RARSS. The request must include the parameters under which the exception is requested. If the request is approved by RARSS and it is later determined non-applicable, the exclusion is void for that entire cost report period.

9.6.A.5. CHANGE OF OWNERSHIP – EXCLUSION REQUEST

If a CHOW occurs, the prior owner's ancillary group exclusion is no longer applicable. The new owner may submit an ancillary group exclusion request to RARSS for approval. The exclusion process is outlined in the Ancillary Group Exclusion subsection of this appendix.

9.6.B. CHANGE IN COST ALLOCATION BASIS

A provider who wishes to change the allocation basis for a particular cost center, or the order in which the cost centers are allocated, must submit a written request to the RARSS. (Refer to the Directory Appendix for contact information.) The request must include reasonable justification and supporting documentation that the new basis is more accurate and appropriate for allocation of the cost activity for Medicaid reimbursement determination. The request must be made prior to the beginning of the cost-reporting period in which the change is to apply. The effective date of the change will be the



beginning of the cost-reporting period for which the request has been made. Failure to submit a timely written request will result in an audit adjustment. The nursing facility provider must maintain both prior and proposed statistics base data until the change is approved.

Medicaid may reject a submitted cost report if a request to change the allocation basis has not been submitted and approved by RARSS. If the previous allocation basis methodology has not been maintained for the current year, Medicaid may accept previous year's statistics for the current year cost reporting.

9.6.C. RELATED OR CHAIN ORGANIZATION COST ALLOCATION [CHANGES MADE 4/1/20]

The Medicare Principles of Reimbursement define a related organization as an organization linked to a nursing facility provider by common ownership or control, including a chain organization. Medicaid extends an option for cost allocation for related or chain organizations. An immediate family relationship establishes an irrefutable presumption of relatedness.

For Medicaid purposes, a chain organization consists of a group of two or more nursing facilities, or at least one nursing facility and any other business or entity owned or operated and controlled by one organization. To the extent that the home office furnishes services related to patient care to the nursing facility, the reasonable costs of the services are included in the nursing facility's cost report. Medicaid policy for related organization costs is determined in accordance with provisions in the federal Provider Reimbursement Manual for related organization costs. Exceptions to the application of federal provisions are addressed in the Cost Classifications and Cost Finding and the Allowable and Non-Allowable Costs sections of this appendix.

Home office costs apportioned to individual nursing facilities through the Home Office Cost Statement are classified as support costs. Cost report requirements for home office are addressed in the Cost Reporting section of this appendix.

Costs incurred by a nursing facility for services furnished by a related organization are allowable. The cost allocated to the nursing facility cannot exceed the price of comparable services, facilities, or supplies that could be purchased in competitive market conditions. The principles of reimbursement applied for the determination of allowable cost to the nursing facility are also applicable to the related organization. If a cost would be unallowable to the nursing facility, it would be unallowable to the related organization.

The operating costs of a related ownership organization are allocated to an individual nursing facility as a "purchased service" and must be identified within the appropriate cost center for Medicaid cost reporting. The type of service determines if the costs qualify to be apportioned between base and support cost using the industry-wide base and support cost percentages. If the service does not qualify to be apportioned by this method, the allocated costs are classified as support costs in the individual nursing facility. Refer to the Cost Classifications and Cost Finding section of this appendix for additional information.



(text deleted per bulletin MSA 19-28)

For cost reports where the home office and the individual nursing facility's fiscal year ends are different, a provider must elect to forego the inclusion of an allocation of the current year's home office costs in the current year's individual provider cost report. A written request must be submitted annually to RARSS, with the individual provider's cost report signed by the appropriate corporate official acknowledging that the cost report is being submitted with the prior fiscal year's home office costs. The written request must also indicate that the corporation is waiving the right to inclusion of any allocation of the current year's home office costs in the current year's individual provider cost report.

For example, a home office fiscal year end (FYE) is December 31 and the individual facility's FYEs are May 31, August 31, September 30 and December 31. For individual facility cost reporting for fiscal year 2018 ending in May, August, September and October, the individual facility must elect to report only the home office costs from the FYE December 31, 2017 home office cost report. The home office allocation of costs from FYE December 31, 2017 to the individual facility would be reported and audited. During the audit of the individual facility cost report, adjustments to allocate actual FYE December 31, 2018 home office costs would not be made. For individual facilities with FYE December 31, 2018, the home office costs from the FYE December 31, 2018 cost report would be reported. **(revisions per bulletin MSA 19-28)**

9.7 DISTINCT PART UNIT REPORTING

For reimbursement purposes, the Nursing Facility is defined as the unit that is certified for participation in the Medicaid program, whether that unit comprises all of, or a distinct part of, a larger institution.

Certification regulations require that a distinct part be physically distinguishable from the larger institution and fiscally separate for cost reporting purposes. The provider must demonstrate to Medicaid that the system used for recording the hours of nursing services can be audited and equitably allocates the nursing services costs between the distinct part and other parts of the facility. The nursing services costs are only the gross salaries and wages of nursing and related personnel, such as RNs, LPNs, and CNAs. Costs applicable to general services areas of the institution must be allocated in accordance with the Cost Finding section of this appendix.

Nursing services costs allocated to that distinct part of the facility must relate only to services provided to those residents. While a provider may choose the record keeping method used to allocate these costs, the system must be capable of accurately reflecting the hours of nursing service applicable to the distinct part and other parts of the institution. Various systems may be employed to record and accumulate the hours of nursing services such as actual time spent taken from payroll records, assignment schedules, sign-in sheets, etc. Providers wishing to use any other method that does not identify actual time must obtain written approval from the RARSS prior to changing its cost allocation method. The request must identify the reason for the change and must demonstrate that the proposed method is representative of actual nursing staffing within the facility and results in an equitable and accurate allocation of nursing services costs.

A nursing services cost allocation alternative may be applied only with the prior written permission from RARSS.



An institution may have more than one Medicaid distinct unit in specific cases where Medicaid has certified beds as special use for specialized nursing care. The specialized nursing care beds must be physically distinguishable, within a designated area, and identified as a separate nursing bed class for Medicaid reimbursement. Requirements for reporting nursing services costs also apply to nursing services for residents in specialized nursing care beds. The nursing facility must have prior approval from Medicaid for participation in a program for specialized nursing care.

9.8 DAY CARE SERVICES PROVIDED IN THE NURSING FACILITY

According to federal principles, day care services provided to an employee's dependent are not a fringe benefit when furnished for the convenience of the provider. Medicaid considers day care services provided to an employee's dependent a convenience to the provider due to potential support of staff recruitment and retention.

9.8.A. EMPLOYEE DEPENDENTS

According to federal principles, the costs of operating a day care center for the children of a facility's or related facility's employees must not be reported as an employee fringe benefit. The costs are allowable to the extent that the amount is reasonable. "Reasonableness" means that the services are provided in accordance with the policies and regulations established for the provision of such services and must take into account both direct and indirect costs. The provision of services must also be considered reasonable in that the costs of operating a facility demonstrate sufficient benefits. For example, the number of children participating justifies the provision of services.

Total cost must not exceed what a prudent and cost conscious buyer pays for like services. If costs are determined to exceed such level and the nursing facility cannot provide clear evidence that the higher costs were unavoidable, the excess costs are not allowable. The day care center operations must be provided in accordance with, and satisfy applicable regulatory requirements governing the operations of, such activities. The nursing facility must maintain accounting records and documentation to demonstrate the total cost and utilization of day care services.

The following costs are non-allowable:

- diapers
- oils
- towelettes
- similarly used hygiene products
- lotions

9.8.B. SERVICES PROVIDED TO NON-EMPLOYEE DEPENDENTS

If a provider renders services to non-employee dependents, the day care center must be established as a separate entity even if services are also provided to employee dependents. Medicaid will allow costs relative to intergenerational activities as an offset when the day care center suffers a financial loss, which is limited to the lesser of total documented intergenerational activities or the amount of the loss. Intergenerational activities must be documented, organized activities between the children attending the day care and the nursing facility residents.



The nursing facility must maintain accounting records and documentation to demonstrate the total cost and utilization of day care services.

9.9 NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAM (NATCEP) AND COMPETENCY EVALUATION PROGRAM (CEP)

The Omnibus Budget Reconciliation Act (OBRA) of 1987 and 1990 requires that any nurse aide employed in a nursing facility complete a competency evaluation program. Medicaid will reimburse a Medicaid certified nursing facility for the Medicaid share of allowable costs directly related to meeting the nurse aide training and competency evaluation requirements. Reimbursement includes only costs incurred with a NATCEP or CEP approved by the SSA. Medicaid reimbursement applies only to Certified Nurse Aides (CNA) working in a Medicaid certified nursing facility and are not available to CNAs in other residential or patient care settings.

A nurse aide who is employed by a nursing facility or who has received an offer of employment from a nursing facility on the date on which the nurse aide begins a NATCEP may not be charged for any portion of the cost of the program. The nursing facility must reimburse newly employed CNAs who have personally paid for NATCEP or CEP costs prior to employment in the facility, in accordance with criteria identified in the Nurse Aide Reimbursement section of this appendix. Medicaid in turn reimburses the nursing facility.

Providers may obtain reimbursement from Medicaid for CNA costs. The reimbursement process and necessary forms are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

9.9.A. NURSE AIDE COMPETENCY EVALUATION PROGRAM AND NURSE AIDE REGISTRY

Nurse aide candidates must pass both a clinical skills test and a knowledge test in order to become certified. Fees for the individual nurse aide to take the tests, and retake each test up to three times, are allowable costs for nursing facility reimbursement. Refer to the Nursing Facility Reimbursement and Nurse Aide Reimbursement subsections of this appendix.

When a nurse aide has successfully passed the CEP, their name is placed on the Michigan Nurse Aide Registry. Fees relating to initial registration and biennial registry renewal are allowable costs for nursing facility reimbursement. For currently employed nurse aides, the nursing facility is responsible for the direct payment of biennial registry renewal fees. Refer to the Nursing Facility Reimbursement and Nurse Aide Reimbursement subsections of this appendix.

Information about training requirements, competency evaluation program and registry data is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

9.9.B. NURSING FACILITY REIMBURSEMENT

Reimbursement to the nursing facility for NATCEP related costs is calculated as an add-on to the routine per diem rate. The Nurse Aide Training and Testing Program Interim Reimbursement Request (MSA-1324) and instructions are available on the MDHHS



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website. The total NATCEP add-on amount will be adjusted through the annual cost report settlement process. The Medicaid share of the costs is computed based on the ratio of Medicaid resident days to total resident days for all nursing care provided in the facility during the cost report period. Refer to the Cost Report Reimbursement Settlement section and the Rate Determination section of this appendix for additional information.

The NATCEP cost center on the Medicaid cost report must be used to report the following:

- Costs of conducting a nursing facility based NATCEP.
- Costs of having employees participate in an approved NATCEP outside the nursing facility.
- Costs of employee competency testing by a regional testing facility.

The costs and staffing levels relating to and charged to the NATCEP cost center must not be included in the nursing facility determination of routine nursing care costs.

The determination of allowable NATCEP costs is made in accordance with provisions in the federal Principles of Reimbursement established for the Medicare Program, and cost limitations in Medicaid policy. Training and evaluation program costs claimed for services and supplies furnished to or purchased by the facility from related organizations must adhere to related party allowable cost principles. The cost of such transactions must not exceed the cost of like items or services in an arms-length transaction with a non-related organization, or the actual cost to the related organization, whichever is lower.

The following are not NATCEP costs and must be classified as routine nursing care costs on the cost report:

- Administrative overhead in a facility-based training program.
- Space costs in a facility-based training program.
- Uniform allowance costs.
- Required in-service training.

NATCEP and CEP allowable cost must only include the costs of activities or items that are directly related to providing approved training and the competency evaluation process. The following table contains eligible training and evaluation activities.

Training Staff	<p>Salaries and wages, employee benefits and payroll taxes for conducting training and evaluation activities, including supervised practical training, and direct time devoted to development and preparation for conducting the NATCEP.</p> <p>Payroll costs allowed for NATCEP do not include the cost of time that the training staff devote to routine in-service training activities, general nursing administration or direct patient care, except for supervised practical training. These costs must be classified as routine nursing care cost for consideration in the routine per diem rate.</p>
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Training Consultants	Costs incurred for non-facility staff to assist in developing and conducting the facility's NATCEP.
Student Staff	Salaries and wages, employee benefits and payroll taxes incurred for the time the student is enrolled in the approved training program, i.e., classroom and required supervised practical training. A reasonable time allowance for student employees traveling to and from the off-site training location or competency evaluation, in accordance with a nursing facility's established and documented travel policy, is allowable as NATCEP cost. Payroll costs allowed for NATCEP do not include the cost of staff time for patient care activities that the nurse aide is performing during the period the student is completing the training program. These costs must be classified as routine nursing care cost for consideration in the routine per diem rate.
Training Program Supplies	Costs of supplies and materials used in conducting an approved NATCEP.
Training Program Transportation	Travel or transportation costs incurred by facility staff in conducting the NATCEP activity, and for transportation or travel reimbursement to student staff for off-site NATCEP or CEP attendance. Refer to the Facility Vehicle and Transportation, Allowable and Non-Allowable Cost section of this appendix for mileage allowance provisions. Use of a facility owned vehicle for staff transportation for training is not charged to NATCEP. Facility vehicle operation cost must be classified as administrative overhead and is considered in the routine per diem rate.
Outside Contracted NATCEP Paid Directly by the Facility	Cost to obtain approved nurse aide training of facility employees by an outside entity approved NATCEP. The nursing facility is responsible to ensure that the contractor is an approved NATCEP.
Outside Contracted NATCEP Costs Reimbursed to Employee	Cost for reimbursement to an employed CNA who had personally paid for an approved NATCEP participation and completion prior to being employed in the facility. Refer to the Nurse Aide Reimbursement subsection of this appendix for additional information.
Competency Evaluation Fees Paid Directly by the Facility	Fees paid by the nursing facility to a State-approved competency evaluator. This includes testing and retesting fees, rescheduling fees, and nurse aide registry.
Competency Evaluation Fees Reimbursed to Employee	Cost for reimbursement to an employed CNA who had personally paid for State-approved competency evaluation and registration fee prior to being employed in the facility. Refer to the Nurse Aide Reimbursement subsection of this appendix for additional information.
Miscellaneous Costs	Allowable costs that are not specifically identified in another category include, but are not limited to, the following items: <ul style="list-style-type: none"> ▪ Rental costs for space located out of the facility are allowable only if the space is used solely for the training and competency evaluation program. Space costs not meeting this requirement are reimbursable with the Plant Cost Component of the routine per diem. ▪ Reasonable rental expense for training equipment necessary for conducting an approved training program. ▪ Nurse aide biennial Registry Document renewal fees for current employees.



Equipment Purchased	Equipment purchased and used specifically for the nursing facility based NATCEP are reported as NATCEP cost center costs for Medicaid cost reporting and reimbursement purposes. NATCEP equipment costing less than \$5,000 may be expensed in the year of acquisition and reported in the NATCEP cost center. Equipment acquired as part of an integrated system costing greater than \$5,000 must be amortized at an annual rate of 15% for each cost reporting year the equipment is used in the NATCEP, up to a maximum of seven years. Instructions for NATCEP equipment reporting are included in the annual cost reporting instructions.
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9.9.C. NURSE AIDE REIMBURSEMENT

A nursing facility must reimburse a newly hired CNA if the CNA paid for nurse aide training, competency evaluation and registry, and completed the approved training program within 12 months prior to employment in that facility. The nursing facility is not required to reimburse the CNA in cases where the expenses were paid by an employment or education training program or were reimbursed by the CNA's previous employer. The nurse aide should not be reimbursed for more than 100 percent of the NATCEP or CEP costs they paid.

The nursing facility is responsible to ensure that a newly hired CNA who requests reimbursement of training and testing expenses has not already received payment for these costs. An aide who paid for any of these eligible costs and received payment of a portion of the expenses from prior facility employment is eligible for only the remaining balance from the new employer.

The CNA must request reimbursement by submitting to the nursing facility the Nurse Aide Training and Competency Evaluation Program, Certified Nurse Aide Training Reimbursement form (MSA-1326), available in the Forms Appendix and on the MDHHS website. The reimbursement should be requested within the first six months of employment or work as a certified CNA.

NATCEP costs that are eligible for reimbursement to the individual nurse aide include:

- Training program cost including fees for textbooks and required course material up to a maximum of \$650. Medicaid will update the maximum allowable reimbursement limit effective October 1, 2006 and biennial thereafter, based on the Global Insight's Skilled Nursing Facility Market Basket Without Capital Index corresponding to that update period. The training program maximum reimbursement amount will be updated biennially on the RARSS website.
- Competency Evaluation Program testing fees, including retesting fees; CEP testing required due to the nurse aide registry document expiration; and rescheduling fees.
- Registry or Registry Renewal Document fees that the CNA personally paid within 24 months prior to being employed in the nursing facility.

For cost reporting and audit purposes, the nursing facility must maintain a copy of the MSA-1326 signed by the employee and documentation reflecting reimbursement to the employee. This documentation must include a copy of a receipt for cash payment, a copy of a cancelled check, or a credit card receipt showing the amount paid by the nurse



aide and the date of payment, as well as copies of the nursing facility's cancelled checks disclosing reimbursement to the employee.

The nursing facility has the option to reimburse the individual via a one-time payment or payment installments. The reimbursement to the individual, regardless of full-time or part-time employee status, must be fully paid within six months of the individual's date of employment, or must be prorated based on their dates of employment in the facility if employed for less than six months. If the nursing facility fails to reimburse a CNA employed in the facility within this timeframe, the unpaid balance will not be an allowable NATCEP or routine nursing care cost. This determination does not relieve the nursing facility of its obligation to reimburse the nurse aide. Wages may not be reduced to offset the facility's obligation to pay the nurse aide for training, competency evaluation, and registry costs.

The nursing facility is not obligated to pay the remaining balance of nurse aide training costs at the time an employee who has worked less than six months leaves facility employment. The CNA has the opportunity to recoup the non-reimbursed costs through subsequent employment at other nursing facilities. The facility should properly record payments so that the unpaid amount is not carried as a payment obligation.

9.9.D. NURSING FACILITY LOCKOUT AND LOSS OF NATCEP APPROVAL

A provider with a facility-based training CNA program is not eligible for Medicaid reimbursement of training costs when it has been issued a final notice from CMS or the SSA of the withdrawal of NATCEP approval, or of a NAT prohibition (lockout). For Medicaid reimbursement purposes, the lockout effective period coincides with the SSA period notice to the nursing facility. The nursing facility must not claim Medicaid reimbursement for costs associated with any facility-based training class beginning after the withdrawal or lockout effective date identified in the final notice. Nurse aide students beginning training prior to the withdrawal effective date are allowed to complete training, and the related costs to complete that training class are eligible for NATCEP reimbursement. Nurse aide training costs incurred for that facility based program subsequent to completion of that student class are not allowable NATCEP costs. This disallowed cost is also not allowable under routine nursing care cost.

Although the nursing facility experiencing approval withdrawal or lockout status cannot conduct its own training, the nursing facility must provide and reimburse for training and competency evaluation of its new nurse aide employees at approved sites. Such costs are eligible for Medicaid cost reporting and reimbursement in the annual cost report under the appropriate NATCEP cost categories. Nurse aide reimbursement for eligible training and competency evaluation personally paid expenses are allowable to be reported as NATCEP cost in the nursing facility annual cost report.

In the event that the nursing facility has been granted a waiver for a NAT program prohibition or lockout by the SSA, the nursing facility must comply with the provisions of the nursing facility waiver request and the requirements set forth by the SSA in the waiver approval. The facility-based NATCEP operating under a waiver is subject to audit by Medicaid for compliance with these requirements. If the nursing facility fails to conduct the program in accordance with these requirements, the training program



expenses are not allowable costs for NATCEP or routine nursing cost reimbursement by Medicaid.

9.10 BEAUTY AND BARBER SERVICE COST CENTER

Personal services for residents, such as simple barber and beautician services (e.g., shaves, haircuts, shampoos, and simple hair sets), that residents need are considered routine patient care. The provision of such services is reimbursed in the routine per diem rate when provided routinely without charge to the resident in the nursing facility. Personal services provided by a professional beautician or barber are unallowable costs.

If the nursing facility designates an area for providing non-routine personal hygiene services, such as professional manicures, or hair styling, costs must be separately reported and accounted for in the cost report. Direct and overhead costs related to these services must be separately accounted for in this special services cost center and should not be included in the cost of providing routine nursing care.

9.11 SPECIAL DIETARY COST CENTER

Medicaid provides for reimbursement outside the per diem rate to non-profit nursing facilities for the cost of meeting residents' special dietary needs for religious reasons. Nursing facilities requesting reimbursement must report these costs as a separate cost center in the Medicaid annual cost report. Direct costs may include food purchase, salary and wages for the extra staff time for preparation, supplies and kitchen utensils necessary for preparation and service. The costs applicable to plant operations costs related to the special dietary needs will be determined through the Medicaid cost finding process.

9.12 HOSPITAL LEAVE DAYS

A separate accounting of costs incurred due to hospital leave days is not necessary.

9.13 NON-AVAILABLE BEDS

In special circumstances, nursing facility beds may be designated "non-available for occupancy" for Medicaid cost reporting when the patient care rooms in which the beds are located are not used for resident care. Beds with a "non-available" designation remain licensed or certified; the designation is for Medicaid cost reporting and reimbursement determinations only. An approved non-available bed plan reduces the total number of beds used for calculating available bed days for the annual cost report period coinciding with the period of the non-available bed plan. Non-available beds must be located in a discrete area and readily identified for statistical cost reporting. During the period the area is designated non-available for patient care, Medicaid does not reimburse for variable and plant costs attributed to the area designated as having non-available beds.

9.13.A. QUALIFYING CRITERIA

A non-available bed plan must include all of the licensed beds in a patient care room. The rooms must be a discrete area and primarily consist of a contiguous physical arrangement of rooms. Rooms may not be a random collection of individual rooms or beds located throughout the nursing facility.



Common physical space located adjacent to or within the designated rooms area will normally be included in the designated non-available bed area. Planned use of any common areas within the designated non-available bed area must be disclosed in the written notice to the RARSS.

Rooms with non-available beds may not be used for resident care service regardless of payer source nor can the space be used for any other normally reimbursable purpose.

Resident rooms that are not used for resident care do not qualify for non-available bed designation. Although the rooms may be used for alternative services, the beds located within the room area must continue to be counted as available for resident care. Physical plant area used for alternative use must appropriately be charged to the applicable alternative services cost center if the services activity results in ancillary care services or other revenue services.

The written request must be submitted within 30 calendar days of the date that the provider removes the beds from service.

9.13.B. WRITTEN NOTICE AND REQUEST FOR PLAN APPROVAL

The provider must submit a written request for a non-available bed plan to RARSS. The RARSS must receive the request within 30 calendar days of the date that the beds are to be removed from resident care service. Non-available bed plan requests will not be approved on a retroactive basis. (Refer to the Directory Appendix for contact information.)

The written notice from the provider to RARSS must:

- Indicate the date that the beds will be removed from resident care service and the expected duration of the non-available plan.
- Indicate the reason for the request.
- Include a floor plan of the facility that marks the beds to be designated as non-available.

The RARSS will review the request and provide a written response of approval, denial or a request for additional information. If approved, the RARSS will notify the SSA of the non-available bed designated rooms and effective period.

9.13.C. LIFE OF AN APPROVED PLAN

Beds must remain non-available for not less than the balance of the provider's fiscal cost reporting year in which the beds are deemed non-available plus the entire following fiscal year. An exception is when the non-available bed plan is effective on the first day of the provider's fiscal year. The cost report year may qualify as the entire period of the non-available bed plan if the cost report period is not less than twelve months.

Non-available bed designations will be effective on the first day of the month. If the notice is not received within the required 30 calendar day period, the plan will become effective on the first of the month in which RARSS received the notice if the beds have not been utilized during that month.



The initial period of the non-available bed plan expires upon completion of the minimum required period.

The nursing facility may request up to two extensions of 12 months each following this minimum period. The agreement may be extended on the basis of the provider's fiscal year. A request for extension must be submitted in writing to the RARSS 30 calendar days prior to expiration of the initial plan. The request for a second extension must be submitted to RARSS 30 calendar days prior to expiration of the first extension. The requests must include at least one of the following items:

- The same rooms and bed area.
- A revision to bring some, but not all, of the beds back into service (if applicable).
- A revision to increase the number of non-available beds that includes all of the beds already designated as non-available.
- A change in the room and bed designation area that is equal to the number of beds designated as non-available in the initial plan.

Requests for a revision to bring some, but not all, beds back into service must include:

- The same rooms and the same bed area.
- If applicable, the change in room and bed designation area that is equal to the number of beds designated as non-available in the initial plan.

The extensions must meet the elements of the qualifying criteria, notice requirements and related policy for initial non-available bed requests.

Non-available bed plans expiring on or after April 1, 2005 are limited to two 12-month extensions. When a provider's initial or extended non-available bed plan ends, the nursing facility must return the beds to service or decertify the beds from Medicaid participation. Medicaid will not approve a non-available bed plan that substitutes beds elsewhere in the facility for the formerly non-available beds.

The nursing facility will not be eligible to submit a new non-available bed plan for 24 months following the expiration of the previously approved plan.

A provider may only request a grace period after the final extension period if the provider can demonstrate progress to place the non-available beds into resident care service. The request for a grace period must be made to LTC Services 30 calendar days prior to the expiration of the final extension period. (Refer to the Directory Appendix for contact information.) The request for a grace period must be submitted before expiration of the final extension period, and must meet the elements of the qualifying criteria, notice requirements and related policy for initial non-available bed requests. The request must specify the date that the beds will be available for occupancy and may not exceed 12 months. An example for such action is gradual facility renovation involving periodic non-available beds in a nursing unit and replacement with non-available beds in another unit as renovation plans progress.



Nursing facilities holding a written agreement with an accredited medical school instructing students in providing geriatric care may request consideration for an exception to policy in this subsection (Life of an Approved Plan). Requests must be submitted in writing to the MDHHS LTC Reimbursement and Rate Setting Section (RARSS) and should outline the provisions of the agreement, stating that the medical school staff determines admissions into the program and facility. The request must establish an area in the facility that is a distinct unit for the purpose of conducting the educational program, and the area must continue to meet all other non-available bed plan requirements. A copy of the agreement or contract between the facility and the medical school must be provided to RARSS with the exception request. If the agreement or contract undergoes change, a copy of the new terms of agreement must be submitted for approval prior to implementation.

All requests for an exception to policy will include a review of the facility's historical and current survey performance. Criteria regarding survey history (found in the Criteria for Evaluation of Medicaid Bed Certification Applications subsection of the Nursing Facility Certification, Survey & Enforcement Appendix of this manual) are also applicable to this exception request.

The provider must meet all appropriate certification requirements for distinct part units for the remaining Medicaid beds. Additional beds may have to be decertified in order to meet the distinct nursing unit requirements. The nursing facility may request re-certification of these beds for Medicaid participation after a 24-month period. A request to re-certify must meet all current Medicaid certification requirements.

9.13.D. CHANGE OF OWNERSHIP (CHOW)

The non-available bed plan approval expires with a change of ownership of the nursing facility. If the new owner wishes to continue the non-available bed plan, they must submit a written request to the RARSS within 90 calendar days of the CHOW. A non-available bed plan submitted after the 90-day period will be considered a new request and must satisfy the qualifying criteria and related policy requirements. If the new owner does not request continuation of the existing plan, the beds will be deemed available for occupancy effective with the date of ownership change.

The new owner may apply to extend the plan to coincide with its cost reporting period by following the extension request policy outlined in the Life of an Approved Plan subsection. The nursing facility change of ownership does not relieve the nursing facility from the restrictions for non-available bed designation limitations for plan extensions other than allow for coinciding with the cost report year of the new ownership.

9.13.E. AMENDING A PLAN

The nursing facility may amend an approved non-available beds designation by submitting a written request to the RARSS. (Refer to the Directory Appendix for contact information.) A non-available bed plan may be amended only one time during the life of the non-available bed plan. A request for an amendment must include the same information as an initial request and will be reviewed using the same criteria. A plan amendment increasing the number of non-available beds is subject to the minimum



period requirement and the designation of all the beds must be effective for the period of not less than the balance of the provider's current fiscal cost reporting year in which the beds are deemed non-available plus the following fiscal cost report year.

A nursing facility holding a written agreement with an accredited medical school that instructs students in providing geriatric care may be permitted to amend a non-available plan more than once in the plan's approved period. Requests to amend a plan under these circumstances must adhere to the requirements outlined in the Life of an Approved Plan subsection of this appendix. As noted, all requests will include a review of the facility's historical and current survey performance consistent with the Criteria for Evaluation of Medicaid Bed Certification Applications subsection of the Nursing Facility Certification, Survey & Enforcement Appendix of this manual.

9.13.F. PENALTY FOR USE OF NON-AVAILABLE BEDS

Admitting residents to any beds in the area designated non-available for occupancy, regardless of payer source, before the end of the plan negates the non-available bed agreement. All beds covered by a non-available bed agreement that is negated during the initial period of the plan will be considered available for patient care for the plan's entire initial period.

All beds covered by a non-available bed agreement that is negated during a plan's extension period will be considered available for patient care beginning with the first day of that cost reporting period of the extension.

9.13.G. RETURNING BEDS TO SERVICE

All of the beds in the non-available bed plan will be considered returned to service and available for occupancy when the non-available bed plan expires.

In special circumstances, such as a sudden increase in demand due to closure of a nearby facility, non-available beds may be returned to service before the end of the approved plan with prior approval of the RARSS. A nursing facility with an approved non-available beds plan may submit a written request to return beds to nursing care if the individual nursing facility experiences the need for the beds due to the exception circumstances. The request must identify the reason for the need and the specific beds and room designations being made available. RARSS will provide immediate review and response to the nursing facility request.



9.13.H. PLANT COST CERTIFICATION

A provider with an approved non-available beds plan has the option to submit to a Plant Cost Certification for the cost report fiscal period in which the beds are approved as non-available for occupancy or the termination of the plan. Refer to the Plant Cost Certification Section in this appendix for additional information.

9.13.I. COST REPORTING

The variable and plant costs attributed to the area designated as non-available and the related capital asset cost are not Medicaid reimbursable costs. The non-available rooms and bed numbers must be reported as a Non-Available Beds cost center on the provider's Medicaid cost report.

Each general service cost center must be evaluated separately to determine if the non-available bed area benefits from the service. The nursing facility may charge specific costs to the Non-Available Beds cost center only when the dollar amount is identifiable. Costs that cannot be specifically identified must be apportioned to the non-available beds cost center using the Medicaid cost report allocation methodology. The statistic or measure used for the general services cost center must also be used to allocate costs to the non-available bed cost center.

Example: If square feet are used to allocate costs to the housekeeping activity, the general services cost center, then square feet must also be used to allocate costs to the non-available bed area. The allocation to the non-available bed cost center is zero when the non-available bed area receives no benefit from the general service.

Example: If a wing is designated as non-available and does not receive any housekeeping services, then the allocation to the non-available cost center is zero.

The reduction in available beds is included in the provider's cost report effective for the fiscal period in which the non-available bed plan is approved by the RARSS. For Medicaid reimbursement determination of tenure and allowable average borrowings, the percentage of the total plant asset costs applicable to available beds must equal the percentage of the facility remaining available for resident nursing care.

9.14 COMPLEX CARE

Medicaid-approved complex care cases provide an enhanced reimbursement rate to the facility due to the cost and/or complexity of nursing care or special needs of the beneficiary. Separate cost records are not required for identifying these costs. The Program has designated the special care revenue amount equal to cost. Providers with an approved complex care case must adjust the annual Medicaid cost report by removing the dollar amount of the total difference between reimbursement at the complex care rate and the established routine Medicaid rate from the appropriate nursing care costs. The approved complex care rate is identified on the Complex Care Prior Approval-Request/Authorization for Nursing Facilities form (MSA-1576) issued to the facility for the specific beneficiary.



9.15 QUALITY MEASURE INITIATIVE (QMI) SPECIAL COST REPORTING REQUIREMENTS

The nursing facility QMI provides payments to facilities based on their average quality measure domain rating on the Nursing Home Compare (NHC) website. For additional information about the QMI, refer to the Nursing Facility Quality Measure Initiative (QMI) subsection of the Rate Determination section of this Appendix.

The Quality Assurance Assessment Program (QAAP) tax levied for the QMI and the payment amount of the QMI are to be reported on the cost report the year they are applicable and in the following manner:

- The QAAP tax assessed during the cost reporting period is to be reported on the "Quality Measure Initiative Assessment" line of the cost report under the Administrative & General cost center.
- The amount of QMI payments in a cost reporting period are to be reported on the "Quality Measure Initiative Payment" line of the cost report under Routine Services Revenue.

The QAAP tax assessed is adjusted from the cost report in accordance with the Quality Assurance Assessment Tax subsection of the Allowable and Non-Allowable Costs section of this Appendix. An adjustment is also made to the cost report to remove the Net QMI Amount. The QMI adjustment may not exceed zero (i.e., the adjustment is either a negative amount or zero), and the adjustment amount is made to "Miscellaneous – Base" in the Medicaid Routine Care Unit #1 cost center of the cost report.

Example: Facility A had \$150,000 in QMI QAAP tax assessed and \$250,000 in QMI payments during their 2019 cost reporting period, so Facility A would apply a -\$100,000 adjustment to the "Miscellaneous – Base" line in the Medicaid Routine Care Unit #1 cost of their 2019 cost report.

Example: Facility B had \$150,000 in QMI QAAP tax assessed and \$100,000 in QMI payments during their 2019 cost reporting period, so Facility A would not apply an adjustment to the "Miscellaneous – Base" line in the Medicaid Routine Care Unit #1 cost of their 2019 cost report.



SECTION 10 - RATE DETERMINATION [CHANGE MADE 4/1/20]

There are six classes of nursing care facilities for which there are specific reimbursement methods. For a definition of the six classes, refer to the Definitions section in this appendix. Providers reimbursed for care using a special reimbursement calculation or method are addressed at the end of this section.

The determination of a nursing facility's class is made by the SSA. If a nursing facility changes ownership or the services it provides such that a change in class is appropriate, the facility will be reimbursed according to the respective facility class to which it has been changed. The effective date of the reimbursement change is the effective date of the SSA's determination. Nursing facility providers other than Class IV are reimbursed under a methodology that pays the lower of the customary charge to the general public or a prospective payment rate determined by Medicaid.

Payment rates described in this section refer to the provider's prospective per resident per diems and are generally set 30 calendar days in advance of the State's fiscal year, which is October 1 through September 30. (Rate determination timing is dependent on legislative approval of the MDHHS budget.)

NOTE: An illustration of the timeline and calculations for per diem rate setting is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

Prospective payment rates are calculated using the facility's cost report ending in the previous calendar year. If the cost reporting period of the Medicaid routine unit is less than seven months, the cost report used for rate setting is the most recent cost report available prior to the previous calendar year that covers a period of at least seven months. The cost reporting period may only cover dates the facility was enrolled in Medicaid and averaged six or more Medicaid residents per day. (revised per bulletin MSA 19-28)

The reimbursement rate determination process uses a provider's most recent fiscal period audited cost data to calculate the routine nursing care per diem rate. If audited data is not available, an interim prospective rate is calculated using the filed cost report, if the cost report was acceptable and was filed with Medicaid within five months from the end date of the cost reporting period. If an acceptable cost report was not filed within this period, Medicaid is not required to set the prospective payment rate in advance of the State's fiscal year. If the nursing facility did not file within the five month period, or has amended an original cost report subsequent to the five month period, Medicaid will calculate the prospective rate for an effective date for services no later than the beginning of the fourth month (January 1) of the State fiscal year. Nursing facilities that are required to file an amended cost report in order to include home office costs that were not included in the original cost report due to the difference in cost reporting period from the home office are exempt from this provision. The amended cost report, if filed timely following the completion of the home office cost statement, will be considered filed timely if the original cost report had met the five month filing requirement. Refer to the Cost Classification and Cost Finding section of this appendix for home office cost statement and nursing facility amended cost reports.

10.1 RATE DETERMINATION PROCESS

The per diem reimbursement rate for Class I and Class III nursing facility providers is made up of three components: a plant cost component, a variable cost component, and add-ons.



- For Class I facilities, the plant cost component is made up of the Property Tax/Interest Expense/Lease Component plus the Return on Current Asset Value Component.
- For Class III facilities, the Plant Cost Component is the lesser of the Facility Per Patient Day Plant Cost or the Facility Plant Cost Limit. The Facility Plant Cost Component is the depreciation, interest and lease expenses calculated on a per patient day basis.
- For Class I and Class III facilities, the Variable Cost Component is made up of the facility's Variable Rate Base plus the Economic Inflationary Update.

Class II facilities, being proprietary nursing facilities for individuals with mental illness or intellectual disability, are reimbursed an all-inclusive prospective payment rate negotiated with the MDHHS State Mental Health Agency on an annual basis. Final reimbursement is a retrospective cost settlement, not to exceed a ceiling limit. The provider may be eligible for a reimbursement efficiency allowance in the final rate if total allowable costs do not exceed the prospectively established ceiling limit.

Class IV facilities, being state-owned and -operated institutions, Intermediate Care Facilities for Individuals with Intellectual Disabilities (Developmentally Disabled), and non-profit nursing facilities for individuals with intellectual disabilities, are reimbursed allowable costs determined in accordance with Medicare Principles of Reimbursement and are retrospectively cost settled.

Per diem rates for Class V facilities, Ventilator Dependent Care Units, are set prospectively. Services included in the per diem rate are outlined by contract with Medicaid.

Payment rates for Class VI Hospital Swing Beds are set prospectively as a flat per resident day rate determined by Medicaid.

10.2 RETROACTIVE RATE CHANGES [CHANGES MADE 4/1/20]

A retroactive rate change may be made for facilities that have interim prospective rates based on filed cost reports. Retroactive rate changes may be made for, but are not limited to, the following:

- audit adjustments to a filed cost report that was used for setting an interim rate;
- facilities that filed timely and were approved for Plant Cost Certification due to capital cost changes, an approved non-available bed plan, a plant rate affected by a DEFRA rate limitation for the cost report period, or when an interim rate was incorrectly calculated;
- audit adjustments that are required because of an appeal;
- audit adjustments that are required because of fraud or facility failure to disclose required financial information; and **(revisions per bulletin MSA 19-28)**
- Class I nursing facilities approved for Rate Relief for the rate year period.

The Plant Cost Component of a rate for the nursing facility that experiences a change of ownership will be retroactively adjusted under the Plant Cost Certification process. The DEFRA Reimbursement Limit application will continue to apply to each rate year until a fiscal year retrospective rate change results in zero DEFRA limit. The nursing facility Plant Cost Component will be calculated on a prospective basis for the year following the zero DEFRA limit rate year.



10.3 PLANT COST COMPONENT CLASS I NURSING FACILITIES

The prospectively established Plant Cost Component for each Class I nursing facility provider is the sum of the facility Net Property Tax/Interest Expense/Lease Component and Return on Current Asset Value Component. The Plant Cost Component is expressed as a per patient day amount.

10.3.A. NET PROPERTY TAX/INTEREST EXPENSE/LEASE COMPONENT PER PATIENT DAY

The Net Property Tax/Interest Expense/Lease Component per patient day is calculated under the following formula:

Property Tax/Interest Expense/Lease Plant Cost	-	CAV Excess Borrowings Limit	+	DEFRA Reimbursement Limit (not to exceed zero)	=	Net Property Tax/Interest Expense/Lease Plant Cost
Net Property Tax/Interest Expense/Lease Plant Cost	÷	Nursing Facility Resident Days	=	Net Property Tax/Interest Expense/Lease Plant Cost Per Patient Day		

10.3.A.1. PROPERTY TAX/INTEREST EXPENSE/LEASE PLANT COSTS

These plant costs consist of allowable costs for real estate and personal property taxes, interest expense, and lease expense defined under the Allowable and Non-Allowable Cost section and the Cost Classification section of this appendix. The aggregate dollar amount for these plant costs is obtained from the nursing facility cost report. The period of the cost report will correspond with the cost basis period identified for the respective State rate year.

10.3.A.2. CAV EXCESS BORROWINGS LIMIT

The CAV excess borrowings limit is unreimbursable interest due to excess borrowings. An example of the calculation is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

The dollar amount of allowable interest expense included in the reimbursable plant cost will be reduced if the nursing facility loan balance applicable to the nursing care unit exceeds the facility reimbursement limit. The nursing facility's average allowable borrowing balance cannot exceed the lesser of the "Nursing Facility Current Asset Value" or the "Nursing Facility Capital Asset Value Limit." If the nursing facility borrowing balance exceeds the limit, a reduction is made to the allowable plant cost for the portion of the excess borrowing. The amount of the reduction is based on the ratio of the limit amount to the average borrowings balance times the dollar amount of allowable interest expense. The following formula is applied to calculate the reduction:



$$\begin{array}{l}
 \boxed{\text{Lesser of (NF CAV) or (NF CAV LIMIT)}} \div \boxed{\text{Facility Average Borrowing Balance}} \times \boxed{\text{Total Allowable Interest Expense}} = \boxed{\text{Reimbursable Interest}} \\
 \left(\boxed{\text{Total Interest Expense}} - \boxed{\text{Reimbursable Interest Expense}} \right) = \boxed{\text{CAV Excess Borrowings Limit (N/A if less than zero)}}
 \end{array}$$

A nursing facility that has undergone a change of ownership and is incurring interest costs relating to the acquisition financing will be subject to a DEFRA Reimbursement Limit disallowance. The DEFRA Reimbursement Limit calculation will determine if the nursing facility acquisition and financing costs exceed the Medicaid allowable reimbursement increase limit. Reductions to the facility total borrowing balance are made to avoid including the borrowings balance in the reimbursable interest, and to avoid including the total allowable interest expense amount in both the DEFRA limit and the CAV excess borrowing limit.

If the nursing facility has a DEFRA Reimbursement Limit due to the nursing facility acquisition, the nursing facility's total average borrowing balance used in the calculation for CAV excess borrowings limit will be reduced by a calculated dollar amount of borrowings corresponding with the DEFRA Reimbursement Limit. The borrowing amount corresponding with the DEFRA Reimbursement Limit is calculated under the following formula:

$$\boxed{\text{Dollar Amount of DEFRA Reimbursement Limit}} \div \boxed{\text{Nursing Facility Total Allowable Interest Expense}} \times \boxed{\text{Nursing Facility Total Borrowing Balance}} = \boxed{\text{Reduction to NF Average Borrowing Balance}}$$

10.3.A.3. DEFRA REIMBURSEMENT LIMIT

Increases in reimbursement for tenure and interest expense subsequent to a sale or resale (after July 18, 1984) are limited under provisions of the Deficit Reduction Act (DEFRA) of 1984 as defined in federal Medicaid law. The Medicaid application of DEFRA provisions is a limit on the dollar amount of plant cost component reimbursement increase to the provider due to the nursing facility change of ownership. An established formula calculation is used to determine the new ownership's eligible increase reimbursement for tenure and interest (DEFRA Application Limit). If the new ownership tenure and interest increase before application of the DEFRA Reimbursement Limit does not exceed the DEFRA Application Limit, the DEFRA Reimbursement Limit is not applicable. If the new ownership tenure and interest increase before application of the DEFRA Reimbursement Limit exceeds the DEFRA Application Limit allowable increase, the DEFRA Reimbursement Limit reduction will be made to the allowable plant costs.



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The calculation is made as follows:

$$\boxed{\text{DEFRA Application Limit}} - \boxed{\text{Increase in tenure and interest for new ownership prior to DEFRA Limit}} = \boxed{\text{DEFRA Reimbursement Limit (not applicable if greater than zero)}}$$

DEFRA Application Limit is determined as:

$$\boxed{\text{Allowable historical capital asset cost to the asset original owner (excluding land) for assets in the NF at the time of sale}} \times \boxed{3.33\%} + \left(\boxed{\text{Allowable land value to the seller}} + \boxed{\text{Historical capital asset cost of the asset's original owner for assets in the nursing facility at the time of sale}} \right) -$$

$$\boxed{\text{Purchaser down payment}} \times \boxed{\text{Purchase Mortgage interest rate}} - \boxed{\text{Allowable interest expense of the seller for the rate period prior to the sale}} = \boxed{\text{DEFRA Application Limit}}$$

For purposes of the DEFRA Reimbursement Limit calculation, allowable acquisition cost is the cost to the original owner of the asset. An example of this calculation is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

Increase in tenure and interest for the new ownership prior to DEFRA Limit is determined as:

$$\boxed{\text{Purchaser tenure and allowable interest after acquisition}} - \boxed{\text{Seller tenure and allowable interest in the Medicaid rate prior to the sale}} = \boxed{\text{Increase in tenure and interest for new ownership prior to DEFRA Limit}}$$

The calculation formula is defined for application when using annualized cost data (reflective of 12-month period). Tenure refers to the purchaser's initial ownership year. Allowable interest refers to interest associated with a facility acquisition. If all of the data elements needed in the calculation do not include data for a 12-month period, the data



elements must be adjusted to reflect a period of equal duration to the cost report base period used in determining the "purchaser tenure and allowable interest after the sale."

The DEFRA Reimbursement Limit continues to apply to the new ownership annual Property Tax/Interest Expense/Lease Component rate using the Plant Cost Certification reimbursement settlement procedure until the limit amount is zero.

10.3.B. RETURN ON CURRENT ASSET VALUE (CAV) COMPONENT

The Return on Current Asset Value Component is a per resident day amount representing a use allowance on facility assets. The return amount is determined by multiplying the "tenure factor" times a CAV calculated for the nursing facility. A nursing facility's CAV is determined by a formula using historical costs of the nursing facility's capital assets, as identified in the Allowable and Non-Allowable Costs section in this appendix, times the difference between an asset value update factor and an obsolescence factor. Assets purchased prior to 1960 are treated as assets brought into service in 1960. A nursing facility's CAV for rate reimbursement calculation cannot exceed the "current asset value upper limit" and will not be less than the "current asset value floor."

The calculation for the return on current asset value component is:

$$\begin{array}{l}
 \boxed{\begin{array}{c} \text{Lesser of NF} \\ \text{CAV or NF CAV} \\ \text{Limit} \end{array}} \times \boxed{\begin{array}{c} \text{Tenure Factor} \end{array}} = \boxed{\begin{array}{c} \text{Total NF Return} \\ \text{on CAV} \end{array}} \\
 \\
 \boxed{\begin{array}{c} \text{Total NF Return} \\ \text{on CAV} \end{array}} \div \boxed{\begin{array}{c} \text{NF Resident} \\ \text{Days} \end{array}} = \boxed{\begin{array}{c} \text{Return on CAV} \\ \text{Component Per} \\ \text{Resident Days} \end{array}}
 \end{array}$$

10.3.B.1. ASSET VALUE UPDATE FACTOR

The asset value update factor used to calculate CAV depends on the type of capital asset. Land improvements, buildings, building improvements, and fixed building equipment are updated using a construction cost index for steel frame buildings in the central United States from the fiscal year the asset was brought into service until the most recent period for which cost report data is available for the respective rate year calculation. The asset value update factor is not applied to land and other assets not specifically listed above.

10.3.B.2. ASSET VALUE OBSOLESCENCE FACTOR

The obsolescence factor is applied based on the classification category of the capital asset. Land has an obsolescence factor of zero. Land improvements, buildings, building improvements, and fixed building equipment have an obsolescence factor of .03 for each year the asset has been in service. Movable equipment and other capital assets have an obsolescence factor of .10 for each year the asset has been in service up to a maximum of 10 years. The number of years that the asset has been in service is determined by subtracting the year the asset was put into service from the most recent fiscal year for which data is available under the standard rate setting timeframe.



10.3.B.3. CURRENT ASSET VALUE FORMULA

A nursing facility's CAV is determined by a formula using historical costs of capital assets. The current asset value for each asset is the historical cost of that asset times the difference between its Asset Value Update Factor and its Asset Value Obsolescence Factor. Assets purchased prior to 1960 are recorded as assets brought into service in 1960. Current asset values are updated annually based on the most recent audited or reviewed cost report. A nursing facility's current asset value is the sum of current asset values for the various asset types.

Example: Building assets with historical cost of \$100,000 in service for 10 years through the cost report year used in the rate calculation; the update factor for the 10 years is 1.50; the obsolescence factor is .30 (10 years times .03); the amount included in the CAV compilation for the nursing facility for these assets is \$120,000 [\$100,000 times (1.50 minus .30)].

If the nursing facility Plant Cost Component is calculated based on Plant Cost Certification data, the new capital assets acquired in the current cost report year and the immediate prior cost report year will be included in the nursing facility historical asset costs for compiling the CAV. The update factor for these assets will be 1.0, and the obsolescence factor will be zero.

10.3.B.4. NURSING FACILITY CURRENT ASSET VALUE

The current asset value calculation process determines the CAV for the entire nursing facility since capital assets are used for all types of service delivery in that facility. Only the portion of the nursing facility assets having a use related to routine nursing resident care are included for reimbursement under the return on current asset value component. The reference to Nursing Facility CAV is defined as the nursing unit portion of the nursing facility's total current asset value applicable to routine nursing care. The apportionment, expressed as a percentage, of a total facility that is applicable to the routine nursing care unit is determined by means of the facility's annual cost report. The SMA cost reporting process apportions the nursing facility asset costs into the appropriate cost centers for reimbursement purposes.

The Nursing Facility CAV is calculated as:

Total CAV for the NF	×	Percentage representing the nursing unit apportionment	=	NF CAV
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10.3.B.5. CLASS I NURSING FACILITY CURRENT ASSET VALUE LIMIT PER BED

The current asset value upper limit is a maximum per bed dollar amount that will be used for calculating the individual Nursing Facility CAV. The per bed value of the upper limit is based on the historical costs of construction and other asset acquisition costs for nursing facilities opened on or after January 1, 1975. The historical costs are updated through



1983 using the U.S. Department of Commerce Composite Construction Index, and annual updates after 1983 are made using a construction cost index for steel frame buildings. The update index does not apply an obsolescence factor. The current asset value limit is the sum of the updated historical costs for the facilities included in this calculation divided by the total number of beds in those facilities. The current asset value limit is recalculated annually to include construction costs of new facilities reported on the most recent calendar year filed cost report and the construction index update. The per bed upper limit is effective for the period corresponding to the State rate year.

The current asset value floor is 30 percent of the current asset value upper limit.

Class I nursing facility current asset value limits per bed for each rate year are available on the MDHHS website. Refer to the Directory Appendix for website information.

10.3.B.6. NURSING FACILITY CURRENT ASSET VALUE LIMIT

A current asset value limit is determined by the individual nursing facility and is dependent on the number of beds in the Medicaid nursing unit for the period corresponding with the respective rate effective date. The current asset value upper limit is a maximum dollar amount for the individual Nursing Facility CAV that will be used for calculating the return on current asset value. The Nursing Facility CAV Limit is the number of available beds in the nursing unit times the Class Current Asset Value Limit Per Bed.

The current asset value floor limit is a minimum dollar amount for CAV that will be used for calculating the return on current asset value for that nursing facility. The individual Nursing Facility CAV floor is the Nursing Facility CAV Limit times 30 percent.

10.3.B.7. TENURE FACTOR [CHANGES MADE 4/1/20 & 7/1/20]

The tenure factor is dependent on the nursing facility provider's number of full years of continued Medicaid certification as of the beginning of the Medicaid rate year (i.e., months of continuous Medicaid certification divided by 12 and disregarding fractions). The continuous Medicaid certification is based on the current ownership of the nursing facility.

Continued Medicaid certification is based on the number of full years that have elapsed from the effective date of a provider's initial Medicaid certification to the beginning of the Medicaid rate year. For example, a provider that has been Medicaid certified for 42 continuous months has, for purposes of the tenure factor, been certified for three full years. The provider's years of ownership are translated into a tenure rate, and applicable rates are identified in the following table. (revisions per bulletin MSA 19-28)

Years of Ownership at Start of Provider Fiscal Year	Rate of Return on Current Asset Value
0-1	.0250
2	.0275



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Years of Ownership at Start of Provider Fiscal Year	Rate of Return on Current Asset Value
3	.0300
4	.0325
5	.0350
6	.0375
7	.0400
8	.0425
9	.0450
10	.0475
11	.0500
12 or more	.0525

The rate of return on current asset value is expressed as an annual return rate. Qualification for the total return rate requires that the period included in the nursing facility cost report used as the basis for the facility plant cost rate include twelve calendar months. In cases where the nursing facility cost report does not include twelve calendar months, the following formula is used to calculate the return rate:

$$\boxed{\begin{array}{c} \text{Number of} \\ \text{calendar days in} \\ \text{the cost report} \\ \text{period} \end{array}} \div \boxed{365} \times \boxed{\begin{array}{c} \text{Rate of return} \\ \text{on CAV (for the} \\ \text{respective years} \\ \text{of ownership)} \end{array}} = \boxed{\text{Return Rate}}$$

Example: A nursing facility has seven years of ownership and the cost report period used for plant costs in the rate calculation is for a nine-month period (275 days). The adjusted return rate is .030 (275/365 times .0400).

If a nursing facility is sold or totally replaced (regardless of facility ownership), years of ownership return to zero. If a facility is remodeled or expanded and facility ownership remains unchanged, the years of ownership remain continuous.

When **licensure (revised 7/1/20)** has changed but there has been no effective change in operator/provider, and there has been no transaction that would affect Medicaid reimbursement other than the tenure factor, the provider may request that Medicaid recognize the continuous tenure such that the tenure schedule would not revert to zero years at the time of the **licensure (revised 7/1/20)** change. The provider's written request must be submitted at the time **licensure (revised 7/1/20)** is changed.

Exception: Where **licensure (revised 7/1/20)** does not change after a sale of nursing facility assets, the nursing facility provider (new owner) must choose either to retain the original tenure schedule and forego increased reimbursement for interest expense, or to



receive increased reimbursement for interest expense, subject to the DEFRA Reimbursement Limit, and allow the tenure schedule to revert to zero years and a tenure factor of .0250. Should the provider elect to retain the previous tenure schedule, Medicaid will not recognize, for allowable cost and per diem rate determination purposes, any interest expense beyond the schedule of borrowings, principal amortization, and interest expenses that would have been incurred were the former owner's loans maintained or assumed by the new owner. This provision applies to all property transactions between lessors, lessees, and/or operators. **(revisions per bulletin MSA 19-28)**

10.4 PLANT COST COMPONENT CLASS III NURSING FACILITIES

The prospectively established plant cost component for each county medical care facility provider and hospital long term care unit provider is the lesser of the allowable per resident day facility plant cost or the per resident day facility plant cost limit. Proprietary providers are permitted to retain, as part of the plant cost component, up to \$.50 of the difference between allowable per resident day plant costs and the per resident day plant costs in effect on March 31, 1985 (\$5.66 per resident day).

10.4.A. FACILITY PLANT COST PER RESIDENT DAY

The allowable per resident day plant cost is the sum of depreciation expense, interest expense, property taxes, and allowable lease costs divided by total resident days as determined from the provider's cost report. A facility with a change in facility asset costs may qualify for plant cost limit updates.

10.4.B. FACILITY PLANT COST LIMIT PER RESIDENT DAY [CHANGE MADE 4/1/20]

The individual provider facility Plant Cost Limit is dependent upon when facility beds were constructed and brought into service for Medicaid residents. Nursing facilities existing prior to July 1, 1978 were initially assigned the facility Class Plant Cost Limit for new construction as of that date. A nursing facility constructed after that date is initially assigned the facility Class Plant Cost Limit effective in the year facility beds are constructed and brought into service for Medicaid.

A facility's Plant Cost Limit, expressed as per resident day, is the sum of the per resident day component limits for depreciation expense, interest expense, financing fees and property taxes. The individual nursing facility Plant Cost Limit is updated for a nursing facility that undergoes a significant change in facility asset costs. The nursing facility must meet the filing requirements and complete the plant cost certification process to qualify for consideration of the update to the individual facility plant cost limit. A plant cost certification filed after the applicable period's cost report will not be accepted for calculation of an updated facility plant cost limit. **(revised per bulletin MSA 19-28)** The provider must meet the qualifying provisions for Plant Cost Certification eligibility, other than non-available bed designation or returning non-available beds to service, to be eligible for a revised plant cost limit. The non-available bed plan designation criteria does not qualify the nursing facility for an update to the facility plant cost limit. An existing provider with a change of facility class, major addition, renovation or new construction may be eligible for a Plant Cost Limit update to reflect the change in facility asset costs. An existing facility that chooses to become a Medicaid-participating provider may also qualify for an updated plant cost limit.



The updated plant cost limit is applicable to a nursing facility dependent upon the facility's capital asset project. A nursing facility that is a total new construction, a facility that incurs major capital asset renovation and/or addition, a facility newly participating in the Medicaid program, or a facility that experiences a change in facility class are eligible for updated depreciation, interest, finance fees and property tax components for the facility Plant Cost Limit. The update in the limit is based on a compilation of the facility limit prior to the capital asset change and the Class Plant Cost Limit.

The individual facility updated Plant Cost Limit effective with the completion of the capital asset project is a weighted average of the historic individual facility Plant Cost Limit for the portion of the facility prior to the new construction, addition or renovation project and the current Class Plant Cost Limit applicable to the new capital asset project. The weighting factors used are the respective ratios of the allowable historic asset costs of the facility prior to the new construction addition or renovation project, and the allowable asset costs of the new capital asset project, to the combined allowable old and new asset costs of the nursing facility after completion of the capital asset project. The current Class Plant Cost Limit used in the weighted calculation applicable to the new capital cost portion will be the class limit in effect for the year corresponding to the new asset acquisitions being placed into service.

Nursing facility providers that incur a capital asset change resulting from a facility sale of assets will use, as a plant cost basis, only those allowable costs identified in the Allowable and Non-Allowable Costs section in this appendix. The individual nursing facility updated Plant Cost Limit after the sale is only eligible for an update for the interest expense component limit to reflect changes in interest rates.

10.4.C. FACILITY CLASS PLANT COST LIMIT PER RESIDENT DAY

The Class Plant Cost Limit is the maximum reimbursement rate, expressed as per resident day amount, for a nursing facility's new construction. The Class Plant Cost Limit is applicable to new construction nursing facilities dependent upon when facility beds were constructed and brought into service for Medicaid residents. The Class Plant Cost Limit is the sum of the per resident day component limits for depreciation expense, interest expense, financing fees and property taxes. The Class Plant Cost Limit components are updated annually to reflect changes in industry construction cost, interest rates and corresponding effect on financing fees and real estate taxes due to changes in capital costs. The new construction limit is used in determining the individual nursing facility limit in cases where the nursing facility is an entire new construction or an existing nursing facility has completed a significant capital improvement.

The per resident day Class Plant Cost Limit is the amount that would be paid for a recently constructed and prudently financed facility. Calculation of the plant cost limit is based on a survey of nursing facilities constructed between January 1, 1975 and December 31, 1977, and initially updated to June 30, 1978. The original Class Plant Cost limit individual components are updated annually using published economic indicators identified in the subsections addressing the specific component of the limit. The Class Plant Cost Limit annual updates are available on the MDHHS website. (Refer to the Directory Appendix for website information.)



10.4.C.1. FACILITY CLASS PLANT COST LIMIT DEPRECIATION EXPENSE COMPONENT

The value for the depreciation expense component is a sum based on the mean of the surveyed values of depreciable assets (referenced above) and the mean depreciation rate for assets of similar type using straight-line depreciation with useful lives determined in accordance with Medicare Principles of Reimbursement. The per resident day depreciation expense component is updated each calendar quarter to reflect the change in costs of construction and changes in standards and regulations which have a direct impact on plant costs. The depreciation component is updated using the economic index release as published under U.S. Department of Commerce, Bureau of Economic Analysis, National Income and Product Accounts Tables for Nonresidential Structures.

10.4.C.2. FACILITY CLASS PLANT COST LIMIT INTEREST EXPENSE COMPONENT

The value for interest expense is based on the surveyed mean of interest rates paid (referenced above) and the mean asset values for facilities constructed during the initial three-year survey period. The per resident day interest component is updated annually based on the changes in interest rates. The interest rate data used to calculate the interest component limit is updated by applying an index of change in interest rates for home mortgage loans (reflected in conventional new home mortgage rates, as published by the Federal Housing Finance Board for Newly Built Homes) to the interest rate used to calculate the original interest component limit.

A nursing facility that undergoes a change of ownership is eligible for an update to the individual facility Plant Cost Limit. The update will only include an adjustment to the interest component of the individual facility Plant Cost Limit in effect prior to the sale. The adjustment will be made to the interest component of that prior limit to reflect the change in the interest rate index between the period reflected in the prior limit calculation and the date of the facility sale.

10.4.C.3. FACILITY CLASS PLANT COST LIMIT FINANCING FEES COMPONENT

The value for financing fees is based on the mean of financing fees of the surveyed construction (referenced above). The per resident day financing fees component limit is updated using the same update factor used for the depreciation expense component limit update. The update factor is applied to the original financing fees component limit.

10.4.C.4. FACILITY CLASS PLANT COST LIMIT TAX EXPENSE COMPONENT

The value for property taxes is based on the mean of property taxes of the surveyed taxable properties (referenced above). The per resident day property tax component limit is updated using the same update factor used for the depreciation expense component limit update. The update factor is applied to the original property tax component limit.



10.5 VARIABLE COST COMPONENT (VCC) – CLASS I AND CLASS III FACILITIES

The variable cost component of the nursing facility per resident day rate reflects the Medicaid determination for reimbursement for the nursing facility base and support costs incurred for routine nursing care. Base and support cost classifications are discussed in detail in the Cost Classifications and Cost Finding subsection of this appendix. The calculation of the component uses nursing facility historical costs and economic index application to adjust cost levels to coincide with the State rate year periods. The support costs and total variable (base plus support) costs are separately subjected to rate ceiling reimbursement limits dependent on individual facility bed size and facility class.

For Class I and Class III nursing facility rate setting periods beginning on or after October 1, 2003, the Variable Cost Component is a per resident day rate and is equal to the lesser of the facility's Variable Rate Base (VRB) or the Class Variable Cost Limit (VCL), plus the Economic Inflationary Update (EIU).

$$\text{VCC} = (\text{lesser of VRB or Class VCL}) + \text{EIU}$$

10.5.A. VARIABLE RATE BASE (VRB)

The facility Variable Rate Base is the sum of the facility's indexed base cost component and the facility's indexed support cost component. For rate setting purposes, the per resident day amount used for the provider's Variable Rate Base is the lesser of the calculated Variable Rate Base or the Class Variable Cost Limit.

$$\text{VRB} = \text{Base Cost Component} + \text{Support Cost Component}$$

10.5.A.1. BASE COST COMPONENT (BCC)

A facility's BCC is the facility per patient day allowable base costs indexed to October 1 of the year that is one year prior to the rate year being calculated.

$$\text{BCC} = (\text{base costs}/\text{total number of resident days}) \times \text{Cost Index}$$

- Facility's base cost per day - the facility base costs divided by the total number of resident days for the cost reporting period.

10.5.A.2. SUPPORT COST COMPONENT (SCC)

A facility's support cost component is the facility's BCC multiplied by the lesser of the facility's support-to-base ratio or the support-to-base ratio limit for that nursing facility bed-size group.

$$\text{SCC} = \text{BCC} \times \text{applicable S/B ratio (Facility or Bed-Size Group Limit)}$$

- Facility's support cost per day - the facility support costs divided by the total number of resident days for the cost reporting period.
- Facility Support-to-Base Ratio (S/B-Facility) - the nursing facility's allowable support costs divided by the allowable base costs for the cost reporting period. The individual provider's S/B ratio for rate calculation is limited to the Support-to-Base Ratio Bed Size Group Limit for the provider's bed-size group. The individual nursing facility bed-size group classification is based on the number of nursing home licensed beds, Home for the



Aged beds, or any other type of licensed beds where nursing care is provided. The provider's S/B ratio is rebased annually from the most recent audited cost period, regardless of ownership.

- Support-to-Base Ratio – Bed Size Group Limit (S/B-Group) – the 80th percentile of the support-to-base ratios for nursing facilities in the same bed-size group for a cost reporting year. The bed-size groups are defined as 0-50, 51-100, 101-150, and 151+ nursing care beds in the nursing facility. The nursing facility bed-size group classification is based on the number of nursing home licensed beds, Home for the Aged beds, or any other type of licensed beds where nursing care is provided. The 80th percentile is determined by rank ordering the provider nursing facilities within the same bed-size group from the lowest to highest S/B ratio, then accumulating nursing facility Medicaid resident days of the rank ordered providers, beginning with the lowest, until 80 percent of the total Medicaid resident days for this group of providers is reached. The S/B ratio limit for the bed-size group equals the support-to-base ratio of the nursing facility in which the 80th percentile of accumulated Medicaid days occurs.

10.5.B. COST INDEX (CI)

A facility cost index is the Global Insight's Skilled Nursing Facility Market Basket Without Capital Index, which is published quarterly in the Global Insight DRI-WEFA Health Care Cost Review. The cost index will be used to index reported costs from the end of the facility's cost report period to October 1 of the year that is one year prior to the rate year being calculated.

Example: Cost report data used to set reimbursement rates for the October 1, 2018 to September 30, 2019 rate year will be indexed to October 1, 2017.

10.5.C. CLASS AVERAGE VARIABLE COSTS (AVC)

The Class Average Variable Cost is defined as the total indexed variable costs for all facilities in the Class divided by the total resident days for all facilities in the class for a cost reporting year. An AVC is calculated for Class I and Class III nursing facilities. The Class AVC is used for rate calculations for nursing facilities that meet the qualifying criteria as a new provider for Medicaid participation and determining provider eligibility for Class I nursing facility rate relief.

$$\text{AVC} = \frac{\text{(total Indexed Variable Costs for all NF's in the class)}}{\text{(total resident days for all NF's in the class)}}$$

- Facility's Variable Costs (VC) - the total allowable base and support costs for a facility to provide routine nursing care services to residents, as determined in accordance with Medicaid allowable costs and reporting requirements.
- Indexed Variable Costs (IVC) – the facility's total VC indexed to October 1 of the year that is one year prior to the rate year being calculated.

Example: The AVC for October 1, 2018, which is used for the rate year October 1, 2018 to September 30, 2019, is based on variable costs reported in cost reports ending in calendar year 2017 indexed to October 1, 2017.



10.5.D. CLASS VARIABLE COST LIMIT (VCL)

The Variable Cost Limit for a class of nursing facilities is set at the 80th percentile of the Indexed Variable Costs (IVC) per resident day for facilities in the class during the current calendar year. The 80th percentile is determined by rank ordering providers from the lowest to the highest IVC per resident day, then accumulating nursing facility Medicaid resident days of the rank ordered providers, beginning with the lowest, until 80 percent of the total Medicaid resident days for the facility class of providers is reached. The VCL for the class of providers equals the IVC per resident day of the nursing facility in which the 80th percentile of accumulated Medicaid resident days occurs. A VCL is calculated for Class I and Class III nursing facilities.

- Facility's Variable Cost per resident day (VC/pd) - the facility VC divided by the total number of resident days for the cost reporting period.
- Indexed Variable Costs Per Resident Day (IVC/pd) – the facility's VC/pd indexed to October 1 of the year that is one year prior to the rate year being calculated.

Example: The VCL for October 1, 2018, which is used for the rate year October 1, 2018 to September 30, 2019, is based on variable costs per resident day reported in cost reports ending in calendar year 2017 indexed to October 1, 2017.

10.5.D.1. CLASS I NURSING FACILITY VCL EXCEPTION - NEW PROVIDER RATE RELIEF

A Class I nursing facility that qualifies for rate relief as a new provider, as defined for rate relief, in a Medicaid enrolled nursing facility with a VRB less than or equal to 80 percent of the class AVC will have an exception VCL in the rebasing rate year. The rate Variable Cost Component for the initial rate year of accelerated rebasing is limited to the Class I Average of Variable Costs. Refer to the Rate Relief for Class I Nursing Facilities subsection in this appendix for additional information.

10.5.D.2. CLASS III NURSING FACILITY VCL EXCEPTION – NEW HOSPITAL LONG TERM CARE UNITS AFTER JULY 1, 1990

Class III nursing facilities that are new long term care units of a hospital, and have a Certificate of Need (CON) approval from the Michigan Department of Health and Human Services (MDHHS) [formerly Michigan Department of Community Health (MDCH) and Michigan Department of Public Health] dated on or after July 1, 1990, are reimbursed according to the method for Class III facilities except that the facility Variable Cost Component is determined as the lesser of the facility Variable Rate Base or the Class I Variable Cost Limit (VCL).

10.5.E. ECONOMIC INFLATIONARY UPDATE (EIU)

The economic inflationary update for a facility is the Economic Inflation Rate (EIR) for the class applied to the lesser of the Variable Rate Base or the Class Variable Cost Limit.

$$\text{EIU} = \text{EIR} \times (\text{lesser of VRB or Class VCL})$$



Economic Inflation Rate (EIR) - the State legislative appropriations process will determine the annual economic inflation percentage for Class I and Class III nursing facilities.

10.6 CLASS V NURSING FACILITIES – VENTILATOR DEPENDENT CARE (VDC) UNITS [CHANGE MADE 4/1/20]

The reimbursement rate for special nursing facilities caring for ventilator-dependent residents (Class V) is set prospectively by Medicaid as an individual nursing unit rate per resident day and is based on actual occupancy.

Reimbursement is made for prior authorized ventilator-dependent services/care for residents who have been transferred to a Medicaid contracted facility. The prospective rate covers all ventilator care requirements of the residents, including all the costs of benefits associated with Medicare Parts A and B while the resident resides in the special nursing facility. This includes, but is not limited to, all routine, ancillary, physician, and other services.

Factors used in the determination of the per diem rate include audited costs of facilities providing similar services, the inflationary factor for the effective period of the prospective rate, the supply response of providers, and the number of residents for whom beds are needed. The prospective rate does not exceed 85 percent, nor fall below 15 percent, of an estimated average inpatient hospital rate for currently placed acute care Medicaid residents who are ventilator-dependent. The prospective rate is periodically re-evaluated to ensure reasonableness of supply and demand for special care. A new VDC unit that has not previously participated in Medicaid for VDC services will have a reimbursement rate in the initial two years (24 months) of Medicaid operations (from the date of admitting the first Medicaid beneficiary) (revised per bulletin MSA 19-28) based upon the statewide average VDC unit reimbursement rate for the current year. The reimbursement rate period beginning on the October 1 after the initial two years of Medicaid operations will utilize the most recent Medicaid cost report ending in the prior calendar year. If this cost report covers a period that is less than seven months or there was no cost report filed in the prior calendar year, the cost report used for rate setting is the most recent cost report available prior to the previous calendar year that covers a period of at least seven months.

10.7 NURSING FACILITY QUALITY ASSURANCE ASSESSMENT PROGRAM (QAAP)

The QAAP was implemented by Medicaid in compliance with Michigan and Federal law. The QAAP provides a QAS payment and Quality Measure Initiative payment to nursing facilities by incorporating funds from the quality assurance assessment tax. When a provider sells a nursing facility, the provider is responsible for all QAAP assessments billed and incurred prior to the date of the sale. The purchaser(s) must assure escrow of any outstanding QAAP amounts owed, or the purchaser(s) becomes responsible for payment of the QAAP and penalty amounts owed before Medicaid participation is granted. If the provider quits the business, the provider is responsible for all QAAP assessments billed and prorated as of the date MDHHS determines the facility closed. The QAAP applies to Class I, Class III and Class V nursing facilities.

10.7.A. QUALITY ASSURANCE SUPPLEMENT (QAS) FOR CLASS I AND CLASS III NURSING FACILITIES

The nursing facility will receive a QAS payment as a monthly gross adjustment. The monthly gross adjustment for an individual nursing facility will be determined based on one-twelfth of the facility's annual historical Medicaid utilization (resident days) multiplied



by the facility's QAS per resident day. The facility's historical Medicaid utilization will include all routine nursing care and therapeutic leave days billed to Medicaid by the facility. A nursing facility that is experiencing a significant increase or decrease in its Medicaid utilization for the current rate year resulting in a difference of greater than five percent in the nursing facility's total QAS payments for the year must contact the SMA for consideration of adjustment to the facility's monthly QAS payment. Current year Medicaid resident census data must be provided to MDHHS to document the change in order to revise the monthly QAS payment amounts. It is the desired intent of MDHHS to assure accuracy of total QAS monthly payments and to approximate the annual reimbursement due the facility. MDHHS reserves the right to adjust the individual nursing facility monthly QAS payment to reflect the current year Medicaid activity to achieve this goal.

A facility's QAS is equal to the lesser of the facility's Variable Rate Base or Class Variable Cost Limit times the Quality Assurance Assessment Factor (QAAF) determined by MDHHS, except for Class III publicly owned facilities, in which the QAAF is multiplied by the lesser of the facility's Variable Cost Component or the Class I Variable Cost Limit. A provider's QAS will be reconciled at the end of the fiscal year to accommodate the actual Medicaid utilization, changes to the variable rate from filed to audited cost report data, and to adjust the increase initially estimated to accommodate the fixed pool of funds established by the QAAP and any legislative offsets to that pool.

The QAAF is determined based on the estimated pool of funds created by the quality assurance assessment tax as well as the projected number of Medicaid nursing facility days for the fiscal year. In aggregate, the quality assurance assessment fee may not exceed 6 percent of total industry revenue for the fiscal year.

QAS payments to Class I, III and V providers will be reduced by the amount of restricted funding revenue written off during the current fiscal year. This reduction will be allocated across Class I, III and V providers participating in the QAAP program that receive QAS payments. QAS payments will be reduced by both the state and federal share of the uncollected restricted revenue. Any restricted revenue that is subsequently collected after being included in a QAS reduction will be restored to providers. The QAS reduction will be equal to the total QAAP shortage divided by the total number of Medicaid days used in the QAS payment calculation multiplied by the number of Medicaid days in each facility.

It is the intent of MDHHS that nursing facilities that provide hospice care for residents by contracting with a hospice provider also benefit from this quality program. Medicaid will reimburse hospice providers 100 percent of a nursing facility's QAS rate add-on for Medicaid beneficiaries provided hospice care in Medicaid participating nursing facilities. It is the responsibility of the hospice provider to pay the room and board rate to the nursing facility as specified in their contract for services.

10.7.B. QUALITY ASSURANCE SUPPLEMENT (QAS) FOR CLASS V NURSING FACILITIES - VENTILATOR DEPENDENT CARE (VDC) UNITS

Qualifying VDC units will receive a QAAP payment as a monthly gross adjustment. The monthly gross adjustment for an individual unit will be determined based on one-twelfth



of the VDC unit's annual historical Medicaid utilization (resident days) multiplied by the unit's QAS per resident day basis. The unit's Medicaid utilization will include all days billed to Medicaid by the VDC unit. A nursing unit that is experiencing a significant increase or decrease in its current rate year Medicaid utilization which will cause a difference of greater than five percent in the nursing unit's total QAS payments for the year must contact MDHHS for consideration of adjustment to the unit's monthly QAS payment. Current year Medicaid resident census data must be provided to the SMA to document the change in order to make revision to the monthly QAS payment amounts. It is the desired intent of MDHHS to assure accuracy of total QAS monthly payments to approximate the annual reimbursement due the VDC unit. MDHHS reserves the right to adjust the individual VDC unit monthly QAS payment to reflect the current year Medicaid activity to achieve this goal.

The VDC unit QAS is equal to the Class I Variable Cost Limit times the Quality Assurance Assessment Factor (QAAF) determined by MDHHS. A provider's QAS will be reconciled at the end of the fiscal year to accommodate the actual Medicaid utilization and to adjust the total increase initially estimated to accommodate the fixed pool of funds established by the QAAP and any legislative offsets to that pool.

The QAAF is determined based on the estimated pool of funds created by collection of the quality assurance assessment tax and the projected number of Medicaid nursing facility days for the fiscal year. In aggregate, the quality assurance assessment tax may not exceed six (6) percent of total industry revenue for the fiscal year.

10.7.C. ANNUAL RECONCILIATION

The reconciliation of approved Medicaid days, changes to the variable rate from filed to audited cost report data, and QAS payments is completed on an annual basis within 90 calendar days after the end of the State's fiscal year.

The Reimbursement and Rate Setting Section (RARSS) will reconcile the QAS payments to the provider against the provider's approved Medicaid days and filed and audited cost report data. If RARSS determines that an underpayment has been made, the provider will receive a gross adjustment payment. If RARSS determines that an overpayment has been made, recovery will be made by gross adjustment recovery against future payments. The gross adjustment process follows the Initial Settlement and Final Settlement practices described in the Cost Report Reimbursement Settlements section of this chapter. A provider may submit a written request to RARSS for an extended repayment schedule to repay the Program. The request must include a written justification of the need for extended payment.

The provider will be given advance notice of the actions taken on QAS payments and has 30 calendar days from the date of the advance notice to request a review of the determination with RARSS. The provider's request for a review must cite specific concerns with the determination.



10.7.D. NURSING FACILITY QUALITY MEASURE INITIATIVE (QMI)

Eligible nursing facilities may receive a supplemental QMI payment. Payments to individual nursing facilities will be determined by their average 5-star quality measure rating on the CMS Nursing Home Compare (NHC) website, Medicaid utilization rate, number of licensed beds, and resident satisfaction survey data as described in this section. In cases of a change of ownership, the new owner's QMI payment will continue to be calculated based off the prior owner's average quality measure rating, Medicaid utilization rate, number of licensed beds, and resident satisfaction survey data.

The average 5-star quality measure rating will be based upon the average rating from July of the prior calendar year to June of the current calendar year (e.g., for the rate year beginning October 1, 2018, the average 5-star quality measure rating would be based on the average rating between July 1, 2017 to June 30, 2018).

For special cost reporting requirements related to the QMI, refer to the Quality Measure Initiative (QMI) Special Cost Reporting Requirements subsection of the Cost Classifications and Cost Finding section of this Appendix.

Refer to the Nursing Facility Resources section of the Directory Appendix for NHC website information, and for additional QMI resources and contact information.

10.7.D.1. ELIGIBILITY FOR QMI PAYMENT

To be eligible to receive a QMI payment, a provider must meet the following conditions:

- The provider must be a Class I or III nursing facility.
- The provider must have a 1, 2, 3, 4 or 5-star quality measure rating on the NHC website.
- The provider must be a Medicaid-certified nursing facility.
- The provider must not be closed for business. That includes a voluntary closure, or an action by MDHHS, CMS or LARA to decertify or delicense a provider.
- The provider must not be designated as a Special Focus Facility (SFF) by CMS. (Refer to the Directory Appendix for SFF list website information.)
- If the provider has an average quality measure rating below 2.5 stars, they must submit an action plan to the Long Term Care Policy Section as described in the QMI Action Plan subsection.
- The provider must deliver at least one day of Medicaid nursing facility services at the room and board level during the state fiscal year in which they receive QMI payments and in their immediate prior year-end cost reporting period. QMI payments made to a provider found to have no days of Medicaid nursing facility services during the state fiscal year shall be recouped by the Michigan Department of Health and Human Services (MDHHS).

MDHHS will generally check in August prior to the beginning of a rate year and approximately every three months thereafter to see which facilities are designated as SFFs or have closed. A provider designated as a SFF will not be eligible to receive any



QMI payments until they graduate from the SFF list. A SFF that graduates after the rate year begins will only be eligible for prorated QMI payments for the balance of the remaining months of the rate year (e.g., a provider that graduates from the SFF list would not receive reimbursement equal to what they would have received had they been eligible for the entire rate year). If a provider has closed or graduated from the SFF list, MDHHS may recalculate some or all QMI payments depending on the amount of available funds.

10.7.D.2. QMI ACTION PLAN

A provider with an average quality measure rating below 2.5 stars must file an acceptable QMI action plan with the Long Term Care Policy Section to be eligible for a QMI payment. The action plan will need to provide specific details reflecting how a provider intends to use QMI funds to increase quality outcomes. The Long Term Care Policy Section will electronically provide written notice to providers with a rating below 2.5 stars and will provide the expectations for the action plan. A plan that does not provide the specific details required in the notice will not be accepted by the Long Term Care Policy Section.

The Long Term Care Policy Section will set a due date in the notice for a provider to submit the action plan. A provider that fails to submit an action plan by the due date cannot receive payment until an action plan is sent to and accepted by the Long Term Care Policy Section. If a provider fails to submit an acceptable action plan within 30 days of the due date, they will be unable to receive a QMI payment for the remainder of the fiscal year. Unless directed otherwise by the Long Term Care Policy Section, the action plan must be sent electronically as specified in the notice.

10.7.D.3. QMI PAYMENT METHODOLOGY [CHANGE MADE 4/1/20]

The Medicaid utilization rate will be determined from the immediate prior year-end cost report covering a period of at least seven months (e.g., 2016 year-end cost reports will set the utilization rate for the fiscal year beginning October 1, 2017). For the purposes of this section, a cost report refers to the uniform Medicaid nursing facility cost report or a less than complete cost report. The sum of the total Title XIX patient days in the Medicaid Routine Care Unit #1 and the Medicaid Special Care Unit #1 over the sum of the total inpatient days in all nursing facility units on the cost report will set the utilization rate (e.g., if the sum of the Title XIX inpatient days in the Medicaid Routine Care Unit #1 and the Medicaid Special Care Unit #1 is 1,000, while the sum of total inpatient days in all units is 1,500, the Medicaid utilization rate would be 66.7%). If the immediate prior year-end cost report does not cover a period of at least seven months, then the Medicaid utilization rate will be determined as follows:

- If the prior year-end cost report covers a period of less than seven months, and if multiple cost reports were filed by the current or prior facility owner, then all cost reports submitted for the prior year-end will be used in calculating the Medicaid utilization rate (i.e., if the current owner and the prior owner each submitted a 2016 year-end cost report, then both cost reports would be used to determine the Medicaid utilization rate).
- If no cost report was filed for the prior year-end because the current or prior owner submitted an extended period cost report, then the most recent cost report filed prior to



the previous calendar year that covers a period of at least seven months will be used in calculating the Medicaid utilization rate.

- If the immediate prior year-end cost report is the only cost report the provider has ever filed, then that cost report will be used in calculating the Medicaid utilization rate even if it covers a cost reporting period of less than seven months.
- A provider that has not filed an immediate prior year-end cost report will be assumed to have no Medicaid utilization.

Per-bed QMI payment amounts are multiplied by a Medicaid utilization scale. The Medicaid utilization scale will be applied as follows:

- For nursing facilities with a Medicaid utilization rate of above 63%, the facility shall receive 100% of the QMI payment.
- For nursing facilities with a Medicaid utilization rate between 50% and 63%, the facility shall receive 75% of the QMI payment.
- For nursing facilities with a Medicaid utilization rate of less than 50%, the facility shall receive a payment proportionate to their Medicaid utilization rate.

Example: Facility A has a Medicaid utilization rate of 64% while Facility B has a Medicaid utilization rate of 35%, so Facility A would receive 100% of their QMI payment while Facility B would receive 35% of their payment.

Effective for rate years beginning on or after October 1, 2018, an adjustment is made for the submission of resident satisfaction survey data from recently performed surveys. The Long Term Care Policy Section will provide notice to facilities prior to the fiscal year on how to submit the data, what documentation is necessary, and where to submit resident satisfaction survey data by a due date specified in the notice. Per-bed QMI payments will be multiplied by 100% for facilities that submit acceptable resident satisfaction survey data and documentation, but payments will be multiplied by a percentage set by MDHHS for facilities that do not submit the data and documentation. The resident satisfaction survey must have been conducted no more than 12 months before the submission of the notice, and survey data submitted for prior year QMI payments will not be accepted.

The following formula demonstrates the monthly adjusted QMI payment (for rate years prior to October 1, 2018, the resident satisfaction survey factor is not included in the formula):

- $$\text{QMI Gross Adjustment} = \left(\left([\text{NHC Per-Bed Amount}] \times [\text{Medicaid Utilization Scale}] \times [\text{Resident Satisfaction Survey Factor}] \right) \times [\text{Number of Licensed Nursing Facility Beds}] \right) / [\text{Number of Eligible Payment Months}]$$

Examples:

- For rate year October 1, 2017, Nursing Facility A has an average NHC rating of 5 stars, a Medicaid utilization rate of 55%, 100 licensed nursing facility beds, and meets all the payment eligibility requirements. The NHC per-bed amount for a 5-star rating is \$2,000, so the QMI Gross Adjustment = $\left((\$2,000) \times (75\%) \times (100) \right) / 12 = \$12,500/\text{month}$.



- For rate year October 1, 2017, Nursing Facility B has an average NHC rating of 2 stars, a Medicaid utilization rate of 32%, 45 licensed nursing facility beds, and meets all the payment eligibility requirements. The NHC per-bed amount for a 2-star rating is \$1,250, so the QMI Gross Adjustment = $((\$1,250) \times (32\%) \times (45))/12 = \$1,500/\text{month}$. **(revised 4/1/20)**
- For rate year October 1, 2018, Nursing Facility C has an average NHC rating of 3 stars, a Medicaid utilization rate of 78%, 200 licensed nursing facility beds, has not submitted resident satisfaction survey data, and meets all the payment eligibility requirements. The NHC per-bed amount for a 4-star rating is \$1,750 and the resident satisfaction survey factor for facilities with no survey is 85%, so the QMI Gross Adjustment = $((\$1,750) \times (100\%) \times (85\%) \times (200))/12 = \$24,791.67/\text{month}$.

All values in the examples above are for example purposes only and do not reflect actual rates.

10.8 CLASS II NURSING FACILITIES – PROPRIETARY NURSING FACILITY FOR INDIVIDUALS WITH MENTAL ILLNESS OR INTELLECTUAL DISABILITIES

The Class II proprietary nursing facilities for individuals with mental illness or intellectual disabilities are reimbursed an all-inclusive prospective payment rate negotiated with the MDHHS State Mental Health Agency on an annual basis. Rate ceiling limits are prospectively set for allowable costs and resident occupancy for determining final reimbursement for the annual services. Final reimbursement is retrospective cost settlement, not to exceed the ceiling limit. Nursing facility allowable costs included for reimbursement are determined in accordance with Medicaid cost reporting requirements and allowable and non-allowable cost policies, including plant cost based on allowable depreciation expense. The provider is paid a reimbursement efficiency allowance equal to the lesser of \$2.50 per resident day or the difference between the prospective ceiling limit and the nursing facility actual allowable cost.

10.9 CLASS IV NURSING FACILITIES – INSTITUTIONS FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

State-owned and -operated institutions, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), and non-profit nursing facilities for individuals with intellectual disabilities are retrospectively cost settled.

The State Mental Health Agency must submit rate information regarding the facility's expected costs for the prospective year in an Interim Rate Request letter to Medicaid at the beginning of the Medicaid rate year. Subsequent requests may be submitted during the rate year if rate adjustments are necessary. The reimbursement rate for the new Medicaid rate year will not be updated until the State Mental Health Agency submits the Interim Rate Request letter.

The provider is reimbursed an interim per diem rate based on the cost information submitted. The interim reimbursement is adjusted to actual allowable costs through annual cost settlement. Refer to the Cost Reporting and the Rate Setting sections of this appendix for additional information.



10.10 CLASS VI NURSING FACILITIES – HOSPITAL SWING BEDS

The reimbursement rate for hospital Swing Beds (Class VI) is set prospectively as a flat per diem rate determined by Medicaid. Swing bed reimbursement occurs after the combined length of stay in an acute care bed and a swing bed exceeds the average length of stay for the Medicaid diagnosis related group (DRG) for the admission.

The rate is the weighted statewide average per diem rate paid for routine nursing care. The rate calculation sums Medicaid per diem payments and divides the sum by the number of Medicaid service days paid to Class I and Class III facilities as reflected on the State’s prior fiscal year’s Medicaid report of services and payments.

10.11 CLASS VII NURSING FACILITIES – STATE VETERANS’ HOMES [CHANGES MADE 4/1/20]

Reimbursement rates to State Veterans’ Homes will be prospective, per patient day, and based on the PDM classification of each resident. MDHHS will utilize the PDM classifications used under the Medicare skilled nursing facility (SNF) prospective payment system (PPS) as calculated by the MDS 3.0. PDPM consists of four case-mix categories and six rate components. The PT and OT component, the SLP component, the NTA component and the Nursing component represent the four case-mix categories. PDPM rates are comprised of a PT component, OT component, a SLP component, an NTA component, a Nursing component and a Non-Case-Mix component. The Variable Per Diem adjustment and the add-on payment for residents with AIDS under the Medicare SNF PPS are not included in this rate methodology.

The formula for PDPM payments is as follows:

$$PDPM\ rate = PT\ rate + OT\ rate + SLP\ rate + NTA\ rate + Nursing\ rate + Non-Case-Mix\ rate$$

Refer to the Directory Appendix for website information regarding PDPM. **(text revised/added per bulletin MSA 19-24)**

The rate associated with an individual PDPM component **(revised per bulletin MSA 19-24)** will be set as a percentage of the rate paid by the Medicare SNF PPS. The percentage used to set rates will not exceed 100% of the corresponding Medicare PPS rate. MDHHS will notify the State Veterans’ Homes of the percentage and specific payment rates by October 1 of each year.

The PDPM categories **(revised per bulletin MSA 19-24)** used for payments will be based on the applicable MDS assessment(s) to the billing period. Example: Services were rendered from April 1 through April 30, and MDS assessments were conducted on January 15 and April 15. The payment to the provider would be based on the January 15 assessment for dates of services from April 1 through April 14, and would be based on the April 15 assessment for dates of services April 15 through April 30.

State Veterans’ Homes are excluded from the reimbursement policy that requires Medicaid to pay the lower of the customary charge to the general public or the prospective rate determined by Medicaid.

In conformance with the Veterans’ Health Programs Improvement Act of 2004, per diem payments received by State Veterans’ Homes from the federal Department of Veterans Affairs will not be considered a third-party liability or otherwise used to directly reduce Medicaid payments to these providers.



State Veterans' Homes are excluded from the NF QAAP and all supplemental payments funded by the QAAP.

State Veterans' Homes will receive payment for services through gross adjustments.

10.12 ADD-ONS

Add-ons are items that provide reimbursement to a provider for costs that are not previously included in the provider's variable cost component.

10.12.A. SPECIAL DIETARY

The Coverages portion of this chapter, Dietary Services and Food subsection, provides for program reimbursement to non-profit nursing facilities for special dietary needs for religious reasons. Interim payment reimbursement to the nursing facility will be made by inclusion of a per diem rate add-on amount to the nursing facility routine nursing care rate. The total special dietary add-on reimbursement to the nursing facility during the reimbursement year will be adjusted through the annual cost report reimbursement settlement. Refer to the Cost Report Reimbursement Settlement section of this appendix for additional information.

A qualifying nursing facility that has previous year cost history of special dietary costs will have the interim payment rate add-on based on special dietary cost center allocated cost and nursing facility resident census data determined in the nursing facility cost report. The most recent annual filed or audited cost report that is used for determining the nursing facility current routine nursing care rate will be the source of the cost data for the current interim rate add-on.

A qualifying nursing facility that does not have previous year cost history of special dietary costs will have an interim reimbursement rate add-on based on estimated cost data. The nursing facility must submit a written request identifying the estimated costs to be incurred in food purchase and preparation associated with special dietary needs for religious reasons. The request must be submitted to the RARSS and must include a certification statement attesting to the accuracy of the data and signed by the nursing facility authorized representative. (Refer to the Directory Appendix for contact information.) The written request must present the following data for the current cost report year:

- Estimated resident days (not less than 85% occupancy rate for all nursing facility resident units)
- Estimated raw food purchase costs, including a detailed listing of the types of food to be purchased for special dietary needs for religious reasons.
- Estimated cost for supplies, tableware, cooking utensils, etc. for food preparation and service associated with special dietary needs for religious reasons.

The submitted data will be subject to review and adjustment by Medicaid for consideration and calculation of the interim rate and the add-on reimbursement rate to



the facility. The submitted data will be utilized for interim rate determination until annual cost reporting data has been filed and accepted by Medicaid.

10.12.B. NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAM (NATCEP) ADD-ON

Certification, Survey & Enforcement Appendix, Staff Certification section provides for nursing facility Medicaid reimbursement for Medicaid's share of costs incurred by the nursing facility for approved Nursing Aide Training and Competency Evaluation Program (NATCEP) expenditures. Interim payment reimbursement to the nursing facility will be made by inclusion of a per diem rate add-on amount to the nursing facility routine nursing care rate. The total NATCEP add-on reimbursement paid to the nursing facility during the nursing facility's cost report reimbursement year will be adjusted through the annual cost report reimbursement settlement. Refer to the Cost Classifications and Cost Finding section and Cost Report Reimbursement Settlement section of this appendix for additional information.

The interim rate add-on amount is limited to a maximum per diem of \$1.00 per resident day; however, the nursing facility cost reimbursement settlement for these training costs is not subject to a per diem limit. The interim payment rate add-on will reflect the nursing facility's prior year cost history of NATCEP costs utilizing the NATCEP cost center allocated cost and nursing facility resident census data determined in the nursing facility cost report. The most recent annual filed or audited cost report that is used for determining the nursing facility current routine nursing care rate is the source of the cost data for the current interim rate add-on, except where a more recent interim reimbursement request has been submitted by the nursing facility.

A nursing facility that is notified by the SSA of loss of NATCEP or CEP, has been placed on NATCEP lockout status, or has a NATCEP withdrawal of program approval will be notified by Medicaid that its interim reimbursement NATCEP add-on amount will be deleted from the reimbursement rate. The nursing facility must submit a completed interim reimbursement request identifying expected NATCEP allowable costs, in accordance with policy provisions referenced above, for consideration of an interim reimbursement add-on amount for allowable NATCEP costs incurred during the lockout period.

A nursing facility is eligible to submit an interim reimbursement request for a change in the interim payment rate add-on amount in the following situations:

- The nursing facility is experiencing a change in its current year NATCEP cost level that would cause a per diem increase or decrease in excess of \$.25 per day in the current period reimbursement rate add-on.
- The nursing facility does not have previous year cost history of NATCEP cost.
- The nursing facility has been identified a lockout facility for NATCEP or CEP, or has loss of approval of its NATCEP, and has made acceptable arrangements for securing approved nurse aide training for nursing facility staff.

The nursing facility must submit a completed Nurse Aide Training and Testing Program Interim Reimbursement Request (form MSA-1324) identifying the estimated costs to be



incurred in providing approved NATCEP training for the nursing facility staff and projected resident census data. The request must be submitted to RARSS and must include the signed certification statement attesting to the accuracy of the data and signed by the nursing facility authorized representative. (Refer to the Directory Appendix for contact information.) Electronic copies of the request form and completion instructions can be accessed on the MDHHS website. (Refer to the Directory Appendix for website information.)

The submitted data is subject to review and adjustment by Medicaid for consideration and calculation of the interim rate add-on payment to the facility. Medicaid will issue the provider a rate notice indicating the accepted cost level for interim rate determination, or a request denial and reason for such action. The submitted data will be utilized for interim rate determination until annual cost reporting data has been filed and accepted by Medicaid.

10.13 SPECIAL CIRCUMSTANCES – RATE DETERMINATION

10.13.A. NEW FACILITY AND PROVIDER

A new facility is a provider operating a nursing facility where there is not Medicaid historical cost. Examples include:

- A newly constructed (non-replacement) facility.
- An existing facility that has never before participated in Medicaid.
- A facility that has participated in Medicaid in a different provider class.
- An existing nursing facility that has not provided nursing care for Medicaid beneficiaries or billed Medicaid in the past two years (24 months).

10.13.A.1. NEW PROVIDER NURSING FACILITY PER RESIDENT DAY PLANT COST

A new provider in the Medicaid program is eligible for the Plant Cost Certification process to reflect the facility asset costs and related plant costs. The Plant Cost Certification data submission will be used for calculation of the nursing facility Plant Cost Component as outlined in the policy for the respective nursing facility class. Refer to the Plant Cost Certification section of this appendix for additional information.

10.13.A.2. NEW PROVIDER NURSING FACILITY VARIABLE COST COMPONENT [CHANGE MADE 4/1/20]

The Variable Rate Base for the new facility and provider will be determined using special methods. During the first two cost reporting periods, new facilities and facilities with a change of class will have a Variable Rate Base equal to the Class Average of Variable Costs. The first two cost reporting periods must cover a period of at least 19 months (the first cost reporting period must cover a period of at least seven months, and the second cost reporting period must cover a period of 12 months) and the facility must have averaged six or more Medicaid residents per day. This rate base will be used in the calculation of the nursing facility Variable Cost Component as outlined in the policy for



the respective nursing class. In subsequent periods, the nursing facility's Variable Rate Base will be determined using the methods described in the [Rate Determination section](#) of this appendix. **(revisions per bulletin MSA 19-28)**

A new provider that purchases an existing facility participating in the Medicaid program or a provider with an existing, participating facility that makes major additions, renovations, or new construction does not qualify for these special methods because there are historical variable costs on which to base rates. The Variable Rate Base will be determined in accordance with Medicaid policy identified in applicable subsections of this appendix.

This section does not apply to Class V providers.

10.13.B. COMPLEX CARE

The Nursing Facility Coverages chapter of this manual details Medicaid policy on complex care cases. Complex care cases are those requiring specialized care beyond services covered by the usual Medicaid per diem rate. The payment rate for specially-placed residents is a negotiated prospective rate per resident day.

Reimbursement is made for prior authorized services/care to residents who have specialized and concentrated nursing and support service needs and who have been transferred from an acute care hospital setting to an approved nursing facility. The negotiated rate provides reimbursement adequate to meet the unusual needs of this type of resident in a less costly and more appropriate environment than an acute care hospital setting.

Factors used in Medicaid's negotiation of the per resident day prospective rate include, but are not limited to, complexity, type of equipment and supplies required, the resident's condition, and the marketplace availability of placement. Any authorized increase in the per diem rate represents only the cost of the service. The negotiated prospective rate is re-evaluated, in consideration of the resident's needs, prior to the last day of the approval period.

10.13.C. HOSPITAL LEAVE DAYS

The Hospital Leave Days Section in the Coverages portion of this chapter identifies the parameters for program reimbursement.

Reimbursement for a hospital leave day is a single rate paid to all nursing facility providers regardless of facility class. The rate is determined annually with an effective period coinciding with the State fiscal year. The rate determination utilizes the Class I nursing facility Class Average Variable Cost (AVC) for the State fiscal year. The hospital leave day reimbursement rate represents a calculated salary and wage component of the room and board cost portion of the total AVC. The room and board portion is equal to 95 percent of the Class I nursing facility AVC, and the salary and wage component is determined as 66 percent of the room and board cost. The formula for calculating the hospital leave day rate is:



AVC (Class I NF)	×	95% (room and board portion)	×	66% (salary and wage component)	=	Hospital Leave Day Rate
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Hospital Leave Day rate information is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

10.13.D. THERAPEUTIC LEAVE DAY

The Therapeutic Leave Days section in the Coverages portion of this chapter identifies the parameters for program reimbursement.

The reimbursement rate for a therapeutic leave day is the nursing facility's established per diem rate in effect for the period coinciding with the leave day.

10.13.E. ONE-DAY STAY

The One-Day Stay section of the Coverages portion of this chapter identifies the parameters for program reimbursement.

The reimbursement rate for an approved one-day stay is the nursing facility's established per diem rate in effect for the period coinciding with the stay.

10.13.F. FACILITY INNOVATIVE DESIGN SUPPLEMENTAL (FIDS) PROGRAM

Effective for dates of service on and after October 1, 2007, Medicaid providers participating in the Facility Innovative Design Supplemental (FIDS) program are eligible to receive supplemental reimbursement for room and board services provided to Medicaid beneficiaries when the beneficiary resides in a FIDS bed. FIDS participating facilities are eligible for the reimbursement supplement for up to 20 consecutive years beginning in the fiscal year of the project completion date. For projects completed on or after January 1, 2008, providers must plant cost certify or forgo the FIDS reimbursement supplement.

The FIDS facility standards and required culture change must be maintained throughout the Medicaid supplemental payment program. FIDS participating facilities will be reviewed annually by the Aging and Adult Services Agency (AASA) to certify continued participation in the culture change. Reimbursement of the FIDS payment will be terminated if it is determined that a facility is not compliant with the culture change requirement. FIDS participating nursing facilities receive increased capital reimbursement for FIDS construction and renovation projects. The increased reimbursement is paid through the claims reimbursement process. Reimbursement of the supplement amount is contingent upon sufficient appropriation to the Medicaid budget.

10.13.F.1. CHANGE OF OWNERSHIP [CHANGE MADE 4/1/20]

A new owner may receive reimbursement for the balance of the facility's eligible years of participation in the FIDS program. The new owner must notify RARSS via File Transfer



within 45 calendar days of the change of ownership if the facility is going to continue participation in the FIDS program, or RARSS will assume participation has been discontinued and end FIDS reimbursement supplemental payments. **(text added per bulletin MSA 19-28)** In order to receive the supplemental Medicaid payment, the new owner must continue the FIDS facility standards and culture change. If the new owner initially decides to discontinue participation as a FIDS facility and subsequently decides to participate as a FIDS facility, the provider must notify the LARA, Bureau of Community and Health Systems (BCHS) team manager and AASA. MDHHS will notify the provider of the supplemental payment amount upon reinstatement of participation in FIDS. MDHHS will notify the provider of the terminated supplemental payment if the facility is determined ineligible for the supplemental payment because the new owner has discontinued or plans to discontinue the FIDS facility standards or culture change.

10.13.F.2. FIDS PROGRAM REIMBURSEMENT METHODOLOGY

FIDS participating facilities that have received approval from LARA for construction or renovation design plans that complied with quality goals of the FIDS program to improve nursing facility quality of life and nursing facility structures are eligible for reimbursement. If a provider chooses to discontinue participation in the design and/or culture change aspects of the FIDS program, the provider must contact the MDHHS LTC Reimbursement and Rate Setting Section (RARSS) 30 days prior to the discontinuance. (Refer to the Directory Appendix for contact information.) The FIDS reimbursement supplement will be discontinued when the facility no longer participates in the design and/or culture change.

MDHHS confirmation and approval that a FIDS participating facility has completed the pre-approved construction or renovation project(s) allows the facility to be eligible for the capital reimbursement supplement. The reimbursement supplement only applies to qualifying FIDS costs above the nursing facility's Capital Asset Value (CAV) Limit for Class I and the Plant Cost Limit (PCL) for Class III. Qualifying costs are the cost of capital assets such as land, land improvement, building, building improvement, and equipment that meet the MDHHS capital asset classification. Providers submitting for plant cost certification can identify all costs for certification but must distinguish FIDS qualifying costs on the certification request. As FIDS qualifying costs fall below the nursing facility's CAV or the nursing facility's PCL, the supplement amount is adjusted. The reimbursement supplement reflects qualifying costs prorated over 20 consecutive years. Medicaid reimbursement methodology for the FIDS program follows current MDHHS nursing facility cost-based principles and rate determination guidelines and policy, including plant cost certification, except as identified below for Class I and Class III providers.

10.13.F.3. CLASS I NURSING FACILITY REIMBURSEMENT FOR FIDS

For Class I nursing facilities participating in the FIDS program, the supplement amount, up to five dollars (\$5) per Medicaid day, is added to the Return on Current Asset Value Component (RCAV) for qualifying FIDS construction or renovation project costs above the nursing facility's CAV Limit. Medicaid reimbursement methodology for the FIDS program follows current Medicaid nursing facility reimbursement guidelines and policy with the exceptions noted below:



- Up to five dollars (\$5) per Medicaid day is added to the nursing facility's RCAF.
- The supplement amount is based on qualifying costs above the nursing facility's CAV Limit determined by MDHHS either by plant cost certification or by cost reporting. When the plant cost certification estimate is used, the amount of the supplement is subject to an adjustment following the completion of an audit to the applicable period's cost report in which the FIDS project is initially reported.
- To determine the amount of the FIDS supplement, MDHHS will utilize the following calculation:
 - Qualifying FIDS construction or renovation costs above the CAV Limit are divided by the number of FIDS beds in the project divided by the number of years remaining in the supplemental program divided by 365 days.

10.13.F.4. CLASS III NURSING FACILITY REIMBURSEMENT FOR FIDS

For Class III nursing facilities participating in the FIDS program, MDHHS will increase the Plant Cost Component (PCC) up to five dollars (\$5) per Medicaid day for FIDS construction or renovation project costs above the nursing facility's PCL. MDHHS reimbursement methodology for the FIDS program follows current MDHHS nursing facility reimbursement guidelines and policy with the exceptions noted below.

- Up to five dollars (\$5) per Medicaid day is added to the nursing facility's PCC.
- The supplement amount is based on qualifying costs above the re-determined PCL determined by MDHHS either by plant cost certification or by cost reporting. When the plant cost certification estimate is used, the amount of the supplement is subject to an adjustment following the completion of an audit to the applicable period's cost report in which the FIDS project is initially reported.
- To determine the amount of the FIDS supplement, MDHHS will apply the following to qualifying project costs:
 - For FIDS renovation projects, the supplement is determined using qualifying costs to calculate the plant cost per resident day above the facility's PCL per resident day.
 - For a newly constructed facility, the calculation will be based on plant cost per resident day above the Class PCL per resident day effective the quarter the new construction is placed into service.

10.13.F.5. FIDS PROGRAM BILLING AND REIMBURSEMENT PROCESS

Participating FIDS providers are reimbursed per Medicaid day when claims are submitted for services provided in the FIDS area. FIDS facilities compliant with facility standards and culture change are eligible for the supplemental payment. Only participating FIDS providers billing for room and board in a FIDS area are to use the following revenue codes:

- For a single occupancy/private room, bill revenue code 0119
- For a double occupancy/semi-private room, bill revenue code 0129
- For Therapeutic Leave Day claims, bill revenue code 0189



- For hospice room and board, bill revenue code 0659

FIDS reimbursement is subject to post-payment audit action, including the prospective elimination of a provider's supplemental payment if the provider submits claims for FIDS services not provided in an approved FIDS area.

10.14 RATE RELIEF FOR CLASS I NURSING FACILITIES

Medicaid reimbursement rate relief for current and new nursing facility providers is determined on a case-by-case basis in accordance with specific criteria for evaluating eligibility for relief and rate methodology for determining the rate level. The following definitions of nursing facility providers are applied in this rate relief policy for Class I nursing facilities:

- Current provider is defined as the provider that operated the facility during the period of the last cost report on which the normal rate setting would occur, and will operate the facility during the period for which rate relief is requested.
- New provider is defined as a person or business entity that has purchased or is purchasing a nursing facility that had immediate prior Medicaid participation, and the new provider ownership individual(s) or business entity is not related through family or business ties to the ownership individual(s) or business entity of the previous provider. A nursing facility sale between family members may be approved by Medicaid and the new owner may be considered a new provider under certain circumstances, as outlined in the Ownership Changes and Medicaid Termination section of this appendix.

10.14.A. ELIGIBILITY CRITERIA [CHANGE MADE 4/1/20]

The provider must be a Class I nursing facility:

- The provider must demonstrate that the current Medicaid reimbursement (Rate + QAS) does not provide adequate funding to deliver a level of care to Medicaid beneficiaries in the facility that assures "each resident attains and maintains the highest practicable physical, mental, and psycho-social well-being" as required by the Omnibus Budget Reconciliation Act (OBRA) of 1987.
- The nursing facility Variable Rate Base amount must meet the following criteria:
 - For a Current Provider – The facility's Variable Rate Base is at or below the corresponding Class Average Variable Cost. The Average Variable Cost used for the class is the one that corresponds with the October 1 to September 30 rate year for which rate relief has been requested.
 - For a New Provider in a Medicaid-enrolled nursing facility – The facility's current Variable Rate Base is at or less than 80 percent of the corresponding Class Average Variable Cost. The Average Variable Cost used for the class is the one that corresponds with the October 1 to September 30 rate year for which rate relief has been requested. A new provider in a facility with a Variable Rate Base between 80 and 100 percent of the corresponding Class Average Variable Cost is eligible for accelerated rebasing and is treated as a current provider.
- A current Medicaid provider agreement for the facility is in effect. The rate relief period is applied to the facility and not the owner, provider, or licensee. A change of ownership,



provider, or licensee during the rate relief period does not end the agreement for rate relief under this policy as long as the new owner, provider, or licensee fully complies with the requirements of the rate relief agreement.

- The nursing facility provider must also meet at least one of the following six criteria:
 - The sum of the provider's Variable Rate Base, Economic Inflation Update, and other associated rate add-ons (excluding Nurse Aide Training and Testing reimbursement), plus the Net QAS, must be less than the provider's audited Medicaid variable cost per resident day for the provider's two fiscal cost reporting periods (not rate setting periods) of not less than seven months immediately prior to the first period of rate relief. This comparison to cost is a measurement to normal reimbursement rate calculation methodology and excludes the effect of Executive Order reimbursement actions. The provider must submit a per diem cost analysis using the outline format presented as a reference titled "Worksheet to Establish Criteria for Nursing Facility Class I Rate Relief". The required cost analysis information is available in electronic file format on the MDHHS website. (Refer to the Directory Appendix for website information.)
 - The provider is required, as a result of a survey by the SSA, to correct one or more substandard quality of care deficiencies to attain or sustain compliance with Medicaid certification requirements. The survey must have occurred within six months prior to the provider's request for rate relief. The provider must submit a copy of the citation and an approved Plan of Correction outlining the action being taken by the provider to address the requirement(s). The provider must submit to the MDHHS LTC Reimbursement and Rate Setting Section (RARSS) a copy of the citation and an approved Plan of Correction outlining the action being taken by the provider to address the deficiencies. A copy of facility staffing levels before and after the survey citation must be provided to RARSS to demonstrate the staffing increase is sustained and is not for short-term training purposes only.
 - The provider has experienced a significant change in the level of care needed for current Medicaid residents in the nursing facility. Significant change is defined as an increase of ten minutes per patient day, as demonstrated by Minimum Data Set (MDS) data, which results in a corresponding increase in direct care staffing equal to or greater than the increase in patient minutes per day. The provider must submit an analysis comparing resident acuity levels from the rate base year to current resident acuity levels. Minimum Data Set (MDS) data must be used for this comparison. The data is subject to a clinical review by Medicaid. The analysis must also include a comparison of the previous and current nurse staffing levels required based on actual residential census or actual patient days and other nursing related costs or requirements likely to increase the operational costs. This does not include nursing administration staff.
 - The provider is new in a Medicaid-enrolled facility and the facility's most recent cost report submitted to Medicaid was incomplete, undocumented or had unsubstantiated cost data by the previous provider. Inadequate cost reporting includes non-payment of accrued liabilities due to the previous provider's bankruptcy as determined by Medicaid auditors or their designees in accordance with Medicaid allowable costs, or inadequate records to support the filed cost report. Proof of the change of ownership must be submitted along with an explanation of why the cost report data is inadequate to calculate the provider's reimbursement rate.



- Rate relief is needed to prevent closure of a Medicaid-enrolled facility due to a regulatory action by the SSA, where the facility's closure would result in severe hardship for its residents and their families due to the distance to other nursing facilities, and no new provider would operate the facility at its current reimbursement rate. A facility would meet this hardship criterion only if a new owner has agreed to take over its operation and it is either the only nursing facility in the county or the facility has at least 65 percent of the Medicaid nursing facility (Class I, III and V) certified beds in that county.
- A nursing facility may qualify for rate relief if all other applicable criteria is met and if their current actual variable costs are **(revised per bulletin MSA 19-28)** less than or equal to 60 percent of the corresponding rate year's Variable Cost Limit. A facility is not eligible under this criterion if an owner's or administrator's compensation is above the current compensation limit. A provider with non-allowable related party transaction costs or non-allowable related party lease costs is not eligible under this criterion.

10.14.B. RATE RELIEF PETITION PROCESS [CHANGE MADE 4/1/20]

All petitions for rate relief must be in writing and submitted to RARSS. An authorized representative from the entity that holds the nursing facility license must sign the petition. A petition is not considered filed or complete unless all required supporting documentation is filed with the petition request. **(text added per bulletin MSA 19-28)**

It is the provider's responsibility to submit supporting documentation with the rate relief petition. A petition from the provider must include:

- Identification of the criterion under which rate relief is requested.
- Supporting documentation for the criterion.
- Detail of the circumstances causing the need for the rate relief request.
- A requested effective date (the actual effective date of the rate relief is based on the date that the petition is received by Medicaid). The earliest effective date would be the first day of the next month (i.e., a petition received on August 31 may be effective as soon as September 1).
- The services period that is the basis for which rate relief is requested.
- Detail of the expenses that are not in the base period for the current or subsequent fiscal year Medicaid rate and how these expenditures relate to the provision of resident care. NOTE: Increases in cost per day due to changes in resident occupancy or changes in the application of rate limitations do not constitute additional expenses.
- Plans on how these changes will ensure the required level of resident care.

Medicaid will make the final determination for the approval or disapproval of the rate relief request. Medicaid will provide a written response within 60 calendar days of Medicaid's receipt of the rate relief request. The response may include a request for additional information. The 60 calendar day period does not begin until the provider has submitted all of the necessary documentation for Medicaid to evaluate the rate relief request. Once the nursing facility provider has complied with the request(s) for



additional information, a written notice of the approval or disapproval is given within 30 calendar days of Medicaid's receipt of the additional information.

If Medicaid requests additional or supporting documentation needed to complete the evaluation of the rate relief request, the provider must submit the documentation within 30 calendar days of the request. If Medicaid does not receive the documentation or the provider has not received a one-time extension for 30 additional calendar days, the SMA will issue a denial notice for rate relief. Appropriate time allowances will be made in cases where the needed data is for a period that is not yet concluded. Subsequent rate relief requests by the provider will only be effective on a prospective basis following receipt of the new requests and documentation for rate relief.

10.14.C. RATE RELIEF AGREEMENT [CHANGE MADE 4/1/20]

If RARSS issues a written notice of approval for rate relief, an authorized representative from the nursing facility must sign and submit the rate relief approval agreement included in the letter to RARSS via File Transfer within 30 calendar days of the issuance of the notice. If the signed rate relief approval agreement is not submitted to RARSS within this time frame, then the rate relief approval is rescinded. **(revised per bulletin MSA 19-28)** Once the agreement is approved, the provider's Medicaid rate is adjusted consistent with the relief granted. The agreement outlines the rate relief granted, the effective date, and any conditions or requirements.

Requirements may include, but are not limited to,:

- Annual and interim cost reporting requirements during the period of rate relief.
- Appointment of a monitor, at facility cost, for oversight if, after consultation with staff in the SSA, such action is deemed appropriate.
- Follow-up surveys by the SSA.

10.14.D. RATE RELIEF PERIOD [CHANGE MADE 4/1/20]

Rate relief is effective on a prospective basis beginning in the month after receipt of the request and all required supporting documentation **(revised per bulletin MSA 19-28)** by RARSS. No retroactive rate relief will be approved.

Nursing facility providers may apply and receive rate relief under this policy once every seven years, i.e., 84 months. This seven-year period begins on the effective date of rate relief.

Example: If rate relief takes effect January 1, 2018, the facility would not be eligible for rate relief again until on or after January 1, 2025.

The rate relief period is based on the facility, not on the owner or licensee. A change of ownership does not void the seven-year period under this policy.



10.14.E. WITHDRAWAL OF RATE RELIEF AGREEMENT

Medicaid may withdraw the rate relief agreement if the facility is cited by the SSA for serious certification violations while receiving rate relief. If the citation(s) is for immediate jeopardy or substandard quality of care, or the provider is not spending the money in accordance with the plan filed for special rate relief, the rate relief agreement may be withdrawn. Medicaid will review the nursing facility actions to determine if rate relief termination is warranted. If Medicaid terminates the agreement, the nursing facility's Medicaid rate will be recalculated in accordance with existing Medicaid reimbursement policy without rate relief. The rate change would take effect at the beginning of the month following issuance of a 30-calendar day notice to the provider.

10.14.F. RATE RELIEF APPEALS

Nursing facility providers that receive notices of denial for rate relief or are notified that a rate relief agreement has been withdrawn may file an appeal. Appeals are handled in accordance with the existing appeals process. Additional information appears in the Appeal Process section in this appendix.

10.14.G. RATE RELIEF FOR A NEW PROVIDER IN A MEDICAID-ENROLLED NURSING FACILITY WITH A VARIABLE RATE BASE LESS THAN OR EQUAL TO 80 PERCENT OF THE CLASS AVERAGE VARIABLE COST

A new provider in a Medicaid enrolled nursing facility with a Variable Rate Base less than or equal to 80 percent of the Class Average Variable Cost may request an increase in the current facility rate. The new provider must be operating in a facility that has previously participated with Medicaid.

10.14.G.1. RATE RELIEF METHODOLOGY

A new rate is calculated using the Class I Average Variable Cost for the appropriate year as the Variable Rate Base for the calculation of the facility Variable Cost Component, thereby increasing the facility per diem rate. This Variable Rate Base is in effect through the current State fiscal year rate period ending September 30.

Effective October 1 of the State fiscal year rate period starting after the new provider begins operation, the Variable Rate Base is determined using accelerated rebasing. The accelerated rebasing utilizes the new provider's first cost reporting period that reflects at least seven months of nursing facility operation. The cost reporting period is based on the new provider's established fiscal year. The nursing facility allowable variable cost is indexed to October 1 of the year that is one year prior to the new rate year being calculated by applying the appropriate cost index. The new provider Variable Rate Base is limited to the Class I Average Variable Cost for the corresponding rate year period.

The new provider receiving rate relief in this category must utilize the standardized data to file a Class I Rate Relief Interim Cost Statement prior to September 15. The Interim Cost Statement excerpted worksheets from the Medicaid annual cost report (Medicaid cost reporting formats identified below) must reflect actual or expected costs incurred by the nursing facility for the new provider's first cost reporting period (as referenced



above). The facility's annual cost report may be used in lieu of the Interim Cost Statement if the cost report will be filed with Medicaid prior to September 15.

The Rate Relief Interim Cost Statement must contain the following completed schedules of the cost report in the MDHHS required electronic format:

- Checklist
- Worksheet A
- Worksheet B
- Worksheet 1
- Worksheet 1-C (only if claiming allocated related party costs)
- Worksheet 2

The Interim Cost Statement is used to determine the interim rate utilizing the accelerated rebasing provisions. The interim rate is revised when the acceptable annual cost report is submitted and used for accelerated rebasing.

The subsequent rate year calculation is in accordance with standard reimbursement methodology.

Example: A new nursing facility provider begins operations on January 1, 2019 and selects a September 30 year-end cost reporting period. Following request, the provider is approved for rate relief for rate year October 1, 2018 to September 30, 2019. The facility per diem rate is set using the Class I Average Variable Costs effective for the rate year beginning October 1, 2018 (effective for the new provider on January 1, 2019). The provider must complete an interim cost statement for variable costs for the period January 1, 2019 through September 30, 2019 that must be filed by September 15, 2019. Effective October 1, 2019, the Variable Rate Base is the lesser of the variable costs from the interim cost statement indexed to October 1, 2018 or the Class Average Variable Cost effective October 1, 2019. Following the filing of the annual cost report, the variable costs from the annual report are indexed to October 1, 2018, and the interim Variable Rate Base is recalculated.

Rate relief is subject to audit and settlement with reimbursement adjustment using the principles and guidelines outlined in Medicaid policy. Rate relief reimbursement cannot exceed the appropriate cost and rate limitations. The provider is reimbursed by Medicaid for any underpayment, and the provider must reimburse Medicaid for any overpayment. If the interim Variable Rate Base determined for rate relief reimbursement to the provider exceeds the audited Variable Rate Base reimbursement by more than three percent, the provider will be assessed a penalty equal to 10 percent of the total overpayment amount.

A nursing facility provider receiving rate relief is allowed to participate in any other add-on reimbursement programs at their election. These programs are handled under the Medicaid policy applicable to the program. The costs associated with these add-on programs are not included in the cost settlement of the variable costs for rate relief as previously described.



10.14.H. RATE RELIEF FOR A CURRENT PROVIDER OR A NEW PROVIDER IN A MEDICAID ENROLLED NURSING FACILITY WITH A VARIABLE RATE BASE BETWEEN 80 PERCENT AND 100 PERCENT OF THE CLASS AVERAGE VARIABLE COST

A current or new provider in a Medicaid enrolled nursing facility with a Variable Rate Base between 80 percent and 100 percent of the Class Average Variable Cost may request accelerated rebasing.

Rate relief applies only to the nursing facility's Variable Rate Base. The facility's qualification for adjustment of the Plant Cost Component in the Medicaid rate and Nurse Aide Training and Testing costs is handled in accordance with current Medicaid policy.

10.14.H.1. RATE RELIEF METHODOLOGY

Accelerated rebasing is the use of the Medicaid cost report data from the period ending in the current calendar year in the rate setting process, rather than using cost report data from the period ending in the previous calendar year under the standard reimbursement methodology. The nursing facility's allowable variable cost is indexed to October 1 of the year that is one year prior to the rate year being calculated by applying the appropriate cost index.

Example: The provider's cost report for the period ending December 31, 2019 could be used to set the October 1, 2019 rate if approved for rate relief under the criteria established in the Eligibility Criteria Section of this Appendix. The provider would be allowed to participate in any add-on reimbursement programs at their election.

The cost reporting is based on the provider's established fiscal year and must not cover a period of less than seven months. The cost report period used for accelerated rebasing must have a reporting period end date prior to January 1 of the State rate year. This example is applicable to the third and fourth criteria for rate relief qualifications as stated in the Eligibility Criteria Section of this Appendix.

Example: A cost report period ending after January 1, 2019 could not be used for accelerated rebasing of a rate effective during the State rate year October 1, 2018 through September 30, 2019.

10.14.I. RATE RELIEF FOR A CURRENT PROVIDER IN A MEDICAID ENROLLED NURSING HOME FACILITY WITH A VARIABLE RATE BASE LESS THAN OR EQUAL TO 60 PERCENT OF THE VARIABLE COST LIMIT

A current provider in a Medicaid enrolled nursing facility with a Variable Rate Base of less than or equal to 60 percent may request rate relief.

10.14.I.1. RATE RELIEF METHODOLOGY

A new Variable Rate Base of the rate is calculated that will be no more than 50 percent of the difference between the Class I Average Variable Cost and the existing Variable Rate Base for the current rate year. The resulting new Variable Cost Component will



thereby adjust the facility's per diem rate. This Variable Rate Base will remain in effect through the current State fiscal year rate period ending September 30.

Example: A nursing facility has a current Variable Rate Base of \$96, the Variable Cost Limit is \$160, and the Class I Average Variable Cost is \$150 (none of the figures are based on actual data, they are used for example purposes). Based on the facility's request for rate relief, they are found eligible for the maximum 50 percent of the difference between their current Variable Rate Base and the Average Variable Cost. Their Variable Rate Base will then increase from \$96 to \$123.

The provider receiving rate relief in this category must utilize the standardized data to file a Class I Rate Relief Interim Cost Statement at the time of application for relief. The Interim Cost Statement excerpted worksheets from the Medicaid annual cost report (Medicaid cost reporting formats identified below) must reflect actual or expected costs incurred by the nursing facility for the provider's cost reporting period. A facility with less than seven months remaining in its cost reporting period may file a second Interim Cost Statement at the end of that fiscal year.

The Rate Relief Interim Cost Statement must contain the following completed schedules of the cost report in the MDHHS required electronic format:

- Checklist
- Worksheet A
- Worksheet B
- Worksheet 1
- Worksheet 1-C (only if claiming allocated related party costs)
- Worksheet 2

The Interim Cost Statement is used to determine the interim rate for the remainder of the rate period. The interim rate is revised when the acceptable annual cost report is submitted and used for accelerated rebasing.

Effective October 1 of the following State fiscal year rate period, MDHHS determines the Variable Rate Base using accelerated rebasing. The accelerated rebasing utilizes the provider's first cost reporting period that reflects at least seven months of nursing facility operation after rate relief. The cost reporting period is based on the provider's established fiscal year. The nursing facility allowable variable cost is indexed to October 1 of the year that is one year prior to the new rate year being calculated by applying the appropriate cost index.

The subsequent rate year calculation is in accordance with standard reimbursement methodology.

Example 1 - Request Received with Less Than Seven Months in the Cost Reporting Period: A provider has a cost reporting period ending on December 31 of each year. The provider is approved for rate relief for rate year October 1, 2018 to September 30, 2019. The facility per diem rate is set using a new Variable Rate Base of



no more than 50 percent of the difference between the Variable Rate Base and Class I Average Variable Costs effective for the rate year beginning October 1, 2018. The provider must complete an Interim Cost Statement for variable costs for their cost report period that must be filed with their rate relief request. In this instance, they may submit a revised Interim Cost Statement for the provider's cost reporting period January 1, 2019 through December 31, 2019. The rate year beginning October 1, 2019 would then utilize the accelerated rebasing to determine the rate for that period based on the December 31, 2019 fiscal year.

Example 2 - Request Received with Seven Months or More in the Cost

Reporting Period: A provider has a cost reporting period ending December 31 of each year. The provider is approved for rate relief and submits their Interim Cost Statement ending on February 1, 2018. The facility per diem rate is set using a new Variable Rate Base of no more than 50 percent of the difference between the Class I Average Variable Cost and the Variable Base Cost effective for the rate period February 1, 2018 through September 30, 2018. The rate relief would be effective through the end of the rate relief period of September 30, 2018. The rate year beginning October 1, 2018 would then utilize the accelerated rebasing to determine the rate for that period based on the December 31, 2018 fiscal year.

Rate relief is subject to audit and settlement, with reimbursement adjustment using the principles and guidelines outlined in Medicaid policy. Rate relief reimbursement cannot exceed the appropriate cost and rate limitations. The provider is reimbursed by Medicaid for any underpayment, and the provider must reimburse Medicaid for any overpayment. If the interim Variable Rate Base determined for rate relief reimbursement to the provider exceeds the audited Variable Rate Base reimbursement by more than three percent, the provider will be assessed a penalty equal to 10 percent of the total overpayment amount.

A nursing facility provider receiving rate relief is allowed to participate in any other add-on reimbursement programs at their election. These programs are defined under the Medicaid policy applicable to the program. The costs associated with these add-on programs are not included in the cost settlement of the variable costs for rate relief as previously described.

10.15 COUNTY MEDICAL CARE FACILITIES SPECIAL PAYMENTS (CMCFSP) PROGRAM

Eligible County Medical Care Facilities (CMCF) may receive special payments for unreimbursed costs incurred for services to Medicaid beneficiaries. Allocations to individual facilities will be determined based upon unreimbursed costs certified as public expenditures in accordance with the Code of Federal Regulations (CFR) 42 CFR 433.51. MDHHS will make special payments to CMCFs who provided services to Medicaid beneficiaries for dates of service on and after January 1, 2009.

10.15.A. ELIGIBILITY FOR CMCFSP PROGRAM

To be eligible for participation in the CMCFSP Program, each provider must meet the following conditions:

- The provider must be a county-owned and -operated licensed CMCF.



- The provider must be certified to serve Medicaid beneficiaries.
- The provider must have reported Medicaid bed days during the fiscal year covered.
- The provider must have incurred allowable costs in excess of Medicaid reimbursement for Medicaid bed days reported during the fiscal year covered.

10.15.B. ENROLLMENT IN CMCFSP PROGRAM

To participate in the CMCFSP Program, a Medicaid-participating CMCF must submit a signed copy of the Attestation of Participation form to the MDHHS LTC Reimbursement and Rate Setting Section (RARSS). (Refer to the Directory Appendix for contact information.) Providers must acknowledge and agree to the terms of participation in the CMCFSP Program as outlined in this section and in the attestation form.

If a provider desires to receive interim payments during their fiscal year, the request to participate in the CMCFSP Program must be received prior to that fiscal year for which participation is desired. A provider may also wait to submit a request to participate until the filing of their annual Medicaid cost report. If a provider opts to participate when they file their annual cost report, the provider may receive payments for unreimbursed costs through the initial and final reconciliation, but will not receive interim payments.

If participation is approved, RARSS will enroll the provider in the CMCFSP Program in the provider's fiscal year following the approval of RARSS. The provider must submit an attestation form for each year that the provider desires to participate in the CMCFSP Program.

10.15.C. CALCULATION OF CMCFSP PAYMENT

An interim payment and reconciliation process will be employed to make payments to qualifying facilities. Allowable unreimbursed costs for services provided to Medicaid beneficiaries will be determined from information reported on the most recently filed cost report. Allowable unreimbursed costs are defined as total allowable Medicaid routine costs before formula limitations minus total Medicaid routine services revenue received. Medicaid routine services revenue includes all revenues received for Medicaid routine services, including all supplemental/enhanced payments (e.g., Net QAS, Net QMI Amount, etc.) from the State and all payments received from residents and other payers for the same services. Costs will be trended to the current state fiscal year using an inflation factor, without capital, taken from the Health Care Cost Review, which is published quarterly by Global Insight. Interim payments will then be made to qualifying CMCFs.

10.15.D. RECONCILIATION PROCESS

Interim payments will be reconciled twice. First, an interim reconciliation of the original payments will be conducted based on allowable Medicaid costs. Information needed to reconcile initial payments will be obtained from the cost report filed with MDHHS for the applicable reporting period. Second, payments will be readjusted based on changes to the filed cost report for the applicable reporting period, resulting from an audit of that cost report conducted by MDHHS.



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Facilities receiving special payments for unreimbursed Medicaid costs are liable for any overpayment amount identified in the reconciliation process. Providers must repay any overpayment amount within 120 days of the date of notification of overpayment.



SECTION 11 - APPEAL PROCESS

A nursing facility participating in the Medicaid program may appeal an adverse action and certain determinations made by Medicaid. The provider will be given a written notice of the determination or action that outlines the proposed action, the provider's appeal rights, and the appeal process.

Adverse actions include, but are not limited to:

- A suspension or termination of a provider's Medicaid program participation.
- A reduction, suspension, or adjustment of provider payments.
- A retroactive adjustment following an audit or review of a facility's daily reimbursement rate or other services reimbursement.
- The prospective reimbursement rate determination.

Some elements of the Medicaid nursing facility reimbursement determination methodology are not appealed through an administrative process, but may be appealed to a court of appropriate jurisdiction. These are elements where an administrative remedy, if permitted for a single provider, would imply or necessitate a change for all providers or for all providers in a class and include, but are not limited to:

- The formula for the determination of the nursing facility cost factor.
- The Principles of Reimbursement and guidelines that define allowable costs.
- Medicaid Interim Payment (MIP) Program normal payment amount or reconciliation of payments and approved service billings.
- Non-Medicaid issues.
- Cost limits established in program policy.
- Medicaid's determination of allowable items and costs until an audit has been completed.

The provider retains their right to an administrative hearing regardless of the outcome of the internal conference. The provider may waive the internal conference and directly request an administrative hearing. The review and hearings process for providers has been promulgated in the administrative rules located on LARA's website. The process is explained in more detail in the MDHHS Administrative Hearing pamphlet on the MDHHS website. (Refer to the Directory Appendix for website information.)

11.1 AUDIT APPEALS [CHANGES MADE 4/1/20]

Each nursing facility cost report is audited to ensure that expenses were reported in adherence with Medicaid policy. Once the Exit Meeting is completed or waived, the provider is given a Preliminary Summary of Audit Adjustments Notice via File Transfer. This notice outlines audit results, serves as the adverse action notice, and advises the nursing facility of subsequent appeal rights, up to and including an administrative hearing. The provider or their designee has 30 calendar days from the date of the Preliminary Summary of Audit Adjustments Notice to request a formal hearing in accordance with MDHHS rules for hearings.



If the provider or the provider's designee does not respond to the Preliminary Summary of Audit Adjustments Notice within 30 calendar days of the date of the notice, then the Preliminary Summary of Audit Adjustments Notice will serve as the Final Summary of Audit Adjustments Notice. If the appeal process is exhausted, the provider will receive a Final Summary of Audit Adjustments Notice. The Final Summary of Audit Adjustments Notice outlines the final audit results and may not be appealed. A Preliminary Summary of Audit Adjustments Notice that serves as a Final Summary of Audit Adjustments Notice is also not appealable.

To ensure faster processing of final settlements, a provider should notify MDHHS via File Transfer if they are not appealing any of the audit adjustments in the Preliminary Summary of Audit Adjustments Notice.

If a provider does not appeal or does not respond to the Preliminary Summary of Audit Adjustments Notice or other notices or processes related to a conference or hearing within the allotted timeframe, the provider has waived the right to any further administrative review. **(revisions per bulletin MSA 19-28)**

11.2 RATE APPEALS

Providers are notified in writing of their Medicaid reimbursement rate(s) at least 30 calendar days prior to the rate's effective date. The provider is given an opportunity for informal review of the rate determination by RARSS. The provider may also formally appeal issues of disagreement or dispute regarding the determined reimbursement rate. A notice of appeal rights, with instructions on how to request an appeal, is included in the final settlement Notice of Medicaid Reimbursement.

11.3 REIMBURSEMENT SETTLEMENT APPEALS

A final settlement reimbursement determination is made to determine the aggregate Medicaid reimbursement to the nursing facility for the period covered by the cost report. Providers are notified in writing of the final reimbursement settlement and given an opportunity for informal review of the settlement determination. The provider may formally appeal issues of disagreement or dispute of the reimbursement settlement determination. A notice of appeal rights, with instructions on how to request an appeal, is included in the final settlement Notice of Program Reimbursement.

11.4 PROVISIONAL RATES

A provider will be given a provisional rate for the new rate year if:

- Medicaid is responsible for a delay in determination procedures.
- An Area Office Conference or Administrative Conference is in progress.
- The potential for an Area Office Conference or an Administrative Conference is still open at the beginning of the rate year that begins a year and a day after the end of the rate year that is being processed.



For this purpose, "delay in the procedures" means (if applicable):

- Medicaid failed to issue the Preliminary Summary of Audit Adjustments in a timely manner.
- Medicaid failed to conduct the Area Office Conference in a timely manner.
- Medicaid failed to issue the Final Summary of Audit Adjustments Notice, including a final determination notice, in a timely manner.

11.5 PROVIDER PAYMENT ADJUSTMENT RESULTING FROM APPEAL DECISION

If the appeal result requires a change in a provider's rate or reimbursement level, the change will be made retroactively for service periods coinciding with the effective dates of the original reimbursement rate notice. Payment adjustments will be made by an aggregate adjustment rather than by individual claim adjustments.



SECTION 12 - MEDICAID INTERIM PAYMENT PROGRAM

A nursing facility has the option of selecting one of two payment methods:

- payment directly related to claims submitted to and processed by CHAMPS, or
- enrollment in the Medicaid Interim Payment (MIP) Program.

Providers enrolled in MIP receive a pre-determined dollar amount in cycled payments. MIP payments represent the expected dollar amount that Medicaid would have paid to the nursing facility in claims reimbursement during a period of time. The MIP payment calculation is based on historical approved billings, current reimbursement rate and claims data. MDHHS may perform interim reconciliation(s) if a significant amount is due the program. After the end of the quarter, a comparison is made of the most recent pre-determined payment and the approved days activity billed. The result of the comparison could result in an increase or a decrease to the MIP payment amount. A reconciliation is done at the end of the provider's fiscal year.

12.1 ENROLLMENT IN MIP

To participate in MIP, a Medicaid participating provider must submit a written request to RARSS. New providers must submit the necessary information outlined in the New Provider Information Data format. Established providers may submit a written request. Providers must acknowledge and agree to the terms of participation in the MIP as outlined in this section. Requests to enroll in MIP must be received one month prior to the beginning of the calendar quarter for which enrollment is desired.

If enrollment is approved, RARSS will enroll the provider in MIP in the calendar quarter following the approval of RARSS. Once MIP payments begin, claims approved through CHAMPS, regardless of date of service, will not generate a separate or additional payment.

12.2 DISENROLLMENT IN MIP

To disenroll in MIP, the provider must submit a written request to RARSS. The request to disenroll must be received by RARSS one month prior to the end of a calendar quarter. Disenrollment is effective at the beginning of the calendar quarter following the receipt of the request by RARSS.

Providers terminating participation in the Medicaid Program will not receive a MIP payment in the final month of participation.

The final month's MIP payment is subject to reconciliation to determine the status of MIP. Special arrangements may be made where there is guaranteed assurance the State can recover any payment difference that may exist as the result of MIP participation. A provider interested in a special arrangement must contact RARSS for consideration.

Providers interested in re-enrollment in the MIP program must wait at least one full quarter before reapplying.



12.3 CLAIMS SUBMISSION

Providers are expected to submit claims for services rendered in a timely manner. Although a provider enrolled in MIP does not receive payment directly from claims submission, future MIP payments are affected by claims submission. MIP payments are calculated for expected days to be reimbursed.

12.4 CALCULATION OF MIP PAYMENT

The MIP amount is recalculated on a quarterly basis. The recalculation is to update the MIP amount to reflect the current Medicaid billing activity for the facility and the provider's Medicaid per diem rate when necessary. A recalculation may occur any time during a calendar quarter due to a change in the provider's per diem rate. The quarterly recalculation is based on the approved claims activity over the most recent twelve months, regardless of the date of service, and Medicaid utilization during the same period. At the end of each quarter, the recently completed quarter's approved claims are used to update the MIP payment calculation.

The annually projected State liability to the provider (total reimbursement less other insurance and patient payments) will be divided by 24 to determine the regularly scheduled payment amount that will be made twice a month. The other insurance and patient payment amounts are based on the most recent quarter payment data projected to an annual amount.

In the case of major problems to Medicaid data system where a significant change has occurred in the approved claims data for a quarter as a result of Medicaid data system, the MIP amount would continue as previously calculated or the provider may request that RARSS perform a recalculation. If a significant reduction in the MIP amount is due to a problem outside the provider's control, such as a payment system error, the provider may request that RARSS perform a recalculation as a special consideration. RARSS staff will analyze and review the request to determine if special consideration is warranted.

Interim recalculations requests as a result of provider delays in billing must be submitted to RARSS for approval or denial. Providers that have demonstrated repeated occurrences of delays in billing may not receive an interim recalculation.

12.5 FREQUENCY OF MIP PAYMENT

The biweekly MIP payment is an estimate of one-half of the Medicaid liability for reimbursable services rendered in the previous month. The MIP payment will be paid on the first and third Thursday of each month. This means a provider could receive 100 percent of the monthly payment as early as the 15th day of the month and no later than the 21st day. Providers enrolled in MIP will receive six regularly scheduled payments during a calendar quarter.

12.6 ANNUAL RECONCILIATION

The reconciliation of approved claims and MIP payments is done annually, generally 90 calendar days after the end of the provider's fiscal year. If a provider changes their cost-reporting fiscal year, they must notify RARSS in advance in writing. Any change in a fiscal year could adversely affect a provider in the reconciliation.



If an underpayment has been made, the provider will receive a gross adjustment payment. If an overpayment is determined, recovery will be made by gross adjustment recovery against future payments. The gross adjustment process follows the Initial and Final Settlement practices in the respective subsections of this appendix. A provider may submit a written request to RARSS for an extended repayment schedule to repay the Program. The request must provide adequate justification for the need for extended repayment.

MIP amount determination, reconciliation and adjustments are not subject to appeal under the administrative rules. The MIP Program does not determine the reimbursement rate; it is an interim payment mechanism substituting for CHAMPS payments. The provider is given advance notice of the MIP actions and can request a review with RARSS. The provider's action must be timely and specific to the problem.

12.7 NEW PROVIDERS

New providers, resulting from a change in facility ownership, may request MIP at the time of Medicaid Program enrollment by submitting the information in the New Provider Information Data format to RARSS.

New providers in facilities without historical Medicaid Program billing data are not eligible for MIP.



SECTION 13 – APPRAISAL GUIDELINES

Where historical cost records of a purchased asset are not available or are incomplete, or where fair market value or current reproduction cost must be established, a timely appraisal of the historical costs, fair market value, or depreciated reproduction cost (as appropriate) of the asset made by an independent, recognized expert is acceptable for depreciation and owner's equity capital purposes. The appraisal of the historical cost of assets should produce a value approximating the cost of reproducing substantially identical assets of like type, quality, and quantity at a price level in a bona fide market as of the date of acquisition. The appraisal must be conducted in accordance with "The Principles of Appraisal Practices and Code of Ethics" of the American Society of Appraisers.

For Medicaid program purposes, the term "appraisal" refers primarily to the process of establishing or reconstructing the historical cost, fair market value, or current reproduction cost of an asset. It includes a systematic, analytic determination and the recording and analyzing of property facts, rights, investments, and values based on a personal inspection and inventory of the property.

Appraisal Date	The date selected for establishing the value of fixed assets. For example, if December 31, 2017 was established as the appraisal date and the actual physical inventory of fixed assets was taken on February 1, 2018, any additions or dispositions of fixed assets between December 31, 2017 and February 1, 2018 must be taken into account in the appraisal values.
Appraised Book Value	The book value of an asset's appraised cost as of the date of acquisition less accumulated depreciation computed on an approved basis up to the appraisal date.
Appraisal Expert	An individual or firm that is experienced and specialized in multi-purpose appraisals of plant assets involving the establishment or reconstruction of the historical cost, fair market value, or current reproduction cost of such assets. The appraisal expert must employ a specially trained and well supervised staff with a complete range of appraisal and cost construction techniques; be experienced in appraisals of plant assets used by providers; and demonstrate a knowledge and understanding of the reimbursement principles, particularly those pertinent to depreciation.

13.1 APPROVAL

Medicaid does not require the nursing facility representatives to get prior approval before an appraisal is made for Medicaid purposes. Medicaid requirements are that the appraisal be conducted in accordance with the provisions of these guidelines. Questions regarding the appraisal of the nursing facility should be directed to the MDHHS LTC Reimbursement and Rate Setting Section (RARSS). (Refer to the Directory Appendix for contact information.) The provider must make the appraisal agreement and final report available to Agency staff for audit review. The scope of the appraisal must conform to Medicare Principles of Reimbursement as modified by Michigan Medicaid for provider costs in effect on the appraisal date.

13.2 NEED FOR APPRAISAL

An appraisal for Medicaid purposes should be made only where the nursing facility provider has no historical cost records, has incomplete records of the depreciable fixed assets, or needs to determine an asset's fair market value or depreciated reproduction cost. The appraisal should develop the historical cost and related information that will assist in the construction, reconstruction, or revision of accounting



records to enable the provider to make proper distribution of depreciation expense in cost reports. Normally, a proprietary provider will not need a historical cost basis of its assets. Where an appraisal is being performed to determine the current reproduction of an asset, the appraisal should represent the cost to reproduce the actual facility in like kind and should not be inflated by such factors as current or anticipated space needs or different construction types, e.g., masonry versus wood frame. Appraisals must be performed within the time limit specified in the proposed agreement and not on a piecemeal or intermittent basis.

13.3 PURCHASE OF ONGOING FACILITY

In establishing the historical cost of assets where an ongoing nursing facility is purchased through a bona fide sale after July 1, 1966 and prior to August 1, 1970, the purchase price or portion thereof attributable to the asset must not exceed the fair market value of the asset at the time of the sale. For depreciable assets acquired after July 1970, the cost basis of the depreciable assets must not exceed the lower of the current reproduction cost adjusted for straight-line depreciation over the life of the assets to the time of the sale or the fair market value of the tangible assets purchased.

If the nursing facility was participating in the Medicaid program at the time of sale, the sale price used by the seller in computing gain or loss for the final cost report must agree with the historical cost used by the new facility owner (the purchaser) in computing depreciation. However, where the basis for depreciation to the purchaser for an asset acquired after July 1970 is limited to the lower of current reproduction cost (adjusted for straight-line depreciation from the time of asset acquisition to the time of the sale) or the fair market value, the basis for computing gain or loss to the seller is the sale price. The gain or loss on the sale of each depreciable asset must be determined by allocating the lump sum sale price among all the assets sold (including land, goodwill, and any assets not related to resident care) in accordance with the fair market value of each asset as it was used by the seller at the time of sale. If the purchaser and seller cannot agree on an allocation of sale price, or if they do agree but there is insufficient documentation of the current fair market value of each asset, the SMA will require an appraisal by an independent appraisal expert to establish the fair market value of each asset and will make an allocation of the sale price in accordance with the appraisal. In any case, the sale price must be allocated among all the assets sold, even if some of the assets will be disposed of shortly after the sale.

If a purchaser cannot demonstrate that the sale is bona fide, the seller's net book value will be used by the purchaser as the basis for depreciation of the asset. In such cases, the purchaser must record the historical cost and accumulated depreciation of the seller recognized under the Medicaid program, and these must be considered as incurred by the purchaser for Medicaid purposes.

The cost basis for the depreciable assets of a nursing facility purchased in a bona fide sale on or after August 1, 1970 is limited to the lowest of the following:

- The total price paid for the facility by the purchaser as allocated to the individual assets;
- The total fair market value of the facility at the time of the sale as allocated to the individual assets;
- The combined fair market value of the individually identified assets at the time of the sale; or
- The current reproduction costs of the depreciable assets, depreciated on a straight-line basis over the life of the assets to the time of the sale.



The purchaser has the burden of proving that the transaction was a bona fide sale, and if the burden is not met, the cost basis may also not exceed the seller's cost basis less accumulated depreciation.

13.4 FIXED ASSETS INCLUDED IN APPRAISED VALUES

Fixed asset values established by an appraisal must include all plant assets owned by the nursing facility provider that are used in resident care or in the overall operation and administration of the facility. Fixed assets used in research and other non-allowable cost areas or functions should be included so that depreciation is reflected in those departmental costs to provide a proper basis for allocating administrative and general expense. Fixed assets of a related organization not used by a provider in rendering resident care, assets acquired in anticipation of expansion, and assets held for investment and not used in the plant operation should not be included as a part of the appraised values.

Generally accepted accounting principles relating to improvements or betterments must be followed in determining the asset values established by the appraisal. Repair or maintenance of a nature that restores an asset to its original condition but does not extend its useful life is not betterment or improvement but an expense of that period.

The pricing of assets to establish historical costs is based on such actual supporting documents as vendor invoices and construction contractor completion statements. In the absence of invoices, such other records as revenue stamps, board minutes, contracts of purchase, and deeds recorded with the county's Recorder of Deeds may be used.

Other methods, such as manufacturer's catalogs, libraries of material prices, or techniques involving reverse trending and price indices may be used to establish acquisition costs and dates. Such methods may be used only when actual supporting documents are not available. When these sources and techniques are used, consideration must be given to the manufacturers and to quantity discounts. The determined value should closely approximate the actual historical cost of an asset at the date of acquisition.

13.5 MINOR EQUIPMENT

Where minor equipment is concerned, the SMA recognizes that the inventory costs of such equipment may not truly reflect the cost of equipment purchased and in use by the nursing facility provider. Differences in the capitalization policies of providers and their desire to limit property record controls over certain classes of small assets cause variations in the recorded costs of assets generally considered depreciable. Medicaid will only recognize an appropriate amount for minor equipment costs where the original equipment acquisition cost was recorded in the accounting records as capital asset cost and had not previously recorded the minor equipment acquisition as current period operations expense.

Minor equipment includes, but is not limited to, such items as wastebaskets, bedpans, syringes, catheters, silverware, mops, and buckets. The general characteristics of this type of equipment are as follows:

- The equipment is in no fixed location and is subject to use by various departments in the nursing facility;
- The items are comparatively small in size and unit cost;
- The equipment is subject to inventory control;



- There is a fairly large quantity of the items in use; and
- The equipment has a useful life of approximately three years or less.

However, where all other depreciable assets are concerned, such as buildings, building equipment, major movable equipment, land improvements, and leasehold improvements, the Medicaid program will not recognize a historical cost of such assets in excess of the historical cost used for federal income tax purposes. Nursing facility providers should be able to support this historical cost by reference to original documents such as contracts, vouchers, checks and other evidence. If the provider does not have such original documentation constituting primary evidence of the historical cost of assets, the SMA will consider the provider's federal income tax returns as secondary evidence to be used in establishing and verifying the historical cost of the assets. Further, it is possible that because of the effects of other provisions within the Medicare Principles of Reimbursement, such as "cost to related organizations," the historical cost under Medicaid might be less than that allowed and used for income tax purposes.

Under the Principles, nursing facility providers may change the useful lives of assets where this can be justified and appropriately adjust the accumulated depreciation applicable to the historical cost of the assets involved. The effect of such adjustments is to change the undepreciated amount of the historical cost for Medicaid purposes. The Principles do not permit providers to increase the historical cost basis of their assets to recognize elements of costs or expenditures that were not capitalized but were considered as expense items.

Example: If a provider determines that a physical modification of the building was a repair, and thus an item of expense not capitalized, and uses the historical cost so determined for federal income tax purposes, the provider may not change the historical cost basis to include that expenditure previously determined a repair and capitalize it, i.e., increase the historical cost basis of the building for Medicaid purposes.

Example: If a provider builds a facility and, in establishing the historical cost of the building, determines that material and labor used were not part of the historical cost of the building and charges the cost of such material and labor into expenses for federal income tax purposes, the provider may not then include such expenditures in the historical cost of the building for Medicaid purposes.

Costs in excess of the cost basis used for federal income tax purposes will not be recognized under Medicaid. Further, for cost reporting periods beginning on or after January 1, 1970, the SMA will also require a redetermination of allowable costs for the reporting period covered to reflect the effects of the adjustment in the historical cost basis of the assets. For cost reporting periods beginning before January 1, 1970, however, no redetermination of such allowable costs need be made for the reporting periods covered. Accumulated depreciation applicable to the depreciable assets under the Medicaid program will include the full amount allowed during those periods in which an increased historical cost basis was used. The net book value will be used for computations of gain or loss on the sale of assets and for any other reimbursement purposes under Medicaid.

13.6 DONATED ASSETS

The fair market value for a donated asset is the price that the asset would bring by bona fide bargaining between well-informed purchasers and sellers at the date of acquisition. Usually, the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition.



Exception: In cases where an asset has been used or depreciated under the Medicaid program and then donated to a provider, the basis of depreciation will be the lesser of the fair market value or the net book value of the asset in the hands of the owner last participating in the program.

If the nursing facility provider's records do not include the fair market value of the donated assets as of the date of donation, an appraisal of such fair market value by a recognized appraisal expert will be acceptable for depreciation and owner's equity capital purposes.

Where material, labor, and services are donated in the construction of an asset, the asset value is the sum of the appraised cost of the material, labor, or services actually donated and the incurred cost of that part which was not donated. Labor costs should be determined in accordance with both the rates prevailing in the community at the time of construction and the type of labor incurred, i.e., if the labor donated was non-union labor, the cost would be at the non-union labor rate rather than at a union labor rate. If records are not available as to the actual labor, services, or material donated, the fair market value at the time of donation may be determined by the other methods shown in Medicare Principles of Reimbursement. Estimated labor costs provided by an owner or shareholder of a facility are not includable in the historical cost of constructed assets.

13.7 ASSETS COSTING LESS THAN \$100

Individual major movable assets costing less than \$100, whether or not purchased in quantity prior to the appraisal date, may be capitalized at the time of appraisal at the purchase cost less accumulated depreciation from the date of acquisition regardless of the provider's past accounting practices. If an election is made to capitalize such assets, this policy must be applied consistently.

Nursing facility providers that have expensed such items while in the Medicaid program may not decide later to capitalize them. This also applies to those providers that eventually decide to have appraisals. The appraisal expert may group major movable equipment with a unit cost of \$100 or less. However, the book value assigned to such grouped assets at appraisal may not exceed the book value of the assets if individually appraised. Identification of the individual assets comprising the group must be available.

13.8 TAGGING OF EQUIPMENT

For Medicaid program purposes, tagging of equipment is not mandatory. In the absence of tagging, however, alternate records must be maintained to satisfy audit verification of the existence and location of the assets.

13.9 APPRAISAL PROGRAMS

Since the condition of nursing facility provider asset records varies significantly, an appraisal program may be comprehensive or partial. For instance, a provider may engage an appraisal expert to appraise a part of its facility for which no historical records have been maintained, or a provider may need to have an appraisal made on a particular class of assets in a specific identified location.

Comprehensive appraisal programs are usually appropriate because of such complexities as lump-sum purchases of assets or a complete lack of historical cost records for all assets.



An appraisal program should include:

- A physical inventory and listing of pertinent data for all applicable assets in use or in standby status as of the appraisal date or report date. The physical inventory may be made by the provider or by the appraiser. If made by the provider, the appraiser must verify the inventory.
- The acquisition cost of each item or unit of property including, but not limited to, architect fees, installation costs, and freight.
- A classification of each item or unit of property in accordance with the American Hospital Association (AHA) Health Data and Coding Standards Group, Estimated Useful Lives of Depreciable Hospital Assets. These classifications are:
 - Land improvements;
 - Buildings, including building improvement, fixed equipment, building services equipment and other fixed equipment;
 - Major movable equipment;
 - Minor equipment; and
 - Leasehold equipment.

Note: Refer to the Cost Classifications and Cost Finding section of this appendix for a comprehensive description for capital assets by category.

- Establishing an estimated useful life for each asset. The estimated useful life for purposes of the appraisal must be consistent with the estimated useful life for each asset used by the provider for depreciation purposes.
- Determining a salvage value for each asset.
- Selecting a depreciation method for each asset.
- Calculating depreciation provisions for the current reporting period.
- Calculating accumulated depreciation using an approved basis, from the date of acquisition to the start of the Medicaid reporting period in which actual depreciation is first claimed.
- Determining square footage for each cost center to identify all rooms on a floor or within a building if the provider did not previously do this. This should be accomplished as explained in the AHA Cost Finding and Rate Setting for Hospitals publication.
- Reconciling appraisal results with provider records. For assets acquired prior to January 1, 1966, the provider's plant asset records, if any, and accounting records must be considered even though they may be inaccurate. This reconciliation must be made for land improvements, buildings, building services equipment and, where possible, for other major asset classifications.

Where applicable, differences discussed by the reconciliation must be reflected as adjustments in the provider's accounting and plant asset records.

13.10 APPRAISAL REPORT

The appraisal expert must prepare a letter of certification. The letter should state that, in the appraisal expert's judgment, the appraisal results were determined in conformity with Medicaid program regulations and requirements. This letter will include such information as:



- Name of the nursing facility provider for which the appraisal was conducted;
- Location(s) of the facility included in the appraisal;
- Appraisal date, the date up to which accumulated depreciation was calculated (if other than the appraisal date), and the period for which current depreciation is calculated;
- Contents of data supplied to the provider, i.e., summaries, schedules, plans, etc.;
- Appraisal program descriptions, including:
 - The extent of asset appraisal, i.e., assets physically inventoried,
 - Pricing basis, and
 - Other pertinent information not readily apparent in the detail results, such as depreciation methods.
- Policy for determining capitalizable assets;
- Depreciation policy in the year of acquisition and disposal; and
- Identification of material items included in the appraisal where the values of such items were obtained from outside sources without independent verification by the appraisal expert.

13.11 LISTING OF ASSETS APPRAISED

If a listing of assets that constitutes the nursing facility provider's Medicaid property records is supplied, it must contain all necessary and pertinent information, even if portions were determined solely by the provider. A listing of assets should include the following information for each asset:

- Building location;
- Cost center or department;
- Asset description, usually including manufacturer's name, model number, serial number, etc.;
- AHA asset classification;
- Historical cost;
- Acquisition date;
- Estimated useful life to provider;
- Salvage value;
- Depreciation provision for current reporting period;
- Accumulated depreciation provision for current reporting period; and
- Pricing method necessary for adequate disclosure, where more than one method was used for various assets.

Reconciliations and comparisons with provider records must also be included, as well as square footage and other allocation basis information for buildings and cost centers within buildings.



13.12 RECORDS

Appraisal work papers must be made available to SMA staff or their designee upon reasonable request.

13.13 APPRAISAL EXPENSE

The expense of an appraisal to establish plant records for Medicaid program purposes, including the expense for appraisal of research and other non-resident departments incurred by a nursing facility provider after entrance into the program, may be included as an allowable cost. The expenses will be considered as administrative costs in the period incurred, subject to apportionment to the Medicaid program. Appraisal expenses incurred relative to assets not connected with provider operations are not allowable costs.

Where providers have appraisals made for other business purposes, such as insurance coverage, tax values or financing, the incurred expenses for such appraisals may be included in allowable costs as part of administrative and general costs. However, appraisal expenses incurred to establish values for the sale or anticipated sale of the nursing facility or provider organization are not allowable costs.

Where the SMA determines that a provider has incurred appraisal expenses to establish the historical cost of assets which were already adequately reflected in its books, records, or tax returns, the cost of performing the appraisal is not allowable.



SECTION 14 – COST REPORTING AND REIMBURSEMENT DESCRIPTIONS AND CLASSIFICATIONS

14.1 GENERAL

Refer to Cost Classifications and Cost Finding section of this appendix for detailed discussion and description of program cost categories for Plant, Variable Base, Support and Base/Support.

Plant 1	Depreciation cost category generally allocated to operational cost centers on the basis of square footage.
Plant 2	Depreciation cost category generally allocated to operational cost centers on the basis of square footage or asset dollar value.
Plant 3	Interest, real and personal property taxes, allowable lease rental and borrowing-related amortization cost category generally allocated to operational cost centers on the basis of square footage.

14.2 PLANT COSTS

Rent/Leases

Leases	Plant 1
Underlying Cost – Depreciation	Plant 1
Underlying Cost – Interest	Plant 3
Underlying Cost – Property Taxes.....	Plant 3
Lease Rental Component.....	Plant 3
Other Nonallowable Costs.....	Support

Interests

Mortgage & Bond.....	Plant 3
Other	Plant 3
Paid to Owner(s).....	Plant 3

Amortization

Interest Related.....	Plant 3
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Property Taxes

Property Taxes	Plant 3
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Depreciation

Building & Improvements (fixed).....	Plant 1
Equipment (moveable)	Plant 2
Vehicles	Plant 2

14.3 EMPLOYEE HEALTH & WELFARE

FICA – Employer's Portion.....	Base/Support
Federal Unemployment Tax	Base/Support



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MESC.....	Base/Support
Workers' Compensation	Base/Support
Pension & Profit Sharing	Base/Support
Employees Group Insurance	Base/Support
Retirement	Base/Support
Other	Base/Support

14.4 ADMINISTRATIVE & GENERAL

Salaries & Wages – Officers	Support
Salaries & Wages – Administrator	Support
Salaries & Wages – Owner/Administrator	Support
Salaries & Wages – Clerical & Other	Support
Employee Benefits	Support
Workers Compensation.....	Base
Payroll Taxes	Support
Director's Fees.....	Support
Management Services	Support
Central Office Overhead	Support
Contracted Services.....	Support
In-service Training	Support
Education	Support
Advertising	Support
Promotion & Public Relations	Support
Telephone & Other Communications.....	Support
Dues & Subscriptions	Support
Insurance - Officer's Life.....	Support
Insurance – General.....	Support
Malpractice Liability Insurance.....	Support
Copier.....	Support
License Fees.....	Support
Quality Assurance Assessment – Long Term Care	Support
Quality Assurance Assessment – Hospital (non-Long Term Care).	Support
Quality Measure Initiative Assessment	Support
Provider Donation for Outstationed State Staff	Support
Transportation	Support
Equipment Repair & Maintenance.....	Support
Vehicles	Support
Office Supplies.....	Support
Printing	Support
Postage, UPS, Freight.....	Support
Legal & Accounting	Support
Utilization Review.....	Support
Income Taxes.....	Support
Other Taxes	Support
General Travel	Support
Travel & Seminars.....	Support
Data Processing	Support
Amortization – Non-interest Related	Support



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Employment Agency Fees	Support
Employee Background Check Fees.....	Support
Employee Fingerprinting Fees	Support
Charitable Contributions	Support
Minor Equipment – Less Than \$5,000	Support
Minor Equipment – More Than \$5,000	Plant 2
Equipment Rental – Less Than 12 Months	Support
Equipment Rental – More Than 12 Months	Plant 2
Direct Allocation – Fixed Assets Depreciation	Plant 1
Direct Allocation – Moveable Equipment Depreciation.....	Plant 2
Direct Allocation – Interest & Property Taxes.....	Plant 3
Security Guard Services.....	Support
Penalties	Support
Miscellaneous	Support
Bad Debt.....	Support

14.5 PLANT OPERATION & MAINTENANCE

Salaries & Wages – Plant Operation & Maintenance	Support
Employee Benefits	Support
Workers' Compensation	Base
Payroll Taxes.....	Support
Contracted Services.....	Support
In-service Training	Support
Education.....	Support
Minor Equipment – Less Than \$5,000	Support
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NURSING FACILITY LEVEL OF CARE DETERMINATION

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SECTION 1 – GENERAL INFORMATION

The Michigan Department of Health and Human Services (MDHHS) is required to assess all individuals seeking Medicaid-funded long-term services and supports (LTSS) that require level of care eligibility to determine their functional need for those services. The determination is an essential component of eligibility for services provided in nursing facilities, the MI Choice Waiver Program, the Program of All-Inclusive Care for the Elderly (PACE), and the MI Health Link Home and Community Based Services (HCBS) Waiver Program. Policies contained herein apply equally and consistently to each of these programs except as noted.

MDHHS uses a standard assessment and process for all programs and services that require an individual meet the nursing facility level of care. Programs may not use any other assessment in place of the Level of Care Determination (LOCD) tool for this determination. The LOCD assures a consistent and reliable process for determining that individuals meet the functional eligibility requirements.

Providers may access the LOCD online in the Community Health Automated Medicaid Processing System (CHAMPS) through the MILogin application. (Refer to the Directory Appendix for website information.) LOCD assessment data is entered and processed in CHAMPS.

The LOCD is a “point in time” assessment; that is, it determines the individual’s functional eligibility at the time of the assessment. MDHHS assumes that beneficiaries will maintain functional eligibility until they are determined otherwise through a reassessment or the LOCD’s End Date. A face-to-face LOCD is an in-person meeting between the qualified and licensed health professional and the individual seeking functional eligibility.



SECTION 2 – ELIGIBILITY REQUIREMENTS

Individuals seeking Medicaid-funded services from nursing facilities, MI Choice Waiver Program, PACE, or the MI Health Link HCBS Waiver Program must meet eligibility criteria. These criteria must be met before Medicaid payment is made for services rendered. Each beneficiary must be eligible for Medicaid services, demonstrate a need for nursing facility level of care, and meet all additional program-specific requirements. Medicaid reimbursement for covered services is only appropriate when both financial and functional eligibility have been established, and the individual meets other program-specific eligibility criteria.

2.1 BASIC MEDICAID ELIGIBILITY

Eligibility for Medicaid is determined by a variety of factors including, but not limited to, financial rules, age, health status, state residency and citizenship status. Providers are instructed to refer individuals who are not yet Medicaid eligible to a local MDHHS office or the MDHHS website for assistance. (Refer to the Directory Appendix for website information.)

2.2 NEED FOR NURSING FACILITY LEVEL OF CARE

An individual's need for nursing facility level of care is determined through the Nursing Facility Level of Care Determination (LOCD) assessment tool. The LOCD is a scientifically-validated and reliability-tested tool utilized during initial application and program eligibility redeterminations. This chapter describes the criteria and processes for administering the LOCD.

2.3 PROGRAM SPECIFIED ELIGIBILITY REQUIREMENTS

In addition to meeting Medicaid financial and functional eligibility requirements, individuals must also meet all program specific requirements before they can be determined eligible for that program. (Refer to the Nursing Facility Coverages, the MI Choice Waiver, the Program of All-Inclusive Care for the Elderly, and the MI Health Link chapters or to provider contracts for specific program requirements.) This chapter applies only to the LOCD process and is not intended to replace program-specific requirements.



SECTION 3 – NURSING FACILITY LEVEL OF CARE DETERMINATION PROCESS

3.1 LOCD ASSESSMENT REQUIREMENT FOR REIMBURSEMENT

The LOCD must be conducted prior to or on the day of an individual’s admission to a nursing facility or enrollment in MI Choice Waiver Program, PACE, or MI Health Link HCBS Waiver Program to ensure reimbursement for a Medicaid eligible beneficiary. The LOCD must be conducted face-to-face by a qualified and licensed health professional. The qualified and licensed health professional conducting the LOCD or a designated employee of the organization must enter the assessment findings online in the CHAMPS system. Except where otherwise noted, only LOCDs entered in CHAMPS are considered valid for establishing functional eligibility.

The LOCD is considered payable when all the following conditions are met:

- the beneficiary meets LOCD criteria;
- the LOCD is entered online in CHAMPS;
- the LOCD is active on the date of service (meaning the date of service is on or after the LOCD Start Date and before the LOCD End Date); and
- the beneficiary is receiving LTSS and meets all program-specific eligibility criteria.

3.2 PERSONS AUTHORIZED TO CONDUCT THE LOCD

A qualified and licensed health professional must be a physician, registered nurse, licensed practical nurse, licensed social worker (Limited License Bachelor of Social Work, Limited License Master Social Worker, Licensed Bachelor Social Worker, or Licensed Master Social Worker), physician’s assistant, nurse practitioner, licensed psychologist, physical therapist, respiratory therapist, occupational therapist or speech therapist. Once the LOCD is completed by a qualified and licensed health professional, a clinical or non-clinical staff person may enter the LOCD information in CHAMPS. When the LOCD data are entered, CHAMPS applies the MDHHS algorithm to determine eligibility.

3.3 INITIAL LOCD ASSESSMENT

The LOCD must be conducted face-to-face by a qualified and licensed health professional (as defined in the Persons Authorized to Conduct the LOCD subsection) before the provider is eligible for Medicaid reimbursement for services rendered to the beneficiary. The LOCD must be conducted prior to or on the day of admission or enrollment. The LOCD assessment findings for all LOCDs conducted, including Door 0 (zero), which indicate the individual does not meet LOCD criteria must be entered online in CHAMPS. (LOCD Doors are described in the Nursing Facility Level of Care Determination Criteria section.)

All LOCD determinations must be entered in CHAMPS. This is regardless of whether the individual or beneficiary meets LOCD criteria.



The provider may conduct LOCDs for individuals without Medicaid eligibility and enter the LOCD in CHAMPS prior to Medicaid eligibility being established. NOTE: Medicaid reimbursement for covered services is only appropriate when both financial and functional eligibility have been established, and the individual meets other program-specific eligibility criteria.

3.4 ADOPTION OF AN EXISTING LOCD BY ANOTHER PROVIDER

The LOCD is associated with the beneficiary, rather than the provider serving the beneficiary. Therefore, if a beneficiary is seeking admission to or enrollment in a program and has a current LOCD in CHAMPS, the provider may adopt that LOCD to confirm functional eligibility. When adopting a current LOCD, the provider must print out the computer-generated FOC from that LOCD record and complete the form with proper signatures and date. A qualified and licensed health professional from the admitting or enrolling provider must sign and date the CHAMPS-generated FOC from the adopted LOCD record. The FOC must also be signed by the beneficiary or their legal representative.

The provider may also choose to conduct a new LOCD. A new LOCD must be conducted if the current LOCD is no longer an accurate representation of the beneficiary's current functional status.

3.5 LOCD START AND END DATES

All LOCDs must be entered in CHAMPS within 14 calendar days from the date the qualified and licensed health professional conducted the face-to-face LOCD. Functional eligibility is valid for 365 days from the conducted date unless the provider conducts a new LOCD because a beneficiary had a significant change of condition. If a subsequent LOCD is conducted prior to the LOCD End Date and confirms the individual meets LOCD criteria, the new LOCD will have a 365-day end-date. Providers should refer to their specific program policies and procedures regarding the definition of a significant change of condition.

Each beneficiary must have a current LOCD in CHAMPS to establish eligibility for Medicaid reimbursement. The provider is responsible for:

- confirming that a current LOCD demonstrating eligibility is in CHAMPS;
- monitoring the beneficiary's LOCD End Date to avoid an interruption in functional eligibility; and
- conducting another LOCD for the beneficiary prior to the current LOCD End Date or when there is a significant change of condition.

The LOCD Start Date will be the date the LOCD was conducted if the LOCD is entered in CHAMPS within 14 days of the conducted date. If the LOCD is entered in CHAMPS more than 14 days from the date the LOCD was conducted, CHAMPS will set the LOCD Start Date as the date the LOCD was entered in the system. The End Date of an LOCD will be 365 days from the date the LOCD was conducted. LOCDs are payable from the Start Date through the End Date. (Refer to the Nursing Facility Level of Care Determination Criteria section for an explanation of each Door.)

3.6 VERIFICATION REVIEW OF LOCD

The purpose of the verification review (LOCD-VR) is to determine if the LOCD was conducted properly according to policy and resulted in the correct determination of eligibility. A randomly selected sample of LOCDs will be reviewed by MDHHS or its designee. CHAMPS will randomly select a statistically significant sample of LOCDs entered in the system. Upon submission of the LOCD in the system, CHAMPS will



immediately notify the provider if the LOCD was selected for review with a pop-up message. The provider is required to submit all relevant documentation used to support the LOCD including, but not limited to, observation notes, assessment reports, physician orders or notes, caregiver reports, cognitive test results, time studies, nursing or case management notes, intervention reports, or evidence of other medical or community services provided. The related CHAMPS LOCD Application ID must be indicated on all documents for tracking purposes. Documents must be uploaded electronically in CHAMPS within one business day of the LOCD being selected for verification review in CHAMPS.

MDHHS or its designee will review the documentation furnished by the provider and make a determination within two business days of receiving the required documentation. Upon conclusion of the review, MDHHS or its designee will inform the provider of the results of the review in CHAMPS. When an LOCD is selected for review, the determination of eligibility is not complete until MDHHS or its designee notifies the provider of the results of the verification review.

When the individual is found to not meet LOCD criteria, MDHHS or its designee will provide to the individual an Adequate Action Notice including appeal rights per Medicaid policy. Services provided to the individual during the verification review process will not be eligible for Medicaid reimbursement.

3.7 ONGOING FUNCTIONAL ELIGIBILITY

Medicaid LTSS providers are required to ensure the individual continues to meet eligibility requirements on an ongoing basis. The functional eligibility that is assessed by the LOCD is one of the eligibility requirements. Therefore, Medicaid LTSS providers must ensure that individuals meet LOCD criteria on an ongoing basis. The LTSS provider is responsible for conducting a new LOCD if there is a significant change in the beneficiary's condition. When a provider possesses information that a beneficiary may no longer meet eligibility, the provider must conduct a face-to-face reassessment. Such information may come in the form of progress notes, routine assessments, staff observations, or any other documentation that might call into question the continued functional eligibility of the beneficiary.

3.8 PASSIVE REDETERMINATION OF FUNCTIONAL ELIGIBILITY

Providers are responsible for reassessing LOCD eligibility prior to the End Date of the current LOCD or when there is a significant change in the beneficiary's condition. The Minimum Data Set (MDS) for nursing facility residents and interRAI Home Care Assessment System (iHC) for MI Choice Waiver Program participants contain items that correspond to the items in the LOCD. Under certain conditions, MDHHS will use a passive redetermination process based upon information from the beneficiary's most recent assessment. When this assessment data is available, MDHHS will apply an algorithm that uses the common assessment items to allow CHAMPS to generate a new LOCD for the beneficiary.

Currently, passive redetermination is only available to nursing facility residents, including those in the MI Health Link program, and MI Choice Waiver program participants because MDHHS does not have electronic assessment data available for PACE or the MI Health Link HCBS waiver program. When MDHHS has electronic assessment data from those programs, MDHHS will use the passive redetermination process to allow CHAMPS to generate a new LOCD for the beneficiary. An LOCD generated by CHAMPS can be adopted by all LTSS programs.



3.8.A. LOCD DOORS ADDRESSED BY PASSIVE ASSESSMENT

The correspondence between MDS and iHC assessment items and LOCD items is extensive but not complete. Therefore, the algorithm used for the passive redetermination process is not able to verify eligibility through all LOCD doors. The passive redetermination process may confirm LOCD eligibility as follows:

Door 1: The passive redetermination process can confirm all criteria.

Door 2: The passive redetermination process can confirm all criteria.

Door 3: The passive redetermination process can confirm criteria from the MDS (nursing facilities). The passive redetermination process cannot confirm criteria from the iHC (MI Choice).

Door 4: The passive redetermination process cannot confirm criteria.

Door 5: The passive redetermination process can confirm all criteria.

Door 6: The passive redetermination process can confirm criteria from the MDS (nursing facilities). The passive redetermination process can partially confirm criteria from the iHC (MI Choice).

Door 7: The passive redetermination process cannot confirm the criteria.

Door 8: The passive redetermination process cannot confirm the criteria.

3.8.B. PASSIVE REDETERMINATION PROCESS

The initial LOCD for a beneficiary must be conducted in a face-to-face meeting by a qualified and licensed health professional. When a current LOCD exists for a beneficiary, MDHHS will use the passive redetermination process to allow CHAMPS to generate a new LOCD for the beneficiary. The amount of time from the provider conducting an assessment to MDHHS having access to the assessment data varies, affecting when the passive redetermination process will be applied.

When this process confirms continued functional eligibility, the Start Date of the CHAMPS-generated LOCD will be the date of the MDS or iHC assessment. CHAMPS will set the End Date at 365 days from the newly established Start Date. This process will repeat with each new MDS or iHC when the passive redetermination process confirms the beneficiary meets LOCD criteria and allows CHAMPS to generate a new LOCD.

When a beneficiary is currently eligible through a door that the passive redetermination process cannot confirm, the LOCD will be bypassed from the passive redetermination process and the current End Date will remain in effect.

The passive redetermination process will not determine ineligibility. If an individual previously met LOCD criteria through a Door the passive redetermination process can assess, and the process cannot establish eligibility from the most recent MDS or iHC, CHAMPS will issue a notice to the provider. Additionally, CHAMPS will generate a new



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LOCD using Door 87 with a Start Date equal to the date the passive redetermination process was applied to the MDS or iHC assessment. Door 87 LOCD will have an End Date of 45 days from the Door 87 Start Date, or the End Date of the previous LOCD, whichever is earlier.

The provider must conduct a face-to-face LOCD before the Door 87 End Date to confirm the beneficiary continues to meet LOCD criteria. If the provider does not conduct a face-to-face LOCD before the Door 87 End Date, the provider will not be eligible for Medicaid reimbursement. Door 87 is not sufficient basis for issuing an Adverse Action Notice to the beneficiary. An Adverse Action Notice must be based upon a face-to-face LOCD.

3.8.C. PASSIVE REDETERMINATION DECISIONS

If the face-to-face LOCD results are:	And the Passive Redetermination results are:	Then the LOCD results are as follows:
Eligible through a Door assessed by Passive Redetermination e.g. Door 1	Confirmed by Passive Redetermination e.g. confirm Door 1	New LOCD created with End Date 365 days from date of the MDS or iHC assessment.
Eligible through a Door not assessed by Passive Redetermination e.g. Door 4	Passive Determination is not applied	No change to existing LOCD or its End Date.
Eligible through any Door e.g. Door 7	Eligible through a different Door e.g. Door 2	New LOCD created with the Passive Redetermination Door and an End Date 365 days from the date of the MDS or iHC assessment.
Eligible through a Door assessed by Passive Redetermination e.g. Door 2	Passive Redetermination does not determine eligibility through any Door	LOCD Door 87 created with an End Date of 45 days from the date the passive redetermination ran.

Note: For the passive redetermination process to occur, a current LOCD must be in CHAMPS and the MDS or iHC must be conducted prior to the End Date of the LOCD.

3.8.D. NEED TO CONDUCT A NEW LOCD

For the Doors that the passive determination is unable to assess, the provider must conduct a face-to-face LOCD prior to the current LOCD End Date. The provider must conduct a new face-to-face LOCD prior to the End Date and enter it in CHAMPS within 14 days of the conducted date.

When the passive redetermination applies but the process cannot confirm eligibility based upon MDS or iHC assessment data, CHAMPS will create a LOCD Door 87 with an End Date 45 days from the date that record is loaded in CHAMPS, or until the current End Date, whichever is earlier. When the passive redetermination process continuously



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confirms that the beneficiary meets LOCD criteria, it is possible that the beneficiary will not require another face-to-face LOCD because the passive redetermination process confirms LOCD eligibility and creates a new LOCD with a new 365-day End Date. In addition, providers must conduct a face-to-face LOCD when there is a significant change in the beneficiary's condition, as defined by the program.



SECTION 4 – NURSING FACILITY LEVEL OF CARE DETERMINATION CRITERIA

The Michigan Nursing Facility Level of Care Determination criteria includes seven domains of need, called Doors. The Doors include: (1) Activities of Daily Living; (2) Cognitive Performance; (3) Physician Involvement; (4) Treatments and Conditions; (5) Skilled Rehabilitation Therapies; (6) Behaviors; and (7) Service Dependency. The Doors and the assessment items are listed below. Guidance on administering the LOCD, including definitions and methods, is provided in the Michigan Medicaid Nursing Facility Level of Care Determination Field Definition Guidelines.

The LOCD should be an accurate reflection of an individual's current functional status. This information is gathered in a face-to-face meeting by speaking to the individual and those who know the individual well, observing the individual's activities, and reviewing an individual's medical documentation. Refer to the Michigan Medicaid Nursing Facility Level of Care Determination Field Definition Guidelines on the MDHHS website for more information. (Refer to the Directory Appendix for website information.)

4.1 DOOR 1: ACTIVITIES OF DAILY LIVING

Door 1 assesses four ADLs: (1) Bed Mobility; (2) Transfers; (3) Toilet Use; and (4) Eating.

4.2 DOOR 2: COGNITIVE PERFORMANCE

Door 2 assesses short-term memory, cognitive skills for daily decision-making and making self-understood.

4.3 DOOR 3: PHYSICIAN INVOLVEMENT

Door 3 assesses the frequency of physician visits and physician order changes.

4.4 DOOR 4: TREATMENTS AND CONDITIONS

Door 4 assesses a set of nine treatments and conditions that may be a predictor of potential frailty or increased health risk. The treatments and conditions include: Stage 3-4 Pressure Sores; Intravenous or Parenteral Feeding; Intravenous Medications; End-stage Care; Daily Tracheostomy Care, Daily Respiratory Care, Daily Suctioning; Pneumonia within the Last 14 Days; Daily Oxygen Therapy; Daily Insulin with Two Order Changes in the Last 14 Days; and Peritoneal or Hemodialysis

4.5 DOOR 5: SKILLED REHABILITATION THERAPIES

Door 5 assesses the presence of rehabilitation interventions, including physical therapy, occupational therapy, and speech therapy.

4.6 DOOR 6: BEHAVIOR

Door 6 assesses behavioral challenges. It includes five behavioral symptoms: wandering, verbal abuse, physical abuse, socially inappropriate or disruptive behavior, and resistance to care. Door 6 also assesses for the presence of delusions and hallucinations.



4.7 DOOR 7: SERVICE DEPENDENCY

Door 7 applies to beneficiaries currently receiving other services and supports in nursing facilities, MI Choice, PACE, or the MI Health Link HCBS Waiver program. It assesses the beneficiary's dependence on services to maintain the current level of functioning and whether there are options for maintaining the level of functioning with services and supports available in the community.

4.8 DOOR 8: FRAILTY

MDHHS or its designee determined that the beneficiary is eligible for Medicaid LTSS services based upon the Frailty Criteria. Individuals who exhibit certain behaviors and treatment characteristics that indicate frailty may be admitted or enrolled to LTSS programs requiring an LOCD. The individual needs to trigger one element of this criteria to be considered for Frailty. Refer to the Michigan Medicaid Nursing Facility Level of Care Determination Exception Process on the MDHHS website for more information. (Refer to the Directory Appendix for website information.) For the MI Health Link program, the Frailty Criteria are applied by the Integrated Care Organization.

4.9 DOOR 0: INELIGIBLE

The LOCD was conducted and the beneficiary did not meet the criteria for any of the doors. The beneficiary is not eligible for Medicaid LTSS services at this time. (Refer to the Individual Does Not Meet LOCD Criteria, Action Notices, and Appeal Rights section for additional information.)

4.10 DOOR 87: ELIGIBLE PENDING FACE-TO-FACE REASSESSMENT

The passive redetermination process could not confirm eligibility. The provider has 45 days from the date of the passive redetermination or until the current End Date, whichever is earlier, to conduct a new face-to-face assessment.



SECTION 5 – INFORMED CHOICE

Informed choice is important for the MDHHS admission or enrollment process for LTSS. It is essential that individuals and their legal representatives fully understand all available options for receiving Medicaid LTSS. When an individual meets LOCD criteria, they automatically meet the functional eligibility requirement for nursing facility care, MI Choice Waiver Program, PACE, and MI Health Link HCBS Waiver Program. The Freedom of Choice form confirms that these options and referral processes have been explained to the individual. All Medicaid-funded LTSS programs are required to make program information available to individuals at admission/enrollment, at a face-to-face reassessment, and upon request from the individual or their legal representative.

Program providers must explain all Medicaid LTSS options as well as other available LTSS to the individual in a language the individual understands, as well as culturally and linguistically appropriate. It is important that individuals understand their options and that they have ongoing access to information about all settings and programs. As the functional ability of the individual may change over time and program options may change, it is important to continue to update their options and discharge plan.

5.1 FREEDOM OF CHOICE FORM

A properly completed Freedom of Choice (FOC) form documents the individual's choice of where to receive LTSS. It is required that all LTSS programs use this form to confirm the individual was made aware of their choices and to document the individual's preference. It is critical that individuals understand their options and have ongoing access to information about settings and programs. This requires providing the information using methods that are effective for the individual and in the individual's primary language. The individual (or their legal representative) must be informed of Medicaid LTSS available through the MI Choice Waiver Program, nursing facilities, PACE, and MI Health Link HCBS Waiver Program. An explanation regarding each program must be provided in a manner and using language that the individual understands. A hard copy of the form must be printed so signatures can be provided, and the signed form retained in the beneficiary's case record. The FOC form must be completed each time the beneficiary changes programs or providers, whether a new LOCD is conducted or not.

A CHAMPS-generated FOC form is automatically created online (and available to print) for every individual for whom an online LOCD was completed, regardless of the individual's determination of eligibility.

When adopting a current LOCD, the provider must print out the computer-generated FOC from that LOCD record and complete the form with proper signatures and date. A qualified and licensed health professional from the admitting or enrolling provider must sign and date the CHAMPS-generated FOC for the adopted LOCD record. The FOC must also be signed by the individual or their legal representative.

The information in Section I of the FOC is automatically populated by CHAMPS when the LOCD is entered. The individual's name, date of birth, conducted date of the LOCD, eligibility status, and, if determined eligible, the door through which the individual qualified is entered by the system. If the individual is found ineligible, a Door 0 will populate. The system also enters the provider's information and the date the LOCD was created. The qualified and licensed health professional who conducted or adopted the LOCD must sign, provide their title, and date the FOC under Section I. If using an FOC form not generated by CHAMPS, the provider must complete the appropriate fields in Section 1 and sign and date the form.



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Section II of the FOC provides a list of LTSS options available to individuals who meet LOCD criteria, including nursing facility care, MI Choice Waiver Program, PACE, or MI Health Link HCBS Waiver Program. Individuals must also be informed of service options that do not require nursing facility level of care, including Home Health, Home Help State Plan services, and other services available locally that are not Medicaid-funded.

Section III of the FOC is completed when an individual does not meet the LOCD criteria. The individual, or their legal representative, must sign their name and provide the date they were notified of their LOCD ineligibility and appeal rights. Appeal rights must be provided according to Michigan Medicaid policy.

The form is completed when the above steps have been taken and it is signed and dated by the qualified and licensed health professional who conducted the LOCD and by the individual or their legal representative. The completed FOC form must be maintained in the individual's record and provided to the individual or their legal representative upon request. A copy of the completed FOC form for non-qualifying individuals must be retained for at least three years.



SECTION 6 – INDIVIDUAL DOES NOT MEET LOCD CRITERIA, ACTION NOTICES, AND APPEAL RIGHTS

If an individual does not meet LOCD criteria for Doors 1 through 7, the provider must provide notice to the individual. The individual may request a Secondary Review from MDHHS or its third-party designee and request a Medicaid Fair Hearing before an Administrative Law Judge.

6.1 ISSUING AN ADVERSE ACTION NOTICE

When a qualified and licensed health professional determines that an individual does not qualify for nursing facility level of care services based on the online LOCD, and the provider does not contact the MDHHS designee to request a Secondary Review, the provider must issue an adverse action notice to the individual or their legal representative. The provider must also offer the individual referral information about other services that may meet the individual's needs.

6.2 ADEQUATE ACTION NOTICE

For individuals who are not currently receiving LTSS in a program or setting that requires an LOCD, an adequate action notice is provided when the initial LOCD determines the individual does not meet LOCD criteria. The adequate action notice must include all the language in the sample adequate action notices for LTSS available on the MDHHS LOCD website. (Refer to the Directory Appendix for website information.)

6.3 ADVANCE ACTION NOTICE

The advance action notice is applicable to beneficiaries who met their initial LOCD, but based upon a significant change in condition, did not meet their subsequent LOCD. The advance action notice must include all of the language in the sample advance action notices for LTSS available on the MDHHS LOCD website. (Refer to the Directory Appendix for website information.)

When a current LTSS beneficiary is determined to not meet LOCD criteria, the provider must follow program-specific procedures for the provision of notice to the beneficiary.

6.4 LOCD SECONDARY REVIEW

The provider or the individual (or their legal representative) may request an LOCD Secondary Review. This review is completed by MDHHS or its designee to ensure full consideration of LOCD eligibility options. The Secondary Review is available only when an LOCD is entered in CHAMPS and results in a Door 0, indicating ineligibility. The review is a secondary review of documentation for all LOCD Doors, including Door 8.

The LOCD Secondary Review Process is conducted as follows:

- A Secondary Review may be initiated by the provider, individual or their legal representative after the qualified and licensed health professional issues an adverse action notice based on a finding of ineligibility. The provider, individual or their legal representative may request a Secondary



Review from MDHHS or its designee. The individual will have three business days to make a request following written notice of the adverse action.

- In the action notice, the provider who conducted the ineligible LOCD must provide the individual with information on how to timely request a Secondary Review following an ineligible LOCD.
- Following the individual's request for review, the MDHHS designee will contact the provider who conducted the LOCD and inform them to upload documentation in CHAMPS for review.
- The provider who conducted the LOCD will upload the relevant documentation in CHAMPS within one business day of being notified to do so.
- The MDHHS designee will review the documentation, obtain information from the individual or their legal representative, if requested, and notify the provider and the individual or their legal representative of the decision.
- If the Secondary Review determines that the individual is eligible, MDHHS or its designee will contact the provider and the individual or their legal representative.
- If the Secondary Review determines that the individual is ineligible, MDHHS or its designee will issue an adverse action notice and inform the individual of their appeal rights.
- MDHHS or its designee will enter the appropriate LOCD in CHAMPS.

6.5 APPEAL RIGHTS AND MEDICAID FAIR HEARING

When an individual is determined ineligible for services and an appeal is requested, it is an adverse action for the individual. If the individual or their legal representative disagrees with the denial, they may request an administrative hearing.

The Michigan Office of Administrative Hearings and Rules (MOAHR) Administrative Hearings Pamphlet explains the process by which an administrative hearing and a preliminary conference are brought to completion. The pamphlet is available for review on the MDHHS website. (Refer to the Directory Appendix for website information.) Both a provider representative and a MDHHS Long Term Care Policy Section representative must be present at the hearing.

When a current LTSS beneficiary is determined to not meet LOCD criteria, the provider must follow program-specific procedures for the provision of notice to the beneficiary.

When a beneficiary is determined to no longer be eligible for Medicaid-funded services and an appeal is requested, Medicaid will continue to pay for services if the beneficiary appeals within required program timeframes. If the beneficiary does not appeal the decision, the provider is eligible for Medicaid-reimbursement through the effective date of the advanced action notice, or the date in which the beneficiary stopped receiving services, whichever is first. When the beneficiary appeals the decision in compliance with MDHHS policy, MDHHS will reimburse the provider for services throughout the appeal process. If the beneficiary's appeal is denied, MDHHS will reimburse the provider for up to 30 days from the date of issuance of the hearing decision and order.



PHARMACY

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SECTION 1 – GENERAL INFORMATION

Michigan Department of Health and Human Services (MDHHS) administers the fee-for-service (FFS) programs for Medicaid, Healthy Michigan Plan, Children’s Special Health Care Services (CSHCS), and Maternity Outpatient Medical Services (MOMS). This chapter and the Michigan Pharmaceutical Product List (MPPL) comprise program policies and explain coverage and reimbursement for the services dispensed and billed by enrolled pharmacies.

Throughout this chapter the terms Medicaid and MDHHS are used to refer to the Michigan Medicaid FFS, Healthy Michigan Plan, CSHCS, and MOMS programs unless otherwise noted.

1.1 MDHHS PHARMACY BENEFITS MANAGER AND OTHER VENDOR CONTRACTORS

MDHHS retains all decisions for policy, coverage, and reimbursement, and contracts with a pharmacy benefits manager (PBM). PBM services provided include pharmacy claims payment (paper and electronic), claims instruction, prior authorization (PA), prospective drug utilization, retrospective drug utilization, clinical consultation, provider information lines, and Maximum Allowable Cost (MAC) rate setting. (Refer to the Directory Appendix for PBM contact information.)

The PBM website contains the:

- Pharmacy Claims Processing Manual for Michigan Medicaid
- Michigan Pharmaceutical Product List (MPPL)
- Preferred Drug List (PDL)
- Drug Utilization Review (DUR) Meeting Notices
- Dose Optimization Program
- Pharmacy and Therapeutics (P&T) Committee Meeting Notices
- Pharmacy Forms
- Maintenance Drug List

Pharmacies may call the PBM for questions or concerns. Beneficiaries may call the PBM Beneficiary Helpline. (Refer to the Directory Appendix for contact information.)

MDHHS contracts with other vendors to perform financial, program or provider audits on behalf of the State of Michigan. (Refer to the Provider Resources portion of the Directory Appendix for additional information.)

1.2 DEFINITIONS

The following definitions have specific meaning in the Pharmacy program:

Brand-Name Drug	A single-source drug, a cross-licensed drug or an innovator drug for which a lower-cost generic equivalent is available.
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Compounded Prescription	The combination of two or more ingredients extemporaneously mixed in usually accepted therapeutic doses. This requires the pharmacist's skill in weighing, measuring, levigating, etc., at the time of dispensing. The allowable compounding fee applies to the preparation of an individual prescription. It does not apply to prescriptions dispensed from a previously prepared stock supply (i.e., premaking a special lotion, cream, or ointment in gallons or pounds).
Dispensing Fee	Payment for filling a prescription and all related services performed by a pharmacist.
Drug Efficacy Study Implementation (DESI) Drugs	FDA designations related to "substantial evidence" of effectiveness. These products are also known as proposed less than effective.
Drug Rebate Program	Administered by the Centers for Medicare & Medicaid Services' Center for Medicaid and State Operations. It was created by the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) and requires drug manufacturers to enter into and have in effect a national rebate agreement with the Secretary of the U.S. Department of Health & Human Services (HHS) for states to receive Federal funding for outpatient drugs dispensed to Medicaid patients. To receive rebates, States must identify the drugs by their national drug code.
Drug Utilization Review (DUR)	A process designed to ensure that prescriptions are appropriate, medically necessary and not likely to result in adverse medical outcomes.
Drug Utilization Review Board (DUR Board)	An advisory board to the State's Medicaid Program that includes physicians and pharmacists.
Fraud	Deliberate, intentional, and willful act with the specific purpose of deceiving MDHHS with respect to any material fact, condition, or circumstance affecting eligibility or need.
Generic Drug	Refers to a nonproprietary drug or class of drugs. The generic name refers to the official chemical composition of the drug as published in the latest edition of a nationally recognized pharmacopoeia or drug compendium. Generics do not refer to a particular brand name product.
Labeler	Any firm that manufactures (including repackers or relabelers) or distributes (under its own name) the drug.
Legend Drug	A drug bearing the statement: "Caution – Federal Law Prohibits Dispensing without a Prescription."
Long Term Care Pharmacy	Refers to pharmacies specializing in provision of drugs and services in an institutional setting such as a nursing facility, medical care facility or hospital long term care unit.
Maximum Allowable Cost (MAC)	The maximum cost allowed by MDHHS for certain multiple source brands, generics, cross-licensed drugs and sometimes for sole-source drugs or classes.
Multiple Source Drug (Multi-Source)	A drug marketed or sold by two or more manufacturers or labelers, or a drug marketed or sold by the same manufacturer or labeler under two or more different proprietary names or both under a proprietary name and without such a name.
National Average Drug Acquisition Cost (NADAC)	Pricing benchmark based on a nationwide survey of retail community pharmacy covered outpatient drug prices.
National Council for Prescription Drug Programs (NCPDP)	Develops standards for electronic pharmacy transactions (Point of Sale claims transactions).



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National Drug Code (NDC)	The 11-digit code assigned to all prescription and over-the-counter products by the labeler/manufacturer of the product under Food and Drug Administration (FDA) regulations.
Out of State Pharmacy	An entity not housed within the state of Michigan but registered by the Michigan Board of Pharmacy. An Out of State Pharmacist is required to be licensed in the state the pharmacy is located in.
Over-the-Counter (OTC) Drug	A drug that can normally be purchased without a physician’s prescription, although it may require a prescription if covered by Medicaid.
Pharmacist	A person licensed under Michigan statutes to provide services within the scope of pharmacy practice.
Pharmacy	An entity registered by the Michigan Board of Pharmacy.
Pharmacy and Therapeutics (P&T) Committee	An advisory committee to MDHHS on issues affecting prescription drug coverage for its various health care programs. The committee recommends guidelines for prescription drugs covered in its various health care programs.
Point of Sale (POS)	Real-time on-line adjudication of pharmacy claims to the PBM. Point of-Sale provides participating pharmacies real-time access to beneficiary eligibility, drug coverage, pricing information, guidelines for drug use, and dispensing fees.
Prescribed Drug	A drug, either legend or over-the-counter, that is ordered by a prescriber to be used by a patient to treat a disease or condition.
Prescriptions Not Picked Up	Retail prescriptions filled but not dispensed or picked up by the beneficiary or his representative.
Prospective Drug Utilization Review (ProDUR)	Detection, evaluation, and counseling components of pre-dispensing drug therapy screening. ProDUR is required at the point of sale before each prescription is delivered to a Medicaid beneficiary. ProDUR screening is the responsibility of each Medicaid participating pharmacy and is a requirement of Medicaid participation.
Retrospective Drug Utilization Review (RetroDUR)	Program that analyzes and interprets patterns of prescribing and dispensing beneficiary drug usage through periodic examinations of claims data to identify patterns of fraud and abuse, gross overuse, and inappropriate or medically unnecessary care.
Tamper Resistant Prescription Pad	A tamper resistant prescription pad must contain all three of the following characteristics: <ul style="list-style-type: none"> ▪ Prevent unauthorized copying of a completed or blank prescription form. ▪ Prevent the erasure or modification of information written on the prescription by the prescriber. ▪ Prevent the use of a counterfeit prescription form.
Wholesale Acquisition Cost (WAC)	The list price determined by a manufacturer for a pharmaceutical sold by a manufacturer to a wholesaler.

1.3 CHILDREN’S SPECIAL HEALTH CARE SERVICES

Pharmacy coverage for beneficiaries who only have CSHCS coverage is limited to those pharmaceutical products that are required for the treatment of the CSHCS qualifying diagnosis. The beneficiary’s CSHCS qualifying diagnosis is listed on his eligibility letter by ICD code. Pharmacies may not bill for



pharmaceutical products not required for the treatment of the CSHCS qualifying diagnosis. Also, the MPPL specifies other coverages unique to this program.

1.4 PLACE OF SERVICE

Coverage and payment policies for products dispensed in the settings listed below are not contained in this chapter or the MPPL. Healthcare providers should refer to the provider-specific chapter for Hospital, Practitioner, Nursing Facility, or Laboratory in this manual for these services:

- Physician's office or clinic: Injectable products used in physician offices or clinics are reimbursed to the healthcare provider administering the drug, not a pharmacy. If a pharmacy sells injectable products to a physician or clinic, a pharmacy must obtain payment directly from the purchasing provider and not MDHHS. Injectable products are not to be dispensed to the beneficiary for the purpose of administration at the physician's office.

Exception: Beneficiaries with a Benefit Plan ID of NH (Nursing Home) can receive injectable drugs as a pharmacy benefit due to the relationship between the nursing facility and its contracted providers.

- Inpatient hospital.
- Mental health, hospital long term care, and medical care facilities with in-house pharmacies.
- Laboratory.

1.5 OUTPATIENT HOSPITAL

Outpatient hospitals with pharmacies enrolled with MDHHS as pharmacy providers must bill for take-home pharmaceutical products in compliance with policies of this chapter and the MPPL. Such services cannot be billed under the outpatient hospital's NPI number.

Injectable drugs and single doses given on the premises, including products used in conjunction with lab, radiology, and other medical procedures, must be billed using the outpatient hospital's NPI number, not the pharmacy's NPI number.

1.6 HOSPICE

Services, including drugs and nutritional supplements related to a beneficiary's terminal illness, are provided by the hospice (Benefit Plan ID of Hospice). The hospice reimburses pharmacies for these services. Coverage, payment amounts, and billing procedures of the particular hospice must be followed. To confirm that a product is not related to the terminal illness, the pharmacist must contact the hospice regarding coverage before billing. A pharmacy must not bill MDHHS for prescription services related to the terminal illness.

The MDHHS PBM messages back to the pharmacy when claims are submitted for beneficiaries with a Benefit Plan ID of Hospice. It is the pharmacy's responsibility to assure that the claim submitted is not related to the beneficiary's terminal illness. If billings contrary to this policy are found in post-payment review, MDHHS will recover inappropriate payment.



1.6.A. EXCEPTION FOR SELECTED HIV DRUGS

MDHHS separately reimburses a pharmacy for selected HIV drugs that the beneficiary had previously used to prevent the terminal illness. These HIV drugs include Protease Inhibitors, Nucleoside/-tide Reverse Transcriptase Inhibitors, and Non-Nucleoside Reverse Transcriptase Inhibitors, even though the product is related to the terminal illness.

1.6.B. PRODUCTS NOT RELATED TO THE TERMINAL ILLNESS

Covered drug products not related to the terminal illness may be separately billed by the pharmacy. For example: A hospice beneficiary has leukemia and a lifelong condition of diabetes. Products related to the diabetes can be separately billed by a pharmacy provider.

1.7 MEDICAID HEALTH PLANS

Providers should verify eligibility to determine if the beneficiary is enrolled in a MHP (Benefit Plan ID of CSHCS-MC, MA-HMP-MC, MA-MC or MME-MC) for the DOS. (Refer to the Beneficiary Eligibility chapter for additional information.)

Coverage criteria (including PA) and reimbursement limits for members of MDHHS contracted Medicaid Health Plans (MHPs) may not follow the policies specified in this chapter applicable to FFS.

Each health plan enrolls its own providers and structures its own billing system. All plan providers are required to enroll/register in CHAMPS. Providers must contact the contracted plan for information regarding reimbursement issues.

Pharmacy Aspects of MHP: Quick Reference

Benefit Plan ID	CSHCS-MC, MA-HMP-MC, MA-MC or MME-MC
Provider Enrollment	Pharmacies must follow the MHP procedures for enrollment to ensure payment.
Pharmaceutical Coverage	<p>Approved MHP pharmaceutical products may differ from Medicaid FFS and CSHCS programs.</p> <p>The MHP Common Formulary establishes the minimum coverage requirements for drugs covered by health plans, as well as drug utilization management tools such as quantity limits, age and gender edits, prior authorization criteria, and step therapies. MHPs may be less restrictive, but not more restrictive, than the coverage parameters of the Common Formulary. Additional information is available on the MDHHS website. (Refer to the Directory Appendix for website information.)</p> <p>With the exception of products that are carved out, MHPs must have a process to approve provider requests for any prescribed medically appropriate product identified on the Michigan Pharmaceutical Product List (MPPL). (Refer to the Directory Appendix for website information.)</p>
Copayment	Copayments may differ.
Payment and Billing	Payment levels and billing methods are set by the MHP, MDHHS.



Prior Authorization (PA)	Follow the MHP PA procedures.
Questions	For general managed care questions, call the MDHHS Provider Inquiry or Beneficiary Helpline. (Refer to the Directory Appendix for contact information.) Contact the individual MHP for specific coverage questions.

1.7.A. CARVE-OUT EXCEPTIONS

Select drugs and classes may be carved-out from the respective health plan’s reimbursement and paid Medicaid Fee For Service. (Refer to the PBM website listed in the Directory Appendix for a listing of these drug classes.)

Any services paid Fee For Service must follow appropriate guidelines for supporting documentation, including attending, billing, prescribing, referring, rendering and supervising provider requirements.

1.8 INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES

Beneficiaries residing in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) are identified by the Benefit Plan ID of ICF/IID. For Medicare/Medicaid dually-eligible beneficiaries, pharmacy services will be covered by Medicare Part D. Drugs not covered by Medicare Part D are included in the ICF/IID per diem rate.

1.9 MEDICARE PART D BENEFIT

The Medicare Modernization Act of 2003 provides a prescription drug benefit to Medicare beneficiaries. The benefit is commonly referred to as Medicare Part D. Dually eligible Medicare/Medicaid beneficiaries must obtain all Part D covered drugs through their Medicare Part D Plan (PDP or MA-PD).

Drugs covered by Medicare Part D, but not included in the beneficiary's Medicare Part D Plan's formulary, will not be covered by Medicaid.

Drugs excluded from coverage by Medicare Part D will not be covered by Medicaid, except for the following:

- Over-the-counter (OTC) drugs listed on the MPPL
- Over-the-counter agents used to promote smoking cessation
- Select group of vitamins and minerals prescribed at therapeutic doses for deficiency diagnoses that meet Medicaid coverage criteria

Questions concerning the Medicare Part D benefit must be directed to Medicare. (Refer to the Directory Appendix for contact information.)



SECTION 2 – PRESCRIBER REQUIREMENTS

All MDHHS-covered legend and over-the-counter drugs (OTCs), except condoms, require a prescription order by a licensed prescriber.

Coverage of pharmaceutical products is based on limitations stated in this chapter, the MPPL, and medical necessity. Determination of medical necessity and appropriateness of service is the responsibility of the prescribing physician/provider (prescriber) within the scope of currently accepted medical practice and MDHHS limitations. Participating providers must observe applicable State and Federal laws, rules, regulations, and policies. MDHHS may impose additional constraints to reduce misuse.

2.1 SCOPE OF PRACTICE

MDHHS only reimburses for products prescribed by a licensed prescriber that are within the prescriber's scope of currently accepted medical practice and MDHHS limitations.

2.2 PRESCRIBER IDENTIFICATION

Pharmacy providers must provide the individual prescriber's National Provider Identifier (NPI) on the submitted claim. MDHHS will deny pharmacy claims where the prescriber is not enrolled in CHAMPS.

Refer to the General Information for Providers chapter and the Practitioner chapter for additional information.

2.3 SANCTIONED PRESCRIBERS

MDHHS does not reimburse for pharmaceuticals prescribed by providers sanctioned by the Federal Government, the State of Michigan, or for prescribers having a limited, expired (lapsed), or revoked license. A list of sanctioned providers is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.4 OTHER PERTINENT SECTIONS

Prescribers should refer to other pertinent sections in this chapter for policies and procedures related to Drug Utilization Review, Prior Authorization, and the MPPL.



SECTION 3 – PHARMACY REQUIREMENTS

3.1 COMPLIANCE WITH APPLICABLE STATE, FEDERAL, AND MDHHS PROVISIONS

A provider who complies with all licensing and regulation laws applicable to the practice of pharmacy in Michigan may enroll as a Medicaid provider. Applicable State and Federal laws, rules, regulations, and policies must be observed by participating pharmacies. MDHHS does not enroll dispensing physicians as Medicaid providers for pharmacy services. (Refer to the General Information for Providers Chapter of this manual for additional information.)

3.2 ENROLLMENT

Pharmacy enrollment is processed through CHAMPS. Refer to the General Information for Providers Chapter, Provider Enrollment section, for additional information.



SECTION 4 – COUNSELING REQUIREMENTS

Pharmacies must follow the counseling requirements mandated in State and Federal statutes and regulations. These requirements do not apply to drugs dispensed in nursing facilities that are in compliance with the drug regimen review procedures specified by the licensing authority.

4.1 OFFER TO DISCUSS

For every new prescription presented by the beneficiary, the pharmacy's representative must offer the beneficiary the opportunity to discuss/receive counseling from the pharmacist regarding the new prescription. The offer for counseling must be in a positive, helpful manner. If practical, the offer to counsel must be face-to-face and verbal. Otherwise, it is permissible for the offer to be made in writing or by telephone. Pharmacies are required to provide toll-free access for beneficiary inquiries related to products dispensed. A pharmacist is not required to provide counseling when a beneficiary or representative refuses the offer for counseling.

4.2 DISCUSSION

When the beneficiary (or representative) accepts the offer for counseling, it must be provided by the pharmacist in person (whenever practical) or by telephone and may include written materials. Information must be in a language that can be understood by the beneficiary (or representative) and must include an opportunity for questions.

In addition to discussing interactions with drugs previously dispensed by the pharmacist, the discussion should also include the potential interaction with any other drugs the beneficiary indicates he is taking. The beneficiary (or representative) must be counseled in a confidential manner, consistent with any State or Federal regulations. Federal law requires that the pharmacist must discuss all the items indicated below, and any others deemed significant in the pharmacist's professional judgment. If an interpreter is required, the provider must provide one free of charge.

- The name and description of the medication.
- The dosage form, dosage, route of administration, and duration of drug therapy.
- Special directions and precautions for preparation and use by the beneficiary.
- Common side effects or interactions and therapeutic contraindications that may be encountered, including their avoidance, and the action required if they occur.
- Techniques for self-monitoring drug therapy.
- Proper storage.
- Prescription refill information.
- Action to be taken in the event of a missed dose.



SECTION 5 – SIGNATURE LOG, DATA COLLECTION AND DOCUMENTATION

5.1 SIGNATURE LOG

Pharmacy providers must maintain a log containing the following information:

- Beneficiary's name;
- The signature of the beneficiary or that of his representative; and
- The date of receipt of the prescription.

The log must effectively differentiate between prescriptions received by a beneficiary for which counseling was accepted and provided, and those for which counseling was offered and was declined. This log must be retained for review by MDHHS or the MDHHS agent for seven years and is subject to audit.

The signature log serves as verification of the beneficiary receiving the prescription billed. The absence of the appropriate signature indicates the beneficiary did not receive the prescription, and funds will be recouped from the pharmacy.

5.2 BENEFICIARY INFORMATION AND DATA COLLECTION REQUIREMENTS

To meet specified State and Federal requirements, pharmacies must make a reasonable effort to obtain, record, and maintain on file at least the following information:

- Name, address, telephone number, date of birth (or age), and gender of the beneficiary.
- Pharmacist notes on the beneficiary's drug therapy.
- Beneficiary history when significant, including:
 - Disease state(s);
 - Known allergies and drug reactions; and
 - Comprehensive list of drugs and relevant devices.
- Whether the offer to counsel was made and whether this offer was accepted or rejected by the beneficiary or the beneficiary's representative.

5.3 DOCUMENTATION REQUIREMENTS

To assure that pharmacy counseling and other data collection requirements were performed, pharmacies must record the required information in the beneficiary's manual or electronic profile, in the prescription signature log, or any other system of records. Regardless of the format used, the associated documentation must be retained electronically or otherwise for a period of seven years, or longer if specified by law.



5.3.A. NON-CONTROLLED ELECTRONICALLY TRANSMITTED PRESCRIPTIONS

If a prescription is created, signed, transmitted and received electronically, all records related to that prescription must be retained electronically. Records must be retained electronically for a period of seven years, or longer if specified by law. Records must be made available within 72 hours or as requested. The electronically transmitted prescription must include all of the following information:

- The name, address, and telephone number of the prescriber;
- The full name of the patient for whom the prescription is issued;
- An electronic signature or other identifier that specifically identifies and authenticates the prescriber;
- The time and date of the transmission;
- The identity of the pharmacy intended to receive the transmission; and
- Any other information required by the federal act or state law.

The electronic equipment or system utilized in the transmission and communication of prescriptions must provide adequate confidentiality safeguards and be maintained to protect patient confidentiality as required under any applicable federal and state law and to ensure against unauthorized access. The electronic transmission of a prescription must be communicated in a retrievable, recognizable form acceptable to the intended recipient. The electronic form utilized in the transmission of a prescription must not include "dispense as written" or "d.a.w." as the default setting.

Prior to dispensing a prescription that is electronically transmitted, the pharmacist must exercise professional judgment regarding the accuracy, validity, and authenticity of the transmitted prescription. An electronically transmitted prescription that meets the above requirements is the original prescription.



SECTION 6 – GENERAL NONCOVERED SERVICES

This section specifies general coverage restrictions. However, drugs in other classes may not be covered. Pharmacies should review the MPPL for specific coverage. When possible, pharmacies are encouraged to suggest alternative covered therapy to the prescriber if a product is not covered.

The following drug categories are **not covered** as a benefit:

- Agents used for anorexia
- Agents used for weight gain
- Agents used for cosmetic purposes or hair growth
- Agents used for symptomatic relief of cough and colds
- Experimental or investigational drugs
- Agents used to promote fertility
- Agents used to promote smoking cessation not on the MPPL
- Vitamin/Mineral combinations not for prenatal care, end stage renal disease or pediatric fluoride supplementation
- Covered outpatient drugs that the Labeler seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the Labeler or their designee
- Covered outpatient drugs where the Labeler limits distribution
- Proposed less-than-effective (LTE) drugs identified by the Drug Efficacy Study Implementation (DESI) program
- Over-the-counter drugs not on the MPPL
- Drugs of Labelers not participating in the Rebate Program
- Drugs prescribed for "off label" use if there is no generally accepted medical indication in peer reviewed medical literature (Index Medicus), or listing of such use in standard pharmaceutical references such as Drug Facts and Comparisons, AMA Drug Evaluations, American Hospital Formulary Service Drug Information, or DRUGDEX Information Systems
- Drugs prescribed specifically for medical studies
- Drugs recalled by Labelers
- Drugs past CMS termination dates (Refer to the Directory Appendix for CMS website information.)
- Lifestyle agents
- Standard Infant Formulas
- Drugs covered by the Medicare Part D benefit
- Drugs not FDA approved or licensed for use in the United States
- Agents used for treatment of sexual or erectile dysfunction



SECTION 7 - MICHIGAN PHARMACEUTICAL PRODUCT LIST

The Michigan Pharmaceutical Product List (MPPL) identifies the pharmaceutical products that are covered by MDHHS. The MPPL pharmaceutical product coverages may vary by MDHHS program or be limited by age, clinical parameters, and/or gender. The Point of Sale pharmacy claim adjudication also provides coverage information related to a specific beneficiary or prescription.

The MPPL is posted on the PBM's website. (Refer to the Directory Appendix for website information.) Providers must refer to the MPPL for the additions and deletions of drug products. Specific notification of changes will not be issued.

7.1 NOTIFICATION OF NEW OUTPATIENT DRUGS

MDHHS receives weekly, comprehensive new information about outpatient drugs from First DataBank. Manufacturers are not required to submit notification of new drug products. New drug products are required to be reviewed by the Pharmacy and Therapeutics (P&T) committee.

Most drug products are required to be on the market for six months prior to review. Products with a "priority" FDA rating may be reviewed earlier than the six month requirement.

7.2 APPROVED LABELERS

MDHHS reimburses MPPL products distributed by approved Labelers who have signed rebate agreements with the Centers for Medicare & Medicaid Services (CMS). A list of these approved Labelers is located on the CMS website and identification is by the first five digits of a National Drug Code (NDC). (Refer to the Pharmacy portion of the Directory Appendix for CMS website information.)

Alcohol swabs, condoms, diaphragms, lancets, syringes, aerochambers, spacers, and peak flow meters provided by a pharmacy are covered regardless of the manufacturer's rebate agreement.



SECTION 8 – PRIOR AUTHORIZATION

8.1 PRIOR AUTHORIZATION PROCESSOR

The MDHHS PBM processes prior authorizations (PAs). Refer to PBM's Pharmacy Claims Processing Manual for PA procedures. (See Directory Appendix for contact information.) Authorization to override denial edits must be obtained from the PBM.

Do **not** call the PBM's Call Centers for:

- Supplies billed by Medical Suppliers, including enteral formula and Total Parenteral Nutrition (TPN), since these are only reimbursed to a Medical Supplier provider. Contact the MDHHS Program Review Division for PA. (Refer to the Directory Appendix for contact information.)
- Information about the member's MHP. The provider must contact the MHP to obtain their policies.

8.2 PRIOR AUTHORIZATION REQUIREMENTS

PA is required for:

- Products as specified in the MPPL. Pharmacies should review the information in the Remarks as certain drugs may have PA only for selected age groups, gender, etc. (e.g., over 17 years).
- Payment above the Maximum Allowable Cost (MAC) rate.
- Prescriptions that exceed MDHHS quantity or dosage limits.
- Medical exception for drugs not listed in the MPPL.
- Medical exception for noncovered drug categories.
- Acute dosage prescriptions beyond MDHHS coverage limits for H2 Antagonists and Proton Pump Inhibitor medications.
- Dispensing a 100-day supply of maintenance medications that are beneficiary-specific and not on the maintenance list.
- Pharmaceutical products included in selected therapeutic classes. These classes include those with products that have minimal clinical differences, the same or similar therapeutic actions, the same or similar outcomes, or have multiple effective generics available.

8.3 RESPONSIBILITY FOR OBTAINING AUTHORIZATION

8.3.A. PHARMACY RESPONSIBILITY

Pharmacies may call the PBM Technical Call Center for exceptions on:

- Quantity;
- Early refills; and
- 72-hour supply of medication for emergency needs only when the prescriber is not available to obtain PA.



Pharmacies may call the PBM Clinical Call Center for exceptions on payment for brand name over the MAC.

The PBM Technical Call Center is available 24 hours per day/seven days a week.

Refer to the Directory Appendix for PBM's Call Center contact information.

8.3.B. PRESCRIBER RESPONSIBILITY

Prescribers or their designees may call the PBM Clinical Call Center for any PA, but must call for any request that falls outside the categories noted above as applying to pharmacies.

The PBM Clinical Call Center is available after hours by telephone and by pager. The PBM may also be contacted by fax or in writing via U.S. mail.

Refer to the Directory Appendix for the PBM Clinical Call Center contact information, PA contact information and hours of operation.

8.4 DOCUMENTATION REQUIREMENTS

For all requests for PA, the following documentation is required:

- Pharmacy name and phone number
- Beneficiary diagnosis and medical reason(s) why another covered drug cannot be used
- Drug name, strength, and form
- Other pharmaceutical products prescribed
- Results of therapeutic alternative medications tried
- MedWatch Form or other clinical information may be required

8.5 ADDITIONAL DOCUMENTATION

Depending on the specific drug being prescribed, additional medical documentation may be required. The most common categories requiring additional documentation are:

8.5.A. BRAND OVERRIDE

Provide documentation of the therapeutic trial and failure reasons of the generic.

8.5.B. WEIGHT LOSS

- Current medical status, including nutritional or dietetic assessment.
- Current therapy for all medical conditions, including obesity.
- Documentation of specific treatments, including medications.
- Current accurate Body Mass Index (BMI), height, and weight measurements.



- Confirmation that there are no medical contraindications to reversible lipase inhibitor use; no malabsorption syndromes, cholestasis, pregnancy and/or lactation.
- Details of previous weight loss attempts and clinical reason for failure (at least two failed, physician supervised, attempts are required).

8.6 PRIOR AUTHORIZATION DENIALS

PA denials are conveyed to the requester. PA is denied if:

- The medical necessity is not established.
- Alternative medications are not ruled out.
- Evidence-based research and compendia do not support it.
- It is contraindicated, inappropriate standard of care.
- It does not fall within MDHHS clinical review criteria.
- Documentation required was not provided.

The PBM reviews the information submitted to determine whether the clinical criteria have been met. If the submitted information does not indicate that the criteria have been met, the PA is then sent to the Office of Medical Affairs in MDHHS for final determination on whether the clinical criteria have been met.



SECTION 9 – H2 ANTAGONIST AND PROTON PUMP INHIBITOR POLICY

For high dose use greater than 102 days in a 365-day period, PA is required for H2 Antagonists and Proton Pump Inhibitors (PPIs). MDHHS defines high dose use as:

H2 Receptor Antagonists	Proton Pump Inhibitors
Cimetidine: 800 mg per day or more	Omeprazole: 40 mg per day or more
Famotidine: 40 mg per day or more	Esomeprazole (Nexium): 40 mg per day or more
Nizatidine: 300 mg per day or more	Lansopazole (Prevacid): 30 mg per day or more
Ranitidine: 300 mg per day or more	Rabeprazole (Aciphex): 20 mg per day or more
	Pantoprazole (Protonix): 40 mg per day or more

Nonpreferred H2 Antagonists or PPIs require PA for both high and low dose use. Compliance with the H2 Antagonists and PPI Policy is monitored with POS or post-payment review.

Prescribers may request PA for high dose therapy over the 102 days through the PBM Clinical Call Center. (Refer to the Directory Appendix for contact information.) The following information is required for PA determination:

- Diagnosis
- Drug and dose for which PA is requested
- Date and results of GI testing
- All alternative H2 Antagonists and PPIs tried, including dose and duration
- Other prescribed medications relating to this diagnosis
- Reason patient cannot endure testing
- Health education or other counseling employed for this condition



SECTION 10 – DRUG UTILIZATION REVIEW

10.1 PROSPECTIVE DRUG UTILIZATION REVIEW

MDHHS utilizes Prospective Drug Utilization Review (ProDUR) edits in its Point of Sale (POS) system. ProDUR encompasses drug therapy screening, including problem detection, evaluation, and counseling components of pre-dispensed drugs.

In the POS system, MDHHS limits the number of messages to providers that concern potential drug problems to those that are critical to quality of care and appropriate dispensing. It is the provider's responsibility to provide ProDUR screening and to adhere to beneficiary information and data collection requirements.

10.1.A. PRODUR SCREENING REQUIREMENT

Before prescriptions are filled or delivered, pharmacists must review the consequences of the drug therapy based on the appropriate standards and guidelines.

The review must screen for potential therapy problems due to:

- Therapeutic duplication
- Drug-disease contraindications (to the extent diagnosis information is available)
- Drug-drug interactions (including interactions with known over-the-counter drugs)
- Incorrect drug dosage or duration of drug treatment
- Drug-allergy interactions
- Clinical abuse/misuse
- Under-utilization or over-utilization

10.1.B. PRODUR ALERT MESSAGES

The PBM's POS system provides online assistance for the dispensing pharmacist. Incoming drug claims are compared to a beneficiary's pharmacy claims history file to detect potential therapeutic problems. ProDUR alert messages are returned to the pharmacist when significant problems are discovered by this review.

10.2 RETROSPECTIVE DRUG UTILIZATION REVIEW

Medicaid utilizes pharmacy data for retrospective drug utilization review (RetroDUR) as required by Federal law and the following compendia:

- American Hospital Formulary Service Drug Information
- United States Pharmacopoeia Drug Information



- DRUGDEX Information System
- Peer-reviewed medical literature

RetroDUR is intended to be an educational tool to reduce costs resulting from drug-induced illnesses and hospitalizations. The purpose of retrospective drug utilization review is:

- To identify high-risk cases for drug-induced illness.
- To communicate risk factors to prescribers and dispensing pharmacists for evaluation.
- To improve patient healthcare outcomes and quality of care.

RetroDUR alerts providers to a beneficiary's medical condition and total drug usage from all prescribers and pharmacies. The MDHHS PBM reviews utilization data on a monthly basis and makes recommendations to the Michigan DUR Board for interventions and educational seminars.

10.3 MICHIGAN DRUG UTILIZATION REVIEW BOARD

The Michigan Drug Utilization Review (DUR) Board includes both physicians and pharmacists. After post-payment review, the DUR vendor sends appropriate intervention letters to pharmacies and prescribers. Based on the DUR intervention information, prescribers may choose to modify therapy. However, prescribers or pharmacists may also choose to correct beneficiary negative patterns by counseling, or provide background for re-evaluation by the DUR vendor or the DUR Board.

As needed, the PBM or DUR Board follows up on re-occurring patterns that have not been justified. Provider education or academic detailing may be provided to address re-occurring patterns.

10.4 CLINICAL CONSULTATION

MDHHS provides feedback to providers through its academic detailing program. Administered by PBM, Medicaid targets topics related to drug therapy where direct educational intervention to medical providers may prove beneficial in improving outcomes. The Michigan DUR Board approves the topics for academic detailing. Clinical consultants are Michigan-licensed pharmacists who are recruited and trained through the Michigan Pharmacists Association under the direction of PBM. Whenever possible, clinical consultants are assigned to call on medical providers who practice in the same geographical area as the detailing pharmacist to provide a personal and professional connection between the healthcare providers. Providers are encouraged to give the clinical consultants feedback on both topics presented and the overall program.



SECTION 11 – DISPENSING POLICY

11.1 DAYS SUPPLY

Prescription quantities are limited to the quantity specified by the prescriber. MDHHS covers up to a 34-day supply for acute medications, and up to a 102-day supply for maintenance medications.

The pharmacy must submit accurate days supply information. Submitting incorrect days supply information can cause false ProDUR messages and claim denials. It could also result in a pharmacy being targeted for a post-payment audit.

11.2 ACUTE AND MAINTENANCE SUPPLIES

Providers must bill and dispense as follows:

- For acute illness: The amount dispensed must be limited to the quantity required for the desired therapy during that episode of illness or up to a 34-day supply.
- For chronic illness:
 - Maintenance drugs must be dispensed in quantities as ordered by the physician and to achieve optimum therapy and economy of dispensing, or up to a 102-day supply.
 - If a prescription for a product on the maintenance list is for more than a month's supply and less than a 102-day supply, only one dispensing fee is allowed.
 - A maximum of 13 dispensing fees are paid for the same drug dispensed to the same beneficiary within a 365-day billing period.

A list of maintenance medications is posted on the PBM's website. (Refer to the Directory Appendix for website information.) This list does not exclude medications from other standard therapeutic class codes from being supplied in maintenance quantities. PA is necessary when a maintenance quantity of other medications is required for specific beneficiaries.

11.3 REFILLS

Refills must conform to the current Administrative Rules of the Michigan Board of Pharmacy, Michigan Public Health Code, state and federal statutes, rules, regulations, and policies. Claims will deny at point-of-sale if the utilization requirements have not been met.

For non-controlled substances, a FFS beneficiary cannot obtain a refill of the prescription until at least 75 percent of the drug quantity limit has been consumed in compliance with the prescribed dose, amount, frequency, and time intervals established by MDHHS. (Refer to the Narcotic Analgesics subsection for additional information regarding refill thresholds for narcotic analgesics.)

Early refill overrides may be granted once per drug per 12 months for any of the following circumstances:

- To replace medication that has been lost, stolen or destroyed.
- For the purposes of vacation or travel.



The early refill will not exceed a 34-day supply. MDHHS or its designee may limit the number of instances early refill overrides are approved in cases of suspected fraud or abuse, and may request additional documentation before an override is authorized.

The pharmacy may contact the MDHHS PBM Technical Call Center to request an override for an instance where an early refill is warranted. (Refer to the Directory Appendix for contact information.)

11.4 PRESCRIPTIONS NOT PICKED UP

MDHHS does not reimburse for retail prescriptions filled but not dispensed or picked up by the beneficiary or his representative, and does not allow restocking fees. For prescriptions not picked up, pharmacies must claim adjust or reverse the claim for any payments received, including the dispensing fee. The pharmacy should reverse claims in a timely manner. However, MDHHS policy allows claim adjustments or reversals to be submitted up to twelve months after the original date of service. For example, if the Medicaid beneficiary does not pick up a prescription from the pharmacy within 14 calendar days from the date the prescription claim was submitted by the pharmacy, the prescription claim should be reversed on the 15th calendar day and must have been reversed by the 365th day. For audit purposes, a record of processed reversals must be retained by the pharmacy for seven years.

11.5 TAMPER RESISTANT PRESCRIPTIONS

A pharmacist can only fill a written prescription for a Medicaid FFS beneficiary or POS carveout drugs for MHP enrollees when executed on a tamper resistant prescription pad. (See the following subsections for special considerations.)

Additional information on the tamper resistant prescription pad policy can be found in CMS guidelines which are available online. (Refer to the Directory Appendix for website information.)

11.5.A. EXEMPTIONS

- A compliant pad is not required if the prescription is transmitted verbally or electronically by telephone, facsimile, or modem to the pharmacy per federal and state laws.
- MHP enrollee if the MHP is reimbursing the prescriptions.
- Medicaid FFS beneficiaries receiving prescription drugs not separately reimbursable to a pharmacy. This includes drugs provided incident to, or part of, another service or as part of a per diem payment in the following settings:
 - Nursing facilities
 - ICF/IIDs
 - Inpatient/Outpatient Hospitals
 - Clinical Settings (hospice, dental, physician office/clinic, laboratory and x-ray, renal dialysis)



11.5.B. EMERGENCY PRESCRIPTIONS

In the event a pharmacy receives a non-compliant emergency prescription, the prescribed drug may be dispensed. However, the prescriber must provide to the pharmacy a compliant prescription within 72 hours of the date the emergency prescription was filled.



SECTION 12 – QUANTITY AND BILLING UNITS

MDHHS uses standard metric billing units and the provider may not round fractions. For example, if the product is 2.500 ml, it must be billed as 2.500 ml, not 3 ml. The PBM's processing allows a quantity entry up to 999,999.999.

12.1 QUANTITY LIMITS

Dispensing quantities are limited according to accepted standards of practice, Food and Drug Administration (FDA)-approved Labeler recommendations and the recommendations of the Michigan DUR Board.

12.2 COMMON UNIT BASES

Quantities are based on the amount dispensed for the unit of the product. Thus, quantity field entries must be based on the amount dispensed for the unit specified in the MPPL. The most common unit bases are EACH, ML, or GM. Following are examples.

Drug Name	Drug Strength	Dosage Form	Unit	Billing Quantity Based On
Alphanate		Vial	EA	AntiHemophilic Factor Units
Amoxicillin Trihydrate	125 mg/5 ml	Susp Recon	ML	Reconstituted Milliliters
Cefazolin Sodium	1 gm	Vial	EA	Vials (Powdered-Filled)
Gentamicin Sulfate	40 mg/ml	Vial	ML	Milliliters (Liquid-Filled)
Humulin-N	100 U/ml	Vial	ML	Milliliters (Liquid-Filled)
Indocin	50 mg	Supp Rect	EA	Suppositories
Prolastin		Vial	EA	Milligrams
Proventil Inhaler		Aerosol	GM	Grams in each canister
Ranitidine	300 mg	Tablet	EA	Tablets



SECTION 13 – REIMBURSEMENT, COPAYMENTS, AND COORDINATION OF BENEFITS

13.1 USUAL AND CUSTOMARY CHARGE

Reimbursement is the lower of the usual and customary (U&C) charge or the MDHHS product cost payment limits and a dispensing fee minus the beneficiary copayment, with the exception of condoms. If a beneficiary has other insurance or Medicare coverage, the related other insurance or Medicare payments are subtracted from the MDHHS payment.

U&C charge is defined as a pharmacy's charge to the general public. If the provider renders a covered service to a beneficiary that the provider offers for free or for a reduced fee to the general public, the provider may only bill Medicaid up to that customary charge as long as all other Medicaid requirements are met. The sum of charges for both the product cost and dispensing fee must not exceed a pharmacy's U&C charge for the same or similar service. The U&C charge must reflect all advertised discounts, special promotions, or other programs initiated to reduce prices for product costs available to the general public or to a special population.

If a pharmacy discounts prescriptions to an inclusive category of customers (e.g., over 60 years), the pharmacy must reflect this discount in its billings for MDHHS program beneficiaries in the same category.

13.2 OVER-THE-COUNTER DRUGS

The U&C charge for prescription-ordered OTC drugs may be different, but not greater, than the retail pharmacy's shelf price of the same product sold without a prescription.

13.3 SALES TAX

Sales tax must not be added to a pharmacy's U&C charge. MDHHS does not reimburse for sales tax.

13.4 PRODUCT COST PAYMENT LIMITS

Product Cost Payment Limits are based on the NDC the pharmacy identifies as the product that was dispensed. Reimbursement is the lower of the National Average Drug Acquisition Cost (NADAC), the Wholesale Acquisition Cost (WAC), the MAC, or the provider's charge. Misrepresentation of the product's NDC results in denied payment and fraud/abuse sanctions subject to applicable Federal and State laws.

Entities that dispense drugs purchased through the Federal 340B program to beneficiaries must bill the 340B price as the actual acquisition cost.

NADAC rates are posted on the CMS website. (Refer to the Pharmacy Resources portion of the Directory Appendix for website information.)

13.4.A. MAXIMUM ALLOWABLE COST

Maximum Allowable Cost (MAC) reimbursement levels for Michigan Medicaid are established and managed by an MDHHS contractor. MAC reimbursement levels are generally applied to multi-source brand and generic products. However, MAC reimbursement may also be applied to single source drugs or drug classifications where appropriate. New or changed MAC prices are posted on the contractor's website the next



business day after they are determined. A monthly online MAC list is also available on the contractor's website. MAC reimbursement reviews will take place on an on-going basis. In addition to the website, specific MAC reimbursement levels are also available by contacting the MAC vendor by US mail, e-mail, fax or telephone. (Refer to the Directory Appendix for the MAC vendor website and contact information.)

All requested MAC price reviews require the following information:

- The brand and generic name, strength, form, and NDC requested for review
- Reason for requested review (availability, price, or other)
- Supporting documentation that the MAC is below cost or the product is not available (wholesaler invoice to support a request)
- Date of service to identify the difference between reimbursement and actual cost
- Prescription number
- Company or pharmacy name, NPI, telephone number, and contact person

13.4.B. MAC OVERRIDES

Specific brand products have a MAC reimbursement level. To receive payment above the MAC reimbursement level, PA through the PBM is required. (Refer to the Directory Appendix for contact information.)

13.5 PROFESSIONAL DISPENSING FEES

The professional dispensing fee is defined as the fee charged for filling a prescription and all related services performed by a pharmacy. MDHHS dispensing fees are posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

13.6 BENEFICIARY COPAYMENTS

13.6.A. MEDICAID COPAYMENTS [CHANGES MADE 10/1/20]

A copayment for each generic/preferred drug dispensed, and for each brand name/non-preferred drug dispensed, may apply for Medicaid beneficiaries age 21 years and older. A copayment may apply to certain brand name drugs that are preferred. Refer to the General Information for Providers Chapter for information about copayments. Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)

Copayments cannot be discounted for promotional purposes.



Copayment Exemptions	
Over Age 21 Exclusions	<ul style="list-style-type: none"> ▪ The pharmaceutical product is a family planning or pregnancy-related product. ▪ The beneficiary is in a nursing facility (Benefit Plan ID of NH). (Refer to the Nursing Facility section of this chapter for additional information.) ▪ The beneficiary is enrolled in a hospice program (Benefit Plan ID of Hospice).
Other Exclusions	<ul style="list-style-type: none"> ▪ Medicaid beneficiaries who are under the age of 21 are excluded from the copay requirement. ▪ All CSHCS and MOMS beneficiaries are excluded, including those over age 21. ▪ Medicare/Medicaid dual eligibles. <p>Claims for drugs related to the treatment of the following chronic conditions are exempt from copayments for Healthy Michigan Plan beneficiaries:</p> <ul style="list-style-type: none"> ▪ Alcohol Use Disorder ▪ Asthma ▪ Chronic Kidney Disease ▪ Chronic Obstructive Pulmonary Disease and Bronchiectasis ▪ Deep Venous Thrombosis (while on anticoagulation)/Pulmonary Embolism (chronic anticoagulation) ▪ Depression ▪ Diabetes ▪ Heart Failure ▪ HIV ▪ Hyperlipidemia ▪ Hypertension ▪ Ischemic Heart Disease ▪ Obesity ▪ Schizophrenia ▪ Stroke/Transient Ischemic Attack ▪ Substance Use Disorder ▪ Tobacco Use Disorder <p>Claims for the following drugs related to the treatment of Mental Health Conditions and Substance Use Disorders are exempt from copayments:</p> <ul style="list-style-type: none"> ▪ Central Nervous System Drugs



	<ul style="list-style-type: none"> ▪ Psychotherapeutic Drugs ▪ Sedative/Hypnotics ▪ Anti-Alcoholic Preparations ▪ Selective Serotonin Reuptake Inhibitors ▪ Narcotic Withdrawal Therapies ▪ Neuropathic Agents ▪ Opioid antidotes (text added per bulletin MSA 20-33) ▪ Drugs used to treat Substance Use Disorder (text added per bulletin MSA 20-46) ▪ Drugs used to treat Tobacco Use Disorder (text added per bulletin MSA 20-46)
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13.6.B. MEDICARE PART D COPAYMENTS

Refer to the Billing Beneficiaries Section of the General Information for Providers Chapter of this manual for additional information regarding co-payment requirements. Beneficiaries may not be denied care or services based on inability to pay a co-payment, except as outlined in that section.

Medicaid will not reimburse:

- Copays, deductibles, or coinsurance for Medicare Part D drugs.
- Commercial insurance drug copays, deductibles, or coinsurance for Medicare/Medicaid beneficiaries who chooses to retain their creditable drug coverage offered by the commercial insurance in place of joining a Medicare Part D plan.
- Copays, deductibles, or coinsurance that exceed the standard Medicare Part D benefit for Medicare/Medicaid beneficiaries.

13.7 NONALLOWABLE CHARGES TO THE BENEFICIARY

A pharmacy must not charge a beneficiary for a prescription if the pharmacy or prescriber fails to request prior authorization (PA). For all products listed in the MPPL indicating PA is required, the pharmacy may contact the PBM for PA or notify the prescriber that a PA is needed.

A pharmacy may charge the beneficiary its U&C charge for a product requiring PA only if the pharmacy has written documentation that the beneficiary was informed of the attempt and failure to obtain PA and of the resultant desire to purchase the drug privately. The pharmacy must not charge any portion of this claim to Medicaid.

The beneficiary must be made aware that PA and reimbursement cannot be obtained later.



13.8 ALLOWABLE CHARGES TO THE BENEFICIARY

A pharmacy may only charge a beneficiary the MDHHS established copayment for covered services. A beneficiary may not be charged for any cost of the prescription above the MDHHS reimbursement level. A pharmacy may only charge a beneficiary its usual and customary charge if the service is a noncovered service and the beneficiary has indicated a desire to purchase the service privately. Furthermore, a beneficiary may not be charged for a prescription in lieu of the pharmacy accepting the reimbursement paid by MDHHS, or in lieu of obtaining PA when indicated.

13.9 ADVERTISING

Advertisements must convey only participation in Medicaid. Advertising must not be used to influence the free choice of a pharmacy by a beneficiary. Promotions offering beneficiaries free goods, gift certificates, or shopping sprees in exchange for filled prescriptions are prohibited. No pharmacy may discount the copayment for promotional purposes.

13.10 COORDINATION OF BENEFITS

Coordination of Benefits (COB) (also referred to as Third Party Liability [TPL]) requires providers to bill other insurances, including Medicare Part B, before billing MDHHS. Pharmacy providers should submit both the primary insurer payment amount and the beneficiary's liability (copayment, coinsurance, and/or deductible) under the primary insurer's plan to MDHHS. Regardless of participation by the pharmacy provider with the other insurance and/or Medicare, MDHHS only reimburses for the coinsurance and deductible amounts up to the Medicaid allowable fee screen. If the other insurance's (including Medicare) reimbursement exceeds the reimbursement level of Medicaid, no additional monies are paid. Providers must submit the charge as the amount allowed by the other insurance, indicating the other insurance payment (including the professional dispensing fee) and the other insurance copayment. In addition, the provider is to use the drug list established by the beneficiary's other insurance carrier. If the other insurance carrier's drug list covers a drug not on the MPPL, the prescriber must obtain PA from MDHHS. (For complete information on MDHHS policy regarding other insurance, refer to the Coordination of Benefits Chapter of this manual.)

If a provider receives payment from another insurance and/or Medicare after MDHHS has made full payment, the payment must be returned to MDHHS through a claim adjustment. Failure to reimburse MDHHS may be construed as fraud under the Medicaid False Claim Act. For billing information on COB, refer to the PBM Pharmacy Claims Processing Manual, the PBM website, or contact the PBM Technical Call Center. (Refer to the Directory Appendix for website and contact information.)



SECTION 14 – SPECIAL PRODUCT COVERAGE

14.1 AMPHETAMINE

Some drugs used to treat narcolepsy or hyperkinesia may be covered for beneficiaries over 17 years of age. The prescriber or designee must obtain PA before the pharmacy dispenses these products.

14.2 ANTIHEMOPHILIC DRUGS

A Medical Supplier must bill for infusion kits necessary for administration. (Refer to the Medical Supplier Chapter of this manual for additional information.)

Antihemophilic drugs are a Medicare Part B benefit. For beneficiaries who are eligible for both Medicare and Medicaid, the pharmacy must bill Medicare prior to billing Medicaid as explained in the Coordination of Benefits Chapter of this manual.

14.3 ANTINEOPLASTIC DRUGS

Covered chemotherapeutic agents are listed in the MPPL. Most injectable chemotherapy forms are not listed in the MPPL as reimbursement is made to the administering healthcare provider (e.g., physicians, outpatient hospitals). A dosage intended for parenteral infusion (continuous or intermittent), perfusion, or intracavity administration in an office, clinic, or outpatient hospital is not a reimbursable Medicaid benefit to a pharmacy. The pharmacy should bill the ordering provider of service.

Injectable chemotherapy and topical uses for these products may be reimbursed to a pharmacy for home use. Some of these agents may require PA. Refer to the MPPL for verification of PA requirements.

14.4 COMPOUNDED DRUGS [CHANGE MADE 7/1/20]

Medicaid defines a compounded drug as the combination of two or more ingredients not available from any Labeler in the combination prescribed. Compounded prescriptions must contain at least one product manufactured by an approved Labeler. The following compounded drug policies do not apply to infusion therapy. Additionally, certain Active Pharmaceutical Ingredients (APIs) and excipients utilized in compounded drug claims are covered. MDHHS maintains a list of these covered products on the Michigan Medicaid Pharmacy Benefits Manager (PBM) website. (Refer to the Directory Appendix for PBM website information to obtain the list of covered products.) (text added per bulletin MSA 20-03)

14.4.A. EXCLUSIONS

Compounded drugs are not covered if active ingredients include:

- A noncovered legend drug or drug class (e.g., cough/cold, DESI);
- Only OTC drugs;
- Reconstitution of a product only; or
- Pre-mixed infusion solutions (Refer to the Directory Appendix for PBM website information to obtain the list of pre-mixed infusion solutions)



A compounded prescription is not covered if it contains noncovered products and is prescribed solely to circumvent program limitations.

14.4.B. PROFESSIONAL DISPENSING FEES

Professional dispensing fees for compounded drugs are available on the MDHHS website. (Refer to the Pharmacy Resources portion of the Directory Appendix for website information.) To receive the compounded fee, a prescription must involve extemporaneous compounding and dispensing prepared only when orders for specific beneficiaries are received.

Medicaid monitors its compounded drug policy on a pre- and post-payment basis.

14.5 FAMILY PLANNING SUPPLIES

14.5.A. CONDOMS

Condoms do not require a prescription. A pharmacy may provide condoms at the beneficiary's request. Both males and females are eligible to receive condoms. Condoms are not a covered benefit for participants in the CSHCS program.

- **Payment Limit** – Payment is the lesser of the pharmacy's retail price or the MAC listed in the MPPL. A dispensing fee is not paid for condoms.
- **Dispensing Limits** – The following quantity requirements are monitored by pre- and post-payment reviews. A pharmacy is not reimbursed for more than:
 - 12 condoms at one time to a beneficiary; or
 - 36 condoms in 30 days to a beneficiary.
- **Documentation** – Pharmacies are responsible for maintaining adequate documentation to substantiate which beneficiaries received condoms. Documentation can be collected on a prescription blank or a log entry. Either form of documentation must contain:
 - An assigned control number (e.g., prescription number);
 - Beneficiary name;
 - Beneficiary Medicaid ID number;
 - Brand name of condom dispensed;
 - Quantity dispensed; and
 - Date dispensed.

14.5.B. DIAPHRAGMS AND CERVICAL CAPS

A dispensing fee is not paid for diaphragms and cervical caps.



14.6 CLOZAPINE

Clozapine may be billed in weekly cycles. A professional dispensing fee may be reimbursed each week when billed in accordance with other MDHHS and FDA product licensure guidelines.

14.7 INFUSION THERAPY

Infusion therapy, except for Total Parental Nutrition (TPN) used in the home setting, is covered for a pharmacy. If a specific drug is not listed in the MPPL, PA must be obtained. A Medical Supplier must bill for infusion-related expendable supplies and durable medical equipment, such as pumps or IV stands and TPN.

MDHHS will reimburse an additional single all-inclusive fee, above the standard dispensing fee, for the diluent and vehicle that is administered with the active ingredient. MDHHS dispensing fees are posted on the MDHHS website. (Refer to the Directory Appendix for website information.)

Daily billing for infusion therapy is not allowed. Drugs for infusion therapy must not be billed more frequently than seven days.

14.8 INHALERS

Depending on the beneficiary's condition, several inhalers per month may be necessary. If dispensing limitations allow and the prescriber writes accordingly, the beneficiary may obtain more than one inhaler per prescription. A dispensing fee for inhalers is not paid to pharmacies.

14.9 METHADONE

Methadone is only covered when used as an analgesic for severe intractable pain such as that produced by some types of terminal illnesses.

14.10 NARCOTIC ANALGESICS

A FFS beneficiary cannot obtain a new prescription or refill of an existing narcotic analgesic, whether the drug is prescribed by the same or different healthcare provider or for a different drug in the same class, until 90 percent (95 percent for Benefits Monitoring Program beneficiaries) of the drug quantity limit has been consumed in compliance with the prescribed dose, amount, frequency and time intervals established by MDHHS.

Hospice (Benefit Plan ID of Hospice) beneficiaries are exempt from refill tolerance restriction. Benefits Monitoring Program beneficiaries are also exempt from refill tolerance restriction.

The refill restriction also does not apply if payment from the other insurance is reported on the claim.

The pharmacy may contact the MDHHS PBM Technical Call Center to request an override for an instance where an early refill is warranted. (Refer to the Directory Appendix for contact information.)

14.11 ORAL CONTRACEPTIVES

Prescriptions for oral contraceptives may be dispensed for a three-month supply when the prescriber writes the prescription accordingly.



14.12 OVER THE COUNTER DRUGS

Covered OTC drugs are listed in the MPPL. A prescription is required. The refill policy is the same as for legend drugs.

14.12.A. OTC DRUGS FOR END STAGE RENAL DISEASE

Certain OTC drugs are covered only for End Stage Renal Disease (ESRD) (that is, prescribed for the treatment of a beneficiary with a kidney transplant or one undergoing maintenance dialysis). Documentation must be kept on file by the pharmacy to substantiate the beneficiary's ESRD condition and must include:

- The date of the transplant (month and year); or
- The name of the facility performing dialysis; or
- An indication that the beneficiary is on Continuous Ambulatory Peritoneal Dialysis (CAPD).

14.12.B. OTC DRUGS FOR NURSING FACILITIES

The MPPL designates when a covered OTC drug is included in the NF per diem. These products and noncovered OTC drugs are included in the per diem rate paid to a nursing facility. It is the responsibility of the nursing facility to provide these products for its beneficiaries. Reimbursement must be obtained from the nursing facility.

Covered OTC drugs, such as insulin (except if covered by the Medicare Part D benefit) and those not designated as included in the NF rate, are reimbursable to a pharmacy for NF beneficiaries.

14.13 PEAK FLOW METERS, SPACERS, AND AEROCHAMBERS

Peak flow meters, spacers, and aerochambers listed in the MPPL may be billed by pharmacies. A dispensing fee is not reimbursed to pharmacies that bill for these supplies. Coverage is limited to four (4) peak flow meters per year, and four (4) spacers and/or aerochambers combined total per year.

Spacers and aerochambers cannot be billed by the pharmacy for NF beneficiaries. These items are included in the NF per diem rate.

14.14 PHYSICIAN-ADMINISTERED INJECTABLE DRUGS

Pharmacy claims for the following physician-administered injectable drugs are reimbursable under Michigan Medicaid and the Healthy Michigan Plan:

- Mental health and substance abuse injectable drugs, as listed on the Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) Physician Injectable Drug Coverage database available on the MDHHS website, administered in an outpatient setting or residential treatment center. (Refer to the Directory Appendix for website information.)
- 17 Alpha Hydroxyprogesterone Caproate (17P and Makena), administered in an outpatient setting.



Pharmacy providers may be reimbursed for these injectable drugs for administration using a rate based on the National Drug Code (NDC). The rates for drug product reimbursement are outlined in the Michigan Medicaid State Plan. Professional or institutional claims for physician-administered injectable drugs are also a covered benefit. Pharmacies and prescribing practitioners must ensure that claims are not duplicated. This policy applies to Fee-for-Service claims.

Pharmacy providers may not dispense a physician-administered injectable drug directly to the beneficiary. To ensure the content and integrity of the drug administered to the beneficiary, the drug must be delivered from the pharmacy directly to the physician for administration. The method of delivery of the injectable drug to the physician should be agreed upon by the pharmacy and physician. The refrigeration, stabilization, and other storage and handling requirements of the drug must be met during delivery and at all points of the transaction. The costs associated with the delivery of the injectable drug to the physician are not reimbursable by MDHHS.

The injectable drug must be administered to the beneficiary within 14 days of the arrival of the drug to the physician's office. For multi-dose vials, the first dose must be administered to the beneficiary within 14 days of the arrival of the drug to the physician's office. For the safety of beneficiaries and to minimize waste, procedures should be established to return unused medications to the pharmacy when appropriate. Restocking returned products should be compliant with Michigan Board of Pharmacy guidelines.

14.14.A. SYNAGIS

Enrolled pharmacy providers may bill for the injectable drug Synagis.

14.15 VACCINES

All vaccines recommended by the Advisory Committee on Immunization Practices (ACIP), including seasonal influenza vaccines, administered by pharmacists are covered for adults aged 19 years and older.

Pharmacies may submit a claim for the vaccine and its administration for Fee-for-Service Medicaid and MOMS beneficiaries. In addition, pharmacies may submit a claim for seasonal influenza vaccine and its administration for CSHCS beneficiaries. For beneficiaries enrolled in a Medicaid Health Plan, the pharmacy provider must confirm coverage of pharmacist-administered vaccines with the plan.

Pharmacists must be in compliance with State of Michigan rules and regulations, have received the appropriate training for vaccine administration, and have a letter of delegation from a physician to be eligible to administer vaccines. Standing orders are required from a Michigan-licensed physician who is responsible for the clinical practice of the vaccine operations. This documentation must be readily available onsite in the event of an audit.

Pharmacists who administer vaccines must register with the Michigan Care Improvement Registry (MCIR). This database provides a complete record of immunizations for Michigan residents. Pharmacists must review the beneficiary's immunization history in MCIR prior to administering the vaccine. MCIR must be updated within 72 hours of administering the vaccine.

In order to receive reimbursement for vaccine administration, pharmacies must submit claims through the MDHHS Pharmacy Benefits Manager (PBM). (Refer to the Directory Appendix for contact information.)



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The pharmacy must submit the National Drug Code (NDC) for the product administered and the appropriate values in the Drug Utilization Review (DUR)/Professional Pharmacy Services (PPS) segment and the Professional Service Code respectively. MDHHS allows pharmacies to bill the cost of the vaccine; therefore, the pharmacy should submit the allowed administrative fee in the incentive fee submitted field.

Dispensing fees are not allowed for the administration of vaccines.

The pharmacy must develop an appropriate mechanism for purposes of properly documenting the identification of the administering pharmacist.

Either a pharmacy or physician can bill for the vaccine administration, but not both. Copayments for vaccine administration services do not apply.



SECTION 15 – NURSING FACILITY

Because of the uniqueness of pharmacy services provided in the nursing facility (NF) setting, separate billing policies were established. Other policies listed in this chapter also apply to NF beneficiaries.

15.1 BENEFIT PLANS

NF beneficiaries typically reside in a nursing home, hospital long term care (LTC) unit, or county-operated medical care facility (MCF). The Benefit Plan ID of NH will be indicated in the eligibility response for beneficiaries who reside in a nursing home.

15.2 DISPENSING FEE

A pharmacy may receive a maximum of 13 dispensing fees for the same drug entity per 365-day billing period.

15.3 COPAYMENT

Medicaid beneficiaries residing in NFs have no pharmacy copayment.

15.4 PHARMACY CONSULTANT SERVICES

Medication reviews and other pharmacy consultant services are the responsibility of the facility and are included in the facility's per diem rate. The pharmacy must make arrangements with the facility for reimbursement of such services.

15.5 PRODUCTS INCLUDED IN THE NURSING FACILITY PER DIEM RATE

MDHHS does not directly reimburse a pharmacy for items included in a facility's per diem rate. If provided, no additional or separate charges may be made to a beneficiary, a member of the beneficiary's family, or other beneficiary representative. If a pharmacy is requested to dispense any of the following, arrangements for payment must be between the pharmacy and the facility.

- Medical Supplies - Examples of medical supplies included in the facility's per diem rate are insulin syringes, reagent strips, aerochambers, spacers, peak flow meters, etc.
- Enteral Formulas – Enteral Formulas are included in the facility's per diem rate.
- OTC products not listed in the MPPL as in the NF's per diem rate may be paid directly to a pharmacy by MDHHS. Noncovered OTCs are included in the NF's per diem rate. Examples of OTCs in the per diem include, but are not limited to:

Analgesics	<ul style="list-style-type: none"> ▪ Acetaminophen ▪ Aspirin ▪ Buffered Aspirin ▪ Enteric-coated aspirin ▪ Ibuprofen
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Cough/Cold Preparations	<ul style="list-style-type: none"> ▪ Guaifenesin with and without Dextromethorphan ▪ Pseudoephedrine/Chlorphen/Dextromethorphan ▪ Pseudoephedrine/Chlorpheniramine ▪ Pseudoephedrine HCl
Ointments	<ul style="list-style-type: none"> ▪ Vitamins A & D Ointment ▪ White Petroleum ▪ Zinc Oxide
Oral Antiseptics	<ul style="list-style-type: none"> ▪ Mouthwash
Topical Antiseptics	<ul style="list-style-type: none"> ▪ Chlorhexidine Gluconate Wash and Solution ▪ Hydrogen Peroxide ▪ Isopropyl Alcohol ▪ Povidone-Iodine Solution/Wash
Vitamins/Minerals	<ul style="list-style-type: none"> ▪ Calcium Carbonate, Calcium Gluconate, Calcium Lactate ▪ Daily Multiple Vitamin with and without Minerals ▪ Oyster Shell Calcium with and without Vitamin D ▪ Vitamin B1, Vitamin B6 ▪ All other OTC vitamins and minerals
Miscellaneous	<ul style="list-style-type: none"> ▪ Epsom Salts (external use) ▪ Glycerin Suppositories ▪ Milk of Magnesia ▪ Mineral Oil or Emulsions of Mineral Oil ▪ Povidone Douches ▪ Sterile Lubricant ▪ Vinegar Douches ▪ Stool Softeners and stool softeners/laxative combinations

15.6 DRUG RETURNED FROM NURSING FACILITY

MDHHS does not reimburse for prescriptions that are not consumed by the beneficiary. The quantity of drug(s) consumed is determined by subtracting the quantity of drug(s) that is returned for the beneficiary from the quantity that was dispensed for the beneficiary. A pharmacy must credit MDHHS for those drugs that are not consumed, except for controlled, adulterated, compromised or unusable. The pharmacy must maintain documentation of the quantity dispensed and consumed by the beneficiary, showing a credit to MDHHS for drugs not consumed.

MDHHS does not allow restocking fees.



SECTION 16 – PUBLIC HEALTH SERVICE AND DISPROPORTIONATE SHARE HOSPITALS

With enactment of Section 602 of the Veterans Healthcare Act of 1992, Public Health Service (PHS) covered entities and selected disproportionate share hospitals (DSH) became eligible for contract drug prices from Labelers (340B Program). A list of participating entities is located on the Bureau of Primary Health Care - Health Resources and Services Administration (HRSA) website. (Refer to the Directory Appendix for website information.)

In addition to these product cost discounts, entities participating in this contract drug program are required by Federal policies to bill drugs covered in the PHS program using the actual acquisition cost for a drug plus a professional dispensing fee. Actual acquisition cost is defined as the actual invoice cost for a drug product to the pharmacy or company, organization, corporation, or affiliate with which it is associated.

Actual acquisition cost must reflect trade and quantity discounts, rebates, free goods, and price concessions.

On a post-payment basis, MDHHS reviews billings from PHS participating entities to track compliance with this requirement.

Covered entities or their contracted pharmacies, or disproportionate share hospital participating entities that are enrolled as Medicaid pharmacy providers who bill 340B prices, must indicate on the claim that the drug was purchased through the 340B program so their claims can be excluded from the drug rebates. Professional/institutional claims for drugs purchased through the 340B program must be indicated on the claim using the modifier U6. Pharmacy claims for outpatient drugs purchased through the 340B program must be indicated on the claim using a Submission Clarification Code of 20.



SECTION 17 – DRUG REBATE PROGRAM

17.1 APPROVED LABELERS AND MPPL

MDHHS covers only those drugs produced by Labelers who have signed rebate agreements with the federal government. Products distributed by companies or a division within a company that did not enroll are not covered.

Approved Labelers are located on the CMS website and are identified by the specific five-digit labeler code (the first five digits of the NDC). (Refer to the Directory Appendix for CMS website information.)

17.2 NATIONAL DRUG CODE ACCURACY

MDHHS invoices pharmaceutical Labelers for rebates quarterly from the pharmacy paid claims history. Pharmacies must bill the actual NDC for a product dispensed. Pharmacies may be contacted periodically to verify product utilization and cost. Contact can include phone or written verification requests. Documentation requirements for verification can include, but are not limited to:

- Copies of the product invoice
- Copies of original prescriptions
- Compounding records



SECTION 18 – BENEFITS MONITORING PROGRAM

The purpose of the Benefits Monitoring Program (BMP) is to monitor and control inappropriate utilization of covered services, including prescribed drugs. (Refer to the Beneficiary Eligibility Chapter for additional information regarding the BMP.)



SECTION 19 – PHARMACY AUDIT AND DOCUMENTATION

19.1 DOCUMENTATION REQUIREMENTS

MDHHS monitors for compliance with Medicaid policy, the Administrative Rules of the Michigan Board of Pharmacy, the Public Health Code, and other applicable federal and state regulations.

The following information serves as a general guide for compliance monitoring during post-payment pharmacy reviews and audits. Additional information regarding audits can be found on the MDHHS post-payment auditor’s website. (Refer to the Directory Appendix for website and contact information.) Non-compliance, especially continued non-compliance, may result in payment recovery, sanctions, or referral to the Michigan Attorney General’s Office.

340B Drug Pricing Program	Billing ingredient costs may not be higher than actual acquisition costs for drugs procured under the 340B Drug Pricing Program. Pharmacy claims for outpatient drugs purchased through the 340B program must be indicated on the claim using a Submission Clarification Code of 20.
Changing Claim Information	Providers may not falsely alter the NDC number, date of service, prescription number, days supply, or any other claim requirement that would allow payment.
Compounds	The compounding of prescription products to gain coverage of noncovered OTC, noncovered legend drugs, or other noncovered categories is prohibited (e.g., the use of injectable Sodium Bicarbonate to compound a Sodium Bicarbonate foot irrigation). Medicaid recovers inappropriate payments for billings found in violation of policy.
CSHCS Only	Pharmaceutical products must relate to the qualifying diagnosis. Payment is recouped for billings for products not related to the qualifying diagnosis.
Days Supply	Accurate days supply information is required. Altering days supply information for purposes of payment will be considered fraud and will be reported to the appropriate unit for investigation. Dosages outside the normal dosage range based on the days supply submitted may prompt a verification request of product usage on reported utilization.
Drug(s) Returned From Nursing Facility	MDHHS does not reimburse for prescriptions that are not consumed by the beneficiary. MDHHS does not allow restocking fees.
Hospice	Pharmacies must not bill MDHHS for prescription services related to the terminal illness except for selected HIV drugs. (Refer to the General Information Section of this chapter for additional information.)
Inaccurate Billing	All claim submission requirements outlined in the PBM Pharmacy Claims Processing Manual must be followed including, but not limited to, accurate Prescription Origin Code, NDC, and NDC unit of measure reporting. The Pharmacy Claims Processing Manual is available on the PBM website. (Refer to the Directory Appendix for website information.)
Medicare Part D	Pharmacies cannot bill Medicaid for drugs covered by Medicare Part D. The Medicaid Program does not coordinate benefits with Medicare Part D.
Other Insurance Payments	Pharmacies must bill other insurances before billing Medicaid. This also applies to Medicare Part B eligible beneficiaries. Failure to bill Medicaid the total due less the amount paid by another insurance or by Medicare Part B may be construed as fraud under the Medicaid False Claim Act.



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Prescriber Information	Accurate prescriber information must be provided as required by MCL 400.111b(21). Submitting incorrect prescriber identification numbers can cause false ProDUR messages and claim denials. It could also cause a pharmacy to be targeted for post-payment audit. Pharmacies are audited for inappropriate identification of prescribers.
Prescription Documentation	Original written prescriptions must be executed on tamper resistant prescription pads. If a prescription is created, signed, transmitted, and received electronically, all records related to that prescription must be readily accessible and maintained for seven years. Prescriber medical record documentation may be provided to validate prescriptions. Prescriber affidavits, attestations, and retroactively dated prescriptions will not be accepted for pharmacy documentation. Notation on a pharmacy’s database is not considered a written form of the prescription. For originals and all refills, accurate prescription documentation must be readily accessible and maintained for seven years. All of the following information must be entered in the record for each prescription: <ul style="list-style-type: none"> ▪ prescription number ▪ full name and address of patient for whom the drug is prescribed ▪ prescriber’s printed name and address ▪ prescriber’s individual NPI ▪ prescriber’s DEA (for controlled substance only) ▪ drug name and strength ▪ quantity prescribed ▪ directions for use ▪ number of refills authorized
Prescriptions Filled But Not Picked Up	Retail prescriptions filled but not dispensed or picked up by the beneficiary or his representative. Restocking fees are not allowed. A record of the reversal log must be maintained for seven years for audit purposes.
Professional Dispensing Fees	Pharmacies may not bill in a pattern that would lead to more than 13 professional dispensing fees in a 365-day billing period for the same drug entity. Splitting prescriptions to increase the number of fees paid is considered fraud and will be reported to the appropriate unit for investigation.
Signature Requirement	Providers must maintain and have accessible the signature log indicating beneficiary’s pick-up of prescription and acceptance or denial of beneficiary counseling. Missing signatures indicate the prescription was not picked-up or the beneficiary was not offered counseling as required. Pharmacies are required to maintain this log for seven years.
Usual & Customary (U&C) Charge	For specified products, the submitted charge is compared to the cash price to the general public.

19.2 INVOICE AND INVENTORY RECORDS

In addition to all other documentation required under state law, federal law, and MDHHS policy, pharmacy providers must maintain invoices, manufacturer and/or wholesaler sales records, distributor delivery records to the provider, inventory transfer records, provider payment records, and all other records necessary to support the size and quantity of the goods paid for by Medicaid during the audit/review period. Failure to do so will result in the recoupment of pharmacy funds related to unsupported Medicaid claims. In the event inventory for any such product cannot be substantiated



through reliable documentation for the beginning of the audit/review period, MDHHS may assume that the beginning and ending inventory quantities are the same for that product. For the purposes of this policy, the "audit/review period" shall be a period defined by MDHHS.

19.3 MEDICATION THERAPY MANAGEMENT DOCUMENTATION REQUIREMENTS

Pharmacists must document each Medication Therapy Management (MTM) service provided. Documentation must include, but is not limited to, the following:

- Beneficiary information
 - Name
 - Address and telephone number
 - Medicaid identification number
 - Gender
 - Date of birth
- Beneficiary's consent for the MTM service, indicated by the beneficiary's signature and date
 - If the beneficiary is a child who is younger than the age of consent per state law, or has physical or cognitive impairments that preclude the beneficiary from managing his or her own medications, a caregiver (e.g., caretaker relative, legal guardian, power of attorney, licensed health professional) may provide written consent on the beneficiary's behalf.
- Pharmacist information
 - Name
 - Pharmacist National Provider Identifier (NPI)
 - Pharmacy Name and NPI
- Date of Service
- Place of Service
- Indication of how the beneficiary meets the criteria to receive an MTM service (e.g., meets the chronic condition requirement)
- Indication if this is an initial assessment or follow-up assessment
- Current medical conditions
- Allergies
- Primary physician and contact information



Other information may include the following (items are required if relevant):

- Date of documentation
- Location of beneficiary if service is provided through telepractice
- Time spent with beneficiary
- Resolved medical conditions
- List of all prescription drugs, along with prescriber information and name of dispensing pharmacy
- List of nonprescription drugs with their indications
- List of drug doses, directions and intended use
- List of all relevant medical devices
- List of all dietary supplements and herbal products
- Alcohol and tobacco use history
- List of environmental factors that impact the beneficiary
- Assessment of drug problems identified, including but not limited to:
 - Determining that the medications are appropriately indicated
 - Determining if the beneficiary needs additional medications
 - Determining if the medications are the most effective products available for the conditions
 - Determining if the medications are dosed appropriately to meet goals of therapy
 - Identifying adverse effects caused by medications
 - Determining if the medications are dosed excessively and causing toxicities
 - Determining if the beneficiary is taking the medications appropriately to meet goals of therapy
 - Evaluating effectiveness and safety of current drug therapy
 - Written plan, including goals and actions needed to resolve issues of current drug therapy
 - Evaluation of success in meeting goals of medication treatment plan
 - Information, instructions and resources delivered to the beneficiary
 - Content of pharmacist's communications to beneficiary's other health care providers
- Description of what was discussed with the beneficiary during the assessment, and whether that information was communicated to the beneficiary's primary care providers

This documentation must be made available to MDHHS upon request. In addition, this documentation and any other relevant documentation may be collected by MDHHS or its designee on an annual basis for the purposes of program evaluation.



SECTION 20 – MEDICAL SUPPLIES

20.1 GENERAL INFORMATION

Covered medical supply items payable (minus a dispensing fee) to a pharmacy are listed in the MPPL. A prescription is required for medical supplies. Covered products include insulin syringes, alcohol swabs, etc.

MDHHS does not separately reimburse a pharmacy for medical supplies dispensed to beneficiaries in nursing facilities, hospital long term care units, or medical care facilities. These items are considered a part of the facility's per diem rate. If provided, no additional or separate charges may be made to a beneficiary, a member of the beneficiary's family, or other beneficiary representative. If a pharmacy is requested to dispense any of these items, arrangements for payment must be between the pharmacy and the facility.

Except for those items listed in the MPPL, medical supplies and equipment are covered only when billed by a Medical Supplier or Orthotist/Prosthetist. These items include equipment (e.g., canes), orthotics (e.g., arch supports), prosthetics, oxygen dispensers, wound care dressings (e.g., transparent film, hydrocolloid absorptive dressings, alginate and gel dressing), splints, ace bandages, TPN, enteral and oral nutritional supplements, etc.

When billing as a Medical Supplier or Orthotist/Prosthetist, refer to the Medical Supplier and the Billing & Reimbursement for Professionals Chapters of this manual for additional information.

To enroll as a Medical Supplier, providers must complete an on-line application through the CHAMPS Provider Enrollment subsystem. (Refer to the Provider Enrollment Section of the General Information for Providers Chapter for additional enrollment information, and the Directory Appendix for contact information.)

20.2 SUPPLIES FOR ADMINISTRATION OF PART D DRUGS

MDHHS will reimburse (minus a dispensing fee) a pharmacy for medical supplies and/or equipment (e.g., IV poles, tubing) associated with the administration of Medicare Part D drug(s) to the dual eligibles (except those residing in a nursing facility) for home infusion therapy.



SECTION 21 - MEDICATION THERAPY MANAGEMENT

21.1 OVERVIEW OF MEDICATION THERAPY MANAGEMENT (MTM)

Medication Therapy Management (MTM) services are face-to-face consultations provided by pharmacists to optimize drug therapy and improve therapeutic outcomes for beneficiaries. Beneficiaries may elect MTM as an optional service provided by participating pharmacists. (Refer to the Eligible Providers subsection for information on enrolling as an MTM provider.) These services are paid through the Fee-for-Service program for beneficiaries enrolled either in FFS or in a Medicaid Health Plan. There is no cost-sharing responsibility to the beneficiary for the MTM service.

The requirements outlined in the Counseling Requirements section may not be billed as an MTM service.

21.2 COVERED SERVICES

MTM services include the following:

- Obtaining necessary assessments of the beneficiary's health status
- Formulating a medication treatment plan
- Monitoring and evaluating the beneficiary's response to therapy, including safety and effectiveness
- Performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events
- Documenting the care delivered and communicating essential information to the beneficiary's other primary care providers
- Referring the beneficiary to his/her primary care provider or specialist, if necessary
- Providing verbal education and training designed to enhance the beneficiary's understanding and appropriate use of medications
- Providing information, support services, and resources designed to enhance adherence with the beneficiary's therapeutic regimens
- Providing an updated personal medication record and medication action plan for the beneficiary
- Coordinating and integrating MTM services within the broader health care management services being provided to the beneficiary

Any recommended changes to the beneficiary's drug therapy must be approved by the original prescriber(s) of the affected drugs.

Refer to the Medication Therapy Management Documentation Requirements subsection for requirements on documenting MTM services.

21.3 NON-COVERED SERVICES

The following are not eligible to be covered as MTM services:

- Services provided by telephone, email or US Postal Service mail



- Services provided in skilled nursing facilities
- Services provided to more than one beneficiary at a time (i.e., group services)
- Services provided in an inpatient, institutional, or incarceration setting

21.4 ELIGIBLE RECIPIENTS

Beneficiaries are eligible for MTM services if they are not eligible for Medicare Part D and are taking a medication to treat or prevent one or more chronic conditions as identified in the List of Chronic Conditions for MTM Eligibility. (Refer to the Directory Appendix for website information.)

MTM services must be provided face-to-face with the beneficiary whenever possible. If the beneficiary is a child who is younger than the age of consent per state law, or has physical or cognitive impairments that preclude the beneficiary from managing his or her own medications, MTM services may be provided face-to-face to a caregiver (e.g., caretaker relative, legal guardian, power of attorney, licensed health professional) on the beneficiary's behalf.

21.5 ELIGIBLE PROVIDERS

To provide MTM services, a pharmacist must be licensed and have successfully completed either the American Pharmacists Association's "Delivering Medication Therapy Management Services" certificate training program or other MTM program(s) approved by the Accreditation Council of Pharmacy Education.

Pharmacists who meet these requirements must enroll in the Community Health Automated Medicaid Processing System (CHAMPS) with an Individual (Type 1) National Provider Identifier (NPI) Number as a Rendering/Service-Only provider. Under this type of enrollment, pharmacists are required to affiliate themselves with the billing NPI of a pharmacy, Federally Qualified Health Center (FQHC), Tribal Health Center (THC), or Rural Health Clinic (RHC). The pharmacist must enroll as a Non-Physician, with a Pharmacist specialty and the subspecialty of Medication Therapy Management. Individual pharmacists are not eligible for direct Medicaid reimbursement; payment for MTM services will be issued to the affiliated pharmacy, FQHC, THC and/or RHC NPI. Refer to the Provider Enrollment section of the General Information for Providers chapter for more information on this process.

These services may not be delegated by pharmacists to pharmacy technicians or other healthcare professionals.

21.6 LOCATION REQUIREMENTS

MTM services may be provided in the following settings:

- Ambulatory care outpatient setting
- Clinic
- Pharmacy
- Beneficiary's home if the beneficiary does not reside in a non-covered services setting

These services must be provided face-to-face in a private or semiprivate patient care area that is separate from the commercial business that also occurs in the setting, or in home settings.



21.7 TELEPRACTICE FOR MTM SERVICES

In the event that the beneficiary is unable to physically access a face-to-face care setting, an eligible pharmacist may provide MTM services via telepractice. Telepractice is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of services. Telepractice must be obtained through real-time interactions between the beneficiary's physical location (origin site) and the pharmacist provider's physical location (distant site). Telepractice services are provided to beneficiaries through hardware or internet connection. It is the expectation that providers and facilitators involved in telepractice are trained in the use of equipment and software prior to servicing beneficiaries. The arrangements for telepractice will be made by the pharmacist. The administration of telepractice services are subject to the same provision of services that are provided to a beneficiary in person. Providers must ensure the privacy of the beneficiary and secure any information shared via telepractice.

Refer to the Billing Instructions subsection (of this section) for instructions on indicating the MTM service was provided through telepractice.

21.8 BILLING INSTRUCTIONS

21.8.A PROFESSIONAL CLAIMS

Pharmacy-based MTM claims must be submitted on the professional claim format (HIPAA 837P). The Billing Provider reported on the claim must be the Pharmacy's (Type 2) NPI and be actively enrolled in CHAMPS to be paid. The Rendering Provider reported on the claim must be the Pharmacist's (Type 1) NPI and be actively enrolled in CHAMPS.

For services provided through telepractice, each procedure code must include the modifier GT. Providers can submit HIPAA 837P electronic claims to CHAMPS through a billing agent, through a batch upload process, or through Direct Data Entry (DDE). Providers can also view claims online and complete claim replacements or voids within CHAMPS.

21.8.B. INSTITUTIONAL CLAIMS

The Billing Provider NPI reported on the claim must be the FQHC, RHC, or THC and be actively enrolled in CHAMPS. The Pharmacist (Type 1) NPI must be reported on the Institutional MTM claim as the Rendering Provider and must be actively enrolled in CHAMPS and associated to the Billing FQHC, RHC, or THC for the date of service. The NPI (Type 1 – Individual) number of the physician (MD or DO) overseeing the patient's care must be entered as the attending provider. The attending provider field is mandatory to complete.



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SECTION 1 – GENERAL INFORMATION

This chapter applies to physicians (MD, DO), Oral-Maxillofacial Surgeons (MD, DO), Doctors of Podiatric Medicine (DPM), Physician Assistants (PAs), Medical Clinics, Physical Therapists (PTs), Advanced Practice Registered Nurses (APRNs) [including Certified Nurse Practitioners (NPs), Certified Clinical Nurse Specialists (CNSs), and Certified Nurse-Midwives (CNMs)], Certified Registered Nurse Anesthetists (CRNAs), and Anesthesiologist Assistants (AAs).

Generally, medically necessary services provided to a Medicaid beneficiary by an enrolled practitioner are covered. This includes, but is not limited to, medically necessary health care services that are evidence-based and provided within generally accepted standards of medical practice to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms. The services addressed in this chapter include services that require explanation or clarification, have special coverage requirements, require prior authorization (PA), or must be ordered by a physician (MD or DO).

Information is included to assist the practitioner in determining how the Michigan Department of Health and Human Services (MDHHS) covers specific services. This information should be used in conjunction with the Billing & Reimbursement for Professionals Chapter of this manual, as well as the Medicaid Code and Rate Reference tool, MDHHS Practitioner and Medical Clinic Fee Schedule and other related procedure databases/fee schedules located on the MDHHS website. (Refer to the Directory Appendix for website information.)

1.1 ADMINISTRATIVE SERVICES

Services of physicians, medical staff or other licensed or certified health professionals functioning in an administrative or teaching capacity for a hospital or nursing facility (including physician-owners or other staff paid by the physician) are not covered separately as physician services.

Pathology services or interpretive studies done for hospital or nursing facility quality improvement purposes or other reasons which do not directly assist with the specific care of a specific beneficiary are considered to be administrative services and are not separately covered as physician services. These services are included in the facility's allowable costs and are paid to the facility.

1.2 COMPONENT SERVICES

Many physician services are covered as global services. A global service includes all resources necessary to perform the procedure (e.g., office overhead, equipment, supplies, and staff) and the services provided by the physician (e.g., interpretation of results and preparation of a report of findings).

Some services are divided into a professional component and a technical component for coverage purposes. The professional component includes the services provided by the physician while the technical component includes equipment, supplies, and technical staff.

Coverage for the professional component or the technical component generally depends on where the service is provided and who provides that portion of the service. Services for which the components are covered for the physician are identified in the Medicaid Code and Rate Reference tool or on the MDHHS Practitioner and Medical Clinic Fee Schedule. (Refer to the Directory Appendix for website information.)



Global services are covered for the physician in non-facility settings or the professional component is covered for the physician in any setting. The technical component is only covered when the service is provided in an appropriate non-facility setting. The global service and its professional component service cannot both be covered for the same service since the professional component is included in the global service.

1.3 COPAYMENTS

A copayment may be required for physician office (evaluation and management) visits for beneficiaries age 21 years and older.

The office visit copayment applies to services provided in the physician's office, urgent care center, or other appropriate setting. It does not apply to professional services provided in the outpatient hospital or inpatient hospital settings. Refer to the General Information for Providers Chapter for information about copayments. Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)

Podiatrists should refer to the Podiatrist Section of this chapter for information regarding beneficiary copayments for podiatry services.

Ophthalmologists providing routine vision services should also refer to the Vision Chapter for information regarding beneficiary copayments for vision services.

Refer to the Billing Beneficiaries Section of the General Information for Providers Chapter of this manual for additional information regarding copayment requirements. Beneficiaries may not be denied care or services based on inability to pay a copayment, except as outlined in that section.

1.4 FACILITY AND NONFACILITY REIMBURSEMENT

Medicaid reduces payment for specified procedures provided in a facility setting. This policy is consistent with the Centers for Medicare & Medicaid Services (CMS) facility and nonfacility reimbursement determination. When a provider performs services in a facility setting, costs for certain procedures are reduced because the practitioner does not incur certain overhead expenses (such as clinical staff, supplies, equipment) necessary to provide the service. When a service is performed in a nonfacility setting, the payment rate is based on the nonfacility relative value units (RVUs). When the service is provided in a facility setting, the payment rate is based on the facility RVUs. The payment difference takes into account the higher expenses for the provider in the nonfacility setting. For the purpose of this payment policy, a facility includes the following:

- Hospital inpatient and outpatient facilities
- Psychiatric facilities
- Skilled nursing facilities
- Ambulatory surgery centers
- Rehabilitation facilities



1.5 HOSPITAL-BASED PROVIDER

Medicaid covers services by hospital-based providers (HBPs). A hospital-based provider is employed by the hospital. Each HBP is assigned his own NPI number.

For purposes of Medicaid, a HBP includes physicians (MD, DO, DPM). Some nonphysician practitioners, such as physician assistants (PAs), certified registered nurse anesthetists (CRNAs), and advanced practice registered nurses (APRNs), can also be considered HBPs under certain circumstances.

Medicaid follows Medicare guidelines for the coverage of HBP services provided by physicians. Generally, professional services provided by nonphysician providers that are employed by a hospital are included in the hospital cost report and are reimbursed to the hospital.

(The HBP should refer to their provider-specific section of this chapter for policies, procedures, and coverage information.)

1.6 MEDICARE RELATED SERVICES

MDHHS reimburses practitioners for the coinsurance and deductible amounts subject to Medicaid reimbursement limitations on all Medicare approved claims even if Medicaid does not normally cover the service. (Refer to the Billing & Reimbursement for Professionals and the Coordination of Benefits Chapters of this manual for additional information.)

1.7 PHYSICIAN DELEGATION AND SUPERVISION

Physician services covered by Medicaid must be performed by the physician personally, the physician's employee, or an employee of the same legal entity that employs the physician, under the physician's delegation and supervision in accordance with State law, professional scope of practice, and program and organizational policy. Only persons currently licensed/certified in an appropriate health occupation/profession (e.g., advanced practice registered nurse or physician assistant) as authorized by Public Act 368 of 1978, as amended, may provide direct patient care under the delegation and supervision of a physician when the physician is not physically present on the premises. The delegating/supervising physician must be continuously available through direct communication such as telephone, radio, or telecommunication when not on the premises. Delegated and supervised services rendered by non-physician practitioners (e.g., advanced practice registered nurses, physician assistants) must be billed under the non-physician practitioner's NPI and include the NPI of the supervising physician as applicable.

In the physician's absence, licensed persons who are under the physician's delegation and supervision at the medical care site where the physician regularly sees beneficiaries may provide medical services. Records must demonstrate that the licensed physician is regularly available and provides medical care to beneficiaries at the site on a routine basis. This does not preclude licensed persons under the physician's delegation and supervision from making calls or going on rounds to private homes, public institutions, hospitals, or other health care facilities, as long as the care is a supplement to and does not replace the physician's personal services.

Medicaid covers services delegated to unlicensed/certified persons only when the delegating physician or licensed non-physician practitioner is physically present and providing direct supervision. For information related to services provided by an advanced practice registered nurse or physician assistant under the



terms of a valid collaborative, practice or alliance agreement, refer to the provider-specific section of this chapter.

1.8 PHYSICIAN RESPONSIBILITY

Determination of medical necessity and appropriateness of services is the responsibility of the physician within the scope of currently accepted medical practice and Medicaid limitations. The physician is held responsible if he orders excessive or unnecessary services (e.g., diagnostic tests, prescriptions) regardless of who actually renders or who receives payment for the service. The physician may also be subject to any corrective action related to these services, including recovery of funds.

Services generally must be ordered by a physician to be covered by Medicaid. Some services provided by other providers, such as medical supplies, lab services, and prescriptions, may require the physician to provide written documentation to support the need for the service. For specifics regarding whether a service is a covered benefit, refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter or the Medicaid Code and Rate Reference tool for more information. (Refer to the Directory Appendix for website information.)

1.9 PRIOR AUTHORIZATION

Medicaid requires prior authorization (PA) to cover certain services before those services are rendered to the beneficiary. The purpose of PA is to review the medical need for certain services. It does not serve as an authorization of fees or beneficiary eligibility. Different types of services requiring PA include:

- Procedures identified as requiring PA in the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)
- Procedures/items that are normally noncovered but may be medically necessary for select beneficiaries (e.g., surgery normally cosmetic in nature, obesity surgery, off-label use drugs, etc.).
- Referrals for elective services by out-of-state nonenrolled providers.

1.9.A. TO OBTAIN PRIOR AUTHORIZATION

Requests for PA for practitioner services such as surgeries, procedures, office-administered pharmaceuticals, biologicals, and out-of-state-care must be submitted utilizing the Practitioner Special Services Prior Approval – Request/Authorization form (MSA-6544-B). (Refer to the Forms Appendix for a copy of the form or download the form from the MDHHS website.) The form must be completed in its entirety. Supportive medical documentation must accompany the form.

Providers receive a written response from MDHHS. If the authorization is granted, the provider receives a PA number to report on the claim. The physician obtaining PA must make the PA number available to other providers, such as other practitioners or the hospital, for billing purposes.

If the beneficiary has Medicare and Medicare covers the service, the provider does not have to obtain PA from Medicaid. If Medicare denies a service as not medically necessary, Medicaid does not cover the service even if a PA has been obtained. If



Medicare identifies a service as an excluded benefit under Medicare and Medicaid requires PA, the provider must pursue PA from Medicaid and a coverage determination is made. If the beneficiary has commercial insurance that covers the service and the provider reports the coverage correctly on the claim, the provider does not have to obtain PA from Medicaid. If a primary insurer covers a service but requires PA and the provider does not follow the primary insurance PA process, Medicaid does not make payment for the service either.

1.9.B. SPECIAL AUTHORIZATIONS

Special authorization requirements must be met for selected surgeries performed in the inpatient setting, all elective inpatient admissions, all readmissions within 15 days, and all transfers to an inpatient hospital/unit. Physicians should refer to the Hospital Inpatient Physician Services and the Surgery Sections of this chapter for specific information.

Some beneficiaries may need authorization of services because they are enrolled in special programs, such as the Benefits Monitoring Program. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.)

1.10 SERVICES IN A TEACHING SETTING

Administrative costs associated with teaching physician services, as well as payment for direct patient care services provided by a resident (including interns or fellows) in a teaching setting and supervised by a teaching physician, are subject to guidelines and conditions developed and published by CMS for Medicare. Services covered by Medicaid under these guidelines must be identified with the appropriate modifier.

Teaching institutions and teaching physicians within those institutions must abide by the CMS teaching physician guidelines which explain when services provided in teaching settings can be covered by Medicaid or must be included as allowable medical education costs in the hospital's cost report.

Guidelines require the presence of the teaching physician during the key portion of the performance of the service in which a resident is involved and the teaching physician seeks payment (or the hospital on the behalf of the physician). The medical record must fully support the physician's presence and participation in the service provided. There are exceptions and other considerations that may apply; therefore, the full text of the guidelines must be consulted to ensure compliance. Any services that meet the teaching physician criteria must be reported with the appropriate modifier.

CMS provides an exception to the physician presence requirement for some low- and mid-level Evaluation and Management (E/M) services furnished in certain primary care centers when specified conditions are met. For Medicaid, the preventive medicine E/M visits are also included under the "presence" exception for services provided in the primary care centers by residents. The appropriate modifier must be reported using the "presence" exception when residents provide E/M services. The E/M services that can be reported with this modifier include office or other outpatient visits requiring straightforward or low complexity medical decision making and comprehensive preventive medicine visits. For higher-level services and all invasive procedures, the teaching physician must be present.

Services of residents or physicians/medical staff functioning in an administrative, teaching or learning capacity in the hospital or long term care facility that are covered as individual physician services are



subject to post payment review and recovery of funds unless the provider can present proof that the services were not included in the allowable facility costs.

1.11 SERVICES TO NEWBORNS

Physician services provided to newborns are covered under the newborn's Medicaid ID number. The mother's Medicaid ID number cannot be used.

If the delivering physician performs the newborn's care and circumcision during the mother's inpatient stay, these services can be covered under the mother's Medicaid ID number if they are billed on the same claim as the services to the mother.

1.12 UNIFORM REPORTING OF SERVICES

MDHHS follows the American Medical Association's manual and guidelines for Current Procedural Terminology (CPT) numeric codes, and the Healthcare Common Procedure Coding System (HCPCS). In conjunction with the CPT/HCPCS coding systems to describe services rendered, MDHHS utilizes the Medicaid National Correct Coding Initiative (NCCI) coding policies and edits as developed by the Centers for Medicare & Medicaid Services (CMS) to promote national correct coding methodologies.



SECTION 2 – ANESTHESIA SERVICES

Medicaid covers anesthesia services provided by qualified practitioners in conjunction with covered surgeries and other procedures. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter or the Medicaid Code and Rate Reference tool for more information regarding coverage parameters. (Refer to the Directory Appendix for website information.) Medicaid does not cover any anesthesia service related to the treatment of infertility.

2.1 MEDICALLY DIRECTED ANESTHESIA SERVICES

Medicaid covers anesthesia services provided by physicians, Certified Registered Nurse Anesthetists (CRNAs), and Anesthesiologist Assistants (AAs) for medically directed anesthesia services consistent with anesthesia team practice. (Refer to the Certified Registered Nurse Anesthetist Section and/or the Anesthesiologist Assistant Section of this chapter for additional information). Medicaid recognizes medical direction of general anesthesia, regional anesthesia, and reasonable and medically necessary Monitored Anesthesia Care (MAC). Physicians cannot medically direct more than four concurrent anesthesia cases at one time and cannot perform any other services during the same period of time except as outlined below. In all cases in which medical direction is furnished, the physician must be physically present in the operating suite.

NOTE: Anesthesiologist assistants must be medically directed by a Medicaid enrolled anesthesiologist and must comply with the requirements for the delegation and supervision of services in the Michigan Public Health Code.

All of the following conditions must be met for medically directed anesthesia services to be reimbursed to the physician. For each beneficiary, the physician must:

- Perform a pre-anesthetic examination and evaluation;
- Prescribe the anesthesia plan;
- Personally participate in the most demanding procedures in the anesthesia plan including, if applicable, induction and emergence;
- Ensure that a qualified individual performs any procedures in the anesthesia plan that he does not personally perform;
- Monitor the course of anesthesia administration at frequent intervals;
- Remain physically present and available for immediate diagnosis and treatment of emergencies; and
- Provide indicated post-anesthesia care.

A medical direction service furnished by a physician is not covered if the physician directs a nonqualified individual. A qualified individual is a CRNA, a student anesthetist, an anesthesiologist assistant, or an intern or resident.

Physicians must document in the beneficiary's medical record that he performed the pre-anesthetic exam and evaluation, provided indicated post-anesthesia care, was present during some portion of the anesthesia monitoring, and present during the most demanding procedures, including induction and emergence, where indicated. Total anesthesia time must be documented in the medical record.



If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another physician member fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. The medical record must indicate the services were furnished by physicians and identify the physician(s) who rendered them.

A physician who is directing the concurrent administration of anesthesia to four or fewer surgical patients should not be involved in furnishing additional services to other patients. If the physician is addressing an emergency of short duration in the immediate area, or administering an epidural or caudal anesthetic to ease labor pain, or providing periodic rather than continuous monitoring of an obstetrical patient, it does not constitute a separate service for the purpose of determining whether the medical direction criteria are met. A physician may also receive patients entering the operating suite for subsequent surgeries, may check on or discharge patients from the recovery room, and may handle scheduling matters while directing concurrent anesthesia procedures without affecting coverage for medical direction.

If the physician leaves the immediate area of the operating suite for other than short durations, devotes extensive time to an emergency case, or is not available to respond to the immediate needs of the surgical patients, the physician's services are considered supervisory and are not covered as medical direction.

Medically directed anesthesia services are covered when provided by an anesthesiologist who is monitoring more than four concurrent anesthesia procedures, or who is performing other services while directing the concurrent procedures, in select instances. The physician must personally provide the pre-anesthesia exam and evaluation, prescribe the anesthesia plan, and be in the operating suite during the entire procedure. A flat rate payment is made to cover the physician's involvement in pre-surgical anesthesia services. Medically supervised CRNA services are covered and are reported with the appropriate modifier.

Medicaid covers anesthesia services consistent with Medicare guidelines when provided under an attending physician relationship in a teaching hospital and/or in accordance with the coverage guidelines established by the Medicare policies for teaching physicians.

2.2 NONMEDICALLY DIRECTED ANESTHESIA SERVICES BY THE CRNA

Anesthesia services provided by a CRNA under the supervision of the surgeon or another physician who is immediately available if needed are covered as nonmedically directed anesthesia services. MDHHS reimburses CRNAs for these services if all of the following conditions are met:

- The facility in which the services are rendered ensures that the anesthesia services are provided in a well-organized manner under the supervision of a physician (MD or DO).
- The facility is responsible for all anesthesia administered in the facility.
- A physician (MD or DO) or a CRNA under the supervision of a physician provided a pre-anesthetic exam and evaluation within 48 hours prior to the surgery.
- An intra-operative anesthesia record identifies the CRNA providing the anesthesia service and the supervising physician.



- For inpatients, the person administering the anesthesia writes a post-anesthesia follow-up report within 48 hours after surgery.
- For outpatients, a post-anesthesia evaluation for proper anesthesia recovery is performed in accordance with the policies and procedures approved by the medical staff.

There is no separate coverage for physicians for any portion of nonmedically directed anesthesia services. The physician's supervisory service is covered as part of the facility charge where the surgery is performed. The pre-anesthetic exam and post-anesthesia evaluation is included in the anesthesia coverage for the nonmedically directed CRNA care and is not separately covered. Payment for the nonmedically directed anesthesia service provided by the CRNA is made to the CRNA or the legal entity employing the CRNA.

There is no separate coverage for anesthesia services performed by physicians who are also performing the medical or surgical service requiring the anesthesia. Any anesthesia service provided personally by the surgeon is included in the coverage for the surgical procedure itself.

2.3 MONITORED ANESTHESIA CARE

Monitored Anesthesia Care (MAC) is covered on the same basis as other anesthesia services as long as it is reasonable and medically necessary. MAC involves intra-operative monitoring by a physician, or by a qualified anesthesia provider under the medical direction of a physician, or by a CRNA under the supervision of a physician of the beneficiary's vital physiological signs, in anticipation of the need for administration of general anesthesia or the development of adverse physiological patient reaction to the surgical procedure. It also includes the performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications (e.g., Atropine, Demerol, Valium) and provision of indicated post-operative anesthesia care.

2.4 MEDICAL AND SURGICAL SERVICES FURNISHED IN ADDITION TO ANESTHESIA SERVICES

2.4.A. ALLOWABLE SERVICES

Separate coverage is available for certain medical or surgical services furnished by a physician while furnishing anesthesia services to the beneficiary. The services may be furnished in conjunction with the anesthesia procedure to the beneficiary or as single services (e.g., the day of or the day before the anesthesia service). These services include insertion of a Swan Ganz catheter, insertion of central venous pressure lines, emergency intubation, and critical care. Separate coverage is not available for medical or surgical services, such as the pre-anesthetic examination of the beneficiary, pre- or post-operative visits, or usual monitoring functions, that are ordinarily included in the anesthesia service.

2.4.B. POST-OPERATIVE PAIN MANAGEMENT

Post-operative pain management is the responsibility of the surgeon (except in special circumstances) and is covered as part of the global service provided by the surgeon.

Placement of a continuous epidural to manage post-operative pain is separately covered under the appropriate CPT/HCPCS code for a continuous epidural when the physician (or CRNA under a physician's supervision) performed the service for post-operative pain



management and the procedure was not used as the mode of anesthesia for the surgery. Daily management of a continuous epidural on subsequent post-operative days is covered under the appropriate procedure code.

2.5 ANESTHESIA TIME

Anesthesia time means the time during which the anesthesia provider (physician, CRNA, or AA providing anesthesia) is furnishing continuous anesthesia care to the beneficiary. It starts when the anesthesia provider begins to prepare the beneficiary for induction of anesthesia and ends when the beneficiary may be safely placed under post-operative supervision and the anesthesia provider is no longer in personal attendance. In counting anesthesia time when an interruption in the anesthesia service occurs, only the actual anesthesia time is counted. The anesthesia start and stop times must be documented in the medical record.

2.6 ELECTRO-CONVULSIVE THERAPY

Anesthesia services related to electro-convulsive therapy are covered by the beneficiary's Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) or Medicaid Health Plan (MHP). The attending physician must obtain authorization from the PIHP/CMHSP or the MHP. Payment is made by the PIHP/CMHSP or MHP that authorized the service.

2.7 PRIOR AUTHORIZATION FOR ANESTHESIA SERVICES

If a surgical procedure requires PA, the operating surgeon is responsible for obtaining the authorization to perform the service. The anesthesia provider is not responsible for providing proof that the surgical procedure was authorized.

2.8 HYSTERECTOMIES AND STERILIZATION PROCEDURES

By federal statute, all services, including anesthesia services related to hysterectomies or sterilization procedures, must be supported by an informed consent that meets Medicaid's consent requirements before the service can be covered. It is the responsibility of the operating surgeon to obtain this consent.

2.9 USING MODIFIERS

Anesthesia services must be coded using the appropriate CPT/HCPCS anesthesia codes with the appropriate modifiers. Anesthesia services for multiple surgeries are reported under the anesthesia procedure code with the highest base unit value with the total anesthesia time, in minutes, including all surgical procedures. (Refer to the MDHHS website for specific modifiers required for use with anesthesia services.)

2.10 ANESTHESIA ADD-ON CODES

Anesthesia add-on codes are covered in addition to the primary anesthesia code. Coverage for anesthesia add-on codes is based on the anesthesia base units (ABUs) established by CMS for the specific anesthesia add-on code.

Obstetrical anesthesia add-on codes are covered based on the ABUs assigned by CMS plus the anesthesia time units associated with the anesthesia add-on code.



2.11 LABOR AND DELIVERY

Coverage of anesthesia services associated with labor and delivery is based on the type of anesthesia provided. If anesthesia is provided by placement of an epidural catheter, it is covered under the appropriate anesthesia code depending on the type of delivery. The coverage for this service includes any needle placement, drug injection, and any replacement of the epidural catheter during labor. If endotracheal or general anesthesia is provided for the delivery, it is covered under the appropriate anesthesia code. If an epidural catheter is inserted for labor and delivery but it is later necessary to provide endotracheal anesthesia for the delivery, the surgical code for the epidural insertion is covered in addition to the anesthesia service code for the delivery. The medical record must fully document the circumstances requiring both types of anesthesia.



SECTION 3 – GENERAL PRACTICE

3.1 ALLERGY TESTING AND IMMUNOTHERAPY

Medicaid covers allergy testing and immunotherapy services. Testing is covered under the appropriate CPT/HCPCS code with the appropriate quantity as indicated by the code description. A visit is covered in addition to the testing. Coverage of the testing includes the interpretation of the test results in relation to the history and physical examination of the beneficiary.

Immunotherapy services are covered under the appropriate CPT/HCPCS component codes. The services of the provider who actually prepares and provides the antigens/venoms are covered on a per dose basis. Services of the provider who parenterally administers the antigen/venom are covered under the appropriate injection codes. The injection and the antigen/venom preparation services are covered separately.

Allergy injection services are not covered in addition to the visit unless the visit represents another significant, separately identifiable service above and beyond the antigen/venom immunotherapy and the appropriate modifier is reported.

MDHHS assumes antigens are prepared for administration over a period of time in increasing doses. Antigens are covered at the same rate per dose regardless of whether multiple or single dose vials are used. Medicaid covers the dose administered and the preparation of the dose administered.

Any allergy testing and treatments that have not been proven to be effective are not covered.

3.2 AMBULANCE SERVICES

Coverage for ambulance services is restricted to medically necessary and appropriate services when medical/surgical or psychiatric emergencies exist or no other effective or less costly mode of transportation for medical treatment can be used because of the beneficiary's medical condition.

Emergency ambulance services do not require a physician's order.

The physician must order all non-emergency, medically necessary ambulance transportation. Refer to the Ambulance Chapter for order requirements and additional information related to ambulance services.

3.3 AUDIOLOGICAL AND HEARING SERVICES

Medicaid covers hearing evaluations and other audiological function testing by a physician. Hearing evaluations are covered when they include pure-tone audiometry, speech audiometry, and a report of findings.

A hearing aid is covered if all of the following criteria are met:

- The physician performs an evaluation within six months prior to the beneficiary obtaining a hearing aid.
- The evaluation reveals that the beneficiary needs a hearing aid and that there is no contraindication to the use of a hearing aid.



- The physician prescribes a hearing aid.
- The beneficiary presents the prescription and a written statement of the evaluation to an enrolled hearing center.
- The enrolled hearing center determines the type of hearing aid that is needed.
- The beneficiary is referred to an enrolled hearing aid dealer for provision of the aid.

3.3.A. NEWBORN HEARING SCREENING EXAMINATION

MDHHS requires that all Medicaid-covered newborns be screened using the automated auditory brainstem response (ABR) method and/or the automated evoked otoacoustic emissions (EOAE) method.

Results must be reported to the child's primary care provider in a timely manner.

If the birthing hospital has the appropriate equipment, the screening must be done at the hospital. When this occurs, the screening is covered as a part of the inpatient stay.

If the hospital is not equipped for ABR or EOAE, the child's physician, CNM, or NP must refer the newborn to a Medicaid enrolled hearing center where screening must be completed prior to one month of age.

Refer to the Hearing Services subsection of the Hospital Chapter for additional information.

3.3.B. LOCAL HEALTH DEPARTMENT SCREENINGS

The primary care provider or Head Start agency (with approval from the child's primary care provider) may refer preschool-aged children to the local health department (LHD) for objective hearing screening. The results of the screening must be reported to the child's primary care provider. If the LHD is unable to report the results to the child's primary care provider, the LHD must clearly document why this was not accomplished. Providers are strongly encouraged to share the results with the Head Start agency if that agency was the referral source, and if the provider receives authorization.

MDHHS monitors the number of MHP referrals reported by LHDs, and may initiate charge-backs to the plans.

Refer to the Additional Information on Objective Hearing & Vision Screening subsection of the Local Health Department Chapter for additional information.

3.4 CARE OF ABUSED CHILDREN

Medicaid covers physician services related to the diagnosis and treatment of suspected abused or neglected children. When the physician has reasonable cause to suspect that a child may have been abused or neglected, he must immediately contact the appropriate Protective Services Unit of the local DHS office to report his suspicions.



Medicaid covers the inpatient stay of an abused or neglected child when, upon admission, the attending physician determines that the child requires further assessment and treatment which is best provided on an inpatient basis.

Physicians cannot admit a child to the hospital for the sole purpose of custodial or protective care.

3.5 CHILDBIRTH/PARENTING EDUCATION

Medicaid covers childbirth/parenting education for pregnant women when referred in writing by the prenatal care provider and provided by qualified educators in a Medicare certified outpatient hospital or by a certified Maternal Infant Health Program (MIHP) program provider.

This service is not covered if rendered by the prenatal care provider in the office setting.

3.6 COMMUNICABLE DISEASE TREATMENT

Medicaid covers the diagnosis and treatment of communicable diseases, including tuberculosis (TB), hepatitis, meningitis, and enteric disease. Cases of communicable disease must be reported to the LHD. Providers may obtain additional information regarding communicable disease prevention and control from the LHD.

3.7 DIABETES PATIENT EDUCATION

Medicaid covers diabetes self-management education for beneficiaries diagnosed with diabetes when ordered by an enrolled physician or qualified non-physician medical practitioner responsible for the beneficiary's diabetic care. Services must be provided by diabetes educators (e.g., nurse, dietitian) in a Medicaid enrolled outpatient hospital or LHD that meets Michigan Medicaid DSME program requirements.

The physician or qualified non-physician medical practitioner treating the beneficiary's diabetes must maintain a documented diabetes diagnosis and any special needs supported by medical necessity in the medical record.

Refer to the Hospital Chapter of this manual for information about DSME program requirements.

3.8 DIAGNOSTIC TESTS

Medicaid covers tests to diagnose a disease or a medical condition. Diagnostic testing must be directly related to the presenting condition of the beneficiary. The ordering or referring of specific diagnostic tests may be restricted to physicians (MD or DO) by program policy.

3.9 FAMILY PLANNING

Medicaid covers family planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis). A visit for family planning typically includes a complete physical examination, including a pelvic examination.



Separately identifiable services provided in addition to the examination are covered separately. Counseling for family planning services, including sterilization, is covered as a part of the family planning visit.

Medicaid covers contraceptives including:

- Oral contraceptives (must be prescribed by a physician and dispensed by an enrolled pharmacy or Family Planning Clinic)
- Diaphragms
- Intrauterine devices
- Condoms (available from a pharmacy without a prescription, or from a family planning clinic)
- Foams, gels, sponges (must be prescribed by a physician and dispensed by a pharmacy or family planning clinic)

3.10 FOOT CARE

3.10.A. ROUTINE FOOT CARE

Medicaid covers these services when provided by a physician or podiatrist and when the beneficiary manifests signs and symptoms from a specific systemic disease of sufficient severity that care by a nonprofessional would be hazardous. The medical necessity for these services must be documented in the beneficiary's medical record, and the beneficiary must be receiving regular care from a physician for the systemic disease.

3.10.B. MYCOTIC NAILS, DEBRIDEMENT

Medicaid covers debridement of mycotic nails once in a 60-day period when provided during or following any appropriate course of medical treatment for the causative fungal infection. Documentation in the beneficiary's medical record must support clinical evidence of the mycosis, identification of the toenail(s) affected, and evidence that the mycosis is likely to result in significant medical complications if appropriate antifungal treatment is not rendered.

The debridement of mycotic nails is covered for beneficiaries in the nursing facility only on the written order of the attending physician (MD or DO). The order must be patient-specific and not for routine care only.

3.11 FRACTURE CARE

Medicaid covers medically necessary fracture care. Coverage includes the initial traction, cast application and removal, and routine follow-up care. Additional reductions are independent procedures not included in the original treatment and are covered separately.

Fracture care includes the insertion and removal of necessary wires, pins, etc. If the wire, pins, etc., are the types that are not normally removed but the removal is medically necessary, Medicaid also covers such removal. Documentation of the need must be included on the claim.



Coverage also includes subsequent recasting required during the course of fracture treatment (i.e., following initial cast application). Medicaid covers cast removal as a separate service only when performed by a physician who was not involved in the fracture care and who is not reapplying another cast.

3.12 IMMUNIZATIONS (VACCINES AND TOXOIDS)

Immunizations* are covered when given according to Advisory Committee on Immunization Practices (ACIP) recommendations. MDHHS encourages providers to immunize all Medicaid beneficiaries according to the accepted immunization schedule.

- For Medicaid children 18 years and younger, the Vaccine for Children (VFC) Program provides covered immunizations at no cost to the provider.
- Medicaid covers immunizations for beneficiaries 19 years of age or older.
- Any Local Health Department (LHD) in the state can be contacted for specifics about the VFC program, what immunizations are available, and instructions on enrolling and obtaining immunizations.

Medicaid does not pay for immunization costs for any product that is available free of charge for Medicaid beneficiaries. An administration fee is covered separately for immunizations given to Medicaid beneficiaries whether the immunization is free or not, and without regard to other services provided on the same day. The administration fee is set for each immunization.

For immunizations available free under the VFC program, the amount a provider may charge for vaccine administration may be limited. Providers cannot charge more for services provided to Medicaid beneficiaries than for services provided to their general patient population. For example, if the charge for administering a vaccine to a private-pay patient is \$5.00, then the charge for immunization administration to the Medicaid patient cannot exceed \$5.00.

For Medicaid beneficiaries enrolled in an MHP, the health plan must ensure that the beneficiary has access to receive complete and timely immunizations. When a provider contracts with a health plan to provide primary care (which includes immunizations), the provider should immunize the beneficiaries assigned to him by the plan. MHP providers enrolled in the VFC program are encouraged to immunize and are discouraged from referring beneficiaries to a LHD for these services.

If a beneficiary is in a nursing facility, the facility is responsible for appropriately immunizing the beneficiary. Coverage of the immunizations is included in the per diem payment made to the facility.

3.13 INJECTABLE DRUGS AND BIOLOGICAL PRODUCTS

3.13.A. COVERAGE OF THE INJECTABLE

Medicaid covers injectable drugs and biological products administered by a physician in the office, clinic setting, and in the beneficiary's home. The drug or biological product must be Food and Drug Administration (FDA) approved and reasonable and necessary according to accepted standards of medical practice for the diagnosis or treatment of the

* An immunization administered for travel to a foreign country is not a Medicaid-covered benefit.



illness or injury of the beneficiary. There must be sufficient clinical evidence demonstrating the effectiveness and safety of the drug or biological product.

An injectable drug is covered if the drug is:

- Specific and effective treatment for the condition for which it is being given.
- Given for the treatment of a particular documented diagnosis, illness, or condition (e.g., vitamin injections which are not specific replacement therapy for a documented deficiency or disease and are given simply for the general good and welfare of the patient).
- Administered by the recommended or accepted administration method for the condition being treated.
- Administered according to the recommended dosing schedule and amount for the condition being treated.

For any injectable drug that a practitioner purchases directly through a pharmacy, distributor or wholesaler which is administered in the office, clinic setting, or the beneficiary's home, the injectable drug is considered a physician service rather than a pharmacy benefit. The physician must not send the beneficiary to a pharmacy to obtain an injectable drug. If a pharmacy sells injectable drug products to a physician, the pharmacy must obtain payment directly from the purchasing physician.

MDHHS allows a select list of physician-administered drugs to be covered through the pharmacy benefit as identified in the Special Product Coverage section of the Pharmacy Chapter. If the practitioner uses a pharmacy to acquire the drug for administration, the pharmacy must submit the claim as a pharmacy claim. (Refer to the Special Product Coverage section of the Pharmacy chapter for additional information.)

If the beneficiary has other insurance that allows the injectable drug product to be obtained at the pharmacy by the beneficiary, then the other insurance rules (e.g., Medicare Part D) must be followed; however, the reimbursement of the beneficiary's liability (i.e., coinsurance/deductible/ copay) may be covered as a physician service.

When administering a dose drawn from a multidose vial, only the amount administered to the beneficiary is covered. If a drug is only available in a single use vial and any drug not administered must be discarded, the amount of the drug contained in the vial is covered.

3.13.B. PHYSICIAN-ADMINISTERED DRUGS AND BIOLOGICAL PRODUCTS NOT COVERED BY MEDICAID HEALTH PLANS

MDHHS will maintain a list of specific Medicaid program covered physician-administered drugs and biological products that are not covered by MHPs. This list of physician-administered drugs and biological products, carved out from MHP coverage, will be reimbursed as a Fee-for-Service (FFS) benefit for all beneficiaries in FFS and for those enrolled in an MHP.

A list of the specific drugs covered under this policy will be maintained on the MDHHS website. The list may be modified as new drugs are approved or added to the physician-



administered carve-out. No notice of changes to the list will be issued directly to providers. (Refer to the Directory Appendix for website information.)

3.13.B.1. PRIOR AUTHORIZATION REQUIREMENTS FOR CARVE-OUT INJECTABLE DRUGS AND BIOLOGICAL PRODUCTS

Certain drugs on the carve-out list of physician-administered drugs and biological products not covered by MHPs may require prior authorization (PA). The purpose of PA is to review the medical need for certain services. It does not serve as an authorization of fees or beneficiary eligibility.

When indicated on the MDHHS-maintained list, PA requests will require a completed Practitioner Special Services Prior Approval-Request/Authorization form (MSA-6544-B), a Program Review Division (PRD) documentation checklist, and all supporting documentation. Providers are to contact the PRD to obtain the PRD documentation checklist for drugs and biological products that require PA. Once all required documentation is collated, information must be submitted according to form MSA-6544-B completion and submission instructions. (Refer to the Forms Appendix for a copy of the form and completion instructions and to the Directory Appendix for PRD contact information.)

3.13.B.2. BILLING CONSIDERATIONS FOR CARVE-OUT INJECTABLE DRUGS AND BIOLOGICAL PRODUCTS FOR MEDICAID HEALTH PLAN ENROLLEES

When multiple medical services are provided in conjunction with a carve-out physician-administered drug, FFS claims will process for payment of the carve-out drug service line only; all other claim lines will be denied with Claim Adjustment Reason Code (CARC) 24 – Charges are covered under a capitation agreement/managed care plan. The associated services that are denied by FFS are to be billed to the beneficiary's health plan for payment.

3.13.C. ADMINISTRATION OF THE INJECTABLE

Medicaid covers the injectable drug and the administration of the drug. If the administration of the drug is an integral component of the procedure, the administration is considered a part of that service and is not separately reimbursed.

Payment for administration of injectables provided through a PIHP/CMHSP clinic or affiliated physician practice is included in the capitation rate to the PIHP/CMHSP and is not separately reimbursable to the physician.

Injections in the office/clinic/beneficiary's home may be administered by appropriate non-physician staff who are employed by the physician or are employed by the same clinic/group as the physician. Administration of the injectable drug by non-physician staff must be under the physician's personal supervision or under the delegation and supervision of the physician as required by the Public Health Code. Providers should refer to the Coordination of Benefits Chapter of this manual for additional requirements that apply when a beneficiary has Medicare or commercial insurance coverage. For a list of the drugs administered under this policy, refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for



additional information. Physician-administered drugs and biologicals are included on the Practitioner and Medical Clinic Fee Schedule. (Refer to the Directory Appendix for website information.)

3.13.D. INJECTABLES ADMINISTERED THROUGH PIHP/CMHSP FOR MHP ENROLLEES

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 MDHHS 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 MDHHS 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.

3.13.E. PSYCHOTROPIC INJECTABLES ADMINISTERED BY PHYSICIANS NOT ASSOCIATED WITH A PIHP/CMHSP

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 MDHHS through FFS must be billed through CHAMPS using the physician's NPI.
- FFS reimbursement by MDHHS to physicians not associated with a PIHP/CMHSP is limited to psychotropic injectable carve-out drugs only. Physicians may not bill MDHHS 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.

3.14 LABORATORY

The program covers medically necessary laboratory services, including the specimen collection, analysis, and report, to diagnose or treat a specific condition, illness, or injury and laboratory tests associated with preventive services assigned a grade A or B by the United States Preventive Services Task Force (USPSTF). A physician, podiatrist, physician assistant, nurse practitioner, clinical nurse specialist, dentist, or CNM must order laboratory services according to their scope of practice.



The ordering practitioner must document required laboratory testing in the beneficiary's medical chart regardless of where the tests are performed. The ordering practitioner is held responsible for the ordering of excessive or unnecessary laboratory tests regardless of who actually renders the services.

MDHHS performs pre- and/or post-payment reviews to monitor laboratory procedures for medical necessity and appropriate practitioner orders. Questionable ordering patterns may result in a prepayment review of each laboratory procedure billed or other corrective measures, including recovery of funds. A beneficiary cannot be charged for any covered laboratory procedure, including those that are determined to be not medically necessary.

3.14.A. MEDICAL NECESSITY

The documentation of medical necessity must include a description of the beneficiary's symptomatology and other findings that have led the practitioner to order the test(s). An explanation of the laboratory testing method or the results of diagnostic tests, whether normal or abnormal, is not considered documentation of medical necessity.

3.14.B. REFERRED SERVICES

If a practitioner refers a beneficiary to an outside laboratory (independent lab, hospital lab, clinic lab, or physician office lab) for testing, the practitioner must indicate his NPI number on the referral.

A physician cannot refer a beneficiary to an outside laboratory where he or an immediate family member has a financial relationship. Noncompliance may result in corrective action by MDHHS or other agencies.

A beneficiary cannot be charged for any covered laboratory procedure, including those that are determined to be not medically necessary.

3.14.C. NON-COVERED SERVICES

Ordering or rendering of "profiles", "batteries" or "panels" of tests that include tests not necessary for the diagnosis or treatment of the beneficiary's specific condition is considered random screening and is not covered. Multiple laboratory tests carried out as a part of the initial evaluation of the beneficiary, when the results of the history and physical examination do not suggest the need for the tests, are considered screening and are not covered. The collection of the lab specimen(s), analysis, and test results are included in the reimbursement for laboratory services and are not covered separately unless otherwise indicated.

Refer to the Laboratory chapter for additional information regarding coverage parameters, ordering limitations, and prior authorization requirements.



3.14.D. CHILDREN’S SPECIAL HEALTH CARE SERVICES COVERAGE

The coverages defined in this section do not apply to beneficiaries with only Children’s Special Health Care Services (CSHCS) eligibility. The coverage limits do apply to beneficiaries with dual Medicaid and CS

HCS eligibility if the laboratory procedures are not related to the crippling diagnosis.

Blood Handling	<p>MDHHS reimburses for blood handling only under the following circumstances:</p> <ul style="list-style-type: none"> ▪ A beneficiary may be referred to a laboratory, clinic, or outpatient hospital for the sole purpose of drawing, packaging, and mailing a blood sample to MDHHS for blood lead analysis. In this instance, the laboratory, clinic, or outpatient hospital may bill for blood handling. The MDHHS provides lead-free vacutainers for the analysis. Requests for vacutainers and the samples for analysis should be sent to MDHHS Blood Lead Laboratory. (Refer to the Directory Appendix for contact information.) ▪ A beneficiary occasionally requires blood tests that are not performed in conjunction with other reimbursable services. Whenever possible, the beneficiary should be sent to the laboratory that will be performing the test(s). If this is not practical (i.e., the laboratory is not a local facility) and the sole purpose of a visit is to draw, package, and mail the sample to a laboratory, the blood handling may be covered. An office visit or other service code is not covered on the same date of service (DOS) as the blood handling service.
Hematology Studies	<p>A practitioner’s order for a complete blood count (CBC) with white blood cell (WBC) differential includes the RBC and WBC count, Hgb, Hct, MCH, MCHC, MCV, RBC morphology, platelet estimate, and WBC differential only. Additional hematology testing must have specific practitioner orders. The ordering practitioner is responsible for documenting medical necessity and recording the order in the beneficiary’s medical record.</p>
Microbiology Studies	<p>Gram, fluorescent/acid fast stain procedures are included in the coverage for microbiology procedures when performed on the same DOS for the same beneficiary.</p>
Pap Smear	<p>Coverage for obtaining the cervical smear is included as a part of the pelvic examination. A pathologist must perform interpretation of the smear. The pathology report must include the printed or typewritten name of the pathologist and his handwritten signature.</p> <p>More than one Papanicolaou test within a 12-month period is covered only when determined medically necessary by the attending practitioner.</p>



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<p>Pathology Consultations</p>	<p>Pathology consultations performed by a hematologist/pathologist for the review of abnormal laboratory test results are covered by Medicaid if:</p> <ul style="list-style-type: none"> ▪ The abnormality relates to the beneficiary's medical condition and corresponding medical care (i.e., a peripheral blood smear review must be necessary for the specific beneficiary's care). ▪ The referring physician orders the review and records the order in the beneficiary's medical record. (Standing consultation orders from a physician to a laboratory are not covered by Medicaid.) ▪ A detailed report is sent to the referring physician. <p>The report prepared from the study performed by the hematologist/pathologist must include:</p> <ul style="list-style-type: none"> ▪ Identification of the laboratory where the review was performed. ▪ Name of the referring physician. ▪ Beneficiary's name. ▪ Date of review. ▪ Identification of material examined. ▪ Comments and descriptions of normal and abnormal findings. ▪ Descriptions detailed enough to support a clinical impression or diagnosis. ▪ Clinical impression or diagnosis presented in relation to the suspected disease, disease process, or state of altered physiology. ▪ Recommendations for investigation or therapy, if any. ▪ The typewritten or printed hematologist/pathologist's name and his handwritten signature. <p>This information must be retained in the beneficiary's medical records.</p>
<p>Pregnancy Related Lab Services</p>	<p>For routine pregnancy testing, Medicaid covers the serum or urine HCG qualitative method.</p> <p>The obstetric profile is covered when ordered by the attending practitioner as an all-inclusive panel of tests for required prenatal laboratory services. The individual tests of the OB Profile are:</p> <ul style="list-style-type: none"> ▪ ABO typing ▪ CBC with WBC differential ▪ Hepatitis B surface antigen ▪ RBC antibody detection ▪ Rh (D) typing ▪ Rubella antibody ▪ Syphilis testing <p>HIV testing and Urinalysis are covered separately when determined to be medically necessary and are ordered by the practitioner.</p>



Practitioner Laboratory Procedures	Clinics and office-based laboratories must be registered as required by the Clinical Laboratory Improvement Amendments (CLIA). Medicaid only covers the procedures contained in the CLIA Certificate of Waiver Testing list for Certificate of Waiver practitioners. Coverage includes only the procedures contained in the CLIA Certificate of Registration Testing list for Certificate of Registration practitioners. Medicaid covers the procedures identified in the CLIA Physician Performed Microscopy list for appropriately certified physicians. Laboratory tests covered for CNMs and podiatrists who have the appropriate CLIA certification are identified in the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)
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3.15 NERVE BLOCKS

Nerve blocks are covered as a surgical procedure when performed for diagnostic or therapeutic purposes. As a surgical procedure, a complete description of the services rendered must be documented in the beneficiary's medical record. When used as anesthesia for another procedure, the anesthesia guidelines apply. Nerve blocks are not separately covered when used as a local anesthetic for another surgical procedure.

A nerve block is the injecting of a local anesthetic or neurolytic agent around a nerve to produce a block of that specific nerve. It is not injecting a painful area under the skin or a trigger point, or an injection into the general muscle mass of subcutaneous tissue that does not follow the anatomy of a specific nerve, to produce temporary relief of pain in that area.

Nerve blocks are payable in the hospital or office setting as appropriate. No more than three nerve blocks to the same area are covered within a six-month period without documentation of medical necessity. Documentation must include the diagnosis or condition, the management/treatment plan, specific nerve(s) affected, indications, and expected benefits. A medical visit is not covered separately on the same day unless documentation is supplied to justify the separate services.

3.16 OXYGEN

Medicaid covers oxygen and the equipment necessary for the administration of oxygen therapy.

A pharmacy or a medical supplier may provide gaseous cylinder oxygen. Portable cylinder oxygen is allowable if the cylinder can be refilled and if the flow rate is adjustable.

Only a medical supplier may provide concentrators, liquid oxygen, and oxygen tents, and PA is required.

All oxygen and equipment requires a physician's prescription and a CMN. The initial prescription is valid for six months. The first follow-up prescription is valid for six months, and each subsequent prescription is valid for one year.

The written prescription for oxygen must include all of the following:

- The date the oxygen was prescribed;
- The beneficiary's diagnosis(es);
- The flow rate (liters per minute);
- The number of hours to be used per day;



- Duration of need;
- Delivery system to be used; and
- PO2 level or oxygen saturation.

(Refer to the Medical Supplier Chapter of this manual for additional information related to face-to-face and PA requirements.)

3.17 SUBSTITUTE AND LOCUM TENENS PHYSICIANS

Medicaid covers substitute physicians or locum tenens physicians and allows payment to be made to the beneficiary's attending physician for these services. Federal statutes and CMS requirements determine parameters for these arrangements.

Medicaid coverage under the beneficiary's attending physician for the services of a substitute physician can only occur under the following substitute physician billing arrangements:

- An informal reciprocal arrangement for a period not to exceed 14 days; or
- A locum tenens or temporary arrangement for 90 continuous days in the case of a per diem or other fee-for-time compensation.

Coverage for services provided by a substitute physician under either a reciprocal billing or a locum tenens arrangement must follow Medicaid policy for the service(s) rendered. Documentation in the beneficiary's medical record must identify the physician actually providing the service.

3.18 SUPPLIES IN THE OFFICE SETTING

RVU-based payment to practitioners includes payment for the office overhead expense associated with the service. In most cases, the overhead includes the supplies used or provided by the practitioner in connection with the service, and the supplies are not separately reimbursed.

Providers must not require beneficiaries to purchase an item in advance from a pharmacy or medical supplier that is an integral component of the service. Surgical dressings applied by a physician in the office or other nonfacility setting are not covered separately.

Medicaid does not cover take-home supplies dispensed from the office setting. If a beneficiary requires in-home supplies, a written prescription must be presented to the pharmacy or medical supplier and supplies dispensed accordingly.

In keeping with the RVU-based fee schedule, Medicaid separately covers a limited number of supplies used in the office setting (such as intrauterine devices and casting supplies) because an allowance for these supplies is not typically included in the respective treatment procedure codes. Casting and splinting supplies are covered separately when used with the fracture and dislocation or casting, splinting or strapping procedure codes listed in the musculoskeletal surgery section of the CPT coding manual.



(Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding separately covered supplies.)

3.19 VISION SERVICES

Refer to the Vision chapter of this manual for specific coverage information.

3.20 ORTHOPTIC SERVICES

Strabismus surgeries are covered for beneficiaries of any age and do not require PA. Providers are reminded that these surgeries must be medically necessary and not performed solely for cosmetic purposes.

Refer to the Vision chapter of this manual for other specific orthoptic coverages.

3.21 WEIGHT REDUCTION [CHANGE MADE 4/1/20]

Medicaid covers treatment of obesity when done for the purpose of controlling life-endangering complications, such as hypertension and diabetes. If conservative measures to control weight and manage the complications have failed, other weight reduction efforts may be approved. The physician must obtain PA for this service. Medicaid does not cover treatment specifically for obesity or weight reduction and maintenance alone.

The request for PA must include the medical history, past and current treatment and results, complications encountered, all weight control methods that have been tried and have failed, and expected benefits or prognosis for the method being requested.

Medicaid policy is generally based on CMS guidelines for Medicare coverage of bariatric surgery. **(text added 4/1/20)** If surgical intervention is desired, a psychiatric evaluation of the beneficiary's willingness/ability to alter his lifestyle following surgical intervention must be included.

If the request is approved, the physician receives an authorization letter for the service. A copy of the letter must be supplied to any other provider, such as a hospital, that is involved in providing care to the beneficiary.

3.22 TUBERCULOSIS TESTING

Medicaid covers TB testing according to the guidelines established by the AAP and USPSTF which are based on risk. A risk assessment may be completed at each visit. Coverage for the TB test includes any return visit to read the results of the TB test.

For assistance in determining high risk, providers may contact the MDHHS Division of Communicable Diseases, the AAP, or the USPSTF. (Refer to the Directory Appendix for contact information.)



SECTION 4 – GENERAL PRACTICE - SPECIAL CONSIDERATIONS

4.1 APHERESIS, THERAPEUTIC

Therapeutic apheresis is covered for the following indications:

- Plasma exchange for acquired myasthenia gravis;
- Leukapheresis in the treatment of leukemia;
- Plasmapheresis in the treatment of primary macro-globulinemia (Waldenstrom);
- Treatment of hyperglobulinemia, including (but not limited to) multiple myelomas, cryoglobulinemia and hyperviscosity syndromes;
- Plasmapheresis or plasma exchange in the last resort treatment of thrombotic thrombocytopenic purpura (TTP);
- Plasmapheresis or plasma exchange in the last resort treatment of life-threatening rheumatoid vasculitis;
- Plasma perfusion of charcoal filters for treatment of pruritis of cholestatic liver disease;
- Plasma exchange in the treatment of life-threatening forms of Goodpasture’s Syndrome;
- Plasma exchange in the treatment of glomerulonephritis associated with antiglomerular basement membrane antibodies and advancing renal failure or pulmonary hemorrhage;
- Treatment of chronic relapsing polyneuropathy for beneficiaries with severe or life-threatening symptoms who have failed to respond to conventional therapy;
- Treatment of life-threatening scleroderma and polymyositis when the beneficiary is unresponsive to conventional therapy;
- Treatment of Guillain-Barre Syndrome; and
- Treatment of life-threatening Systemic Lupus Erythematosous (SLE) when conventional therapy has failed to prevent clinical deterioration

Coverage is limited to the following settings:

- In a hospital setting (either inpatient or outpatient). Nonphysician services furnished to hospital patients are covered as hospital services. When covered services are provided to hospital patients by an outside provider/supplier, the hospital is responsible for paying the provider/supplier for the services.
- In a nonhospital setting, such as a physician directed clinic, when all of the following conditions are met:
 - A physician is present to perform medical services and to respond to medical emergencies at all times during patient care hours.



- Each patient is under the care of a physician.
- All nonphysician services are furnished under the personal supervision of a physician.

When the physician provides direct supervision of the procedure or personally performs any services, professional services are covered as therapeutic apheresis (plasma and/or cell exchange).

4.2 CHEMOTHERAPY ADMINISTRATION

Medicaid covers the services of a physician who administers antineoplastic chemotherapy to beneficiaries with a cancer diagnosis in the office setting and in the beneficiary's home. The chemotherapy drugs administered by the physician are covered separately.

Administration of other drugs for diagnoses other than cancer is covered under therapeutic, diagnostic, or prophylactic injection/infusion services.

Chemotherapy administration by push and by infusion techniques is covered on the same day; however, only one push administration is covered on a single day.

Physicians must personally administer the drug or be present when a qualified employee of the physician administers the drug. If chemotherapy is administered without face-to-face contact between the physician and the beneficiary, the services are covered if furnished in the physician's office by a qualified employee under the physician's supervision and the medical record reflects the physician's active participation in and management of the course of treatment.

In the hospital setting, chemotherapy administration is only covered when the physician personally administers the drug.

Refilling and maintenance of an implantable pump or reservoir is covered. Chemotherapy administration by IV push, infusion, or intra-arterial technique is not covered in addition to refilling the implantable pump or reservoir. Flushing of a vascular port prior to chemotherapy is included in the administration and is not covered separately. If a special visit is made to the physician's office only for port flushing, the service is covered under the appropriate E/M code.

Hydration therapy intravenous (IV) infusion is covered as a part of the chemotherapy IV infusion service when administered simultaneously. Hydration therapy is covered separately when administered sequentially or as separate procedures. The distinct procedural service modifier should be reported with the hydration therapy code when performed sequentially.

Supplies necessary to administer chemotherapy in the office setting are included in the overhead expense portion of the administration services and are not covered separately. (Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters for chemotherapy drugs.)

4.3 HEMODIALYSIS AND PERITONEAL DIALYSIS

Medicaid covers physician services required to manage care of beneficiaries with end-stage renal disease (ESRD) who are receiving ongoing dialysis in an outpatient facility or at home.



Most physician services are covered through a monthly capitation payment (MCP) to the managing physician. The MCP covers ESRD related physician services in all settings necessary to manage the beneficiary's dialysis care, except declogging of shunts, dialysis training, and nonrenal-related medical services.

Self-dialysis training services provided by the physician are covered.

4.4 HOME HEALTH CARE

Medicaid covers home health care subject to the requirements in this section.

Home Health services include intermittent nursing care, home health aide services, and physical therapy provided in the beneficiary's home by a Medicaid enrolled Home Health Agency (HHA). The service must be reasonable and necessary for the treatment of a specific illness, injury, or disability, and must be consistent with the nature and severity of the beneficiary's condition, particular medical need and accepted standards of medical practice. Limited services to ensure stability of beneficiaries with an established disability or frail condition, or to prevent an illness, injury or disability for women and newborns during the postpartum period are covered.

Home health is intended for beneficiaries whose conditions require intermittent rather than continuous medical/nursing care. In special instances, intensive nursing care in the home may be approved if MDHHS determines that home care is appropriate and is a cost-effective alternative to institutional care.

4.4.A. PHYSICIAN ORDER FOR CARE

The beneficiary's physician must order covered home health services as part of a written plan of care (POC), and must review the POC every 60 days for continuing need. A HHA should not provide home care prior to the date of the physician's order for the care. The agency must maintain a patient plan of treatment form which must be signed and dated by the physician, or a narrative summary of the POC which must have the physician's signed and dated order attached. The HHA is responsible for obtaining necessary authorization from MDHHS for special or extended care which may be provided.

For initial certification, a physician certifying eligibility for home health services must provide documentation of a face-to-face encounter with the beneficiary within 90 days prior to or 30 days after the start of care. Refer to the Face-to-Face Encounter section in the Home Health Chapter for additional information.

Home health services are not to replace the services of a physician and are not covered solely for the lack of transportation or as a convenience to the beneficiary. Home health services may be appropriate when leaving the home is medically contraindicated or special transportation or effort is required.

4.4.B. MEDICAL SUPPLIES AND EQUIPMENT

Medical supplies, durable medical equipment, orthotic and prosthetic appliances, shoe supplies, and oxygen are covered for beneficiaries receiving services from an enrolled HHA. The physician (MD, DO, DPM, NP, PA) must prescribe these items. (Refer to the Home Health and the Medical Supplier Chapters of this manual for specific information)



concerning which equipment/supplies are covered for the medical supplier and which are covered for the HHA.) Face-to-face visits and prior authorization may apply.

4.4.C. PERSONAL CARE

If beneficiaries are not in need of nursing care or physical therapy, but have a need for nonspecialized, unskilled personal care or chore services, such services are available through the MDHHS Home Help Program. The local MDHHS office should be contacted for information.

4.5 HOSPICE SERVICES

Medicaid covers hospice services which include palliative and supportive services to meet physical, psychological, social, and spiritual needs of terminally ill beneficiaries and their families in the home, adult foster care facility, home for the aged, nursing facility, or an inpatient hospice setting. Medicaid enrolled Hospice programs are responsible for providing all physician services related to a beneficiary's terminal illness as part of its core services.

To enroll in hospice, the beneficiary must have a life expectancy of six months or less, have knowledge of the illness and life expectancy, and elect to receive hospice services rather than active treatment for the illness. Both the referring physician and the hospice medical director must certify the life expectancy.

If the physician is not familiar with Medicaid-enrolled hospices in his area, hospice names, addresses, and telephone numbers may be obtained from MDHHS Provider Inquiry. (Refer to the Directory Appendix for contact information.)

Refer to the Billing & Reimbursement for Institutional Providers and the Hospice chapters of this manual for specific requirements related to the provision of hospice services.

4.6 IMPLANTABLE INFUSION PUMPS

Medicaid covers the refill and reprogramming of implantable infusion pumps by physicians in the physician's office. The refill kit and the electronic analysis of the pump are covered as a part of the refill and reprogramming procedure. Injectable drugs used during this procedure are covered separately in the physician's office.

4.7 PEDIATRIC MULTICHANNEL RECORDINGS

Multichannel recording is covered for a child under age 21 when provided in the inpatient or outpatient hospital setting by qualified personnel and interpreted by a physician. Multichannel recordings are not covered in the beneficiary's home.

A pediatric multichannel recording is a continuous and simultaneous recording of at least four channels that may include ECG, thoracic impedance, airflow measurements, oxygen saturation, esophageal pH, or strain gauge measurements. Other additional recording parameters may be included. A multichannel recording does not have to include an electroencephalogram (EEG). When an EEG is performed in addition to the four or more channels, it is covered separately. Payment for the multichannel recording is the same regardless of the number of channels or the length of time required. Use of a video camera is not separately covered.



Two multichannel recordings may be covered in one year for the same beneficiary. If more than two are medically justified for CSHCS beneficiaries, the physician must obtain PA. The PA number must be included on the claim for payment. (Refer to the General Information for Providers Chapter for additional prior authorization information.)

A multichannel recording is covered as a professional service to the physician and as a technical service to the hospital. The professional service includes the interpretation with written report, and the scanning and scoring.

4.8 PREVENTIVE SERVICES

The program covers preventive services assigned a grade A or B by the USPSTF and all adult vaccines and their administration recommended by ACIP for beneficiaries age 21 years and older. (Refer to the Directory Appendix for USPSTF and ACIP website information.)

Preventive services for beneficiaries under 21 years of age are covered as part of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. (Refer to the Early and Periodic Screening, Diagnosis, and Treatment Chapter for specific information.)

Providers submitting claims for services in accordance with the USPSTF grade A and B recommendations are to identify the service with the appropriate International Classification of Diseases (ICD) diagnosis code(s). To identify the service as a preventive service, providers are encouraged to include HCPCS Modifier 33, Preventive Services. (Refer to the Billing & Reimbursement for Professionals Chapter for specific information.)



SECTION 5 – EVALUATION AND MANAGEMENT SERVICES

Medicaid covers medically necessary evaluation and management (E/M) services provided by a physician or other practitioner authorized by the State. Providers should refer to the CPT explanations, coding conventions, and definitions for E/M services.

Most E/M services are covered once per day for the same beneficiary. In these cases, only one office or outpatient visit is covered on a single day for the same beneficiary unless the visits were for unrelated reasons and at different times of the day (e.g., office visit for blood pressure medication evaluation, followed five hours later by a visit for evaluation of leg pain following an accident).

Coverage of an E/M service includes related activities such as coordination of care, telephone calls, writing prescriptions, completing insurance forms, review and explanation of diagnostic test reports to the beneficiary.

Do not report the modifier for increased procedural services with E/M services in order to request individual consideration, unless specifically directed by this manual. This does not follow CPT coding guidelines and causes longer delays in processing the claims for payment.

5.1 PREVENTIVE MEDICINE SERVICES

The program covers one preventive visit annually. For beneficiaries under 21 years of age, EPSDT screening services are covered according to the AAP periodicity schedule and CMS requirements. (Refer to the Early and Periodic Screening, Diagnosis, and Treatment Chapter for specific information.)

A preventive medicine E/M visit and another E/M visit on the same date are covered separately if, during the preventive visit, a problem or abnormality is detected which requires additional work which meets the key component requirements of a problem oriented E/M visit. When this occurs, the office/outpatient E/M procedure code is covered using the modifier for a separately identifiable service, and the preventive E/M visit is covered without using a modifier. (Refer to CPT guidelines for additional information.)

5.2 E/M VISITS IN RELATION TO GLOBAL SURGERY PACKAGE

An E/M service that results in the decision for surgery is covered separately when provided by the surgeon on the day before or the day of a procedure with a 90-day global period and the decision for surgery modifier is reported. This same E/M service provided the day before or the day of a procedure with a 0-day or 10-day global period is not covered separately.

An E/M service is not covered separately on the same day as a procedure with any global surgery period unless the beneficiary's condition requires a significant, separately identifiable E/M service that is above and beyond the pre- and post-operative care associated with the procedure or service performed.

If the surgeon performs E/M services during the post-operative global surgery period for a reason unrelated to the surgical procedure, report the appropriate modifier with the E/M service. All care provided during the inpatient stay in which the surgery is performed is compensated through the global surgery package and is not covered separately.



5.3 CONSULTATIONS

Medicaid covers consultations rendered by a physician whose opinion or advice is requested by another appropriate practitioner (e.g., physician, CNM, dentist) for the further evaluation and management of the patient. A consultation includes preparation of a report of findings that is provided to the referring provider for the referring provider's use in the treatment of the beneficiary. A consultant may initiate diagnostic and/or therapeutic services. If the referring provider transfers complete responsibility for treatment either orally or in writing to the consultant at the time of the request for consultation, the receiving physician's services are covered as normal E/M services rather than as a consultation.

If the referring provider transfers responsibility for the beneficiary's care to the consultant after the consultation is completed, the consultant's service is covered as a consultation. After the consulting physician assumes responsibility for the beneficiary's care, subsequent visits are covered as established patient office visits or subsequent hospital care, depending on the setting.

A consultation is covered if one provider in a group practice requests a consultation from a physician of a different specialty in the same group practice as long as all of the requirements for use of the CPT/HCPCS consultation codes are met. A request for a consultation from the attending provider and the need for consultation must be documented in the beneficiary's medical record. In an inpatient setting, the request may be documented as part of a plan written in the requesting physician's progress notes, an order in the hospital record, or a specific written request for the consultation.

Medicaid covers second opinions for surgery. The second opinion is covered as a consultation as long as all requirements for a consultation are met.

Ancillary services provided to a beneficiary in a nursing facility must be ordered by the attending physician and are not covered as consultations unless a specific request for opinion and advice is documented. Requests for services by another physician are covered as the actual service provided (e.g., nursing facility visit or eye examination).

5.4 INITIAL VISITS

Medicaid covers one new patient visit for a physician or a group practice for the same beneficiary, regardless of the type of new patient visit billed (e.g., office visit, clinic visit, long term care visit, home visit).

5.5 OBSERVATION CARE

Medicaid covers physician services for beneficiaries admitted and discharged from observation status in the hospital setting for a stay less than 24 hours. Coverage is based on CPT coding conventions to report observation stays occurring on a single date and observation stays which start on one date and end on the subsequent date. It is expected that the beneficiary would be discharged from the hospital at the end of observation care. The medical record must include the following documentation:

- the length of time of the observation stay
- the physician was present and personally performed the services
- the physician wrote the observation admission and/or discharge notes



For outpatient surgical procedures, the global surgery rules apply. The surgeon is responsible for all post-operative care in the hospital and observation care is not covered separately.

Observation care for psychiatric reasons must be authorized by the PIHP/CMHSP. The PIHP/CMHSP is responsible for coverage of authorized psychiatric observation care services.

5.6 NURSING FACILITY SERVICES

Visits necessary to perform Medicare and Medicaid required assessments are covered under the appropriate E/M services involving comprehensive resident assessments.

Visits required to monitor and evaluate residents at the frequencies detailed in the coverage portion of the Nursing Facility chapter of this manual are also covered under the appropriate E/M service for subsequent nursing facility care.

Additional visits for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member, are only covered when documentation of the medical necessity for the visit is included on, or attached to, the claim. Documentation must include diagnoses describing the acute illness or injury; or remarks documenting the necessity for the additional visit recorded on the claim; or documentation such as notes from the visit supporting the above criteria attached to the claim. Providers may report modifier 22. Additional visits which repeatedly reflect the same chronic diagnoses and additional visits for the purpose of routine monitoring are not covered.

Refer to the Coverages portion of the Nursing Facility chapter of this manual for timeframes and additional details for required nursing facility visits.



SECTION 6 – EMERGENCY SERVICES

Medicaid covers all medically necessary emergency services. Federal statutes prohibit prior authorization (PA) for coverage of emergency services. Emergency services include covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and the services are necessary to evaluate or stabilize an emergency medical condition. All professional services must be identified as either an emergency or not an emergency.

6.1 SCREENING EXAM AND STABILIZATION IN THE EMERGENCY DEPARTMENT

MDHHS and its contracted health plans must follow the applicable requirements and definitions of the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

Medicaid covers the medical screening examination, any ancillary service(s) when performed in a hospital emergency department (ED) for the sole purpose of determining if an emergency medical condition exists, and any necessary stabilizing treatment.

For both Medicaid FFS and MHP beneficiaries, the screening examination and any physician-ordered procedures (e.g., x-rays, lab, etc.) necessary to determine the beneficiary's condition are covered without PA. For Medicaid FFS beneficiaries, the screening examination and related diagnostic procedures are covered by MDHHS. For Medicaid MHP beneficiaries, these services are covered by the beneficiary's MHP.

Professional services for the medical screening and stabilization in the ED are covered separately from the facility fees.

6.2 TREATMENT OF EMERGENCY MEDICAL CONDITION IN THE EMERGENCY DEPARTMENT

PA is not required for the treatment of emergency medical conditions.

An emergency medical condition is defined by the Balanced Budget Act of 1997 and its regulations.

An emergency medical condition may exist whether the beneficiary is discharged from the ED or admitted to the inpatient hospital. This includes admissions where death occurs before a bed is occupied.

If an emergency medical condition exists, the medical findings must be fully documented in the beneficiary's medical record.

6.3 NON-EMERGENCY MEDICAL CONDITIONS IN THE EMERGENCY DEPARTMENT

If the medical findings from the screening indicate the beneficiary's condition does not meet the definition of an emergency medical condition, but requires additional, follow-up treatment, the following rules apply:

- FFS Medicaid beneficiaries without private health insurance should be referred to their primary care provider to obtain treatment. However, treatment may be rendered in the ED and does not require PA.



- FFS Medicaid beneficiaries with private health insurance must follow the rules of the private health insurance. Private insurers frequently require that the primary care provider perform the follow-up care.
- MHP enrollees must be referred to their primary care provider for treatment, or the MHP can be contacted to request authorization to provide the treatment. If the MHP fails to respond within one hour to the request to provide additional services beyond those required for stabilization, the request for authorization is deemed approved.

6.4 PSYCHIATRIC EMERGENCY SERVICES IN THE EMERGENCY DEPARTMENT

Screening and stabilization of a psychiatric emergency does not require PA. These services are covered in the same manner as other emergency services provided in the ED detailed above. If it is determined that the beneficiary requires post-stabilization psychiatric services, the PIHP/CMHSP must be contacted for PA. The need for PA from the PIHP/CMHSP includes, but is not limited to, inpatient psychiatric admission, psychiatric partial hospitalization, and specialty mental health services.

A psychiatric emergency is defined as a situation in which an individual must be treated to protect him from inflicting injury to self or others as the result of a serious mental illness, emotional disturbance, or developmental disability, or could reasonably be expected to intentionally or unintentionally injure himself or others in the near future. The emergency may result from an inability to provide food, clothing, or shelter for him or others, inability to attend to activities of daily living, or when judgment is so impaired the individual is unable to understand the need for treatment.

6.5 URGENT CARE SETTINGS

Physician services rendered in urgent care centers or similar settings that are not part of a licensed hospital are covered. Coverage is based on the appropriate office or other outpatient services E/M procedure codes. Coverage for any additional professional services rendered in these settings follows CPT guidelines.



SECTION 7 – MATERNITY CARE AND DELIVERY SERVICES

Medicaid covers maternity care and delivery services. The services normally provided in uncomplicated maternity cases include antepartum care, delivery, and postpartum care. These services are included in the global obstetrical package. The global obstetrical package is covered when one physician or physician group practice provides the obstetric care to a beneficiary. The global obstetrical package is covered as long as the provider or group has provided seven or more antepartum visits, the delivery, and the postpartum care. If less than seven antepartum visits are provided, report the global package with the modifier for reduced services and indicate the number of antepartum visits on the claim.

7.1 ANTEPARTUM CARE

Includes the initial and any subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. Typically, if a beneficiary enrolls in the first trimester and delivers at term, she has about 13 antepartum visits. This varies depending on the actual start of antepartum care and the delivery date. If the total number of antepartum visits exceeds 13 due to a high-risk condition, the additional visits are covered when using the appropriate E/M codes with the diagnosis for the high-risk condition.

7.2 DELIVERY

Includes admission to the hospital, the admission history and physical examination, management of uncomplicated labor, and delivery. All hospital visits within 24 hours of delivery are generally considered part of the global package. If the beneficiary is admitted more than 24 hours before delivery and stays more than 24 hours, then hospital care rendered prior to the day of delivery is covered separately as an E/M code. Medical problems complicating labor and delivery management that require additional resources are also covered separately.

7.3 POSTPARTUM

Includes all the visits following a delivery, both in the hospital and in the office. Services provided by physicians within the same group practice are considered as provided by the primary physician responsible for the beneficiary's overall obstetrical care.

7.4 OBSTETRICAL PACKAGE VS. COMPONENTS

If the same physician or group practice does not provide all of the obstetric care, Medicaid covers the portion of the care provided by each provider. Postpartum care or antepartum care is covered separately if provided by a different physician or group than the physician providing the delivery services. To be consistent with some commercial payers and Medicare, the physician or group providing the entire global obstetrical package may choose to report either the entire global package or may report the antepartum care, delivery, and postpartum care separately as each of these services is provided. Combinations of these components must be allowable under Medicaid NCCI editing. Components such as the antepartum care or postpartum care cannot be unbundled into individual visits.



Services that are not included in the global package include:

- Maternal or fetal echography or fetal echography procedures
- Fetal biophysical profile
- Chorionic villus sampling, any method
- Fetal contraction stress test
- Fetal nonstress test
- Hospital and observation care visits for premature labor (prior to 36 weeks gestation)

7.5 HIGH-RISK PREGNANCY

High-risk pregnancies are those with complicating conditions that are life-threatening to either the mother or fetus and, therefore, require more services than those provided in a routine pregnancy. When high-risk pregnancies require more visits than described for routine obstetrical care and more laboratory data than normally required, the additional services are covered in addition to the global obstetrical package. If beneficiary visits are required due to conditions unrelated to the pregnancy, they are also covered in addition to the global obstetrical package. Medicaid follows CPT guidelines for reporting high-risk pregnancy services.

7.6 MULTIPLE GESTATION

In the case of multiple gestation, Medicaid covers the services provided. Payment follows the multiple procedure rules. (Refer to the Billing & Reimbursement for Professionals Chapter, Maternity Care Services subsection, for additional information.) Providers must use a diagnosis code representing multiple gestation.

7.7 OB ENHANCED PAYMENTS

MDHHS provides an enhanced payment for each Medicaid delivery performed. This additional reimbursement is added to the fee reimbursed under FFS for the global maternity and delivery procedure codes. The maternity case rate paid to MHPs is also enhanced.

7.8 MATERNITY OUTPATIENT MEDICAL SERVICES PROGRAM

Under the Maternity Outpatient Medical Services (MOMS) program, pregnant women can enroll and receive pregnancy related care early in the pregnancy. Refer to the MOMS Chapter for additional information.

7.9 LACTATION SUPPORT SERVICES

Medicaid will reimburse for evidence-based lactation support services provided to Medicaid eligible postpartum women in the outpatient setting up to and through 60 days post-delivery. Services must be rendered by a licensed, qualified health professional as outlined. A maximum of two visits per pregnancy will be reimbursed for either a single or multiple gestation pregnancy. One visit is reimbursable per date of service.



7.9.A. PROVIDER CRITERIA

Lactation support and counseling services must be rendered by an Internationally Board Certified Lactation Consultant (IBCLC) credentialed by the International Board of Lactation Consultant Examiners (IBLCE) with possession of a valid and current IBCLC certification.

Rendering IBCLC providers must be Medicaid-enrolled physicians, physician assistants or advanced practice registered nurses. When a Medicaid-enrolled practitioner provides delegation and supervision within the confines of his/her scope of practice to an individual with possession of a valid and current IBCLC certification, that Medicaid-enrolled health professional may bill for comprehensive lactation support services.

For all IBCLC rendered services, a copy of the current, valid IBCLC certification is to be maintained by the supervising physician or employing organization, where applicable, in accordance with the record keeping requirements of the Medicaid program.

7.9.B. COVERED SUPPORTS AND SERVICES

Comprehensive lactation counseling services must include the following:

- A face-to-face encounter with the beneficiary lasting a minimum of 30 minutes.
- Comprehensive maternal, infant and feeding assessment related to lactation.
- Provision of evidence-based interventions that, at a minimum, include:
 - Instruction in positioning techniques and proper latching to the breast;
 - Counseling in nutritive suckling and swallowing, milk production and release, frequency of feedings, and reasons to contact a health care professional; and
 - The provision of community support resource referrals, such as the Women, Infants, and Children (WIC) program, as indicated.
- Evaluation of outcomes from interventions.

Documentation must include a begin time and end time of services and a comprehensive description of the professional interventions provided. Documentation may be subject to review and post-payment audit.

Prenatal lactation education and support services are provided as part of the curriculum of childbirth education programs and will not be separately reimbursed. Reimbursement for lactation education and support received by beneficiaries post-delivery in the inpatient hospital is included in the inpatient hospital payment and will not be separately reimbursed.

Refer to the Billing & Reimbursement for Professionals Chapter of this manual for additional billing information.



7.10 MATERNAL INFANT HEALTH PROGRAM

Maternal Infant Health Program (MIHP) provides preventive health services that are delivered by certified MIHP agencies to high-risk pregnant women and infants born to high risk mothers. The purpose of MIHP is to reduce infant morbidity and mortality. The goal is to deliver a healthy, full term infant. Refer to the Maternal Infant Health Program Chapter for additional information about this program.



SECTION 8 – PHARMACY

A practitioner must report his individual National Provider Identifier (NPI) with a prescription order. An emergency room practitioner must report his individual NPI with a prescription order. Each practitioner at a teaching hospital must report his individual NPI with a prescription order that is submitted to the dispensing pharmacy. A prescription or prescription order must comply with state and federal laws.

Refer to the Pharmacy Chapter of this manual for additional information.



SECTION 9 – RADIOLOGY, RADIATION THERAPY AND NUCLEAR MEDICINE

9.1 RADIOLOGY AND DIAGNOSTIC IMAGING SERVICES

Medically necessary radiological services are covered when ordered by a qualified practitioner to diagnose or treat a specific condition based on the beneficiary's signs, symptoms, and past history as documented in the medical record. Radiology services include diagnostic imaging services and therapeutic radiology services such as proton beam therapy, nuclear medicine, computed tomography (CT) procedures, magnetic resonance imaging (MRI) services, diagnostic ultrasound, and other diagnostic and therapeutic services. Practitioners are required to perform or interpret radiologic services within their professional expertise and education within the confines of federal and State law. It is the expectation that practitioners conform with professional practice parameters and technical standards to ensure the most efficacious use of radiology and the delivery of safe, quality care. Medical need for all services must be documented in the medical record and is subject to post-payment review.

9.1.A. GLOBAL/COMPONENT SERVICES

Global services are covered for the physician in non-facility settings or the professional component is covered for the physician in any setting. The technical component is only covered when the service is provided in an appropriate non-facility setting. The global service and its professional component service cannot both be covered for the same service since the professional component is included in the global service.

When a physician reports a global procedure, the physician is responsible for the overall performance and quality of the test. The physician must either personally perform the test or it must be performed under the physician's supervision and direction. The physician must personally interpret the results and complete the written report. While some radiology procedures and diagnostic tests may not require the presence of the supervising physician on the premises, other procedures dictate that the physician be present and may even need to be directly involved in the performance of the procedure.

Interpretation of radiology services are covered for any physician trained in the interpretation of the study. The provider who interprets the study must be the one who evaluates the study and prepares and signs the written report for the medical record. Review of results and explanation to the beneficiary are part of the attending physician's E/M service and are not considered as interpretation of the study.

9.1.B. MULTIPLE SERVICES ON SAME DAY

Medicaid covers bilateral x-rays when medically necessary. Bilateral services are studies done on the same body area, once on the right side and once on the left side. Comparison films obtained for routine purposes are not covered. Providers should use a bilateral code when available. Medicaid also covers multiple studies of both areas if reported with the appropriate modifier. Examples would include bilateral wrist studies done before and after fracture care on both wrists the same day for the same patient or doing films to assess a patient's response to medical care, such as multiple chest films to monitor the cardiopulmonary status of a critically ill patient.



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<p>Contiguous Areas</p>	<p>Studies of contiguous areas, such as the wrist and hand, lumbosacral spine and pelvis, ankle and foot, are covered on the same day when medically necessary to visualize each space. The medical record must support the need for individual studies. If cervical, lumbosacral and thoracic views are performed, an entire spine study should be reported.</p>
<p>Screening Mammography</p>	<p>Screening mammography is covered according to the American Cancer Society guidelines. Women age 40 and older should have annual breast cancer screening consisting of a clinical breast examination and a mammogram.</p>
<p>Transrectal or Prostate Ultrasound</p>	<p>Transrectal or prostate ultrasound is covered when the patient is considered at high risk for prostate cancer. It is also covered for pathologic indications that include evaluation of prostatic nodule(s) or abnormalities of the seminal vesicles, staging of prostatic cancer, and monitoring of response to therapy for prostatic cancer.</p>
<p>CT, MRI, PET Scans</p>	<p>For CT, MRI and PET scans to be covered, all conditions of Certificate of Need (CON) must be met. These services are subject to standards for provision of the service that include specific staff and designation of who is qualified to interpret the results.</p> <p>Radiographic images, including CT or MRI studies of the same anatomical area, are covered on the same day when medically indicated. The provider is responsible for using the most appropriate diagnostic test(s) according to current standards of practice. A CT and a myelogram may be covered on the same day; however, an MRI and a myelogram are not covered separately if done on the same day. Coverage of a CT of the spine is limited to one level per day, and coverage of an MRI is limited to two levels of the spine on the same day. Providers should be directing the study at the area of the suspected problem.</p> <p>CT and MRI scans may be done with or without contrast media or both. When a scan is done without contrast followed by another with contrast, only the full service is covered. The global RVUs for CT and MRI contrast scans include allowance for high osmolar contrast media, and the RVUs for global MRIs include allowance for paramagnetic contrast media.</p> <p>In certain instances, the use of low osmolar contrast media (LOCM) is separately covered. In the case of intra-arterial and intravenous radiological procedures, LOCM is covered separately for nonhospital patients with one or more of the following:</p> <ul style="list-style-type: none"> ▪ A history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting; ▪ A history of asthma or allergy; ▪ Significant cardiac dysfunction, including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension; ▪ Generalized severe debilitation; or ▪ Sickle cell disease. <p>If the patient does not meet any of these criteria, the contrast media is considered bundled into the global service and is not covered separately.</p> <p>When high dose contrast technique is used with MRI, the global service is covered for the procedure designated without contrast, then with contrast. The third MRI (again with contrast) is not covered separately. The contrast material used in the second MRI procedure is not covered separately; however, the contrast material for the third MRI procedure is covered separately.</p>



Obstetrical Ultrasound	Obstetrical ultrasound studies are covered in addition to the global obstetrical package. More than two studies are covered only for high-risk conditions such as bleeding, placental abnormalities, fetal post-maturity, etc. The need for the additional studies, including the change in clinical symptoms, must be documented. Pelvic ultrasounds are not covered to diagnose pregnancy or vaginal infections. The use of ultrasound studies for routine fetal age determination in or preparatory for pregnancy termination procedures is considered part of the termination procedure and is not covered separately.
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9.2 RADIATION THERAPY

Medicaid covers medically necessary radiation therapy services provided to beneficiaries. CPT/HCPCS guidelines for radiation therapy services are followed.

Following the Medicare guidelines, many services are bundled into the treatment management codes and are not covered separately when the diagnosis is related to the weekly treatment diagnosis and the services are provided by the radiation oncologists or in conjunction with the therapy. The following services are included in the weekly treatment management service:

- Anesthesia
- Care of infected skin
- Checking treatment charts
- Continuing-care patient evaluation and examination
- Final medical examination
- Nutritional counseling
- Pain management
- Medical prescription
- Review and revision of the treatment plan
- Routine medical management of related problems
- Special care of ostomy
- Verification of dosage
- Written reports, progress notes
- Follow-up examination and care 90 days after the last treatment

Medicaid separately covers services furnished by a radiation physicist only when provided to a nonhospital beneficiary in a freestanding facility.

Professional services provided to hospital patients are covered only when personally performed by a physician.

Global physician services are only covered if provided in a freestanding, nonhospital setting.



9.3 NUCLEAR MEDICINE

Medicaid covers medically necessary nuclear medicine procedures. Providers are responsible for complying with Federal and State law requirements. Only professional services rendered to hospital patients are covered for the practitioner.

Medicaid covers global services when provided in a freestanding, nonhospital setting. Radionuclides used in the procedures are covered separately.

When specific nuclear medicine diagnostic procedures are performed, multiple procedure coverage rules apply. Generation and interpretation of automated data is covered as a part of the primary procedure.

9.4 TRANSPORTATION AND SET-UP OF PORTABLE X-RAY EQUIPMENT

The transportation of portable x-ray equipment, set-up, and personnel is covered when furnished in a place or residence used as the patient's home as reported by the corresponding HCPCS code. These services must be provided under the order and general supervision of a physician. No transportation charge is payable unless the portable x-ray equipment was actually transported to the location where the x-ray was taken. For patients residing in a nursing facility, the transportation, set-up and personnel costs are included in the nursing facility's per diem rate and not separately reimbursable. (Refer to the Nursing Facility and the Independent Diagnostic Testing Facilities and Portable X-ray Suppliers chapters of this manual for additional information.)

If only one patient is served, report the appropriate HCPCS code. When more than one patient is served during a single trip to the same location, report the appropriate HCPCS code with the appropriate Level II HCPCS modifier (UN, UP, UQ, UR, US) relative to the number of patients served, irrespective of their insurance. Total payment for services will be adjusted by the number of patients.



SECTION 10 – HOSPITAL INPATIENT PHYSICIAN SERVICES

Medicaid covers physician services to hospital inpatients that are medically necessary and follow the requirements in this section.

10.1 VENTILATION MANAGEMENT

Ventilation management provided in the inpatient hospital setting is covered separately unless an E/M service is provided on the same day.

10.2 CRITICAL CARE

Medicaid covers critical care consistent with the CPT/HCPCS definitions and guidelines. Each day that critical care is provided, the medical record must support the level of service provided. The actual time spent with the patient delivering critical care services must be documented in the medical record.

10.3 RESPIRATORY CARE

Medicaid covers respiratory care as a separate service in the inpatient hospital setting for the anesthesiologist/physician who initiates respiratory care by setting up the respirator, placing the beneficiary on the respirator, and providing daily supervision of the beneficiary for the respiratory care alone.

10.4 STANDBY SERVICES

Medicaid does not cover the services of a standby surgeon, anesthesiologist or surgical team. Only direct beneficiary care is covered. Physician standby services are covered as a part of the hospital services.



SECTION 11 – SURGERY – GENERAL

Medicaid covers medically necessary surgical procedures.

11.1 GLOBAL SURGERY

Coverage for the global surgery package includes related services that are furnished by the physician who performs the surgery or by members of the same group with the same specialty. Medicaid policy is based on CMS guidelines for Medicare services for the global surgery package.

11.1.A. SERVICES INCLUDED IN THE GLOBAL SURGERY PACKAGE

- Pre-operative visits beginning with the day before the surgery for major surgeries and the day of the surgery for minor surgeries.
- Intra-operative services that are a usual and necessary part of a surgical procedure.
- Complications following surgery. This includes all additional medical or surgical services required of the surgeon during the post-operative period due to complications that do not require return to the operating room. The surgeon's visits to a patient in an intensive care or critical care unit are also included.
- Follow-up visits within the post-operative period related to recovery from the surgery.
- Post-surgical pain management by the surgeon.
- Supplies for certain services furnished in a physician's office.
- Miscellaneous services and items such as dressing changes, local incisional care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes, and changes and removal of tracheostomy tubes.

11.1.B. SERVICES NOT INCLUDED IN THE GLOBAL SURGERY PACKAGE

- The surgeon's initial consultation or evaluation of the problem to determine the need for surgery.
- The office or hospital visit to decide upon surgery if it occurs on the day before or the day of a major surgery.
- Other physicians' services, except when the surgeon and the other physician(s) agree on the transfer of care. (The transfer of care agreement may be in the form of a letter or an annotation in the discharge summary, hospital records, or ambulatory surgical center records.)
- Visits unrelated to the diagnosis for which the surgical procedure was performed.
- Treatment of the underlying condition or an added course of treatment that is not part of the normal recovery from surgery.
- Diagnostic tests and procedures, including diagnostic radiology procedures.



- Clearly distinct surgical procedures that are not repeat procedures, or treatment for complications during the post-operative period. A new post-operative period begins with the subsequent procedure.
- Staged procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Examples include procedures to diagnose and treat epilepsy in succession within 90 days of each other.
- Laser eye surgeries (and all other services whose CPT/HCPCS description includes one or more sessions) performed in a series over a period of weeks or months are not considered staged procedures. All sessions during the post-operative period of the first session are covered as a part of the global package.
- Chemotherapy and/or radiation therapy following cancer surgery.
- Treatment for post-operative complications that requires a return to the operating room. For this purpose, an operating room is a place of service specially equipped and staffed for the sole purpose of performing surgical procedures, including a cardiac catheterization suite, a laser suite, and an endoscopy suite. Not included is a patient's room, a minor treatment room, a recovery room, or intensive care unit unless the patient's condition is so critical there is insufficient time for transportation to an operating room.
- A second, more extensive procedure when a less extensive procedure fails.
- A therapeutic service that is required during the post-operative period of a diagnostic service. Example: A D&C followed by a therapeutic hysterectomy performed during the D&Cs global period.
- Immunosuppressive therapy for organ transplants.
- Critical care services unrelated to the surgery when a seriously injured or burned patient is critically ill and requires constant attendance of the physician.
- Visits that are a significant, separately identifiable service on the same day as a minor surgery or endoscopy. For example, a visit for a full evaluation of a lump in the breast on the same day as a removal of a lesion on the back.
- When a beneficiary is returned to the operating room for treatment of complications, only the intra-operative portion of the service is covered.

11.2 PARTIAL GLOBAL PACKAGE

Services of physicians furnishing less than the full global surgery package are covered. Modifiers are used to identify the portion of the global surgery package that is covered separately when performed by different physicians under certain circumstances. Only procedures with 10- or 90-day global periods are eligible for partial global surgery package coverage.

Surgeons should use the modifier for surgical care only when another physician provides all or part of the outpatient post-operative care. MDHHS assumes that the surgeon is responsible for pre-operative, intra-operative and inpatient hospital post-operative care at a minimum. The modifier for post-operative management only is used when a second physician provides all or part of the post-operative care after hospital discharge in the global package. Surgeons must transfer care to the second physician, and both must keep a copy of the written transfer agreement in the beneficiary's medical record.



11.3 BILATERAL SURGERY

Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day. The descriptions for some procedure codes include the terms "bilateral" or "unilateral or bilateral". The RVUs for these codes reflect the work involved if done bilaterally as the description states. Other procedure code descriptions do not include bilateral but may be performed bilaterally. The bilateral procedure modifier is used with these procedure codes.

Reimbursement for a bilateral procedure reported appropriately with modifier 50 is based on the lower of the amount billed or 150 percent of the fee screen for the procedure.

11.4 MULTIPLE SURGICAL PROCEDURES

Multiple surgeries are separate procedures performed by a physician on the same beneficiary during the same operative session or on the same day for which separate coverage may be allowed. Co-surgeons, surgical teams, or assistants at surgery may participate in performing multiple surgeries on the same beneficiary on the same day.

When the same physician performs multiple surgical procedures during one operative session, all services are covered separately. MDHHS follows CMS multiple surgery guidelines for coverage of the procedures. If an integral procedure (one that is part of a larger surgery and is necessary to perform the larger surgery) is performed, it is covered as a part of the larger procedure. If two or more physicians each perform distinctly different, unrelated surgeries on the same patient on the same day (e.g., in some multiple trauma cases), the procedures are covered separately.

Multiple surgery reimbursement policy applies to procedures performed during the same operative session or on the same day by the same physician or physicians of the same specialty in the same group practice. Medicaid reimburses up to 100 percent of the fee screen for the most complex surgical procedure and up to 50 percent of the fee screens for the second through the fifth surgical procedures. If more than five multiple procedures are performed, an operative report must be provided with the claim.

11.5 MULTIPLE ENDOSCOPY PROCEDURES

Multiple endoscopy procedures are reimbursed based on the full fee for the highest paid service, plus the difference between the next highest and the base endoscopy. When related endoscopies are performed on the same day as other endoscopies or other surgical procedures, the standard multiple surgery rules apply. The multiple surgery rules consider the coverage for the related endoscopies as one service, and any other unrelated endoscopy or procedure as another service.

11.6 MULTIPLE SURGEONS

Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same beneficiary during the same operative session. This may be required due to the complex nature of the procedures or the beneficiary's condition. Medicaid reimbursement policy is based on CMS guidelines for Medicare services for multiple surgeons.



11.7 Co-Surgeons

Two surgeons who work together as primary surgeons performing distinct parts of a total service are considered co-surgeons. The medical record must contain sufficient documentation supporting the medical necessity for co-surgeons. Report the modifier indicating two surgeons for the services furnished by each co-surgeon. The primary procedure is reimbursed at the full screen times 62.5 percent. Second and subsequent services are paid at 50 percent of the full-allowed amount times 62.5 percent.

11.8 TEAM SURGEONS

Three or more surgeons who work together as primary surgeons to perform a specific procedure are considered team surgeons. Sufficient documentation must be submitted with the claim to establish that a team was medically necessary. If two or more surgeons are of the same specialty, the reason each was needed must be documented also. Report the surgical team modifier when billing for services rendered by each team surgeon. Each surgeon's dictated operative report must be included with the claims. Reimbursement is based on individual consideration.

11.9 ASSISTANT AT SURGERY/ASSISTANT SURGEON

Medicaid covers assistant at surgery services for designated surgical procedures. Assistant at surgery services must be considered reasonable and necessary for the surgery performed. An assistant at surgery actively assists the primary surgeon during the surgical procedure. Coverage for assistant at surgery services is not allowed when co-surgeons or team surgeons are utilized.

Medicaid does not cover assistant surgeon services in a teaching hospital setting unless a qualified resident is not available. The medical record must document the circumstances causing the unavailability of a qualified resident. The surgical procedure is reported with appropriate modifier identifying use of an assistant surgeon.

Medicaid covers assistant at surgery services performed by a second physician, a physician's assistant (PA), a certified nurse practitioner (NP), a certified clinical nurse specialist (CNS) and, in limited instances, a certified nurse midwife (CNM). PA, NP, CNS and CNM services as assistant at surgery must be under the delegation and supervision of the physician employing the PA, NP, CNS or CNM, or a physician employed by the same group practice that employs the PA, NP, CNS or CNM. If the PA, NP, CNS and/or CNM are employees of the hospital, their services are covered as a part of the hospital charges.

11.10 SURGEONS PERFORMING DISTINCTLY DIFFERENT UNRELATED PROCEDURES

If two or more physicians each perform distinctly different, unrelated surgeries on the beneficiary on the same day, the payment adjustment rules for multiple surgeries or co-surgeons do not apply. In such cases, the multiple procedures modifier should not be used unless one of the surgeons individually performs multiple surgeries.

11.11 VISION PROCEDURES AND CARE

Ophthalmologists may transfer post-operative care associated with cataract removal or insertion of intraocular lens prosthesis to an optometrist. In this case, the ophthalmologist who performs eye surgery but does not provide the post-surgical care must report the surgical care only modifier with the surgery procedure code. This includes the pre-operative care, the surgery, and any in-hospital post-operative



care. Post-operative care after hospital discharge is covered separately for the provider that the care was transferred to using the surgery code with the post-operative management only modifier.

Surgical procedure descriptions that include the phrase "one or more sessions" include all sessions. These procedures include the 90-day global period during which the procedure(s) can be completed in one or more session(s). These procedures include trabeculoplasty by laser surgery, iridotomy/iridectomy by laser or photocoagulation, repair of retinal detachment, destruction of retinal or choroid lesions. The code description in CPT identifies when one or more sessions are included. Separate coverage for a second or subsequent session of the same procedure during the global period of the initial service is limited to cases where the modifier reported with the procedure code indicates that services were performed on different eyes.



SECTION 12 – SURGERY - SPECIAL CONSIDERATIONS

12.1 ABORTIONS

Medicaid only covers an abortion performed by a physician and related hospital charges (e.g., room, supplies) when it has been determined medically necessary to save the life of the mother or the pregnancy is the result of rape or incest. Medicaid funding is not available for any elective therapeutic abortion or service related to the performance of such abortion unless one of these criteria has been met.

Physicians must certify on a completed Certification for Induced Abortion form (MSA-4240) that, for medical reasons, an abortion was necessary to save the life of the mother or the beneficiary's medical history indicates that the terminated pregnancy was the result of rape or incest.

The physician who completes the MSA-4240 must also ensure completion of the Beneficiary Verification of Coverage form (MSA-1550) and is responsible for providing copies of the forms for billing purposes to any other provider (e.g., anesthesiologist, hospital, laboratory) that would submit claims for services related to the abortion.

Copies of the MSA-4240 and the MSA-1550 are not required for claims for ectopic pregnancies or spontaneous, incomplete, or threatened abortions.

Providers may attach copies of the MSA-4240 and the MSA-1550 to the claim or submit them via fax.

Federal regulations require that these forms be submitted to Medicaid before reimbursement can be made for any abortion procedure. This process can eliminate submitting paper attachments for abortion claims and pre-confirms the acceptability of the completed forms, as well as reduces costly claim rejections.

The medical record must include a complete beneficiary history, including the medical conditions that made the abortion necessary to save the life of the mother. When the pregnancy is the result of rape or incest, the medical record must include the circumstances of the case and that the pregnancy was the result of rape or incest.

(Refer to the Forms Appendix for copies of MSA-4240 and MSA-1550. The forms are also available on the MDHHS website. Refer to the Directory Appendix for website and contact information.)

12.2 BREAST RECONSTRUCTION SURGERY

Medicaid covers breast reconstruction surgery following the diagnosis and treatment of breast cancer. Covered services include procedures related to the affected and the contralateral unaffected breast following a medically necessary mastectomy. The prior authorization requirements for these specified breast reconstruction procedure codes are waived when billed with appropriate ICD breast cancer diagnosis codes. The specified CPT codes subject to this PA waiver are identified in the Medicaid Code and Rate Reference tool. (Refer to the Directory Appendix for website information.)



12.3 COSMETIC SURGERY

Medicaid only covers cosmetic surgery if PA has been obtained. The physician may request PA if any of the following exist:

- The condition interferes with employment.
- It causes significant disability or psychological trauma (as documented by psychiatric evaluation).
- It is a component of a program of reconstructive surgery for congenital deformity or trauma.
- It contributes to a major health problem.

The physician must identify the specific reasons any of the above criteria are met in the PA request.

Physicians should refer to the General Information for Providers Chapter for specific information for obtaining authorization.

12.4 DESTRUCTION OF LESIONS

Medicaid covers destruction of lesions by methods such as electrocautery, cryocautery, laser, and surgery.

Coverage of the surgical destruction of lesions that involves more extensive procedures is limited to the hospital/facility setting. Less extensive procedures are covered in the office/non-facility setting. (Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding which procedures require a hospital/facility setting for coverage and which procedures are covered in the office/non-facility setting.) If a repeat procedure to the same lesion is necessary, it is covered as an office visit.

Chemocautery or chemical destruction of any lesion, such as the use of a nitrate stick or podophyllin, is covered as a part of the office visit.

12.5 HYSTERECTOMY

Hysterectomies are covered only if the beneficiary has been informed orally, prior to surgery, that a hysterectomy will render her permanently incapable of reproducing. The beneficiary or her representative must sign a written acknowledgment of receipt of that information. The Acknowledgment of Receipt of Hysterectomy Information (MSA-2218) serves as the written acknowledgment.

All items on the MSA-2218 must be completed and the form must be signed by the beneficiary (or representative) and the physician (MD or DO).

Federal regulations prohibit Medicaid coverage for hysterectomies performed solely for the purpose of sterilization. Hysterectomies are also prohibited when performed for family planning purposes even when there are medical indications, which alone do not indicate a hysterectomy.



12.5.A. EXCEPTIONS

The MSA-2218 is not required in the following situations:

- The beneficiary was already sterile before the hysterectomy.
- The beneficiary requires a hysterectomy because of a life-threatening emergency situation. It was not possible for the physician to inform the beneficiary in advance that the surgery would make her permanently incapable of reproducing.
- The hysterectomy (as covered according to Medicaid policy) was performed during a period of retroactive eligibility.

12.5.B. ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

Providers may attach a copy of the MSA-2218 to the claim or submit the MSA-2218 via fax.

Federal regulations require that this form be submitted to Medicaid before reimbursement can be made for any hysterectomy procedure. This process can eliminate submitting paper attachments for hysterectomy claims and pre-confirms the acceptability of the completed acknowledgement form, as well as reduces costly claim rejections.

(Refer to the Forms Appendix for a copy of MSA-2218. The form is also available on the MDHHS website. Refer to the Directory Appendix for website and contact information.)

12.5.C. PROCEDURE FOR ACKNOWLEDGEMENT OF RECEIPT OF HYSTERECTOMY INFORMATION APPROVAL

- The provider who obtains the required Acknowledgement completes a cover sheet (typed or printed) which must include: beneficiary name, beneficiary Medicaid ID number, provider's contact person, provider fax number, and provider phone number.
- Fax the cover sheet and completed acknowledgement form to the Medicaid Payments Division, Hysterectomy Acknowledgement Form Approval. (Refer to the Directory Appendix for contact information.) Do not fax invoices.
- The form is reviewed within five working days, and a notice of errors or acceptance is returned to the provider. When notified that the acknowledgement form has been accepted and is on file, inform the other providers via a copy of the response. All invoices related to the service may be submitted without attachments.
- If there is no response within five working days:
 - Confirm that the fax is working.
 - Be sure that the cover sheet included the necessary information for Medicaid staff to respond to the provider.
 - Resend the information if necessary.



12.6 ORGAN TRANSPLANTS

Medicaid covers organ transplants and related services if all requirements for these services are met. PA is required for all beneficiary, donor, and potential donor services related to all organ transplants except cornea and kidney transplants. If transplantation of additional organ(s) is to occur during the same operative session as a cornea or kidney transplant, PA is required.

Prior to surgery, the beneficiary must be evaluated at an accepted transplant center approved by the Office of Medical Affairs (OMA) to determine if he is a good transplant candidate. The attending physician must obtain the PA for this evaluation. If the beneficiary is accepted as a transplant candidate, the PA for the evaluation also covers the transplant and related services.

Authorization Instructions	<p>If Medicare eligibility is denied, the denial notice must be attached to the PA request.</p> <p>If the Medicare application is still pending, this should be indicated on the PA request. Once a final determination is made, MDHHS must be notified.</p> <p>The donor must exhaust all possible insurance sources before Medicaid is billed for the services.</p> <p>A copy of the letter of authorization for the evaluation for transplant that was sent to the attending physician from the OMA must be submitted with the claim.</p>
Transportation and Lodging	<p>Transportation and lodging expenses associated with the evaluation and the transplant are covered for the beneficiary and one accompanying individual (e.g., spouse, parent, guardian). The beneficiary's local MDHHS office should be contacted to make travel arrangements if the beneficiary has only Medicaid coverage or they are dually eligible for CSHCS and Medicaid. If the beneficiary has CSHCS-only coverage, they must contact the CSHCS office in the LHD of the county where they reside to make travel arrangements. The mode of transportation should be that deemed medically necessary for the beneficiary by the attending physician.</p>
Donor Searches	<p>Charges for donor searches which do not result in an organ acquisition and transplant are covered as an outpatient service by the hospital and not covered for the physician.</p>

12.7 STERILIZATION

Medicaid covers sterilization procedures when specific requirements are met. Medicaid defines a sterilization procedure as any medical procedure, treatment, or operation for the purpose of rendering an individual (male or female) permanently incapable of reproducing. Surgical procedures performed solely to treat an injury or pathology are not considered sterilizations under Medicaid's definition of sterilization, even though the procedure may result in sterilization (e.g., oophorectomy). The physician is responsible for obtaining the signed Consent for Sterilization (MSA-1959/HHS-687).

Sterilizations are only covered if all of the following are met:

- The beneficiary is at least 21 years of age at time of informed consent.
- The beneficiary is not legally declared to be mentally incompetent.
- The beneficiary is not institutionalized in a corrective, penal, or mental rehabilitation facility.
- Informed consent is obtained.



- Informed consent is not obtained while the beneficiary is in labor or childbirth; seeking to obtain or obtaining an abortion; or under the influence of alcohol or other substances that affect the beneficiary's state of awareness.
- Informed consent must be obtained not less than 30 days nor more than 180 days prior to sterilization.

The only exception is in the case of premature delivery or emergency abdominal surgery. If the premature delivery or emergency abdominal surgery occurred before the 30-day waiting period is over, at least 72 hours must have passed between the time of obtaining informed consent and the sterilization procedure.

- In cases of premature delivery, informed consent must have been given at least 30 days before the expected delivery date. The consent form must indicate the expected date of delivery.
- In cases of abdominal surgery, the emergency nature of the surgery must be clearly identified (e.g., diagnosis, physician's statement, or hospital summary). The nature of the emergency must be included on the consent form.

12.7.A. INFORMED CONSENT PROCESS

The following procedures must be included in the process of informed consent:

- The beneficiary must be advised that the sterilization will not be performed for at least 30 days after the MSA-1959/HHS-687 is signed, except in cases of emergency abdominal surgery or premature delivery.
- The person who obtains informed consent must offer to answer any questions the beneficiary may have concerning the procedure.
- Suitable arrangements must be made to ensure that information is effectively communicated to the deaf, blind, or otherwise handicapped.
- An interpreter must be provided if the beneficiary does not understand the language used on the consent form or the language used by the person obtaining informed consent.
- The beneficiary is permitted to have a witness of his choice present when informed consent is obtained.
- At the time of the informed consent, a copy of the consent form must be given to the beneficiary.

All of the following sterilization information and advice must be presented orally to the beneficiary both at the time the beneficiary signs the MSA-1959/HHS-687 and again by the physician performing the sterilization shortly before the procedure (e.g., during the pre-operative examination):

- Advice that the beneficiary is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the beneficiary might be otherwise entitled.



- A description of available alternative methods of family planning and birth control.
- Advice that the sterilization procedure is considered to be irreversible.
- A thorough explanation of the specific sterilization procedure to be performed.
- A full description of the discomforts and risks that may accompany or follow the procedure, including an explanation of the type and possible effects of any anesthetic to be used.
- A full description of the benefits or advantages that may be expected as a result of the sterilization.

The beneficiary, the person who obtained the consent, and the interpreter (if required) must sign the MSA-1959/HHS-687 not less than 30 days nor more than 180 days prior to the sterilization. The physician performing the sterilization must also sign and date the MSA-1959/HHS-687 after the sterilization has been performed.

No additional reimbursement is allowed for the examination or the sterilization explanation.

If the procedure occurs in a place other than that in which the consent form is signed (e.g., forms were signed in the physician's office, but the procedure will be rendered in the hospital), the person obtaining consent must send a copy of the completed form to the place of surgery. The second provider (e.g., hospital) is responsible for acquiring the physician's statement (if not previously documented) and for photocopying the signed form and supplying copies to any other Medicaid provider who is billing as a participant in the sterilization.

A copy of the completed MSA-1959/HHS-687 is required for coverage of charges related to a sterilization procedure. This form may be faxed or attached to the claim form.

12.7.B. CONSENT FOR STERILIZATION FORM

Providers may attach a copy of the Consent for Sterilization (MSA-1959/HHS-687) form to the claim or submit the MSA-1959/HHS-687 via fax.

Federal regulations require that this form be submitted to MDHHS before reimbursement can be made for any sterilization procedure. This process can eliminate submitting paper attachments for sterilization claims, and pre-confirms the acceptability of the completed consent form.

(Refer to the Forms Appendix for a copy of MSA-1959/HHS-687. Refer to the Directory Appendix for website and contact information.)

12.7.C. PROCEDURE FOR CONSENT FOR STERILIZATION FORM APPROVAL

- The provider who obtains the required Consent and completed MSA-1959/HHS-687 completes a cover sheet (typed or printed) which must include: beneficiary name, beneficiary Medicaid ID number, provider's contact person, provider fax number, and provider phone number.



- Fax the cover sheet (according to Document Management Portal instructions) and completed MSA-1959/HHS-687 to the Medicaid Payments Division, Sterilization Consent Form Approval. (Refer to the Directory Appendix for contact information.) Do not fax invoices.
- The MSA-1959/HHS-687 is reviewed within five working days, and a notice of errors or acceptance is returned to the provider. When notified that the MSA-1959/HHS-687 has been accepted and is on file, inform the other providers via a copy of the response. All invoices related to the service may be submitted without attachments.
- Providers may then submit claims (either electronic or hard copy) to Medicaid. The remarks section or appropriate electronic segment must include the statement "Consent on File."
- When sterilization claims are received with this information in the remarks section, consent form edit requirements are forced if the submitted invoice matches the consent form on file.
- If there is no response within five working days:
 - Confirm that the fax is working.
 - Be sure that the cover sheet included the necessary information for Medicaid staff to respond to the provider.
 - Resend the information if necessary.

12.7.D. REVERSAL OF STERILIZATION

Services to reverse a previous sterilization are not covered by Medicaid.



SECTION 13 – DURABLE MEDICAL EQUIPMENT/ORTHOTICS/PROSTHETICS

Refer to the Medical Supplier Chapter of this manual for additional information.



SECTION 14 – BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

14.1 BEHAVIORAL HEALTH SERVICES

Medicaid covers behavioral health services for diagnostic or active treatment purposes. Behavioral health services are covered by the local PIHP/CMHSP for services included under the capitation payments to the PIHPs/CMHSPs. (Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter for additional information.) For services not included in the capitation payments to the PIHP/CMHSP, behavioral health services are covered through Medicaid Health Plans or FFS Medicaid. Under FFS, behavioral health services may be provided by a physician (MD or DO), psychologist, social worker, professional counselor, or marriage and family therapist (as defined in the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, Non-Physician Behavioral Health Appendix). (Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding covered services.)

Beneficiaries enrolled in an MHP will receive behavioral health services through the health plan. (Refer to the Medicaid Health Plans Chapter of this manual for additional information.)

(Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of this manual for services covered by the PIHPs/CMHSPs and authorization requirements.)

Psychological Testing	Medicaid covers psychological testing that is reasonable and necessary for diagnosing the beneficiary's mental or developmental status and strengths and needs. If a beneficiary requires psychological testing more than once per year, documentation of medical necessity must be maintained in the medical record. Psychological testing must be ordered by a physician (MD or DO) and may be performed by a psychologist who is fully licensed, limited-licensed, or temporary limited-licensed. This order must be kept in the beneficiary's clinical record. Supervision of limited-licensed and temporary limited-licensed psychologists must comply with the requirements of Michigan Public Act 368 of 1978, as amended.
Inpatient Psychiatric Admissions	<p>Inpatient stays in a psychiatric unit of a general hospital are covered for beneficiaries of any age. Inpatient treatment, including related psychiatric visits, in a freestanding psychiatric hospital, both private and state owned, is limited to eligible beneficiaries under age 21, and age 65 and older. If the beneficiary was an inpatient immediately prior to attaining age 21, he would be eligible to continue as an inpatient until age 22. If the beneficiary is discharged at some time following his 21st birthday, coverage terminates on the discharge date.</p> <p>All psychiatric admissions and continued stays must be authorized by the local PIHP/CMHSP. (Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of this manual for specific coverages and authorization requirements.)</p>



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Psychiatric Partial Hospitalization	<p>Psychiatric coverage includes partial hospitalization on a day-care or night-care plan for all beneficiaries, regardless of age. To be eligible for partial hospitalization, the beneficiary must be receiving active psychiatric treatment provided under the direction of a psychiatrist.</p> <p>All partial hospitalization admissions and continued stays must be authorized by the local PIHP/CMHSP. (Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of this manual for specific coverages and authorization requirements.)</p>
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14.2 SUBSTANCE USE DISORDER SERVICES

Most substance use disorder services provided to Medicaid beneficiaries are covered through the local PIHP/CMHSP. PIHPs/CMHSPs are responsible for direct payment for inpatient psychiatric or partial hospitalization services, related physician services, and specialized community mental health clinical and rehabilitation services that the PIHP/CMHSP has prior authorized. Providers should not bill MDHHS for these services.

Acute Care Detoxification	<p>Acute detoxification services are reimbursed directly by MDHHS for both MHP enrollees and FFS beneficiaries.</p> <p>Admission to the acute care setting for a diagnosis of substance use must meet at least one of the following criteria as reflected in the physician's orders and patient care plans:</p> <ul style="list-style-type: none"> ▪ Vital signs, extreme and unstable ▪ Uncontrolled hypertension, extreme and unstable ▪ Delirium tremens, (e.g., confusion, hallucinations, seizures) or a documented history of delirium tremens requiring treatment ▪ Convulsions or multiple convulsions within the last 72 hours ▪ Unconsciousness ▪ Occurrence of substance abuse with pregnancy and monitoring the fetus is vital to the continued health of the fetus ▪ Insulin treated diabetes complicated by diabetic ketoacidosis ▪ Suspected diagnosis of closed head injury based on trauma injury ▪ Congestive heart disease or ischemic heart disease, or significant arrhythmia as examples of active symptomatic heart disease ▪ Suicidal ideation and gestures necessitating suicidal precautions as part of treatment ▪ Blood alcohol level 350 mg/dl with a diagnosis of alcohol abuse ▪ Blood alcohol level 400 mg/dl with diagnosis of alcohol dependence ▪ Active presentation of psychotic symptoms reflecting an emergent/urgent condition
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Additional Substance Use Disorder Services	Medicaid covers additional substance use disorder services through capitation payments to the PIHPs/CMHSPs. (Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of this manual for coverage details and authorization requirements.)
Office-Based Opioid Treatment (OBOT)	<p>OBOT services are reimbursed directly by MDHHS for both MHP enrollees and FFS beneficiaries. Physician and non-physician practitioner (Physician Assistant [PA] and Nurse Practitioner [NP]) services related to opioid dependence may be reimbursed through the Medicaid Fee-for-Service (FFS) program.</p> <p>Working within their scope of practice, physician and non-physician practitioner (PA and NP) services related to OBOT will be considered for reimbursement through the FFS program when the beneficiary meets the American Society of Addiction Medicine (ASAM) criteria for outpatient treatment. Providers are required to provide services consistent with clinical practice guidelines established by the Substance Abuse and Mental Health Services Administration (SAMHSA) and ASAM.</p> <p>The following services related to opioid treatment qualify for FFS reimbursement when a beneficiary has a primary diagnosis of opioid dependence:</p> <ul style="list-style-type: none"> ▪ Evaluation and Management services ▪ Consultation services <p>Physicians and non-physician practitioners (PA and NP) seeking FFS reimbursement for OBOT services must be enrolled in the Community Health Automated Medicaid Processing System (CHAMPS) as a FFS provider. Enrolled providers cannot duplicate and/or be reimbursed through the PIHP/CMHSP for the same service.</p> <p>According to SAMHSA opioid treatment standards, use of medication with counseling is crucial to successful treatment for individuals with opioid dependence. Beneficiaries must be actively involved in their treatment and, as such, it is important that all providers coordinate care.</p> <p>OBOT providers should ensure beneficiaries have access and receive referral to PIHPs for further assessment and treatment and any of the other supports and services that are available (i.e., PIHP specialty services, community based services, and natural supports). PIHP/CMHSP, FFS and Managed Care must partner in overseeing and coordinating the treatment plan knowing that OBOT is only part of the services necessary to achieve successful outcomes.</p> <p>(Refer to the General Information for Providers Chapter for additional information on enrollment in CHAMPS.)</p>

14.3 PSYCHIATRIC COLLABORATIVE CARE MODEL (CoCM) SERVICES [SUBSECTION ADDED 10/1/20]

14.3.A. GENERAL INFORMATION [SUBSECTION ADDED 10/1/20]

CoCM is a model of integrated behavioral health service which is typically provided within the primary care setting. The evidence-based model includes a person-centered care team, weekly and/or monthly monitoring of person-centered goals, and referral to behavioral health support services if goals are unmet after an initial six-month episode of care. CoCM uses team-based collaborative and management services which are provided under the direction and supervision of a treating physician or other qualified healthcare professional and utilizes a measurement-based treatment-to-target approach. The CoCM team includes the primary care provider, a behavioral health care manager, a psychiatric



consultant and the FFS or MHP beneficiary. The model requires the use and maintenance of a patient registry, typically maintained by the behavioral health care manager, which is to be accessible by the primary care provider and psychiatric consultant. CoCM allows for behavioral health integration services to be delivered in a familiar setting that helps engage beneficiaries in care, adapts to their changing needs over time, and reduces the likelihood of duplication of services by addressing both physical and behavioral health care in one setting. (added per bulletin MSA 20-38)

14.3.B. TARGET POPULATION [SUBSECTION ADDED 10/1/20]

CoCM is intended for beneficiaries who typically have behavioral signs and/or symptoms of a newly diagnosed behavioral health condition, need help engaging in treatment, have not responded to care delivered in a non-psychiatric setting or require further assessment, engagement and management prior to consideration of a referral to a psychiatric care setting.

These services are not intended to manage severe and/or persistent conditions which require specialty care. Eligible conditions include, but are not limited to, mild to moderate depression, anxiety, bipolar disorder, attention deficit disorder, substance use disorder (SUD), and individuals who may not be deemed eligible for specialty services through CMHSP. (added per bulletin MSA 20-38)

14.3.C. PSYCHIATRIC COLLABORATIVE CARE MODEL [SUBSECTION ADDED 10/1/20]

Medicaid enrolled providers must be able to demonstrate they are following the evidence-based best practices of CoCM. The model is most effective when all five core principles are in place and incorporated into service delivery. These principles include:

- **Person-centered care:** The beneficiary is part of the team and makes the ultimate decisions regarding their treatment and based on their own goals.
- **Measurement-based treatment-to-target strategy:** The use of validated tools allows measurement of beneficiary signs and symptoms.
- **Population-based care:** The patient registry allows monitoring of beneficiary outcomes by the care team over time and can be utilized in conjunction with, or alongside, existing beneficiary health records.
- **Evidence-based treatment:** Beneficiaries are offered evidence-based treatment that may include medications and brief therapeutic interventions.
- **Accountable care:** The CoCM team of providers is accountable for all beneficiary care, including quality and clinical outcomes for beneficiaries receiving CoCM support services. (added per bulletin MSA 20-38)



14.3.C.1. EPISODE OF CARE [SUBSECTION ADDED 10/1/20]

An episode of care begins when a beneficiary starts CoCM and an episode of care ends when a beneficiary either:

- Fulfills treatment goals and the beneficiary returns to usual primary care follow-up;
- Fails to attain treatment goals, fails to improve or their condition worsens and requires referral to specialty services, or
- A break in services for six consecutive months or more occurs, at which point a new episode of care begins. **(added per bulletin MSA 20-38)**

14.3.C.2. MEASUREMENT-BASED TREATMENT TO TARGET STRATEGY [SUBSECTION ADDED 10/1/20]

The model utilizes validated tools which allows for measurement of beneficiary signs and symptoms. At a minimum, the POC for each beneficiary should be adjusted every 10-12 weeks based on the goal of reducing measured symptoms. Outcome measures are tracked in a patient registry. For example, if a beneficiary is recommended to engage in evidence-based therapy and does not exhibit symptom measurement improvement after 10 weeks, the psychiatric consultant may recommend an adjustment to treatment in an effort to reach person-centered goals. **(added per bulletin MSA 20-38)**

14.3.C.3. REQUIRED DOCUMENTATION [SUBSECTION ADDED 10/1/20]

CoCM is a data-driven service delivery model that requires the use of a patient registry and corresponding POC for each beneficiary. The registry can be part of, or maintained alongside, an already existing Electronic Health Record (EHR). Typically, the behavioral health care manager is responsible for maintaining these tools and ensuring all documentation is included. CoCM services are most effective when the psychiatric consultant has direct access. Documentation must support the services provided and follow Medicaid documentation requirements, including consent for treatment. Services must be provided within the confines of state and federal law. Behavioral health care managers are required to ensure all aspects of registry/POC are included in the documentation.

Documentation requirements, at a minimum:

- Beneficiary information,
- Assessment, treatment plan, including evidence-based treatment interventions,
- Monitoring of individual beneficiary progress,
- Referrals, and
- Medication management.



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The patient registry, at a minimum, must include the following key components:

- Date of enrollment and date of most recent contact with care team,
- Initial and most recent validated outcome measure,
- Prompt treatment-to-target strategies for treatment adjustment according to changes in validated tool scores, such as a flagging/alert system or systematic weekly review of the patient registry, and
- Facilitation of efficient, systematic psychiatric caseload review. **(added per bulletin MSA 20-38)**

14.3.D. COLLABORATIVE CARE TEAM CRITERIA [SUBSECTION ADDED 10/1/20]

All team members must participate in the care and treatment of the beneficiary to be considered as a covered CoCM service. Services are reported by the primary care provider and include the services of the treating physician, behavioral health care manager and the psychiatric consultant who is contracted to provide consultative services to the primary care provider. Psychiatric consultants typically make recommendations to the behavioral health care manager who will then convey recommendations to the treating physician. The psychiatric consultant does not typically provide direct consultation to the treating physician or direct treatment to beneficiaries, but instead works through the behavioral health care manager.

<p>Primary Care Provider or Treating Physician</p>	<p>A licensed Medicaid-enrolled health care provider (e.g., MD/DO, certified Nurse Practitioner [NP], certified Clinical Nurse Specialist [CNS], Physician Assistant [PA]), who will:</p> <ul style="list-style-type: none"> ▪ Direct the behavioral health care manager, ▪ Continue to provide and direct beneficiary behavioral health and physical care, ▪ Prescribe and manage medications based on psychiatric consultant recommendations, and ▪ Make referrals to specialty care as needed.
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<p>Behavioral Health Care Manager</p>	<p>A licensed master’s or doctoral level clinician, or individual with specialized training in behavioral health (such as a licensed social worker, registered nurse, or licensed psychologist) working under the direction and supervision of the primary care provider, who will:</p> <ul style="list-style-type: none"> ▪ Provide care management services through face-to-face and non-face-to-face interactions, ▪ Assess beneficiary needs, ▪ Develop a POC, ▪ Administer validated screening tools (PHQ-9 or GAD-7) at least monthly, or more frequently if clinically indicated, ▪ Provide evidence-based interventions, ▪ Engage in ongoing collaboration with the primary care provider, ▪ Maintain the patient registry, and ▪ Consult weekly with the psychiatric consultant (may be non-face-to-face).
<p>Psychiatric Consultant</p>	<p>Medical professional (MD or DO) who is trained in psychiatry or behavioral health and qualified to prescribe the full range of medications. The psychiatric consultant will:</p> <ul style="list-style-type: none"> ▪ Recommend treatment strategies, ▪ Recommend medication and changes in medication based on beneficiary status, ▪ Recommend referral to specialty services when needed, ▪ Consult weekly with the behavioral health care manager, ▪ Consult with and advise the treating primary care provider as clinically indicated, ▪ Have infrequent contact with beneficiaries (refer to the Reimbursement subsection within the Psychiatric Collaborative Care Model [CoCM] Services subsection of this chapter for additional information), and ▪ On rare occasions, directly prescribe medications to a beneficiary.
<p>Beneficiary</p>	<p>The beneficiary is an active member of the care team and participation in care has proven to increase motivation, adherence to treatment plan, satisfaction with care and positive beneficiary outcomes. (added per bulletin MSA 20-38)</p>

14.3.E. COVERAGE OF CoCM SERVICES [SUBSECTION ADDED 10/1/20]

CoCM is a covered service for beneficiaries who are diagnosed with a psychiatric disorder that requires behavioral health care assessment; establishing, implementing, revising, or monitoring a care plan; and brief interventions. For primary medical care practices that meet all CoCM team criteria, Medicaid will cover CoCM services provided by the care team and rendered by the primary care provider for six months of care. After the initial six months, prior authorization is required for six additional calendar months if the beneficiary shows improvement and there is a need for continued care. If no improvement occurs after the initial six months or their condition worsens, the beneficiary is to be referred to specialty services. An episode of care does not have to be six consecutive months. A beneficiary can be absent from services for five months and



still return to their initial episode of care. After a six-month break in service, a new episode of care begins and prior authorization is not required.

CoCM services are based on reaching person-centered goals through the planning and management of the behavioral health care manager and primary care provider all in consultation with the psychiatric consultant.

CoCM services must include:

- **Initial assessment:** Face-to-face visit in which the beneficiary sets goals and is screened by a diagnosis-appropriate and consistent validated clinical rating scale, such as the PHQ-9 or GAD-7, which also must be done prior to subsequent CoCM services.
- **Continued monitoring:** Face-to-face or non-face-to-face weekly to monthly follow-up by the behavioral health care manager that must include monthly screening with validated rating scale, monitoring of goals and/or medication, and may include recommended evidence-based therapies.
- **Monthly monitoring:** Continues until goals are met, the beneficiary stops participating or the beneficiary is referred to specialty services. **(added per bulletin MSA 20-38)**

14.3.F. NON-COVERED SERVICES [SUBSECTION ADDED 10/1/20]

Psychiatric CoCM services do not include:

- Treatment related to severe and persistent behavioral health conditions that require specialty care beyond the intent of CoCM services.
- Direct interaction between the beneficiary and the psychiatric consultant, either in person or by telephone. CoCM services typically include the psychiatric consultant as recommending treatment to the behavioral health care manager and are ultimately directed by the primary care provider.
- SUD-related Medication Assisted Treatment (MAT) is not covered under CoCM services and should be reported separately. **(added per bulletin MSA 20-38)**

14.3.G. PRIOR AUTHORIZATION [SUBSECTION ADDED 10/1/20]

After an initial six-month episode of care, prior authorization is required for an additional six months. Prior authorization requests must include documentation showing progress toward beneficiary goals through validated screening tool scores and an explanation for the medical necessity of continued services. If a six-month lapse in CoCM occurs, a new episode of care can begin without prior authorization. (Refer to the Prior Authorization subsection of this chapter for additional information.) **(added per bulletin MSA 20-38)**

14.3.H. REIMBURSEMENT [SUBSECTION ADDED 10/1/20]

CoCM is a bundled monthly payment that represents a model of care rendered by all team members. The primary care provider is the sole biller for CoCM and services are not to be billed by the psychiatric consultant. The primary care provider agency is expected to have its own contract with the psychiatric consultant and will pay for his or



her services as part of the CoCM. Providers are expected to adhere to the American Medical Association's CPT coding guidelines for Psychiatric Collaborative Care Management Services as reported by CPT codes 99492, 99493, and 99494.

Direct consultant services delivered to beneficiaries by the psychiatric consultant outside of CoCM, such as evaluation and management or therapeutic interventions, may be reported separately.

To avoid duplication of services, CoCM services should not be provided to beneficiaries receiving the following Medicaid program services:

- MI Care Team benefit,
- Behavioral Health Home benefit,
- Opioid Health Home benefit, or
- Other care management services that include mental health treatment.

Providers may check the beneficiary's assigned benefit plan information in CHAMPS. **(added per bulletin MSA 20-38)**

14.3.I. FEDERALLY QUALIFIED HEALTH CENTER AND RURAL HEALTH CLINIC REIMBURSEMENT [SUBSECTION ADDED 10/1/20]

CoCM services provided by a FQHC or RHC provider (e.g., MD/DO, certified NP, certified CNS, PA) do not qualify as an encounter. It may, however, be reimbursed outside of the Prospective Payment System. FQHCs and RHCs should use HCPCS code G0512 to report CoCM services. **(added per bulletin MSA 20-38)**

14.3.J. SUBSTANCE USE DISORDER CoCM REIMBURSEMENT [SUBSECTION ADDED 10/1/20]

For MHP-enrolled beneficiaries, CoCM services provided for a primary diagnosis of SUD are carved-out of the MHPs. Such services will be reimbursed by the PIHPs, or FFS as applicable, per Medicaid policy. **(added per bulletin MSA 20-38)**



SECTION 15 – PRIVATE DUTY NURSING

Refer to the Private Duty Nursing Chapter of this manual for additional information.



SECTION 16 – OUTPATIENT THERAPY

Refer to the Therapy Services Chapter of this manual for additional information.



SECTION 17 – TELEMEDICINE

Telemedicine is the use of telecommunication technology to connect a patient with a health care professional in a different location. MDHHS requires a real time interactive system at both the originating and distant site, allowing instantaneous interaction between the patient and health care professional via the telecommunication system. Telemedicine should be used primarily when travel is prohibitive for the beneficiary or there is an imminent health risk justifying immediate medical need for services.

Providers must ensure the privacy of the beneficiary and the security of any information shared via telemedicine. The technology used must meet the needs for audio and visual compliance in accordance with current regulations and industry standards.

Telecommunication systems using store and forward technology, including asynchronous transmission of medical data or the use of robotics for remote access surgical procedures, are not included in this policy.

17.1 TELEMEDICINE SERVICES

The following services may be provided via telemedicine:

- ESRD-related services
- Behavior change intervention
- Behavioral Health and/or Substance Use Disorder Treatment
- Education Services, Telehealth
- Inpatient consultations
- Nursing facility subsequent care
- Office or other outpatient consultations
- Office or other outpatient services
- Psychiatric diagnostic procedures
- Subsequent hospital care
- Training service – Diabetes (Refer to the Diabetes Self-Management Education (DSME) Training Program subsection in the Hospital Chapter for specific program requirements)

Where face-to-face visits are required (such as ESRD and nursing facility related services), the telemedicine service may be used in addition to the required face-to-face visit but cannot be used as a substitute. There must be at least one face-to-face hands-on visit (i.e., not via telemedicine) by a physician, physician’s assistant or advanced practice registered nurse per month to examine the vascular site for ESRD services. The initial visit for nursing facility services must be face-to-face.

Procedure code and modifier information is contained in the MDHHS Telemedicine Services Database available on the MDHHS website. (Refer to the Directory Appendix for website information.)



17.2 AUTHORIZATION REQUIREMENTS

There are no prior authorization requirements when providing telemedicine services for fee-for-service beneficiaries.

Authorization requirements for beneficiaries enrolled in Medicaid Health Plans (MHPs) may vary. Providers must check with individual MHPs for any authorization or coverage requirements.

17.3 AUTHORIZED ORIGINATING SITES

The originating site is the location of an eligible beneficiary at the time the service being furnished via a telecommunications system occurs.

The following are authorized as originating sites for telemedicine services:

- County mental health clinic or publicly funded mental health facility
- Federally Qualified Health Center (FQHC)
- Hospital (inpatient, outpatient, or critical access hospital)
- Office of a physician or other practitioner (including medical clinics)
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites)
- Rural health clinic
- Skilled nursing facility
- Tribal Health Center (THC)

Information regarding billing for the originating site facility fee is contained in the Billing & Reimbursement for Institutional Providers and the Billing & Reimbursement for Professionals chapters. Providers at the originating site may bill services they provide on the same date as a service that is performed via telemedicine. The originating site provider is not limited to services listed on the Telemedicine Services database but must bill the medically necessary service they performed.

17.4 DISTANT SITE

The location of the physician or practitioner providing the professional service via a telecommunications system is called the distant site. A medical professional is not required to present the beneficiary to the physician or practitioner at the distant site unless medically necessary. Providers at the distant site can only bill services listed in the Telemedicine Services database.

17.5 AUTHORIZED PRACTITIONERS

In compliance with the Michigan Insurance Code of 1956 (Act 218 of 1956), telemedicine services must be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in his or her health care profession in the state where the patient is located.

The physician or practitioner at the distant site who is licensed under State law to furnish a covered telemedicine service (as described in the Telemedicine Services subsection) may bill, and receive payment for, the service when it is delivered via a telecommunications system.



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If providing services through the PIHP/CMHSP, the provider must have a contract with or be authorized by the appropriate entity.

In order to be reimbursed for services, distant site providers must be enrolled in Michigan Medicaid.

When providing services via telemedicine, providers can only bill for services listed on the Telemedicine Services database. Procedure code and modifier information is contained in the MDHHS Telemedicine Services Database available on the MDHHS website. (Refer to the Directory Appendix for website information.)



SECTION 18 – ANESTHESIOLOGIST ASSISTANT

Medicaid covers anesthesia services provided by qualified anesthesiologist assistants (AAs). AA services are covered for the AA or for the entity with which the AA has an employment or contract relationship that provides for payment to be made to the entity.

For specific coverage parameters, refer to the Anesthesia Services section of this chapter.

To enroll as a Medicaid provider, an AA must meet all of the following requirements:

- Works under the delegation and direction of a Medicaid enrolled anesthesiologist.
- Is in compliance with all applicable requirements of State law.
- Is a graduate of a medical (MD or DO) school-based anesthesiologist assistant education program that:
 - Is accredited by the Committee on Allied Health Education and Accreditation; and
 - Includes approximately two years of specialized basic science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background.
- Is currently certified by the National Commission for Certification of Anesthesiologist Assistants.



SECTION 19 – CERTIFIED REGISTERED NURSE ANESTHETIST

Medicaid covers anesthesia services provided by a Medicaid enrolled Certified Registered Nurse Anesthetist (CRNA). CRNA services are covered for the CRNA or for the entity with which the CRNA has an employment or contract relationship that provides for payment to be made to the entity. CRNAs must comply with Michigan scope of practice licensing laws and regulations.

If a rural hospital elects reasonable cost reimbursement for CRNA services under Medicare, the CRNA costs are included in the facility payments to the hospital and are not covered separately by Medicaid.

For specific coverage parameters, refer to the Anesthesia Services Section of this chapter.

To enroll as a Medicaid provider, a CRNA must meet all of the following requirements:

- be currently licensed in Michigan as a registered professional nurse;
- be certified by the State as a CRNA; and
- complete an on-line application through the CHAMPS Provider Enrollment subsystem.

(Refer to the Provider Enrollment Section of the General Information for Providers Chapter for additional enrollment information, and the Directory Appendix for contact information.)



SECTION 20 – CERTIFIED NURSE PRACTITIONER

Medicaid covers services provided by qualified Medicaid enrolled nurse practitioners (NPs). Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter or the Medicaid Code and Rate Reference tool for additional information regarding coverage parameters.

20.1 COVERED SERVICES

Medicaid covers medically necessary services provided by a NP, as defined in Public Act 368 of 1978 as amended, when all of the following requirements are met:

- the services are the type that are considered physician’s services if furnished by a Doctor of Medicine or Osteopathy (MD/DO);
- the services are performed by a person who is licensed as an advanced practice registered nurse (APRN) under state law with the NP specialty certification granted by the Michigan Board of Nursing;
- the NP is legally authorized to perform the service in compliance with state law;
- the services are performed in collaboration with or under the terms of a valid practice agreement with a Medicaid-enrolled MD/DO; and
- the services are not restricted to physicians or otherwise excluded by Medicaid program policy or federal and state statutes.

NP services are subject to the limitations that apply to physician services. Certain services may be restricted to physicians by program policy or federal and state statutes and may not be covered for NPs. Professional services are only covered when the NP has personally performed the service and no other provider or entity has been paid for the service. Services provided jointly by the NP and physician are covered for a single practitioner only.

20.2 ENROLLMENT OF NURSE PRACTITIONERS

A NP who provides professional services to Medicaid beneficiaries is required to be a Medicaid-enrolled provider and uniquely identified on claims. To enroll as a Medicaid provider, the NP must complete an on-line application in the Community Health Automated Medicaid Processing System (CHAMPS) and enroll with an Individual (Type 1) National Provider Identifier (NPI) as either a Rendering/Serviceing-Only or Individual/Sole Provider.

20.2.A. RENDERING/SERVICING-ONLY PROVIDER

A physician-employed NP who renders services only under the physician’s delegation and supervision under an employment relationship or agreement is required to be an enrolled provider and uniquely identified on claims for services. He/she may enroll as a Rendering/Serviceing-Only Provider, and payment for services will be made to the employing, supervising physician or physician group.



20.2.B. INDIVIDUAL/SOLE PROVIDER

NPs enrolled as Individual/Sole Providers may receive direct reimbursement for services. Claims for services provided to FFS beneficiaries may be directly submitted to MDHHS. For beneficiaries enrolled in a MHP, the NP must negotiate provider terms and payment arrangements with each MHP.

During enrollment and enrollment revalidation processes, the NP must report the NPI of their Medicaid enrolled collaborating physician by including the collaborating physician's NPI on the checklist and associating to the collaborating physician in the "Associate to Billing Provider/Other Association" step in CHAMPS. Disenrollment of the collaborating physician from the program may prompt disenrollment of the NP. To avoid interruption in enrollment, the NP must ensure his/her CHAMPS enrollment information reflects current collaborating physician information. Additional provider enrollment information can be found on the MDHHS website (refer to the Directory Appendix for website information) and in the General Information for Providers Chapter of this manual.

20.3 NURSE PRACTITIONER COLLABORATIVE PRACTICE AGREEMENT

As part of the enrollment and enrollment revalidation processes, the NP must attest to having a valid collaborative practice agreement with a Medicaid enrolled physician. Determination of medical necessity and appropriateness of services is the responsibility of the practitioner and physician based on the terms of the collaborative practice agreement. The collaborating physician does not have to be physically on the premises where the services are provided.

The collaborative practice agreement is a written document that the practitioner and physician utilize to outline the performance of medical care services or the prescribing of schedule 2 to 5 controlled substances, or both. The agreement shall not include an act, task, or function that the practitioner or collaborating physician is not qualified to perform by education, training, or experience and that is not within the scope of the license held by the practitioner or physician. The agreement must include the effective date of delegation and subsequent review dates. The NP must maintain the collaborative practice agreement at his/her primary place of practice and provide the agreement to MDHHS upon request.

The terms of the agreement, at a minimum, must include the following:

- A process between the practitioner and collaborating physician for communication, availability, and decision making, including an emergency plan;
- A protocol for designating an alternative physician for consultation in situations in which the collaborating physician is not available;
- A description of the duties and responsibilities of the practitioner and collaborating physician based upon their education, training and experience;
- A provision that allows the practitioner or collaborating physician to terminate their agreement; and
- The signatures of the practitioner and physician.



The NP must notify MDHHS if the collaborative practice agreement is terminated. Termination or suspension of the agreement by either professional, or termination of the collaborating physician's enrollment, may lead to disenrollment of the NP from the program.

20.4 NURSE PRACTITIONER BILLING AND REIMBURSEMENT

Professional claims must include the NPI of the NP in the Rendering Provider field and the supervising or collaborating physician in the Supervising Provider field as applicable. Refer to the Billing & Reimbursement for Professionals and the Billing & Reimbursement for Institutional Providers Chapters for additional information.

Fee-for-Service reimbursement for NP services is based upon the limits and rates associated to physician professional services and are published on the NP/CNS fee schedule located on the MDHHS website. Provider specific information may be located utilizing the Medicaid Code and Rate Reference tool within CHAMPS. Refer to the Billing & Reimbursement Chapters for additional information.

MHPs are responsible for reimbursing contracted providers or subcontractors for their services according to the conditions stated in the subcontract established between the practitioner and the MHP. Noncontracted providers must comply with all applicable authorization requirements of the MHP and uniform billing requirements. Refer to the Medicaid Health Plans Chapter for additional information.

(Refer to the Surgery-General section of this chapter for information on an NP functioning as an assistant at surgery.)



SECTION 21 – CERTIFIED CLINICAL NURSE SPECIALIST

Medicaid covers services provided by qualified Medicaid enrolled clinical nurse specialists (CNSs). Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter or the Medicaid Code and Rate Reference tool for additional information regarding coverage parameters.

21.1 COVERED SERVICES

Medicaid covers medically necessary professional services provided by a CNS, as defined in Public Act 368 of 1978 as amended, when all of the following requirements are met:

- the services are the type that are considered physician's services if furnished by a Doctor of Medicine or Osteopathy (MD/DO);
- the services are performed by a person who is licensed as an advanced practice registered nurse (APRN) under state law, with the CNS specialty certification granted by the Michigan Board of Nursing;
- the CNS is legally authorized to perform the service in compliance with state law;
- the services are performed in collaboration with or under the terms of a valid practice agreement with a Medicaid enrolled MD/DO; and
- the services are not restricted to physicians or otherwise excluded by Medicaid program policy or federal and state statutes.

CNS services are subject to the limitations that apply to physician services. Certain services may be restricted to physicians by program policy or federal and state statutes and may not be covered for CNSs. Professional services are only covered when the CNS has personally performed the service and no other provider or entity has been paid for the service. Services provided jointly by the CNS and physician are covered for a single practitioner only.

21.2 ENROLLMENT OF CLINICAL NURSE SPECIALISTS

The CNS who provides professional services to Medicaid beneficiaries is required to be an enrolled provider and uniquely identified on claims for services to be considered eligible for reimbursement. To enroll, the CNS must complete an on-line application in the Community Health Automated Medicaid Processing System (CHAMPS) and enroll with an Individual (Type 1) National Provider Identifier (NPI) as either a Rendering/Service-Only or Individual/Sole Provider.

21.2.A. RENDERING/SERVICING-ONLY PROVIDER

A physician-employed CNS who renders services only under the physician's delegation and supervision under an employment relationship or agreement is required to be an enrolled provider and uniquely identified on claims for services. He/she may enroll as a Rendering/Service Only Provider, and payment for services will be made to the employing, supervising physician or physician group.



21.2.B. INDIVIDUAL/SOLE PROVIDER

CNSs enrolled as Individual/Sole Providers may receive direct reimbursement for services. Claims for services provided to FFS beneficiaries may be directly submitted to MDHHS. For beneficiaries enrolled in an MHP, the CNS must negotiate provider terms and payment arrangements with each MHP.

During enrollment and enrollment revalidation processes, the CNS must report the NPI of their Medicaid-enrolled collaborating physician by including the collaborating physician's NPI on the checklist and associating to the collaborating physician in the "Associate to Billing Provider/Other Association" step in CHAMPS. Disenrollment of the collaborating physician from the program may prompt disenrollment of the CNS. To avoid interruption in enrollment, the CNS must ensure his/her CHAMPS enrollment information reflects current collaborating physician information. Additional provider enrollment information can be found on the MDHHS website (refer to the Directory Appendix for website information) and in the General Information for Providers Chapter of this manual.

21.3 COLLABORATIVE PRACTICE AGREEMENT

As part of the enrollment process, the CNS must attest to having a valid collaborative practice agreement with a Medicaid enrolled physician. Determination of medical necessity and appropriateness of services is the responsibility of the practitioner and physician based on the terms of the collaborative practice agreement. The collaborating physician does not have to be physically on the premises where the services are provided.

The collaborative practice agreement is a written document that the practitioner and physician utilize to outline the performance of medical care services or the prescribing of schedule 2 to 5 controlled substances, or both. The agreement shall not include an act, task, or function that the practitioner or collaborating physician is not qualified to perform by education, training, or experience and that is not within the scope of the license held by the practitioner or physician. The agreement must include the effective date of delegation and subsequent review dates. The CNS must maintain the collaborative practice agreement at his/her primary place of practice and provide the agreement to MDHHS upon request.

The terms of the agreement, at a minimum, must include the following:

- A process between the practitioner and collaborating physician for communication, availability, and decision making, including an emergency plan;
- A protocol for designating an alternative physician for consultation in situations in which the collaborating physician is not available;
- A description of the duties and responsibilities of the practitioner and collaborating physician based upon their education, training and experience;
- A provision that allows the practitioner or collaborating physician to terminate their agreement; and
- The signatures of the practitioner and physician.



The CNS must notify MDHHS if the collaborative practice agreement is terminated. Termination or suspension of the agreement by either professional, or termination of the collaborating physician's enrollment, may lead to disenrollment of the CNS from the program.

21.4 BILLING & REIMBURSEMENT

Professional claims must include the NPI of the CNS in the Rendering Provider field and the supervising or collaborating physician in the Supervising Provider field as applicable. Refer to the Billing & Reimbursement for Professionals and the Billing & Reimbursement for Institutional Providers Chapters for additional information.

Fee-for-Service reimbursement for CNS services is based upon the limits and rates associated to physician professional services and is published on the NP/CNS fee schedule located on the MDHHS website. Provider specific information may be located utilizing the Medicaid Code and Rate Reference tool within CHAMPS. Refer to the Billing & Reimbursement Chapters for additional information.

MHPs are responsible for reimbursing contracted providers or subcontractors for their services according to the conditions stated in the subcontract established between the practitioner and the MHP. Noncontracted providers must comply with all applicable authorization requirements of the MHP and uniform billing requirements. Refer to the Medicaid Health Plans Chapter for additional information.

(Refer to the Surgery-General section of this chapter for information on a CNS functioning as an assistant at surgery.)



SECTION 22 – CERTIFIED NURSE MIDWIFE

Medicaid covers services provided by qualified Medicaid enrolled certified nurse midwives (CNMs). (Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter or the Medicaid Code and Rate Reference tool for additional information regarding coverage parameters.)

22.1 COVERED SERVICES

Medicaid covers medically necessary professional services provided by a CNM, as defined in Public Act 368 of 1978 as amended, when all the following requirements are met:

- the services are the type that are considered physician’s services if furnished by a Doctor of Medicine or Osteopathy (MD/DO);
- the services are performed by a person who is licensed as an advanced practice registered nurse (APRN) under state law, with the CNM specialty certification granted by the Michigan Board of Nursing;
- the CNM is legally authorized to perform the service in compliance with state law; and
- the services are not restricted to physicians or otherwise excluded by Medicaid program policy or federal and state statutes.

Covered services include those within the CNM’s scope of practice as defined in state law. Services focus on inpatient and outpatient obstetric, gynecologic and women’s primary health care. Services must be administered within the framework of an alliance agreement that provides for physician consultation and referral as indicated by the health of the beneficiary. Covered CNM services include the following:

- Maternity care, including antepartum care, hospital delivery and postpartum care;
- Newborn care;
- Primary care services for women throughout their lifespan, including physical exams;
- Diagnosis and treatment of common health problems;
- Gynecological services;
- Reproductive health services;
- Contraceptive services;
- Treatment of male partners for sexually transmitted infection and reproductive health; and
- The prescribing of pharmacological and nonpharmacological interventions and treatments that are within the CNM’s specialty role, scope of practice, and state law.

22.2 MATERNITY CARE

Medicaid covers antepartum care, delivery, and postpartum care rendered by a CNM when provided in compliance with Medicaid policy.



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Antepartum Care	<p>Coverage for antepartum care includes all usual and customary antepartum services provided prior to delivery and referral to MIHP when there are psychosocial or nutritional factors that could adversely affect the pregnancy or the health and well-being of the mother or infant.</p> <p>If the provider initiated prenatal care within the first six months of pregnancy through the month of delivery, the appropriate antepartum care CPT code is covered. If the beneficiary is seen by multiple CNMs or physicians within a group practice, the antepartum care package may be covered. (Refer to the Maternity Care and Delivery Services Section of this chapter for details on coverage of antepartum care and when individual E/M services are covered.)</p>
Delivery	<p>Deliveries performed by a CNM are covered in a licensed hospital setting only. Home deliveries and services associated with these deliveries are not covered. Coverage of the delivery includes the usual and customary services associated with the hospital admission, management of labor, monitoring, vaginal delivery, and resuscitation of the newborn infant when necessary.</p>
Post-partum Care	<p>Medicaid covers usual and customary inpatient and outpatient post-partum services provided after the delivery. Routine post-partum hospital care for the mother is covered as a part of the delivery. Routine care of the newborn in the hospital is covered for the provider who examines and provides the total hospital care of the newborn regardless of whether he or she performed the delivery. (Refer to the Services to Newborns subsection in this chapter for additional coverage information.)</p>

22.3 OFFICE VISITS

Visits not directly related to antepartum care or follow-up to a delivery, such as family planning visits, are covered under the appropriate office visit procedure code. (Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters. Refer to the Evaluation and Management Services Section of this chapter for specific coverage information related to office visits.)

22.4 ENROLLMENT OF CERTIFIED NURSE MIDWIVES

The CNM who provides professional services to Medicaid beneficiaries is required to be an enrolled provider and uniquely identified on claims for services to be considered eligible for reimbursement. To enroll, the CNM must complete an on-line application in the Community Health Automated Medicaid Processing System (CHAMPS) and enroll with an Individual (Type 1) National Provider Identifier (NPI). Additional provider enrollment information can be found on the MDHHS website (refer to the Directory Appendix for website information) and in the General Information for Providers Chapter of this manual.

Practitioners who wish to provide services to Medicaid Health Plan (MHP) enrollees are encouraged to contact the individual MHP for additional enrollment, credentialing, and contract requirements.

22.5 BILLING & REIMBURSEMENT

Professional claims must include the NPI of the CNM in the Rendering Provider field and the supervising or collaborating physician in the Supervising Provider field as applicable. Refer to the Billing & Reimbursement for Professionals and the Billing & Reimbursement for Institutional Providers Chapters for additional information.



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Professional services are only covered when the CNM has personally performed the service and no other provider or entity has been paid for the service. Services provided jointly by the CNM and physician are covered for a single practitioner only.

Fee-for-Service reimbursement for CNM services is based upon the limits and rates associated to physician professional services and are published on the CNM fee schedule located on the MDHHS website. Provider specific information may be located utilizing the Medicaid Code and Rate Reference tool within CHAMPS. Refer to the Billing & Reimbursement Chapters for additional information.

MHPs are responsible for reimbursing contracted providers or subcontractors for its services according to the conditions stated in the subcontract established between the practitioner and the MHP. Noncontracted providers must comply with all applicable authorization requirements of the MHP and uniform billing requirements. Refer to the Medicaid Health Plans Chapter for additional information.

(Refer to the Surgery-General section of this chapter for information on a CNM functioning as an assistant at surgery.)



SECTION 23 – PHYSICIAN ASSISTANT

Medicaid covers physician assistant (PA) services provided by qualified, Medicaid enrolled practitioners in conjunction with covered surgeries and other procedures. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter or the Medicaid Code and Rate Reference tool available through CHAMPS for more information regarding coverage parameters. (Refer to the Directory Appendix for CHAMPS access information.)

23.1 COVERED SERVICES

Medicaid covers medically necessary services provided by a PA, as defined in Public Act 368 of 1978 as amended, when all the following requirements are met:

- the services are the type that are considered physician’s services if furnished by a Doctor of Medicine or Osteopathy (MD/DO);
- the services are performed by a person who is licensed as a PA under state law;
- the PA is legally authorized to perform the service in compliance with state law;
- the services are performed under the terms of a valid practice agreement with a Medicaid-enrolled MD/DO; and
- the services are not restricted to physicians or otherwise excluded by Medicaid program policy or federal and state statutes.

23.2 ENROLLMENT OF PHYSICIAN ASSISTANTS

PAs who provide professional services to Medicaid beneficiaries are required to be enrolled providers in the Medicaid program and uniquely identified on claims for their services to be considered eligible for reimbursement. To enroll, the PA must complete an online application in the Community Health Automated Medicaid Processing System (CHAMPS) with an Individual (Type 1) National Provider Identifier (NPI) as a Rendering/Service-Only provider. Additional provider enrollment information can be found on the MDHHS website and in the General Information for Providers Chapter of this manual. (Refer to the Directory Appendix for website information.)

23.2.A. PARTICIPATING PHYSICIAN

Professional services rendered by a PA will be covered when provided under the terms of a valid practice agreement established with a participating physician as defined in state law. A group of physicians practicing other than as sole practitioners may designate one or more physicians in the group to enter into a practice agreement.

During enrollment and enrollment revalidation, the PA must report the NPI of their Medicaid-enrolled participating physician by including the participating physician’s NPI on the checklist and associating to the participating physician in the “Associate to Billing Provider/Other Association” step in CHAMPS. Disenrollment of the participating physician from the program may prompt disenrollment of the PA. To avoid interruption in enrollment, the PA must ensure his/her CHAMPS enrollment information reflects current/accurate participating physician information.



Practitioners who wish to provide services to Medicaid Health Plan (MHP) enrollees are encouraged to contact the individual MHP for additional enrollment, credentialing, and contract requirements.

23.2.B. PRACTICE AGREEMENT

As part of the enrollment process, the PA must attest to having a valid practice agreement with a participating physician that complies with applicable state law requirements. Determination of medical necessity and appropriateness of services is the responsibility of the PA and participating physician based on the terms of the practice agreement. The participating physician does not have to be physically on the premises where the services are provided. The PA shall maintain the practice agreement at his/her primary place of practice and provide the agreement to MDHHS upon request.

23.3 BILLING & REIMBURSEMENT

23.3.A. CLAIMS

Professional claims must include the NPI of the PA in the Rendering Provider field and the participating or supervising physician in the Supervising Provider field as applicable. Refer to the Billing & Reimbursement for Professionals and the Billing & Reimbursement for Institutional Providers Chapters for additional Information.

23.3.B. REIMBURSEMENT

As a Rendering/Service-Only provider, PAs are not eligible to receive direct reimbursement. Payment for PA services will be issued to the participating physician, physician group or billing provider. Professional services are only covered when the PA has personally performed the service and no other provider or entity has been paid for the service. Services provided jointly by the PA and physician are covered for a single practitioner only.

Fee-for-Service reimbursement for PA services is based upon the limits and rates associated to physician professional services and are published on the Practitioner fee schedule located on the MDHHS website. Provider specific information may be located utilizing the Medicaid Code and Rate Reference tool within CHAMPS. Refer to the Billing & Reimbursement Chapter for additional information.

MHPs are responsible for reimbursing contracted providers or subcontractors for their services according to the conditions stated in the subcontract established between the practitioner and the MHP.

Noncontracted providers must comply with all applicable authorization requirements of the MHP and uniform billing requirements.

(Refer to the Surgery - General section of this chapter for information on a PA functioning as an assistant at surgery.)



SECTION 24 – PHYSICAL THERAPIST

Refer to the Therapy Services Chapter for additional therapy information.



SECTION 25 – PODIATRIST

Medicaid covers the medically necessary services of a podiatrist. (Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.)

Podiatrists should refer to the appropriate sections of this chapter for specific information related to the coverage of specific services.

25.1 COPAYMENT

A copayment is required for each separately covered visit for beneficiaries age 21 and older. If more than one separately covered service is rendered on the same day, such as an office visit and laboratory services, only one copayment is required. If a procedure such as a surgery with a global period is rendered, only one copayment is required. Refer to the General Information for Providers Chapter for information about copayments. Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)

25.2 CONSULTATIONS

Medicaid covers limited and intermediate level consultations if requested by a physician.

25.3 NURSING FACILITY SERVICES

Podiatry services provided to a beneficiary in a nursing facility are considered an ancillary service and require the written order of the beneficiary's attending physician. All terms and conditions related to Medicaid covered and non-covered services, including PA and billing requirements, apply to services provided to beneficiaries in a nursing facility.



PRACTITIONER REIMBURSEMENT APPENDIX

SECTION 1 – REIMBURSEMENT METHODOLOGY

1.1 PRACTITIONER FEE SCREENS

Practitioner payment rates are established by MDHHS as a fee screen for each procedure. The Medicare prevailing fees, the Resource Based Relative Value Scale (RBRVS) and other relative value information, other state Medicaid fee screens, and providers' charges may be utilized as guidelines or references in determining the maximum fee screens for individual procedures. The Practitioner fee schedule is updated annually following the CMS January release of the RBRVS. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

Any rate discrepancies will be resolved by using the policy language describing reimbursement methodology for the established fee schedules.

1.2 EMERGENCY DEPARTMENT SERVICES

Physician services provided in the ED are covered as individual services. Critical care services are covered according to the CPT/HCPCS definitions and coding conventions for critical care. If critical care is required for a beneficiary in the ED, then only the critical care codes are covered. ED E/M or visit codes are not covered on the same day as critical care for the same provider.

When a beneficiary is seen in the ED, the appropriate level of ED E/M service is covered unless another E/M service is more appropriate (e.g., observation care, initial inpatient hospital care, or critical care). The ED E/M service which includes the medical screening exam is covered without regard to whether the medical screening results in the medical condition being deemed an emergency or not. The results of the medical screening examination, along with any medically necessary appropriate diagnostic services, determine if further treatment must be provided. If the attending physician determines that an emergency medical condition does exist, all subsequent medically appropriate services to stabilize the patient must be provided and are covered in addition to the ED E/M service. CPT/HCPCS coding conventions and Medicaid guidelines must be followed.

The medical record must support the need for the type and extent of diagnostic services performed based on the presenting symptoms of the beneficiary. The ED physician's review of x-rays and EKGs performed on the beneficiary are covered as a part of the E/M service. Professional component services are covered only for the physician who prepares a complete, written report of the findings for the medical record. If a specialist in the field prepares this, then the ED physician's review of the findings does not meet the conditions for separate coverage of the service.

The ED E/M services provided by the attending physician, regardless of the level of the service, are covered using a two-tiered rate based on whether the beneficiary was released or admitted. If the beneficiary was released from the ED, a single rate is used as the fee screen. If the beneficiary was admitted to the hospital or transferred to another hospital from the ED, a higher single rate is used as the fee screen.



SECTION 2 – ENHANCED PRACTITIONER PAYMENTS

MDHHS makes payment adjustments for practitioner services payable under Medicaid Fee-For-Service (FFS) through entities identified in the Medicaid State Plan, Attachment 4.19-B, page 1a. (The Medicaid State Plan is available on the MDHHS website; refer to the Directory Appendix for website information.)

2.1 QUALIFYING PRACTITIONERS

Adjustments apply to both public and private practitioners and practitioner groups who are either employees of the public entities identified in the state plan, or are under contract with one or more of the public entities, and include the following:

- University medical and dental faculty, employed practitioners, and private practice groups with contractual arrangements with one or more of the above universities and provide services to Medicaid beneficiaries in a variety of settings.
- Hurley Hospital-employed or -contracted physicians, dentists, and other practitioners who provide services to Medicaid beneficiaries in a variety of settings.

Services eligible for the payment adjustments are billed under the federal employer identification number of the public entity or under the federal employer identification number of the practitioner/practitioner group.

Inpatient and outpatient services provided by the following practitioners, when not included in facility payments to the public entity, are included:

- Physicians (MD and DO)
- Ophthalmologists
- Oral-Maxillofacial Surgeons
- Dentists
- Podiatrists
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Nurse Midwives
- Certified Registered Nurse Anesthetists
- Anesthesiologist Assistants
- Optometrists



2.2 PAYMENT ADJUSTMENT AMOUNT

The payment adjustment amount for services provided to Medicaid beneficiaries who do not have other insurance coverage will be the lesser of:

- The difference between the practitioner Medicaid fee-for-service fee screen and the practitioner's customary charge; or,
- Up to 100% of the Average Commercial Rate for the service rendered.

The payment adjustment amount for services provided to Medicaid beneficiaries with other insurance coverage will be the lesser of:

- The difference between the total of the Medicaid, Medicare, and commercial insurance payments and the practitioner's customary charge; or,
- The difference between the total of the Medicaid, Medicare, and commercial insurance payments and up to 100% of the Average Commercial Rate.

2.3 FINANCING THE PAYMENT ADJUSTMENTS

The public entities must certify to MDHHS that they will provide the non-federal share of the payment adjustments established by this policy. These public entities must also certify to MDHHS that the financial arrangements used to offset the non-federal share of these Medicaid payment adjustments do not violate Title XIX of the Social Security Act, §1903 Payment to States, Subsection (W) Prohibition on Use of Voluntary Contributions, and Limitation on Use of Provider-Specific Taxes to Obtain Federal Financial Participation Under Medicaid.

No additional state funds are available beyond the amount needed to pay designated providers up to the standard Medicaid fee screens for these services. The non-federal share of the Medicaid payment adjustments is supplied by the public entity through an intergovernmental transfer (IGT) to MDHHS.

2.4 PAYMENT ADJUSTMENT PROCESS

Upon receipt of the provider information from the public entity, MDHHS will generate a report which will include the federal employer identification numbers and utilization data for the providers affected by this policy for each covered period. The public entity must review the report and acknowledge the completeness and accuracy of the report. After receipt of this confirmation, MDHHS will make the payment adjustment. The payment adjustments will be made for the federal employer identification number used to bill Medicaid under the FFS program. The payment adjustments will be processed quarterly. Each quarterly payment adjustment will include a reconciliation that takes into account all claims submitted to MDHHS and paid after the prior Physician Adjustor payment quarter cut-off date.



SECTION 3 – PRIMARY CARE PRACTITIONER SERVICES INCENTIVE PAYMENT

For dates of service on and after January 1, 2015, MDHHS applies an increased payment rate to enrolled providers for primary care services delivered by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine and, for dates of service on and after January 1, 2018, physicians with the specialty designation of general practice. The increase applies to a set of designated primary care services.

3.1 PROVIDER ELIGIBILITY

Physicians with primary specialty designations of family medicine, general internal medicine, pediatric medicine, and general practice may qualify as primary care practitioners for purposes of increased payment. Eligibility for this payment is limited to being board certified or board eligible in one of the three designated primary care specialties as recognized by the American Board of Medical Specialties, American Osteopathic Association, and the American Board of Physician Specialists. Primary care physicians may also be determined eligible by conducting a thorough review of the physician's practice characteristics as identified through their billing history.

Physician practitioners whose CHAMPS Provider Enrollment profile information reflects that they provide specialty or subspecialty (e.g., cardiology, endocrinology, or oncology, etc.) services are not eligible for the adjusted payment. Providers with multiple subspecialties are also not eligible for the adjusted payment. Exceptions will be made for practitioners who have subspecialty practices in adolescent and geriatric medicine.

Before enhanced payments are made, MDHHS will verify that a practitioner meets the eligibility criteria which are identified as the following:

- **Board Certification:** A primary care physician who has designated their primary specialty in their CHAMPS enrollment file as one of the eligible specialties and has provided applicable Board certification information will be validated by MDHHS prior to any enhanced payment.
- **Board Eligible:** A primary care physician who has designated their primary specialty in their CHAMPS enrollment file as one of the eligible specialties and has provided applicable documentation to support board eligibility status is also eligible for the enhanced payment. MDHHS will recognize physicians as board eligible for the period of time as defined by the applicable medical board following completion of their medical residency training program in one of the defined specialties.
- **Review of Practice Characteristics:** For non-board certified or non-board eligible primary care physicians, MDHHS will review an enrolled practitioner's billing history for the previous calendar year. At least 60 percent of the physician's codes paid by Medicaid must be for the evaluation and management (E/M) codes specified in this policy, including the preventive medicine E/M codes. This review of practice characteristics will be done by MDHHS only for providers who have self-attested by designating in their CHAMPS enrollment file that their primary specialty is one of the eligible specialties.
- **Non-physician Practitioners:** Nurse practitioners (NPs) and physician assistants (PAs) who provide primary care services under the personal supervision of a physician who is one of the designated primary care specialty types may be reimbursed at the enhanced rate. Claims submitted by NPs and PAs must include their own NPI as the rendering provider and the NPI of their supervising/delegating physician. If the NP's or PA's supervising/delegating physician has



not been identified as an eligible provider for the primary care rate, as verified by CHAMPS enrollment, services performed by the NP or PA will not receive the enhanced rate.

Practitioners delivering primary care services at Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Local Health Departments (LHDs) are not eligible for these enhanced payments. Practitioner services in these settings are reimbursed using a payment methodology designed to reimburse those providers at cost and are made on a facility basis, not specific to the physician's services.

Practitioners who participate in the MDHHS Physician Adjustor Program are eligible for the primary care practitioner services incentive payment. For these participating providers, MDHHS calculates the Physician Adjustor Program payment adjustment consistent with the existing methodology.

Physicians with primary specialty designations of family medicine, general internal medicine, pediatric medicine, and general practice who are affiliated with Medicaid Health Plans (MHP) are eligible for the primary care practitioner rate increase as identified by their Primary Care Provider status within the MHP network.

3.2 ELIGIBLE PRIMARY CARE SERVICES

Primary care practitioner services subject to the enhanced primary care rate are defined as Healthcare Common Procedure Coding System (HCPCS) codes:

- 99201 through 99215 for new and established patient office or outpatient evaluation and management (E/M) visits
- 99304 through 99318 for initial, subsequent, discharge and other nursing facility E/M services
- 99324 through 99337 for new and established patient domiciliary, rest home or custodial care E/M services
- 99341 through 99350 for new and established patient home E/M visits
- 99381 through 99397 for new and established patient preventive medicine services

3.3 ENHANCED RATES FOR PRIMARY CARE

For primary care practitioners identified as eligible for the primary care rate, payment will be made on the qualified procedure codes as published in a separate fee schedule as published on the MDHHS website. The Primary Care Fee Schedule reflects rates that have been adjusted in compliance with funding levels established by state law. (Refer to the Directory Appendix for website information.)



PRIVATE DUTY NURSING

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SECTION 1 – GENERAL INFORMATION

This chapter applies to Independent and Agency Private Duty Nurses.

Private duty nursing (PDN) is a Medicaid benefit when provided in accordance with the policies and procedures outlined in this manual. Providers must adhere to all applicable coverage limitations, policies and procedures set forth in this manual.

PDN is covered for beneficiaries under age 21 who meet the medical criteria in this section. If the beneficiary is enrolled in or receiving case management services from the Habilitation Supports Waiver (the Community Mental Health Services Program) and over 21 years of age, that program authorizes the PDN services.

For a Medicaid beneficiary who is not receiving services from the Habilitation Supports Waiver (the Community Mental Health Services Program), the MDHHS Program Review Division (PRD) reviews the request for authorization and authorizes the services if the medical criteria and general eligibility requirements are met.

For beneficiaries 21 and older, PDN is a waiver service that may be covered for qualifying individuals enrolled in the Habilitation Supports Waiver or MI Choice Waiver. When PDN is provided as a waiver service, the waiver agent must be billed for the services.

Beneficiaries who are receiving PDN services through one Medicaid program cannot seek supplemental PDN hours from another Medicaid Program (i.e., Habilitation Supports Waiver, MI Choice Waiver).

1.1 DEFINITION OF PDN

Private Duty Nursing is defined as nursing services for beneficiaries who require more individual and continuous care, in contrast to part-time or intermittent care, than is available under the home health benefit. These services are provided by a registered nurse (RN), or licensed practical nurse (LPN) under the supervision of an RN, and must be ordered by the beneficiary's physician. Beneficiaries requiring PDN must demonstrate a need for continuous skilled nursing services, rather than a need for intermittent skilled nursing, personal care, and/or Home Help services. The terms "continuous" and "skilled nursing" are further defined in the Medical Criteria subsection for beneficiaries under age 21.



1.2 ENROLLMENT REQUIREMENTS

<p>Medicaid Enrolled Nurse (RN/LPN)</p>	<p>To enroll as a Medicaid provider, the nurse must meet the following criteria:</p> <ul style="list-style-type: none"> ▪ Be a Registered Nurse (RN) licensed to practice in Michigan; or a Licensed Practical Nurse (LPN) licensed to practice in Michigan working under the supervision of an RN. Supervision of a Medicaid-enrolled LPN must be by an RN who has at least one year of experience in any of the following areas: community health nursing, pediatric nursing, maternal and child health nursing, or a similar nursing practice. Medicaid requires an on-site (beneficiary's home) supervisory visit by the RN of the LPN at least once every two months. The Medicaid-enrolled LPN must maintain documentation that verifies who the supervising RN is, a copy of the RN's license and documentation that supports that the RN supervisory visits were rendered. Documentation of the supervisory visit as signed by the RN must be included in the medical record. The medical record must be complete enough to allow another professional to reconstruct what transpired during the supervisory visit. ▪ Cooperate with MDHHS in quality monitoring activities, beneficiary complaint resolution, and post-payment audit reviews. Medicaid-enrolled nurses must document complaints made by a beneficiary or the beneficiary's family regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the beneficiary's property, and must document both the existence of the complaint and the resolution of the complaint.
<p>Private Duty Nursing Agency</p>	<p>To enroll as a Medicaid provider, the PDN agency must meet the following criteria:</p> <ul style="list-style-type: none"> ▪ Be accredited by the Community Health Accreditation Program (CHAP) or the Accreditation Commission for Health Care (ACHC) as a PDN agency; or be accredited by The Joint Commission as a Home Health Agency; or be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) as a Home and Community-Based Rehabilitation Program. ▪ If a PDN agency delivers services from more than one location (office), each location (office) must be accredited. <p>PDN agencies are not permitted to avoid the above accreditation requirements by individually enrolling RNs or LPNs in the Medicaid Program.</p> <ul style="list-style-type: none"> ▪ Cooperate with MDHHS in quality monitoring activities, beneficiary complaint resolution, and post-payment audit reviews. Providers must document complaints made by a beneficiary or the beneficiary's family regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for the beneficiary's property, and must document both the existence of the complaint and the resolution of the complaint.

1.3 PROVISION OF PRIVATE DUTY NURSING

PDN must be ordered by a physician and provided by a Medicaid enrolled private duty nursing agency, a Medicaid enrolled registered nurse (RN), or a Medicaid enrolled licensed practical nurse (LPN) who is working under the supervision of an RN (per Michigan Public Health Code). It is the responsibility of the LPN to secure the RN supervision.



Supervision of a Medicaid enrolled LPN must be by an RN who has at least one year of experience in any of the following areas:

- Community health nursing,
- Pediatric nursing,
- Maternal and child health nursing, or
- A similar nursing practice.

MDHHS requires an onsite supervisory visit by the supervising RN at least once every two months. The Medicaid enrolled LPN must maintain documentation that identifies the supervising RN.

If a beneficiary's services are performed exclusively by LPNs, the supervisory RN is responsible for completing a physical assessment for each beneficiary the LPN is caring for, and is required to participate in the development of the beneficiary's plan of care (POC). The above assessments and supervisory visits are not covered by Medicaid, including when provided by a home health agency.

PDN is not covered when rendered in a hospital or nursing facility, including an intermediate care facility for individuals with intellectual disabilities (ICF/IID) or licensed adult foster care facility (AFC).

PDN is not covered when provided by an RN or LPN who is the beneficiary's spouse, legally responsible relative, stepparent, adoptive parent, legal guardian, or foster parent.

When more than one agency is authorized to provide PDN for a beneficiary, the hours rendered by each must be reported to the PRD on a monthly basis in order to permit the adjustment of authorized hours as necessary between the providers. Payment cannot be made until all utilized hours are reported. The primary agency on the case (the first agency involved) is responsible for contacting the other PDN provider(s) caring for the beneficiary to obtain the actual number of hours rendered during the preceding month, and must fax the total hours provided by each to the PRD. The authorization letter will detail all PDN providers that are caring for a beneficiary during the authorization period.

1.4 PRIOR AUTHORIZATION

PDN services must be authorized by the PRD, before services are provided. (Refer to the Directory Appendix for contact information.) PDN services are authorized and billed in 15-minute incremental units (1 unit = 15 minutes). Prior authorization of a particular PDN provider to render services considers the following factors:

- Available third party resources.
- Beneficiary/family choice.
- Beneficiary's medical needs and age.
- The knowledge and appropriate nursing skills needed for the specific case.
- The understanding of the concept and delivery of home care and linkages to relevant services and health care organizations in the area served.

The Private Duty Nursing Prior Authorization – Request for Services form (MSA-0732) must be submitted when requesting PDN for persons with Medicaid coverage before services can begin and at regular



intervals thereafter if continued services are determined to be necessary. A copy of the form is provided in the Forms Appendix and is also available on the MDHHS website. (Refer to the Directory Appendix for website information.) This form is **not** to be used for beneficiaries enrolled in the MI Choice Waiver. Private Duty Nursing is not a benefit under CSHCS. Individuals with CSHCS coverage may be eligible for PDN under Medicaid.

The MSA-0732 must be submitted every time services are requested for the following situations:

- for initial services when the beneficiary has never received PDN services under Medicaid, such as following a hospitalization or when there is an increase in severity of an acute or chronic condition;
- for continuation of services beyond the end date of the current authorization period (renewal);
- for an increase in services; or
- for a decrease in services.

Following receipt and review of the MSA-0732 and the required documentation by the PRD, a notice is sent to the PDN provider and beneficiary or primary caregiver, either approving or denying services, or requesting additional information. The provider must maintain this notice in the beneficiary's medical record. For services that are approved, the Notice of Authorization will contain the prior authorization number and approved authorization dates. It is important to include this PA number on every claim and in all other communications to the PRD.

If a beneficiary receiving PDN continues to require the services after the initial authorization period, a new MSA-0732 must be submitted along with the required documentation supporting the continued need for PDN. This request must be received by the PRD no less than 15 business days prior to the end of the current authorization period. Failure to do so may result in a delay of authorization for continued services which, in turn, may result in delayed or no payment for services rendered without authorization. The length of each subsequent authorization period will be determined by the PRD and will be specific to each beneficiary based on several factors, including the beneficiary's medical needs and family situation.

MDHHS will not reimburse PDN providers for services that have not been prior authorized. All forms and documentation must be completed according to the procedures provided in this chapter. If information is not provided according to policy (which includes signatures and correct information on the MSA-0732, POC and nursing assessment), requests will be returned to the provider. Authorization cannot be granted until all completed documentation is provided to MDHHS. Corrected submissions will be processed as a new request for PDN authorization and no backdating will occur.

If during an authorization period a beneficiary's condition changes warranting an increase or decrease in the number of approved units or a discontinuation of services, the provider must report the change to the PRD. (Refer to the Directory Appendix for contact information.) It is important that the provider report all changes as soon as they occur, as well as properly updating the POC. The request to increase or decrease units must be accompanied by an updated and signed POC; and documentation from the attending physician addressing the medical need if the request is for an increase in PDN units.

Often the request to begin services will be submitted by a PDN agency or individual PDN; however, a person other than the PDN provider (such as the hospital discharge planner, CSHCS case manager, physician, or physician's staff person) may submit the MSA-0732. When this is the case, the person



submitting the request must do so in consultation with the PDN agency or individual PDN who will be assuming responsibility for the care of the beneficiary.

If services are requested for more than one beneficiary in the home, a separate MSA-0732 must be completed for each beneficiary.

When a parent/guardian requests a transfer of care from one PDN provider to another, a completed MSA-0732 must be submitted to the PRD along with signed and dated documentation from the parent/guardian indicating that they are requesting a change in providers. The balance of hours authorized to a previous PDN provider will not be automatically transferred to a new provider. The new PDN provider is responsible for submitting the MSA-0732 to the PRD along with documentation from the parent/guardian requesting a new provider.

The PA number is for private duty nursing only. Any CMHSP prior authorized respite services must be billed to the authorizing CMHSP.

Other services provided in the home by community-based programs may affect the total care needs and the amount of PDN authorized. These other services must be disclosed on the MSA-0732 and documented in the POC. Although the amount of PDN authorized considers the beneficiary's medical needs and family circumstances, community-based services provided in the home are also part of this assessment. Disclosure is necessary to prevent duplication of services to allow for an accurate calculation of authorized PDN hours. Providers are advised that failure to disclose all community resources in the home may be cause for recoupment of funds.

1.4.A. DOCUMENTATION REQUIREMENTS

The following documentation is required for all PA requests for PDN services and must accompany the MSA-0732:

- Most recent signed and dated nursing assessment, including a summary of the beneficiary's current status compared to their status during the previous authorization period, completed by a registered nurse;
- Nursing notes for two (2) four-day periods, including one four-day period that reflects the most current medically stable period and another four-day period that reflects the most recent acute episode of illness related to the PDN qualifying diagnosis/condition;
- Most recent updated POC signed and dated by the ordering/managing physician, RN, and the beneficiary's parent/guardian. The POC must support the skilled nursing services requested, and contain dates inclusive of the requested authorization period.

The POC must include:

- Name of beneficiary and Medicaid ID number
- Diagnosis(es)/presenting symptom(s)/condition(s)
- Name, address, and telephone number of the ordering/managing physician
- Frequency and duration of skilled nursing visits, and the frequency and types of skilled interventions, assessments, and judgments that pertain to and support the PDN services to be provided and billed



- Identification of technology-based medical equipment, assistive devices (and/or appliances), durable medical equipment, and supplies
- Other services being provided in the home by community-based entities that may affect the total care needs must be documented.
- List of medications and pharmaceuticals (prescribed and over-the-counter)
- Statement of family strengths, capabilities, and support systems available for assisting in the provision of the PDN benefit (for renewals, submit changes only)
- If the beneficiary was hospitalized during the last authorization period, include documentation related to the PDN qualifying diagnosis/condition, i.e., all hospital discharge summaries, history and physical examination, social worker notes/assessment, consultation reports (pulmonary; ears, nose and throat [ENT]; ventilator clinic; sleep study; etc.), and emergency department reports (if emergency services were rendered during the last authorization period).
- Teaching records pertaining to the education of parents/caregivers on the child's care.
- Other documentation as requested by MDHHS.

1.4.B. BENEFICIARY ELIGIBILITY

Approval of the MSA-0732 confirms that the service is authorized for the beneficiary. The approval does not guarantee that the beneficiary is eligible for Medicaid. If the beneficiary is not eligible on the date of service, MDHHS will not reimburse the provider for services provided and billed. To assure payment, the provider must verify beneficiary eligibility monthly at a minimum.

1.4.C. RETROACTIVE PRIOR AUTHORIZATION

Services provided before PA is requested will not be covered unless the beneficiary was not Medicaid eligible on the date of service but became eligible retroactively. If the MDHHS eligibility information does not demonstrate retroactive eligibility, then the request for retroactive PA will be denied.

1.5 OTHER INSURANCE

It is the responsibility of the family, private duty nursing agency, RN or LPN to assess, investigate and exhaust all commercial insurance for the beneficiary prior to billing Medicaid. A private duty nursing agency, RN, or LPN should not accept any Medicaid PDN case until it has been determined what, if any, commercial insurance a beneficiary may have.

For any Medicaid case accepted in which the beneficiary has other insurance, the provider must first follow the rules of the other insurance. Such rules may include obtaining a physician's order, obtaining prior authorization, and being a participating provider with the other insurance carrier. Failure to follow the rules of the other insurance may result in nonpayment from Medicaid.

If a beneficiary's commercial insurance does not cover PDN, the PDN agency, RN or LPN must inform the PRD prior to billing MDHHS. (Refer to the Directory Appendix for contact information.) A copy of the letter of explanation or explanation of benefits (EOB) must be kept in the beneficiary's medical record.



Once it has been established that the commercial insurance does not cover PDN, a letter of explanation or EOB is valid as long as the insurance coverage remains unchanged. On an annual basis, the policyholder and provider should confirm with the commercial insurance that PDN coverage has not changed.

(Refer to the Coordination of Benefits Chapter of this manual for additional information.)

1.6 GENERAL ELIGIBILITY REQUIREMENTS

The beneficiary is eligible for PDN coverage when all of the following requirements are met:

- The beneficiary is eligible for Medicaid in the home/community setting (i.e., in the noninstitutional setting).
- The beneficiary is under the age of 21 and meets the medical criteria for PDN.
- PDN is appropriate, considering the beneficiary's health and medical care needs.
- PDN can be provided safely in the home setting.
- The beneficiary, his family (or guardian), the beneficiary's physician, the Medicaid case manager, and RN (i.e., from the PDN agency or the Medicaid enrolled RN, or the supervising RN for the Medicaid enrolled LPN) have collaborated and developed an integrated POC that identifies and addresses the beneficiary's need for PDN. The PDN must be under the direction of the beneficiary's physician; the physician must prescribe/order the services. The POC must be signed and dated by the beneficiary's physician, RN (as described above), and by the beneficiary or beneficiary's parent/guardian. The POC must be updated at least annually or more frequently as needed based on the beneficiary's medical needs.

1.7 BENEFIT LIMITATIONS

The purpose of the PDN benefit is to assist the beneficiary with medical care, enabling the beneficiary to remain in their home. PDN is intended as a transitional benefit to support and teach family members to function as independently as possible. Authorized hours will be modified as the beneficiary's condition and living situation stabilizes or changes. A decrease in hours will occur, for example, after a child has been weaned from a ventilator or after a long term tracheostomy no longer requires frequent suctioning, etc. The benefit is not intended to supplant the caregiving responsibility of parents, guardians, or other responsible parties (e.g., foster parents). There must be a primary caregiver (i.e., parent, guardian, significant other adult) who resides with a beneficiary under the age of 18, and the caregiver must provide a monthly average of a minimum of eight hours of care during a typical 24-hour period. The calculation of the number of units authorized per month includes eight hours or more of care that will be provided by the caregiver during a 24-hour period, which are then averaged across the time authorized for the month. The caregiver has the flexibility to use the monthly-authorized units as needed during the month. Substantial alterations to the scheduled allotment of daily PDN hours due to family choice (i.e., vacations) unrelated to medical need or emergent circumstances require advance notice to the PRD. The remaining balance of authorized hours will not be increased to cover this type of utilization. Authorized time cannot be carried over from one authorization period to another.

The time a beneficiary is under the supervision of another entity or individual (e.g., in school, in day/child care, in work program) cannot be used to meet the eight hours of obligated care as discussed above, nor can the eight hours of care requirement for beneficiaries under age 18 be met by other public funded



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programs (e.g., MDHHS Home Help Program) or other resources for hourly care (e.g., private health insurance, trusts, bequests, private pay).

PDN providers are encouraged to work with families to assist in developing a backup plan for care of their child in the event that a PDN shift is delayed or cancelled, and the parent/guardian is unable to provide care. The parent/guardian is expected to arrange backup caregivers that they will notify, and the parent/guardian remains responsible for contacting these backup caregivers when necessary.

1.8 SERVICE LOG

If PDN is prior approved and care is initiated, a detailed log for each date of service must be maintained. The service log must be beneficiary specific, with the beneficiary's name and birth date in the header portion of the document and must clearly identify the specific time worked by each PDN in the home and for each date of service. In cases where the nurse is caring for two or more beneficiaries in the same home, a separate service log for each beneficiary must be maintained. This log must be kept in the beneficiary's record and may be documented in electronic or paper format. The medical record itself or nursing flow sheets containing other information are not considered a service log for the purposes of this policy. Failure to maintain a log or to submit this information to MDHHS upon request may result in recoupment of PDN reimbursement.

The following service log provides an example of the required fields.

(Beneficiary Name and Birth Date)						
Name	Date of Service	Start Time	Stop Time	Units	Nurse Signature & Date	Parent/Caregiver Signature & Date
(name RN/LPN)	10/06/10	8:00 a.m.	12:00 p.m.	16		
(name RN/LPN)	10/07/10	8:00 a.m.	4:20 p.m.	33		
(name RN/LPN)	10/08/10	7:45 a.m.	1:00 p.m.	21		
(name RN/LPN)	10/9/10	12:00 p.m.	5:45 p.m.	23		

PDN agencies should refer to the Billing & Reimbursement for Institutional Providers chapter for instructions on claim completion and requirements for the processing of claims. Medicaid-enrolled Registered Nurses (RN) or Licensed Practical Nurses (LPN) should refer to the Billing & Reimbursement for Professionals Chapter for instructions on claim completion and requirements for the processing of claims.

Each signature must be accompanied by a date. The date of the nurse's signature must be the same as the date of service. The date of the parent/caregiver signature should be within one week of the date of service. A claim must not be submitted before the service log is completed for those dates of service.

1.9 CLINICAL RECORD

In addition to the Service Log, the provider must maintain clinical records as detailed in the General Information for Providers Chapter of this manual. The clinical record must be sufficiently documented to



allow another professional to reconstruct what transpired during each hour of nursing service and billed to Medicaid in 15-minute incremental units.

1.10 PDN IN CONJUNCTION WITH HOME HELP OR PERSONAL CARE SERVICES

If the beneficiary receiving PDN demonstrates a need for personal care or Home Help services in addition to PDN, there must be coordination between the delivery of personal care or Home Help services and the PDN services, as well as documentation in the POC to verify there is no duplication of services.

1.11 HOLIDAYS

MDHHS allows additional reimbursement for holidays. Currently recognized holidays are: New Year's Day, Easter, Memorial Day, July 4th, Labor Day, Thanksgiving and Christmas Day.

A holiday begins at 12:00 a.m. and ends at 12:00 midnight of that holiday day.

1.12 MILEAGE

Staff mileage to the beneficiary's home is covered as a part of the PDN service and may not be billed separately.

1.13 CARING FOR MORE THAN ONE PATIENT AT A TIME

For ratios of more than two patients per nurse, the provider must contact the entity authorizing the beneficiary's PDN services: Children's Waiver (the Community Mental Health Services Program), Habilitation Supports Waiver (the Community Mental Health Services Program), Home and Community-Based Services Waiver for the Elderly and Disabled (MI Choice Waiver) or the PRD. These ratios are considered exceptional cases and require prior approval.

When two Medicaid beneficiaries less than 21 years of age reside in the same home and require PDN services, one nurse will be authorized to provide care for both individuals. (The PDN rate is adjusted to accommodate this ratio.) In the event of an exceptional and emergent circumstance, a ratio of 1:1 nursing will be authorized for a limited period of time when two PDN beneficiaries reside in the same home. During this time period, PDN services must be reassessed on at least a monthly basis, documented in the POC, and submitted to the PDN authorizing entity to demonstrate the need for continuation of 1:1 nursing services. The POC must document efforts being made to wean the beneficiaries from 1:1 care.

A PDN authorized to provide services to two children at the same location may find that, at times, only one child is present to receive services. This may occur when one child is in school, at a medical appointment, hospitalized, or on a family outing. The beneficiary record must document why only one child was present to receive services, as well as the beginning and ending time of the services. (Refer to the appropriate Billing and Reimbursement chapter for billing instructions.)

1.14 BILLING FOR PRIVATE DUTY NURSING

For billing instructions, nurses should refer to the Billing & Reimbursement for Professionals Chapter of this manual and agencies should refer to the Billing & Reimbursement for Institutional Providers Chapter of this manual.



SECTION 2 – CARE REQUIREMENTS

2.1 PLAN OF CARE

A written plan of care (POC) guides all services provided to the beneficiary by the PDN provider. The POC identifies and addresses the beneficiary's need for PDN. The POC and the process for developing it reflect the beneficiary's and family's basic rights of self-determination and autonomy.

- Family members and the beneficiary (as appropriate to his maturity) participate in developing the POC. They are provided with accurate information and support appropriate to informed decision-making. They must give informed consent for the planned services by signing and dating the POC annually and when updating the POC as needed based on the beneficiary's medical needs.
- Beneficiary/family strengths, including cultural and ethnic identity, are respected and utilized in the delivery of care. Services delivered in the home accommodate beneficiary/family life activities.
- The plan includes goals directed toward increasing beneficiary/family capability, effectiveness, and control.
- The plan includes compensatory services to support the growth and developmental potential of each beneficiary, given his disability or illness.
- Appointments are coordinated and services are scheduled with the goals of minimizing inconvenience to the beneficiary/family, and of facilitating the family's participation in the beneficiary's care.
- If the services are provided by LPNs, the POC must identify the frequency of the supervisory RN visits.

The written POC must be retained in the beneficiary's medical record.

2.2 SUSPECTED ABUSE/NEGLECT

If there is reasonable cause to suspect that a beneficiary may be in danger of abuse, neglect, exploitation, cruelty, or other hazards, the PDN must report the suspected abuse to the Adult or Child Protective Services Unit of the local MDHHS office. (Refer to the General Information for Providers Chapter of this manual for additional information.)

2.3 MEDICAL CRITERIA

To qualify for PDN, the beneficiary must meet the medical criteria of **either** I and III below **or** II and III below:



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<p>Medical Criteria I</p>	<p>The beneficiary is dependent daily on technology-based medical equipment to sustain life. "Dependent daily on technology-based medical equipment" means:</p> <ul style="list-style-type: none"> ▪ Mechanical ventilation four or more hours per day, or assisted respiration does not automatically include ventilation through Bi-level Positive Airway Pressure (Bi-PAP) or Continuous Positive Airway Pressure (CPAP). Use of these devices to satisfy this criteria will be evaluated on a case-by-case basis; or ▪ Oral or tracheostomy suctioning 8 or more times in a 24-hour period; or ▪ Nasogastric tube feedings or medications when removal and insertion of the nasogastric tube is required, associated with complex medical problems or medical fragility; or ▪ Total parenteral nutrition delivered via a central line, associated with complex medical problems or medical fragility; or ▪ Continuous oxygen administration, in combination with a pulse oximeter and a documented need for observations and adjustments in the rate of oxygen administration.
<p>Medical Criteria II</p>	<p>Frequent episodes of medical instability within the past three to six months, requiring skilled nursing assessments, judgments or interventions as described in III below, due to a substantiated progressively debilitating physical disorder.</p> <ul style="list-style-type: none"> ▪ "Frequent" means at least 12 episodes of medical instability related to the progressively debilitating physical disorder within the past six months, or at least six episodes of medical instability related to the progressively debilitating physical disorder within the past three months; ▪ "Medical instability" means emergency medical treatment in a hospital emergency room or inpatient hospitalization related to the underlying progressively debilitating physical disorder; ▪ "Emergency medical treatment" means covered inpatient and outpatient services that are furnished by a provider who is qualified to furnish such services and which are needed to evaluate or stabilize an emergency medical condition. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to place the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. ▪ "Progressively debilitating physical disorder" means an illness, diagnosis, or syndrome that results in increasing loss of function due to a physical disease process, and that has progressed to the point that continuous skilled nursing care (as defined in III below) is required; and ▪ "Substantiated" means documented in the clinical/medical record, including the nursing notes. <p>For beneficiaries described in II, the requirement for frequent episodes of medical instability is applicable only to the initial determination of medical necessity for PDN. Determination of continuing eligibility for PDN for beneficiaries defined in II is based on the original need for skilled nursing assessments, judgments, or interventions as described in III below.</p>



Medical Criteria III	<p>The beneficiary requires continuous skilled nursing care on a daily basis during the time when a licensed nurse is paid to provide services.</p> <ul style="list-style-type: none"> ▪ "Continuous" means at least once every three hours throughout a 24-hour period, and/or when delayed interventions may result in further deterioration of health status, in loss of function or death, in acceleration of the chronic condition, or in a preventable acute episode. ▪ Equipment needs alone do not create the need for skilled nursing services. ▪ "Skilled nursing" means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse. Skilled nursing care includes, but is not limited to, performing assessments to determine the basis for acting or a need for action; monitoring fluid and electrolyte balance; suctioning of the airway; injections; indwelling central venous catheter care; managing mechanical ventilation; oxygen administration and evaluation; and tracheostomy care.
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2.4 DETERMINING INTENSITY OF CARE AND MAXIMUM AMOUNT OF PDN

As part of determining the maximum amount of PDN a beneficiary is eligible for, his Intensity of Care category must be determined. This is a clinical judgment based on the following factors:

- The beneficiary's medical condition;
- The type and frequency of needed nursing assessments, judgments and interventions; and
- The impact of delayed nursing interventions.

Equipment needs alone do not determine intensity of care. Other aspects of care (e.g., administering medications) are important when developing a plan for meeting the overall needs of the beneficiary, but do not determine the number of hours of nursing for which the beneficiary is eligible.

High Category	Medium Category	Low Category
Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time each hour throughout a 24-hour period, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition.	Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours throughout a 24-hour period, or at least 1 time each hour for at least 12 hours per day, when delayed nursing interventions could result in further deterioration of health status, in loss of function or death, or in acceleration of the chronic condition. This category also includes beneficiaries with a higher need for nursing assessments and judgments due to an inability to communicate and direct their own care.	Beneficiaries requiring nursing assessments, judgments and interventions by a licensed nurse (RN/LPN) at least one time every three hours for at least 12 hours per day, as well as those beneficiaries who can participate in and direct their own care.

Medicaid uses the "Decision Guide for Establishing Maximum Amount of Private Duty Nursing to be Authorized on a Daily Basis" (below) to establish the amount of PDN that is approved. The Decision Guide is used to determine the appropriate range of nursing hours (prior authorized and billed in 15-minute increments) that can be authorized under the Medicaid PDN benefit and defines the "benefit



limitation" for individual beneficiaries. The Decision Guide is used by the authorizing entity after it has determined the beneficiary meets both general eligibility requirements and medical criteria as stated above. The amount of PDN (i.e., the time) that can be authorized for a beneficiary is based on several factors, including the beneficiary's care needs which establish medical necessity for PDN, the beneficiary's and family's circumstances, and other resources for daily care (e.g., private health insurance, trusts, bequests, private pay). To illustrate, the number of hours covered by private health insurance is subtracted from the hours approved under Medicaid PDN. These factors are incorporated into the Decision Guide. The higher number in the range is considered the maximum number of hours that can be authorized. Except in emergency circumstances, Medicaid does not approve more than the maximum hours indicated in the guide.

Only those factors that influence the maximum number of hours that can be authorized are included on this decision matrix. Other factors (e.g., additional dependent children, additional children with special needs, and required nighttime interventions) that impact the caregiver's availability to provide care should be identified during an assessment of service needs. These factors have implications for service planning and should be considered when determining the actual number of hours (within the range) to authorize.

Decision Guide for Establishing Maximum Amount of Private Duty Nursing to be Authorized on a Daily Basis

FAMILY SITUATION/ RESOURCE CONSIDERATIONS		INTENSITY OF CARE		
		Average Number of Hours Per Day		
		LOW	MEDIUM	HIGH
Factor I – Availability of Caregivers Living in the Home	2 or more caregivers; both work or are in school F/T or P/T	4-8	6-12	10-16
	2 or more caregivers; 1 works or is in school F/T or P/T	4-6	4-10	10-14
	2 or more caregivers; neither works or is in school at least P/T	1-4	4-8	6-12
	1 caregiver; works or is in school F/T or P/T	4-8	6-12	10-16
	1 caregiver; does not work or is not a student	1-4	6-10	8-14
Factor II – Health Status of Caregiver(s)	Significant health issues	Add 2 hours if Factor I <= 8	Add 2 hours if Factor I <= 12	Add 2 hours if Factor I <= 14
	Some health issues	Add 1 hour if Factor I <= 7	Add 1 hour if Factor I <= 9	Add 1 hour if Factor I <= 13
Factor III – School *	Beneficiary attends school 25 or more hours per week, on average	Maximum of 6 hours per day	Maximum of 8 hours per day	Maximum of 12 hours per day

* Factor III limits the maximum number of hours which can be authorized for a beneficiary:

- Of any age in a center-based school program for more than 25 hours per week; or
- Age six and older for whom there is no medical justification for a homebound school program.

In both cases, the lesser of the maximum "allowable" for Factors I and II, or the maximum specified for Factor III, applies.



When using the Decision Guide, the following definitions apply:

- "Caregiver": legally responsible person (e.g., birth parents, adoptive parents, spouses), paid foster parents, guardian or other adults who are not legally responsible or paid to provide care but who choose to participate in providing care.
- "Full-time (F/T)": working at least 30 hours per week for wages/salary, or attending school at least 30 hours per week.
- "Part-time (P/T)": working at least 15 hours per week for wages/salary, or attending school at least 15 hours per week.
- "Significant" health issues: one or more primary caregiver(s) has a health or emotional condition that prevents the caregiver from providing care to the beneficiary (e.g., beneficiary weighs 70 pounds and has no mobility and the primary caregiver just had back surgery and is in a full-body cast).
- "Some" health issues: one or more primary caregiver(s) has a health or emotional condition, as documented by the caregiver's treating physician, that interferes with, but does not prevent, provision of care (e.g., caregiver has lupus, alcoholism, depression, back pain when lifting, lifting restrictions, etc.).
- "School" attendance: The average number of hours of school attendance per week is used to determine the maximum number of hours that can be authorized for the individual of school age. The average number of hours is determined by adding the number of hours in school plus transportation time. Authorization of PDN hours will not automatically be increased during breaks from school (vacations) or adjusted beyond the limits of factors I and II.

The Local School District (LSD) or Intermediate School District (ISD) is responsible for providing such "health and related services" as necessary for the student to participate in his education program. Unless medically contraindicated, individuals of school age should attend school. Factor III applies when determining the maximum number of hours to be authorized for an individual of school age. The Medicaid PDN benefit cannot be used to replace the LSD's or ISD's responsibility for services (either during transportation to/from school or during participation in the school program) or when the child would typically be in school but for the parent's choice to home-school the child.

2.5 EXCEPTION PROCESS

Because each beneficiary and his family are unique and because special circumstances arise, it is important to maintain an exception process to ensure the beneficiary's safety and quality of care. PDN services that exceed the beneficiary's benefit limitation, as established by the Decision Guide, must be prior authorized by the appropriate Medicaid case management program. Limited authority to exceed the published PDN benefit limitations may be granted on a time-limited basis as detailed below.

The beneficiary or his primary care giver must initiate the request for an exception. The applicable Medicaid case management program's representative is responsible for facilitating the request and documenting the necessity for an exception. Factors underlying the need for additional PDN must be identified in the beneficiary's POC, which must include strategies directed toward resolving the factors necessitating the exception, if applicable. Documentation must substantiate all of the following:



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- Current medical necessity for the exception;
- Current lack of natural supports required for the provision of the needed level of support; and
- Additional PDN services are essential to the successful implementation of the beneficiary’s written POC, and are essential to maintain the beneficiary within the least restrictive, safe, and humane environment suitable to his condition.

Exceptions are time-limited and must reflect the increased identified needs of the beneficiary. Consideration for an exception is limited to situations outside the beneficiary’s or family’s control that place the beneficiary in jeopardy of serious injury or significant deterioration of health status. Exceptions may be considered for either of the following general situations:

<p>A temporary alteration in the beneficiary’s care needs following a hospitalization, resulting in one or both of the following:</p>	<p>The temporary inability of the primary caregiver(s) to provide required care as the result of one of the following:</p> <p>("Inability" is defined as the caregiver is either unable to provide care or is prevented from providing care.)</p>
<ul style="list-style-type: none"> ▪ A temporary increase in the intensity of required assessments, judgments, and interventions. ▪ A temporary need for additional training to enable the primary caregiver(s) to identify and meet the beneficiary’s care needs. <p>The total number of additional PDN hours cannot exceed two hours per day, for a maximum of six months.</p>	<ul style="list-style-type: none"> ▪ An acute illness or injury of the primary caregiver(s). The total number of additional PDN hours cannot exceed two hours per day for the duration of the caregiver’s inability, not to exceed six months. In the event there is only one caregiver living in the home and that caregiver is hospitalized, a maximum of 24 hours per day can be authorized for each day the caregiver is hospitalized. ▪ The death of the primary caregiver(s) or an immediate family member. "Immediate family member" is defined as the caregiver’s spouse, partner, parent, sibling, or child. The maximum number of hours allowable under this exception criterion is 24 hours per day for a maximum of seven days. ▪ The home environment has been determined to be unstable, as evidenced by MDHHS protective or preventive services involvement. <p>The written POC and community-based care coordination activities must include strategies directed toward stabilizing service supports and/or the family situation. The maximum number of hours varies by the beneficiary’s Intensity of Care category: High = maximum of 18 hours per day; Medium = maximum of 14 hours per day; Low = maximum of 10 hours per day. The length of time for this exception is three months or the time needed to stabilize service supports and/or family situation, whichever is less. A one-time extension of up to three months may be made if there is documented progress toward achieving the stabilized home environment.</p>



2.6 CHANGE IN BENEFICIARY'S CONDITION/PDN AS A TRANSITIONAL BENEFIT

Medicaid policy requires that the integrated POC be updated as necessary based on the beneficiary's medical needs. Additionally, when a beneficiary's condition changes, warranting a decrease in the number of approved hours or a discontinuation of services, the provider must report the change to the appropriate authorizing agent (i.e., the PRD, Children's Waiver, or Habilitation Supports Waiver) in writing. Changes such as weaning from a ventilator or tracheostomy decannulation can occur after months or years of services, or a beneficiary's condition may stabilize to the point of requiring fewer PDN hours or the discontinuation of hours altogether. It is important that the provider report all changes resulting in a decrease in the number of hours to the authorizing agent as soon as they occur, as well as properly updating the POC. MDHHS will seek recovery of monies inappropriately paid to the provider if, during case review, the authorizing agent determines that a beneficiary required fewer PDN hours than was provided and MDHHS was not notified of the change in condition.

In some cases, the authorized PDN services may be considered a transitional benefit. In cases such as this, one of the primary reasons for providing services should be to assist the family or caregiver(s) to become independent in the care of the beneficiary. The provider, in collaboration with the family or caregiver(s), may decide that the authorized number of hours should be decreased gradually to accommodate increased independence on the part of the family, caregiver(s), and/or beneficiary. A detailed exit plan with instructions relating to the decrease in hours and possible discontinuation of care should be documented in the POC. The provider must notify the authorizing agent that hours are being decreased and/or when the care will be discontinued.

2.7 HOSPICE SERVICES

If a beneficiary receiving private duty nursing (PDN) becomes eligible for hospice, the hospice is required to notify the PRD before a claim is submitted for the services. (Refer to the Directory Appendix for contact information.)

The hospice must provide the following information on agency letterhead to the PRD.

- beneficiary name and Medicaid ID number;
- a request for a case review and approval of hospice services;
- a statement confirming that the beneficiary has been certified terminally ill with six months or less to live, signed by the hospice medical director and the beneficiary's attending physician; and
- name, e-mail address, and telephone number of the contact person.

PRD staff may request additional medical record documentation for their review. PDN authorization cannot occur unless the hospice submits the requested documentation to the PRD. If services are approved, the hospice must work with the PDN agency to develop a coordinated POC. Both the hospice and PDN staff must ensure that duplication of services does not occur. While hospice maintains the lead in coordinating the services, the PDN agency must continue to obtain prior authorization from MDHHS for the PDN services. Hospice services must be utilized to the fullest extent before PDN services will be authorized.



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This does not apply to beneficiaries receiving PDN services under the Habilitation Supports Waiver (HSW) and over 21 years old, or the MI Choice Waiver. For beneficiaries under the HSW (over 21 years old), providers should contact the beneficiary's case manager to inform them of hospice eligibility. If the beneficiary is under the MI Choice Waiver, providers should contact the MI Choice Waiver Supports Coordinator.



PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

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SECTION 1 – GENERAL INFORMATION

The Program of All-Inclusive Care for the Elderly (PACE) is an innovative model of community-based care that enables elderly individuals, who are certified by their state as needing nursing facility care, to live as independently as possible.

PACE provides an alternative to traditional nursing facility care by offering pre-paid, capitated, comprehensive health care services designed to meet the following objectives:

- Enhance the quality of life and autonomy for frail, older adults;
- Maximize the dignity of, and respect for, older adults;
- Enable frail, older adults to live in the community as long as medically and socially feasible; and
- Preserve and support the older adult's family unit.

The PACE capitated benefit was authorized by the Balanced Budget Act of 1997 and features a comprehensive service delivery system with integrated Medicare and Medicaid financing.

An interdisciplinary team, consisting of professional and paraprofessional staff, assesses beneficiary needs, develops a plan of care, and monitors delivery of all services (including acute care services as well as nursing facility services, when necessary) within an integrated system for a seamless provision of total care. Typically, PACE organizations provide social and medical services in an adult day health center supplemented by in-home and other services as needed.

The financing model combines payments from Medicare and Medicaid, allowing PACE organizations to provide all needed services rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems. PACE organizations assume full financial risk for beneficiary care without limits on amount, duration, or scope of services.

Physicians currently treating Medicaid patients who are in need of nursing facility care may consider PACE as an option. Hospital discharge planners may also identify suitable candidates for referral to PACE as an alternative to a nursing facility. (Refer to the Directory Appendix for PACE contact information.)



SECTION 2 – SERVICES

The PACE organization becomes the sole source of services for Medicare and Medicaid beneficiaries who choose to enroll in a PACE organization.

The PACE organization is able to coordinate the entire array of services to older adults with chronic care needs while allowing elders to maintain independence in the community for as long as possible. The PACE service package must include all Medicare and Medicaid covered services, in addition to other services determined necessary by the interdisciplinary team for the individual beneficiary. Services must include, but are not limited to:

- Adult day care that offers nursing, physical, occupational and recreational therapies, meals, nutritional counseling, social work and personal care
- All primary medical care provided by a PACE physician familiar with the history, needs and preferences of each beneficiary, all specialty medical care, and all mental health care
- Interdisciplinary assessment and treatment planning
- Home health care, personal care, homemaker and chore services
- Restorative therapies
- Diagnostic services, including laboratory, x-rays, and other necessary tests and procedures
- Transportation for medical needs
- All necessary prescription drugs and any authorized over-the-counter medications included in the plan of care
- Social services
- All ancillary health services, such as audiology, dentistry, optometry, podiatry, speech therapy, prosthetics, durable medical equipment, and medical supplies
- Respite care
- Emergency room services, acute inpatient hospital and nursing facility care when necessary
- End-of-Life care



SECTION 3 – ELIGIBILITY AND ENROLLMENT

3.1 ELIGIBILITY REQUIREMENTS

To be eligible for PACE enrollment, applicants must meet the following requirements:

- Be age 55 years or older.
- Meet applicable Medicaid financial eligibility requirements. (Eligibility determinations will be made by the Michigan Department of Health and Human Services (MDHHS).)
- Reside in the PACE organization's service area.
- Be capable of safely residing in the community without jeopardizing health or safety while receiving services offered by the PACE organization.
- Receive a comprehensive assessment of participant needs by an interdisciplinary team.
- A determination of functional/medical eligibility based upon the online version of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD) that was conducted online within fourteen (14) calendar days from the date of enrollment into the PACE organization.
- Be provided timely and accurate information to support Informed Choice for all appropriate Medicaid options for Long Term Care.
- Not concurrently enrolled in the MI Choice program.
- Not concurrently enrolled in an HMO.

3.2 COMPLETION OF THE MEDICAID NURSING FACILITY LOC DETERMINATION

A PACE applicant's eligibility for coverage of nursing facility services and enrollment in the PACE organization is determined by the online application of the Michigan Medicaid Nursing Facility Level of Care Determination (LOCD). The PACE organization will not be reimbursed for nursing facility services rendered when the applicant is determined not to meet the LOCD criteria. Providers must submit the LOCD information into its online version no later than fourteen (14) calendar days following the start of services. Instructions and required forms related to the completion of the Medicaid Nursing Facility Level of Care Determination are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

The LOCD must be completed by a health professional (physician, registered nurse, licensed practical nurse, clinical social worker (BSW or MSW), or physician assistant) representing the proposed provider. Nonclinical staff may perform the evaluation when clinical oversight by a professional is performed. The PACE organization will be held responsible for enrolling only those participants who meet the criteria outlined in this section.



The Michigan Medicaid Nursing Facility Level of Care Determination must be completed using the online version in the following situations:

- all new enrollments of Medicaid-eligible beneficiaries.
- re-enrollment of Medicaid-eligible beneficiaries.
- significant change in condition of a current PACE Medicaid-eligible beneficiary.

The online LOCD must be completed only once for each admission or readmission to the program.

3.3 INFORMED CHOICE

When a beneficiary is determined eligible for nursing facility level of care through completion of the online LOCD, he must be provided timely and accurate information to support informed choice for all appropriate Medicaid options for long-term care.

Process Guidelines available on the MDHHS website define the required process. (Refer to the Directory Appendix for website information.)

3.4 NURSING FACILITY LEVEL OF CARE EXCEPTION PROCESS - EXCEPTION REVIEW

A Nursing Facility (NF) Level of Care (LOC) Exception Process is a review that is available for financially eligible beneficiaries who have demonstrated a significant level of long term care need but do not meet the LOCD. The NF LOC Exception Process is initiated when the PACE organization telephones the MDHHS designee and requests the NF LOC Exception Review on the date that the applicant was determined ineligible based on the online version of the LOCD. The NF LOC Exception criteria and information on how to request an Exception Review is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

3.5 TELEPHONE INTAKE GUIDELINES

The Telephone Intake Guidelines are questions that identify potential PACE participants for further assessment. The Telephone Intake Guidelines do not determine program eligibility. Use of the Telephone Intake Guidelines is at the discretion of the PACE organization. The guidelines are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

3.6 DEEMING PROCESS

MDHHS may deem a participant who no longer meets the State Medicaid nursing facility level of care requirements to continue to be eligible for the PACE program if, in the absence of continued coverage under the program, MDHHS determines the participant reasonably would be expected to meet the nursing facility level of care requirement in the next six months.

To be eligible for deeming, a participant must meet the following requirements:

- Participant must have been receiving PACE services for at least the past six months and no longer than one year.
- Participant no longer meets nursing facility level of care requirements.



- In the absence of continued coverage under PACE, the participant reasonably would be expected to meet the nursing facility level of care requirement in the next six months.

When a deemed PACE participant has been in the program for one year, the PACE organization must conduct an in-person annual reassessment to determine if the participant meets nursing facility level of care.

3.7 ENROLLMENT AND DISENROLLMENT

PACE provider staff must submit PACE enrollment and disenrollment forms electronically within CHAMPS by the end of card cut-off.

3.7.A. ENROLLMENTS

PACE providers must upload and submit the following signed enrollment materials with the electronic enrollment.

- Enrollment Agreement Benefits and Coverages
- Nursing Facility Level of Care Freedom of Choice Form
- If necessary, Durable Power of Attorney (DPOA) or guardianship documents

Once completed and all eligibility requirements have been checked, CHAMPS will assign the participant a PET code and enrollment start date.

3.7.B. DISENROLLMENTS

Voluntary	A signed disenrollment form must be uploaded to CHAMPS.
Involuntary	Once the electronic form has been completed, PACE providers will submit appropriate supporting documentation to their MDHHS contract manager. MDHHS will review and approve or deny the electronic disenrollment in CHAMPS and determine the appropriate date of disenrollment.
Death	Providers will enter the date of death with the electronic disenrollment. A completed disenrollment will end-date the corresponding PET code.

3.8 ANNUAL RECERTIFICATION

MDHHS must annually certify that PACE participants continue to meet PACE financial eligibility requirements. PACE organizations must also ensure that participants continue to meet the LOCD criteria on an ongoing basis. If the participant continues to meet the LOCD criteria, it must be demonstrated in the medical record by way of initial comprehensive assessments, reassessments and progress notes. Additional online LOCDs are not conducted for the purpose of determining ongoing LOCD eligibility.



If the PACE participant no longer meets the LOCD criteria, federal regulations may deem the participant to be eligible for the PACE program until the next annual reevaluation if, in the absence of continued coverage under PACE, the participant reasonably would be expected to again meet the nursing facility level of care criteria within the next six months.

3.9 RETROSPECTIVE REVIEW AND MEDICAID RECOVERY

At random and whenever indicated, MDHHS will perform retrospective reviews to validate the Michigan Medicaid Nursing Facility Level of Care Determination. If the participant is found to be ineligible for PACE services, MDHHS will recover all Medicaid payments made for PACE services rendered during the period of ineligibility. The Retrospective Review process (defined in the Beneficiary Eligibility and Admission Process Section of the Nursing Facility Coverages Chapter) is applicable to PACE organizations.

3.10 ADVERSE ACTION NOTICE

When the provider determines that the beneficiary does not qualify for services based on the Michigan Medicaid Nursing Facility Level of Care Determination, the organization must immediately issue an adverse action notice to the beneficiary or his authorized representative. The action notice must include all of the language of the sample letters for long term care. Copies of the letters are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

As with any benefit denial, the beneficiary may request an administrative hearing. The Michigan Office of Administrative Hearings and Rules (MOAHR) Policies and Procedures Manual explains the process by which each different case is brought to completion. The manual is available for review on the MDHHS website. (Refer to the Directory Appendix for MOAHR contact and website information.)

3.11 NURSING FACILITY LEVEL OF CARE PROCESS - IMMEDIATE REVIEW UPON ISSUANCE OF AN ADVERSE ACTION NOTICE

The MDHHS designee may conduct a Nursing Facility (NF) Level of Care (LOC) Process Immediate Review for a Medicaid pending/eligible beneficiary who was determined functionally/medically ineligible based on the online Michigan Medicaid Nursing Facility Level of Care Determination. The beneficiary, or their representative, must request an Immediate Review before noon of the first working day after the date of receipt of the notice as follows:

- The MDHHS designee will request the PACE organization to provide medical documentation by close of business of the first business day after the date the beneficiary requests an Immediate Review.
- The MDHHS designee will review the medical documentation, obtain information from the beneficiary and/or their representative, and notify the beneficiary and the provider of the determination within three business days of receipt of the medical documentation.

The beneficiary (or representative) may still request an MDHHS appeal of the Michigan Medicaid Nursing Facility Level of Care Determination. (Refer to the Directory Appendix for contact information.)



3.12 FREEDOM OF CHOICE

When an applicant has been determined eligible for nursing facility level of care through completion of the online LOCD, the beneficiary must be informed of his benefit options and elect to receive services in a specific program. This election must take place prior to initiating PACE services.

The applicant (or legal representative) must be informed of the following:

- services available under PACE
- services available in other community settings, such as the MI Choice Program
- services available through Medicaid-reimbursed nursing facilities

If applicants are interested in nursing facility or MI Choice Program care, the PACE organization must provide appropriate referral information using the Access Guidelines to Medicaid Services for Persons with Long Term Care Needs. These guidelines are available on the MDHHS website. (Refer to the Directory Appendix for website information.)

Applicants must acknowledge that they have been informed of their program options in writing by signing the Freedom of Choice form that is witnessed by the applicant's representative when appropriate. A copy of the completed form for non-participants must be retained for a period of three years. The completed form must be kept in the medical record if the applicant chooses to receive PACE services.

A copy of the Freedom of Choice form is included with the Michigan Medicaid Nursing Facility Level of Care Determination on the MDHHS website. (Refer to the Directory Appendix for website information.)

3.13 APPLICANT APPEALS

3.13.A. FINANCIAL ELIGIBILITY

A determination that an applicant is not financially eligible for Medicaid is an adverse action. Applicants may appeal to MDHHS. (Refer to the Directory Appendix for contact information.)

3.13.B. FUNCTIONAL/MEDICAL ELIGIBILITY

A determination that a beneficiary is not functionally/medically eligible for PACE services is an adverse action. If the beneficiary and/or representative disagrees with this determination, they have the right to request an administrative hearing before an administrative law judge. Information regarding the appeal process may be found on the MOAHR website. (Refer to the Directory Appendix for website information.)

3.13.C. PACE SERVICES

Noncoverage or nonpayment of services by the PACE organization for a beneficiary enrolled in PACE is an adverse action. If the beneficiary and/or representative disagrees with the noncoverage or nonpayment of services by the PACE organization, they have the right to request an administrative hearing before an administrative law judge. Information regarding the appeal process may be found on the MOAHR website. (Refer to the Directory Appendix for website information.) The beneficiary may request



continuation of the disputed service with the understanding that he may be liable for the cost of the disputed service if the determination is not made in his favor.

3.14 PROVIDER APPEALS

A Retrospective Review of the Michigan Medicaid Nursing Facility Level of Care Determination that results in a denial is an Adverse Action for PACE when MDHHS proposes to recover payments made for services rendered to the beneficiary for whom the Retrospective Review was conducted. If the PACE organization disagrees with the MDHHS Adverse Action Notice, the PACE organization may appeal if their written request is received by MOAHR within 30 calendar days from the date of the MDHHS Adverse Action Notice.

Information regarding the MDHHS appeal process is available in the General Information for Providers Chapter and on the MDHHS website. (Refer to the Directory Appendix for website information.)



SECTION 4 – PACE ORGANIZATION EVALUATION CRITERIA

4.1 INITIAL APPLICATIONS

A prospective PACE organization can be a not-for-profit or for profit private or public entity that is primarily engaged in providing PACE services and participates in both Medicare and Medicaid. Michigan licensure as a health care entity is not required; however, unlicensed entities may only serve Medicare and Medicaid beneficiaries. Federal regulations (42 CFR Part 460) describe administrative requirements for PACE. At a minimum, prospective entities must meet the federal requirements for PACE organizations, enroll as a Michigan Medicaid provider, and complete a feasibility study. MDHHS will evaluate potential PACE organizations using the following criteria:

- Submission of a feasibility study that:
 - identifies the proposed service area;
 - shows evidence of demand for PACE services in the proposed service area (the potential pool of PACE beneficiaries should be sufficient to have 250 to 300 beneficiaries enrolled within four to five years of start-up);
 - identifies competing PACE organizations, documents the organization’s timeline for development and anticipated costs;
 - identifies the anticipated source of referrals for potential beneficiaries; and
 - assesses the supply of alternative long-term care services already in existence in the community.

If MDHHS receives multiple letters of intent for the same service area, the feasibility studies will be reviewed in the order in which they are received.

- Organizational commitment to principles consistent with the PACE model.
- Evidence of experience in providing primary, acute and/or long-term care services to the target population and evidence of positive community support.
- Evidence that the organization has the depth in leadership and experience required to develop and implement PACE successfully.
- Evidence that the PACE organization will either be cost neutral or save money for long term care services provided by MDHHS in the PACE organization’s service area (i.e., total Medicaid expenditures for services in the service area will not increase and may decrease).
- Assurance of adequate financial capacity to fund program development and start-up costs, including identification of patient capacity and break-even consideration.
- Evidence of the proposed provider network and assurance that the organization will have staff and professionals experienced in providing care to the target population.
- Evidence that the Executive (Program) Director position will be staffed with a full-time employee.
- Evidence that the key positions of Medical Director, Center Manager, Financial Manager, and Quality Improvement Manager are sufficiently staffed, as determined by MDHHS, to meet the needs of the PACE organization.
- Ability to meet federal PACE requirements.



A prospective PACE program must submit to MDHHS:

- Feasibility Study: within 90 calendar days of submitting their letter of intent.
- Provider Application: within one year of MDHHS approval of the feasibility study.

Other evaluation criteria may be considered and will be available to organizations who file a letter of intent with MDHHS to become a PACE organization.

4.2 EXPANSION APPLICATIONS

Expansion applications will not be accepted by MDHHS until the first CMS audit has been completed with good standing and the organization is fiscally sound.

4.3 ALTERNATIVE CARE SETTINGS

To be eligible to request an ACS, the following guidelines must be met:

- The PACE organization must have successfully completed their first trial period audit and be in good standing with CMS, per CMS audits.
- An ACS participant must belong to a PACE organizations center.
- The PACE organization's enrollment limit must have adequate space to accommodate projected ACS attendants.
- MDHHS must tour the proposed ACS location prior to approval.
- The ACS must be less than one (1) hour travel time from PACE Center.

The ACS is subject to MDHHS Readiness Review and will be included in the PACE organization's annual audits. ACSs are also subject to all state and federal regulations.

The following documents must be submitted to MDHHS when an ACS is requested:

- Previous year's annual financial report for the PACE organization;
- The PACE organization's business plan for ACS;
- Financial projection for ACS site (to include cost of ACS site, renovations, staff, equipment, etc.);
- Description of what population of participants will attend the ACS;
- Description of what and how services will be provided at the ACS:
 - ACS services must include, but are not limited to, meals, activities, personal care, laundry, and nursing (triage);
- Description of how services that are not provided at the ACS will be available to participants; and
- Description of plan for participants to attend a PACE Center, at least quarterly or more often, as determined by the PACE organization interdisciplinary team.

MDHHS may request additional information when necessary.



SECTION 5 – BECOMING A PACE ORGANIZATION

Information regarding the process to become a PACE organization is available on the MDHHS website. Any entity seeking to become a PACE organization in Michigan may contact MDHHS regarding state-specific requirements. (Refer to the Directory Appendix for contact and website information.)



RURAL HEALTH CLINICS

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SECTION 1 – GENERAL INFORMATION

1.1 RURAL HEALTH CLINIC CERTIFICATION

This chapter provides policy and reimbursement information specific to Rural Health Clinics (RHCs) and is to be used in combination with other chapters of the Medicaid Provider Manual.

In compliance with the Rural Health Clinic Services Act of 1977 (Public Law 95-210), the Medicaid program reimburses certified and enrolled RHCs for services provided to Medicaid beneficiaries in the State of Michigan. To become certified as a RHC in Michigan, clinics must make application for RHC status through the designated state-certifying agency. (Refer to the Directory Appendix for contact information.) Based on information in the application, the certifying agency determines if an applicant clinic meets the staffing and location requirements for certification. If a clinic appears eligible, an on-site visit is conducted. If a clinic meets all the requirements, the certifying agency makes a recommendation for certification to the Centers for Medicare & Medicaid Services (CMS). CMS makes the final determination as to a clinic's eligibility for RHC status and notifies the Michigan Department of Health and Human Services (MDHHS) when eligibility is granted.

RHCs may be provider-based or independently operated. Provider-based RHCs may be operated by a hospital, skilled nursing facility (SNF) or home health agency (HHA). An independent RHC is permitted to occupy a permanent structure or be located in a mobile unit. RHCs may be publicly or privately held clinics and they may be operated on a profit or not-for-profit basis.

1.2 GENERAL REIMBURSEMENT INFORMATION

Medicaid-enrolled RHCs are reimbursed with a prospective payment system (PPS) in compliance with Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. Section 702 of BIPA created a new section 1902(bb) in the Social Security Act. Specific information related to RHC reimbursement is contained in the Rate Setting Section of this chapter.



SECTION 2 – MEDICAID ENROLLMENT

2.1 PROVIDER ENROLLMENT [CHANGE MADE 7/1/20]

MDHHS requires all RHCs to have a Group (Type 2 - Organization) National Provider Identification (NPI) number in order to receive the enhanced RHC reimbursement. For RHCs with multiple locations and multiple rates, an NPI number for each location may be necessary so that the proper reimbursement rate of all encounters can be determined. If the RHC fails to obtain and/or use the correct NPI number, the RHC reimbursement will be determined under fee for service rules. The NPI number must be reported to MDHHS before billing Medicaid services.

Individual providers (doctors, dentists, optometrists, etc.) are required to obtain a Provider (Type 1 - Individual) NPI number and report the number to MDHHS.

In accordance with 42 CFR 455.104 and the Provider Ownership and Control Disclosures subsection of the General Information for Providers chapter of this Manual, clinics are required to disclose ownership information to MDHHS within 35 days of a change of ownership. Failure to notify MDHHS of any change in identification information may result in the loss of Medicaid enrollment, lapse of provider eligibility, or nonpayment of services. **(text added 7/1/20)**

All inquiries related to provider enrollment should be directed to the MDHHS Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.)

2.1.A. NON-PHYSICIAN BEHAVIORAL HEALTH SERVICE

Licensed psychologists (Master's Limited or Doctoral level), social workers (Master's level), professional counselors (Master's or Doctoral level), and marriage and family therapists who serve Medicaid beneficiaries are required to enroll as Medicaid providers. The NPI of the psychologist, social worker, professional counselor, or marriage and family therapist is reimbursed under the RHC PPS. These services must be billed using the appropriate evaluation and management (E/M) codes listed in the American Medical Association's Current Procedural Terminology (CPT) Book or Healthcare Common Procedure Coding System (HCPCS) codes. Providers should refer to the Non-Physician Behavioral Health provider database on the MDHHS website for the current list of covered procedure codes. The list of allowable services is reviewed annually and updated as applicable. Refer to the Additional Code/Coverage Resource Materials Section of the General Information for Providers Chapter for additional information regarding coverage parameters.

For information relating to service coverage and authorization requirements, refer to the Practitioner and the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapters of this manual.

2.2 NONENROLLED PROVIDERS

Professional services performed by limited licensed psychologists (except as noted in Section 333.18223 of the Public Health Code), social workers, professional counselors, marriage and family therapists, or student interns must be performed under the supervision of an enrolled, fully-licensed provider of the same profession. These services are reimbursed under the RHC PPS. Since MDHHS does not directly



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enroll these providers, claims for their services must be billed using the NPI of the supervising provider responsible for ensuring the medical necessity and appropriateness of the services. Claims submitted with the non-enrolled provider's NPI in the rendering provider field will reject.



SECTION 3 – BENEFITS

RHC services subject to PPS reimbursement are RHC services defined at Section 1861 (aa)(1)(A)-(C) of the Social Security Act.

- Physician (MD, DO), podiatrist, chiropractor, and optometrist professional services, and services and supplies incidental to physician services, including certain drugs and biologicals that cannot be self-administered, immunizations and their administration.
- Licensed physician's assistant and advanced practice registered nurse (NP, CNS, CNM) services, and the services and supplies incidental to these services as would otherwise be furnished by, or incidental to, physician services.
- Clinical psychologist and clinical social worker services, and services and supplies incidental to these services as would otherwise be furnished by, or incidental to, physician services.
- Dental services, and services and supplies incidental to dental services.

Primary care services that are covered and reimbursed under the PPS are defined as the above listed services provided in a place of service that is the RHC's office or clinic, patient's home, skilled NF, domiciliary facility or NF.

3.1 SERVICES AND SUPPLIES INCIDENTAL TO AN RHC VISIT

RHC services and supplies incidental to an RHC visit are included in the PPS reimbursement if the service or supply is:

- Of a type commonly furnished in a physician's office.
- Of a type commonly rendered either without charge or included in the professional bill.
- Furnished as an incidental, although integral part of professional services furnished by a physician (MD, DO), dentist, optometrist, podiatrist, chiropractor, NP or CNS (under the terms of a collaborative agreement with a physician), CNM or licensed physician's assistant (under the terms of a practice agreement).
- Furnished under the direct personal supervision of a physician (MD, DO), dentist, optometrist, podiatrist, chiropractor, NP or CNS (under the terms of a collaborative agreement with a physician), CNM or licensed physician's assistant (under the terms of a practice agreement).
- In the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic.

The direct personal supervision requirement is met in the case of a NP, CNS, CNM, or licensed physician's assistant only if such a person is permitted to supervise such services under the written policies governing the RHC.

3.2 SERVICES EXCLUDED FROM RHC REIMBURSEMENT

Payment for any other Medicaid covered services not defined as a primary care service are Medicaid-covered under fee-for-service (FFS) policies. Services not listed as primary care services are excluded from the RHC prospective payment rate (PPR).



3.3 TELEMEDICINE

An RHC can be either an originating or distant site for telemedicine services. Refer to the Billing & Reimbursement for Institutional Providers Chapter for specific billing instructions. Refer to the Telemedicine Section of the Practitioner Chapter for additional information regarding telemedicine services.

Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

3.4 CHILDREN'S HEALTH INSURANCE PROGRAM SERVICES

Section 503 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 authorizes states to incorporate a PPS rate for reimbursement of services provided to children receiving health care services through RHCs when covered by the Children's Health Insurance Program (CHIP).

Reimbursement for eligible services must comply with the requirements of section 1902 (bb) of the Social Security Act.

For beneficiaries enrolled in state CHIP-funded programs (MICHild, Healthy Kids–Expansion, and Maternity Outpatient Medical Services [MOMS]), providers must bill the program according to their existing processes. For beneficiaries enrolled in a health plan, the MDHHS HCRD will perform an annual reconciliation of these encounters provided by RHCs. (Refer to the Eligibility Groups Subject to PPS Methodology subsection of this chapter for additional information.)

For Healthy Kids–Expansion, MICHild and MOMS beneficiaries, the HCRD will perform an annual reconciliation of these encounters provided by RHCs. The RHC PPS rates established for eligible CHIP services are equivalent to those applicable to Medicaid for each respective year they are in effect.



SECTION 4 – ENCOUNTERS

4.1 DEFINITION

Reimbursement to RHCs under the PPS requires that each office visit that meets the following definition of an encounter be counted for payment purposes.

An encounter is a face-to-face visit between a patient and the provider of health care services who exercises independent judgment in the provision of health care services. For a health service to be defined as an encounter, the provision of the health service must be recorded in the patient's medical record. Encounters may be classified as medical or behavioral health.

An RHC may be credited with one encounter for each different type of visit provided to a beneficiary during a single day, regardless of the number of services provided at the visit. A maximum of two encounters are allowed per beneficiary per day (one medical and one behavioral health). In cases where the beneficiary, after the first visit, suffers illness or injury requiring additional diagnosis or treatment, these visits may be classified as two encounters.

- Example 1: A beneficiary sees a physician at the RHC to treat bronchitis and then sees an optometrist on the same day for an eye exam. These visits count as one encounter (medical).
- Example 2: A beneficiary sees a physician at the RHC, and then later sees a social worker on the same day. These visits may be classified as two encounters (one medical and one behavioral health).
- Example 3: A beneficiary sees a physician for flu symptoms early in the day, and then later the same day sees the same physician for a broken leg. These visits may be counted as two encounters (both medical – subsequent injury).

Encounters include provision of service by the following professionals:

- Licensed physicians (MD, DO), dentists, optometrists, podiatrists, chiropractors, CNPs (who have a collaborative agreement with a physician), CNMs, physician assistants or dental hygienists.
- Clinical psychologists or clinical social workers.

The following examples help to define an encounter:

- To meet the encounter criterion for independent judgment, the provider must be acting independently and not be assisting another provider. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history, or drawing a blood sample is not credited with a separate encounter.
- Such services as drawing blood, collecting urine specimens, performing laboratory tests, taking x-rays, filling/dispensing prescriptions, in and of themselves, do not constitute encounters. However, these procedures may accompany professional services performed by physicians, dentists, or other health providers that do constitute encounters.



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- An RHC may be credited for more than one encounter by the same health professional on the same day. For example, a beneficiary suffers illness or injury requiring additional diagnosis or treatment on the same date of service, or a patient sees a physician for flu symptoms early in the day and then later the same day sees the same physician for a broken leg. These visits are classified as two encounters, and the patient’s medical record must document the circumstances of the two encounters.
- An RHC may be credited for encounters by different health professionals on the same day. For example, if a patient first sees a physician at the RHC and then sees a clinical psychologist, these visits are classified as two encounters.
- An encounter may take place in the RHC or at another approved location.

The encounter criteria are **not** met in the following circumstances:

- Provider participation in a community meeting or group session that is not designed to provide health services.
- When the only service provided is part of a large-scale effort, such as a mass immunization program, screening program, or community-wide service program.
- Nursing services such as taking vital signs, taking a history, drawing a blood sample, collecting urine specimens, performing laboratory tests, taking x-rays, and/or filling or dispensing prescriptions.
- Calling in prescriptions, filling out insurance forms, etc.
- Allergy injection(s).

4.2 ELIGIBILITY GROUPS SUBJECT TO PPS METHODOLOGY

The following list identifies Medicaid eligibility groups that are subject to the PPS methodology:

Medicaid	RHC primary care services constitute encounters covered by Medicaid.
Qualified Medicare Beneficiaries	Medicaid is billed coinsurance and deductibles for Qualified Medicare Beneficiaries (QMBs), and the services covered by Medicare are included as encounters.
Medicaid Health Plan Enrollees	Medicaid-covered services provided by a RHC to Medicaid-eligible beneficiaries enrolled with a Medicaid Health Plan (MHP) are Medicaid encounters if the following conditions are met: <ul style="list-style-type: none">▪ The RHC and MHP must have a signed contract outlining payment provisions in order for the RHC to provide Medicaid-covered services to the MHP enrollee.▪ The contract must provide for the MHP to reimburse the RHC at a fair market rate for similarly situated beneficiaries served by a non-RHC provider. The MHP must implement a level of payment equal to, or above, that of other subcontracting arrangements when entering into a subcontract with a RHC.▪ The RHC must file information with the MDHHS HCRD in a format determined by MDHHS showing encounters and payments of Medicaid beneficiaries enrolled with MHP.▪ RHCs may not bill Medicaid for MHP beneficiaries.



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	<ul style="list-style-type: none">▪ After verification of the fair market rate by the HCRD, the difference between the RHC prospective payment rate and MHP payments are reconciled by MDHHS annually.▪ The contract between RHCs and MHP services is subject to review and verification by MDHHS.
Healthy Kids Dental	Dental services provided to Medicaid beneficiaries enrolled in the Healthy Kids Dental program are eligible for the PPR. RHCs should report Medicaid information on encounters and revenue in the annual reconciliation report. The RHC receives the difference between the PPR and the revenue received as part of the annual reconciliation.
Medicare/Medicaid	Medicaid covered primary care services provided to Medicare/Medicaid dual eligibles are considered Medicaid encounters and are reimbursed under the PPS methodology.

4.3 ELIGIBILITY GROUPS NOT SUBJECT TO PPS METHODOLOGY

If an individual does not have Medicaid eligibility (i.e., is eligible for CSHCS-Title V), the services and costs are not Medicaid RHC services. CSHCS may be paid FFS rates only.



SECTION 5 – RATE SETTING

The RHC is reimbursed on a per visit basis for RHC services. In accordance with section 1902(bb) of the Social Security Act, the PPS per visit payment is equal to 100 percent of the average of the RHC's reasonable costs of providing Medicaid services during fiscal years 1999 and 2000. MDHHS defines reasonable costs as the per-visit amount approved and paid by Medicare. For RHCs that have a fiscal year ending other than September 30, the PPR is prorated based on the number of months in each period covered by a different prospective rate.

The per visit amount is adjusted each year (beginning on October 1, 2001) by 100 percent of the Medicare Economic Index for the prior calendar year (i.e., the adjustment effective October 1, 2001 reflects the index for calendar year 2000).

The per visit amount may also be adjusted to reflect changes in the scope of services provided to Medicaid beneficiaries by the RHC. An adjustment to the per-visit amount based upon a change in the scope of services becomes effective as determined by MDHHS.

Any rate setting/cost settlement related questions should be directed to the MDHHS HCRD. (Refer to the Directory Appendix for contact information.)

5.1 ESTABLISHING RATES FOR NEW CLINICS

An entity that initially qualifies as an RHC after fiscal year 2000 will be paid as follows:

- Upon enrollment, an interim prospective payment rate (PPR) will be established for new RHCs equal to the facility type average rate for the county in which they are located or the statewide average (if no previous average exists for the county subject to any limit applied to the specific facility type). The RHC will be cost settled at the end of its first fiscal year of operation.
- After the facility has been in operation for two full cost reporting periods, the average rate per visit for those two periods will be considered the revised PPR for the facility, subject to the following criteria:
 - The first year will be inflated to the second fiscal year end using the appropriate Medicare Economic Index (MEI) factors.
 - For independent RHCs, the rebased PPR shall not exceed the Medicare limit.
 - For provider-based RHCs (associated with a hospital with fewer than 50 enrolled beds), the PPR shall not exceed the statewide average cost per visit. The limit will increase annually at a minimum of the MEI factor.
 - For provider-based RHCs (associated with a hospital with 50 or more beds), the PPR shall not exceed the Medicare limit.

5.2 ALTERNATE PAYMENT METHODOLOGY

The State and the RHC may agree to an alternative payment methodology that provides reimbursement at least equal to that which an RHC would receive under the PPS.



5.3 QUARTERLY PAYMENTS

RHCs receive a quarterly payment. This payment is an estimate of the difference between the payment the RHC receives from various sources (FFS, MHP, Medicare and other insurance) and the amount the RHC should receive under the PPS. These quarterly payments are included in the annual reconciliation.



SECTION 6 – BILLING

6.1 BILLING RURAL HEALTH CLINIC SERVICES

RHC services must be billed according to instructions contained in the Billing & Reimbursement for Institutional Providers Chapter of this manual. RHCs must refer to that chapter for information needed to submit claims for Medicaid services, as well as information about how MDHHS processes claims and notifies the RHC of its action. If the RHC performs a service that must be billed on the professional claim form, refer to the Billing & Reimbursement for Professionals Chapter of this manual. Policies for specific services are found in the provider-specific chapters of this manual.

It is the responsibility of the RHC to properly bill all Medicaid FFS claims. Incorrect or improper billing may adversely affect reimbursement since the annual reconciliation and final reimbursement is based on approved claims.

The Group (Type 2 - Organization) NPI number must be used as the billing provider on all electronic and paper claims submitted to Medicaid. Do not use Provider (Type 1 - Individual) as the billing provider. The billing provider loop or field is mandatory to complete.

The NPI (Type 1 – Individual) number of the physician (MD or DO) overseeing the beneficiary's care must be entered as the attending provider. The attending provider field is mandatory to complete. Additionally, the NPI (Type 1 – Individual) number of the practitioner who performed the service should be entered as the rendering provider. Do not enter a Group (Type 2) NPI number as the attending or rendering provider.

MDHHS will use the billing provider NPI field (Type 2 - Organization) to determine the number of encounters and calculate the settlement for the year-end reconciliation.

6.2 PLACE OF SERVICE REQUIREMENTS

Place of service codes are not applicable to institutional billing. However, if the RHC performs a service that must be billed on the professional claim form within the clinic, RHCs must use place of service (POS) code 72. For services provided outside the RHC, bill with the appropriate POS code noted in the Billing & Reimbursement for Professionals Chapter of this manual.

RHCs may provide Medicaid covered services in settings other than the RHC office, beneficiary's home, nursing facility or domiciliary facility, but these services are not included in the PPS reimbursement methodology. Services provided outside of the settings noted here are reimbursed at FFS rates.

6.3 BILLING FOR MATERNITY CARE

Global codes for maternity care are used to reimburse a package of services (prenatal visits and delivery) at different places of service (RHC and hospital). In order for the RHC to be reimbursed for prenatal visits under the PPS methodology, the RHC should not bill for global maternity care. The claims for delivery and prenatal care should be billed separately. The claim for delivery should show a hospital place of service and will be paid under the FFS methodology. The claim for prenatal care will be reimbursed under the PPS methodology.

If the RHC elects to bill for global maternity care, all services will be reimbursed under the FFS rules.



6.4 OTHER INSURANCE

Billing instructions related to coordination of benefits are published in the Coordination of Benefits Chapter of this manual. Other insurance and all other payments received for services rendered to a Medicaid beneficiary must be reported. Even if the other insurance payment for a specific service exceeds the amount Medicaid would have paid, the RHC must still bill the procedure code to receive credit for the encounter. (Refer to the Billing & Reimbursement Chapters of this manual for specific billing guidelines.)

6.5 MEDICARE AND MEDICAID CROSSOVER CLAIMS

Refer to the Billing & Reimbursement Chapters of this manual for specific instructions regarding Medicare and Medicaid claims. If the Medicare payment exceeds the Medicaid fee screen, the appropriate FFS procedure code should still be billed to Medicaid for encounter and reconciliation purposes.

6.6 COPAYMENTS

Medicaid copayments for chiropractic, dental, physician, podiatry, and vision services are waived under the RHC benefit as part of the reconciliation. (Services requiring copayments are listed in the General Information for Providers Chapter of this manual.)

6.7 DENTAL CLAIMS

RHCs providing dental services must refer to the Dental and to the Billing & Reimbursement for Dental Providers Chapters of this manual for information regarding program coverages, prior authorization requirements, claims completion and billing instructions.



SECTION 7 – RISK CONTRACTS

RHCs may enter into risk contracts with MHPs for nonprimary care services. However, these contracts are not included in the reconciliation process. All RHC reconciliations are for primary care services only.

7.1 SCOPE OF SERVICE

The prospective payment rate may be adjusted for an increase or decrease in scope of service. Any facility approved for rebasing due to a change in scope of services shall be treated as a new facility. In order to qualify for a scope of service change, the cost related to the specific change must account for an increase or decrease to the existing PPR of five percent or greater. A facility that changes classification to a system utilizing a different rate limit or methodology shall be considered a change of scope (by default). For example, an independent RHC that changes ownership to a provider-based RHC when the hospital has less than 50 beds is considered to have a change of scope.

7.1.A. INCREASE IN SCOPE OF SERVICE

An increase in scope of service results from the addition of a new professional staff member (i.e., contracted or employed) who is licensed to perform medical services that are approved RHC benefits that no current professional staff is licensed to perform.

7.1.B. DECREASE IN SCOPE OF SERVICE

A decrease in scope of service results when no current professional staff member is licensed to perform the medical services currently performed by a departing professional staff member.

7.1.C. CHANGES THAT DO NOT CHANGE THE SCOPE OF SERVICE

An increase or decrease in scope of service does not result from any of the following (although some of these changes may occur in conjunction with a change in scope of service):

- an increase, decrease or change in number of staff working at the clinic.
- an increase, decrease or change in office hours.
- an increase, decrease or change in office space or location.
- the addition of a new site that provides the same set of services.
- an increase, decrease or change in equipment or supplies.
- an increase, decrease or change in the number or type of patients served.



7.2 NOTICE OF INTENT TO CHANGE SCOPE OF SERVICE

If a RHC intends to change its scope of service, the MDHHS HCRD must be notified 90 days before any financial commitments (i.e., money paid or committed to be paid, contracts signed, etc.) have been made. Notification should include the following documentation:

- Complete description of the service to be changed (addition or deletion).
- A listing of procedure codes to be billed as a result of this new service.
- A budget for the fiscal year showing an estimate of the total increase or decrease in cost resulting from change.
- An estimate of the change in number of encounters.
- Estimates of the cost change on the current Medicaid encounter rate.
- The proposed customary charges for this service by the RHC.
- The customary charges for this service by other providers in the area served by this RHC.
- The amount to be paid by an MHP for this service for various programs (Medicare/Medicaid).
- The current Medicare encounter rate.
- Medicare fee screen for this service for non-full cost providers.
- Total encounters for last two years by program (Medicaid, Medicare, uninsured, etc.), and type (MHP, fee screen/contracted amount).
- Estimated change in encounters by program for two fiscal periods following the change in scope of service.
- Copies of notices, certifications, applications, approvals and other documentation from the state-licensing agency, CMS, Medicare intermediary, or other organizations documenting the change in scope of service.
- Other information showing cost, encounters or approvals/denials of the change.
- Other information as requested by the HCRD.

After a review of the information submitted, the HCRD notifies the RHC of its determination regarding a rate change, including the effective date of any change.



SECTION 8 – RECONCILIATION REPORTING

Medicaid Reconciliation Reports must be completed by each RHC in order to receive reimbursement under the PPS.

The RHC must file the following documents at the end of its fiscal year for PPS reimbursement:

- A copy of its filed Medicare Cost Report and Trial Balance
- A completed copy of the Medicaid Reconciliation Report

Encounter data for RHC services provided to beneficiaries through Medicaid Health Plans, *Healthy Kids Dental*, and/or regional Prepaid Inpatient Health Plans (PIHP) is accessible through the Community Health Automated Medicaid Processing System (CHAMPS).

No individual payment information is needed if payments are made on a capitated basis; however, a separate summary of the monthly payments must be provided.

Upon review and audit, MDHHS will reimburse the difference between the RHC PPS rate and the amount received from the Medicaid Health Plans, *Healthy Kids Dental*, and/or the regional Prepaid Inpatient Health Plan (PIHP).

8.1 REPORT FILING

RHCs must file Reconciliation Reports and supplemental documents to the MDHHS HCRD annually. Due dates are consistent with the Medicare Cost Report filing requirement. If the required reconciliation report and supplemental documents are not submitted within the required time limit, the RHC waives its right to the PPS reimbursement for that year.

The reconciliation report is the basis for determining future quarterly payments and the current year's reconciliation. The report must be an original(s) and signed by the authorized individual who normally signs the RHC's federal income tax return or similar reports and should be for the same fiscal period and cover the same sites as the Medicare Cost Report. Improperly completed or incomplete filings are returned to the facility for proper completion and must be resubmitted to MDHHS within 30 days of date of receipt.

8.2 ACCOUNTING AND RECORD KEEPING

RHCs must maintain, for a period of not less than seven years from the end of the fiscal year of the Reconciliation Report, financial and clinical records for the period covered by the reconciliation report that are accurate and in sufficient detail to substantiate the information reported. If there are unresolved issues at the end of this seven-year period, the records must be maintained until these issues are resolved.

The MDHHS HCRD retains each required Reconciliation Report and supplemental documents submitted by the RHC for seven years after issuance of a final decision. In the event there are unresolved issues at the end of this seven-year period, the report is maintained until such issues are resolved.



SECTION 9 – AUDIT, SETTLEMENTS AND APPEALS

An annual reconciliation is performed to assure that the prospective payment rate is paid to the RHC for all eligible encounters. The reconciliation process begins with the receipt of the Reconciliation Report and supplemental documents and ends with the issuance of the Notice of Amount of Program Reimbursement.

9.1 DESK REVIEWS AND FIELD AUDITS

The desk review may include procedures that:

- Verify the completeness and mathematical accuracy of all schedules in the report.
- Compare the Reconciliation Report with MDHHS paid claim and encounter data.
- Identify the need for supporting documentation and arrange to receive same.
- Identify the need for a field audit examination necessary to conclude final reconciliation calculations.
- Compare reported data with industry norms as an aid to the audit scope determination.

Field audits may be conducted to verify information on the Reconciliation Report.

9.2 MEDICARE AUDIT

The Medicare intermediary may perform audits of the RHC. These audit results may be used to verify information or for statistical purposes.

9.3 INITIAL RECONCILIATION AND SETTLEMENT

An initial reconciliation is calculated after the annual reconciliation report is received. The initial reconciliation is processed approximately four months after the reconciliation report is received, with the payment or recovery made at that time. Future quarterly payments are adjusted based on the information in the initial reconciliation.

9.3.A. UNDERPAYMENTS TO AN RHC

Based on the annual reconciliation, MDHHS reimburses any underpayment due an RHC through a gross adjustment. This gross adjustment is shown in a Remittance Advice (RA). MDHHS retains the right to withhold a portion of any initial payment based on individual circumstances.

9.3.B. OVERPAYMENTS TO AN RHC

Once a determination of overpayment has been made, the amount so determined is a debt owed to the State of Michigan and will be recovered by MDHHS. The recovery starts approximately 30 days after notification to the RHC. The gross adjustment stops all payments to the RHC's physician(s) until the full amount is recovered.



9.4 AUDIT ADJUSTMENT REPORT

The Audit Adjustment Report contains a list of all Program data adjustments made to the Medicaid Reconciliation Report by MDHHS audit staff.

9.4.A. AUDIT ADJUSTMENT REPORT

The Audit Adjustment Report must be accepted or rejected by the RHC within 30 calendar days of its mailing date.

If the RHC accepts the findings contained in the Audit Adjustment Report, an appropriate officer of the RHC should sign the report and mail it to MDHHS HCRD. (Refer to the Directory Appendix for contact information.) A Notice of Amount of Program Reimbursement is then mailed to the RHC. No further administrative appeal rights are available for the adjustments contained in the Audit Adjustment Report.

If the RHC has not responded within this time period, MDHHS shall issue a Notice of Amount of Program Reimbursement that is the final determination of an adverse action. No further administrative appeal rights are available.

9.4.B. NOTICE OF AMOUNT OF PROGRAM REIMBURSEMENT

The Notice of Amount of Program Reimbursement is the notice of final determination of an adverse action and is considered the offer of settlement for all reimbursement issues for the reporting period under consideration.

9.4.C. RHC REJECTION OF THE AUDIT ADJUSTMENT REPORT

Within 30 calendar days of the mailing date of the Audit Adjustment Report, the RHC may reject any or all of the findings in the Audit Adjustment Report and request a post-audit conference.

The Post-Audit Conference is an informal process where the MDHHS HCRD staff and the RHC may resolve differences prior to an appeal and/or formal hearing. The process is initiated by the RHC after the receipt of the Audit Adjustment Report. The RHC must request in writing a Post-Audit Conference with the HCRD and indicate in that letter the area(s) of disagreement. The letter must state the appropriate regulation and/or other appropriate decisions that support the RHC's position and be sent to MDHHS HCRD. (Refer to the Directory Appendix for contact information.)

The RHC or its representative must present, either before or at the time of the Post-Audit Conference, the audit staff with the documents and arguments that support its position relative to the disputed issue(s). The audit staff will explain to the RHC the basis for its findings. This step does not stop the recovery of monies due Medicaid.



9.5 APPEALS

RHCs have the right to appeal any adverse action taken by MDHHS, unless that adverse action resulted from an action over which MDHHS had no control (e.g., Medicare termination, license revocation). The appeal must be submitted in writing and mailed to the Michigan Office of Administrative Hearings and Rules (MOAHR). (Refer to the Directory Appendix for contact information.)

The appeal process is outlined in the MDHHS Medicaid Provider Reviews and Hearings administrative rules, Michigan Administrative Code R400.3402 through R400.3425. Any questions regarding the appeal process should be directed to MOAHR.

RHCs may appeal their respective Notice of Program Reimbursement if the contested issue(s) is other than those precluded due to failure to appeal rate adjustment(s) in the Audit Adjustment Report according to established time frames. Appeals accepted as appropriate are also governed by the aforementioned MDHHS Medicaid Provider Reviews and Hearings rules.



SCHOOL BASED SERVICES

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SECTION 1 – GENERAL INFORMATION

This chapter applies to enrolled Intermediate School Districts, Detroit Public Schools Community District, and Michigan School for the Deaf.

This chapter describes the coverage and reimbursement policy for direct medical services, targeted case management, and personal care services. Coverage applies to individuals up to the age of 21 who are eligible under the provisions of the Individuals with Disabilities Education Act (IDEA) of 1990 as amended in 2004 and to those enrolled in programs that require an Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP). The Centers for Medicare & Medicaid Services (CMS) has determined that services provided in the "school" setting include services provided by qualified school staff in the "home" setting when necessary.

These services assist students with a disability to benefit from special education and related services. Medicaid reimbursement, through the Michigan Department of Health and Human Services (MDHHS), addresses the medical service needs of beneficiaries receiving special education and related services and provides funding for those services. The Social Security Act, as amended in 1988 by the Medicare Catastrophic Coverage Act, specifically provides for medical assistance (Medicaid) to cover "related services" which are specified in Federal Medicaid statute as medically necessary and "included in the child's IEP established pursuant to Part B of the IDEA or furnished to a handicapped infant or toddler because such services are included in the child's IFSP adopted pursuant to Part C (formerly called Part H) of such Act."

Section 504 of the Rehabilitation Act of 1973 requires local school districts to provide or pay for certain services to make education accessible to handicapped children. These services are described in an individualized service plan and provided free of charge to eligible individuals. Medicaid reimbursement is not allowed for these services.

Medicaid school based services are not covered for beneficiaries involuntarily residing in a detention setting with a Benefit Plan ID of INCAR-ESO, INCAR-MA, INCAR-MA-E, or MA-HMP-INC.

Coverage is based on medically necessary, Medicaid-covered services already being provided in the school setting and enables these services provided to Medicaid-eligible beneficiaries to be billed to Medicaid. This ensures federal participation in the funding of these Medicaid covered services. Enrollment as a Michigan Medicaid provider for services delivered in the school setting is limited to the Intermediate School Districts (ISDs), Detroit Public Schools Community District, and Michigan School for the Deaf. For the purpose of this document, the ISDs, Detroit Public Schools Community District, and Michigan School for the Deaf will be referred to as "ISDs" for simplicity.

Enrolled providers are required to establish an interagency agreement to facilitate coordination and cooperation with other human service agencies operating within the same service area. Medicaid services provided by the ISDs are to be provided as outlined in the IEP/IFSP treatment plan and are not expected to replace or substitute for services already provided by other agencies. If services are being provided by another program, ISDs are expected to coordinate the services to prevent service overlap and to assure continuity of care to the Medicaid beneficiary. Enrollment as a SBS provider is not expected to result in any change in the education agency's set of existing services or service utilization. MDHHS periodically evaluates the impact of Medicaid enrollment on special education programs through review of service utilization and other program data and information.



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Covered services do not require prior authorization but must be documented and provided by qualified personnel as specified in the Covered Services Section of this chapter.

The following terms have specific meanings in the school setting:

Assistive Technology Device (ATD)	<p>Per IDEA, Section 602, the term "assistive technology device" means any item, piece of equipment or product system, whether acquired commercially off the shelf or modified or customized, that is used to increase, maintain, or improve functional capabilities of a child with a disability.</p>
Assistive Technology Service	<p>The term "assistive technology service" means any service that directly assists a child with a disability in the selection, acquisition or use of an assistive technology device.</p>
Certified Public Expenditure	<p>A certified public expenditure is an expenditure of a governmental unit whose state share is supported by tax dollars, or a mix of tax dollars and appropriated dollars, and is certified as eligible for federal match.</p>
Claims Development Software	<p>The claims development software is a custom-developed software that automates the school district claiming process. The claims development process is comprised of three components: sampling, training, and costs/claim generation.</p>
Direct Medical Services Program	<p>Direct medical services, specialized transportation, targeted case management and personal care services provided in the school setting and reimbursed by Medicaid.</p>
Durable Medical Equipment, Supplies, Prosthetics and Orthotics (DMEPOS)	<ul style="list-style-type: none"> ▪ DME items are those that can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of an illness or injury, and can be used in the beneficiary's home. DME is a covered benefit when: <ul style="list-style-type: none"> ➤ It is medically and functionally necessary to meet the needs of the beneficiary. ➤ It may prevent frequent hospitalization or institutionalization. ➤ It is life sustaining. ▪ Medical Supplies are those items that are required for medical management of the beneficiary, are disposable or have a limited life expectancy, and can be used in the beneficiary's home. Medical supplies are items that: <ul style="list-style-type: none"> ➤ Treat a medical condition. ➤ Prevent unnecessary hospitalization or institutionalization. ➤ Support DME used by the beneficiary. ▪ Prosthetics artificially replace a portion of the body to prevent or correct a physical anomaly or malfunctioning portion of the body. Prosthetics are a benefit to: <ul style="list-style-type: none"> ➤ Improve and/or restore the beneficiary's functional level. ➤ Enable a beneficiary to ambulate or transfer. ▪ Orthotics assist in correcting or strengthening a congenital or acquired physical anomaly or malfunctioning portion of the body. Orthotics are a benefit to: <ul style="list-style-type: none"> ➤ Improve and/or restore the beneficiary's functional level. ➤ Prevent or reduce contractures. ➤ Facilitate healing or prevent further injury.



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Enrolled Medicaid Provider	The 56 Michigan Intermediate School Districts, Detroit Public Schools Community District, and Michigan School for the Deaf that have enrolled and revalidated with the MDHHS CHAMPS Provider Enrollment subsystem.
HT Modifier (Multi-disciplinary team)	The HT modifier is used when billing for an assessment, evaluation or test performed for the IDEA Assessment. Each qualified staff bills using the appropriate procedure code followed by the modifier HT (multi-disciplinary team).
IEP (Individualized Education Program)	A written plan for services for eligible students between the ages of 4 and 26 in Michigan as determined by the federal IDEA statute. Medicaid funds are available to reimburse for health and medical services that are a part of a student's IEP for beneficiaries up to the age of 21.
IFSP (Individualized Family Service Plan)	A written plan for a child with a disability who is between the ages of zero and three years that is developed jointly by the family and appropriate qualified personnel, and is based on multi-disciplinary evaluation and assessment of the child's unique strengths and needs, as well as a family-directed assessment of the priorities, resources and concerns. Medicaid funds are available to reimburse for health and medical services that are a part of a child's IFSP.
IDEA (Individuals with Disabilities Education Act)	The federal statute, IDEA of 1990 as amended in 2004, which requires public schools to determine whether a child has a disability, develop a plan that details the education and support services that the student will receive, provide the services, and evaluate the plan at least annually. There may be federal funding available for some of these responsibilities.
IDEA Assessment	An IDEA assessment is a formal evaluation that includes assessments, evaluations, tests and all related activities performed to determine if an individual is eligible under provisions of the IDEA of 1990, as amended in 2004, and are related to the evaluation and functioning of the individual.
ISD (District)	A corporate body established by statute in the Michigan Revised School Code (PA 451 of 1976) that is regulated by an intermediate school board. Michigan has 56 intermediate school districts.
MDE (Michigan Department of Education)	A department within the State of Michigan.
Random Moment Time Study	A random moment sampling to determine the extent to which Medicaid-reimbursable activities are being performed by capturing what is done during a specific moment in time.
School-Based Services	A program which provides medically necessary Medicaid covered services in the school setting. All Michigan ISDs, Detroit Public Schools Community District, and Michigan School for the Deaf participate in the Direct Medical Services Program.
School Clinical Record	All the written or electronic information that has been created and is necessary to fully disclose and document the services requested for reimbursement.
Special Education Transportation	Transport to and from the student's pick-up and drop-off site where school based services are provided.
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.



TM Modifier (Individualized Education Program [IEP])	The TM modifier is used when billing for the multi-disciplinary team assessment for the development, review and revision of an IEP/IFSP treatment plan. Each qualified staff bills for this assessment using the appropriate procedure code with the modifier TM (Individualized Education Program [IEP]).
Treatment Plan	If an evaluation indicates that Medicaid-covered services are required, the qualified staff must develop and maintain a treatment plan for the student. The student's IEP/IFSP form may suffice as the treatment plan as long as the IEP/IFSP contains the required components described under the Treatment Plan subsection of this section.

1.1 CHILDREN'S SPECIAL HEALTH CARE SERVICES

The Medicaid School Based Services program covers services provided to children who are determined either dually eligible for Children's Special Health Care Services (CSHCS) and Medicaid (Title V/XIX), or those eligible for only Medicaid (Title XIX). SBS providers are not reimbursed for beneficiaries enrolled only in the CSHCS program (Title V only), and must not submit claims for these beneficiaries.

1.2 THIRD PARTY LIABILITY

Federal regulations require that all identifiable financial resources available for payment be billed prior to billing Medicaid. If a Medicaid-eligible child is presently covered by another resource and the school district does not bill the other resource, Medicaid cannot be billed for the services. (Refer to the Coordination of Benefits chapter for additional information.)

1.3 MEDICAL NECESSITY

A Medicaid service provided by an ISD is determined medically necessary when all of the following criteria are met:

- Addresses a medical or mental disability;
- Needed to attain or retain the capability for normal activity, independence or self care;
- Is included in the student's IEP/IFSP treatment plan; and
- Is ordered, in writing, by a physician or other licensed practitioner acting within the scope of his/her practice under State law. Students who require speech, language and hearing services must be referred. The written order/referral must be updated at least annually. A stamped signature is not acceptable.

1.4 UNDER THE DIRECTION OF AND SUPERVISION

Certain specified services may be provided under the direction of or under the supervision of another clinician. For the supervising clinician, "under the direction of" means that the clinician is supervising the individual's care which, at a minimum, includes seeing the individual initially, prescribing the type of care to be provided, reviewing the need for continued services throughout treatment, assuring professional responsibility for services provided, and ensuring that all services are medically necessary. "Under the direction of" requires face-to-face contact by the clinician at least at the beginning of treatment and periodically thereafter.



"Supervision of" limited-licensed mental health professionals consists of the practitioner meeting regularly with another professional, at an interval described within the professional administrative rules, to discuss casework and other professional issues in a structured way. This is often known as clinical or counseling supervision or consultation. The purpose is to assist the practitioner to learn from his or her experience and expertise, as well as to ensure good service to the client or patient.

1.5 COVERED SERVICES

Medicaid covered services billed by ISDs include:

- Evaluations and tests performed for assessments
- Occupational Therapy Services
- Orientation and Mobility Services
- Assistive Technology Device Services
- Physical Therapy Services
- Speech, Language and Hearing Therapy Services
- Psychological, Counseling and Social Work Services
- Developmental Testing Services
- Nursing Services
- Physician and Psychiatrist Services
- Personal Care Services
- Targeted Case Management (TCM) Services
- Specialized Transportation Services

1.6 SERVICE EXPECTATIONS

The IEP/IFSP treatment plan must include the appropriate annual goals and short-term objectives, criteria, evaluation procedures, and schedules for determining whether the objectives are being achieved within an appropriate period of time (at least annually). 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). Interventions expected to be provided by another practitioner (e.g., teacher, registered nurse), family member or caregiver are not reimbursable as occupational, physical, or speech, language and hearing therapy by this program.

To be covered by Medicaid, occupational, physical, and speech, language and hearing therapy must address a beneficiary's medical need that affects his/her ability to learn in the classroom environment. MDHHS does not reimburse for therapies that do not have medically related goals (i.e., handwriting, increasing attention span, identifying colors and numbers, enhancing vocabulary, improving sentence structure, and reading).

Group therapy or treatment must be provided in groups of two to eight. Services provided as part of a regular classroom activity are not reimbursable. When regularly scheduled attention is provided to one beneficiary who is part of the class currently in session, the service is not reimbursable.



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Supplies or equipment utilized in service delivery are included as part of the service and are not reimbursed separately. Art, music and recreation therapies are not covered services.

Medicaid is required to follow the procedure code definition from the Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) manuals. Procedure codes referencing office or outpatient facility include the medical services provided in the school setting. Procedure codes that do not specify a unit of time are to be billed per session. Group therapy is billed per beneficiary.

Certain CPT/HCPCS code descriptions include a specified unit of service time. Service times are based on the time it generally takes to provide the service. If the procedure code specifies "up to 15 minutes of service", the service may be billed in a unit of time from 1-15 minutes. If the procedure code specifies a unit of time "each 15 minutes", the code may be billed when the service time equals the specified unit of time. Any additional time cannot be billed unless the full time specified is reached.

Consultation or consultative services are an integral part or an extension of a direct medical service and are not separately reimbursable.

1.7 TREATMENT PLAN

Requirements	If an evaluation indicates that Medicaid-covered services are required, the qualified staff must develop and maintain a treatment plan for the beneficiary. The beneficiary's IEP/IFSP form may suffice as the treatment plan as long as the IEP/IFSP contains the required components described below. Only qualified staff may initiate, develop or change the beneficiary's treatment plan. The treatment plan must be signed, titled and dated by the qualified staff prior to billing Medicaid for services and must be retained in the beneficiary's school clinical record. (Refer to the Covered Services Section of this chapter for definitions of qualified staff.)
Components	The treatment plan, which is an immediate result of the evaluation, must consist of the following components: <ul style="list-style-type: none"> ▪ Beneficiary's name; ▪ Description of the beneficiary's qualifying diagnosis and medical condition; ▪ Time-related goals that are measurable and significant to the beneficiary's function and/or mobility; ▪ Long-term goals that identify specific functional achievement to serve as indicators that the service is no longer needed; ▪ Anticipated frequency and duration of treatment required to meet the time-related goals; ▪ Plan for reaching the functional goals and outcomes in the IEP/IFSP; ▪ A statement detailing coordination of services with other providers (e.g., medical and educational); and ▪ All services are provided with the expectation that the beneficiary's primary care provider and, if applicable, the beneficiary's case manager are informed on a regular basis.



Review

The treatment plan must be reviewed and updated at least annually as part of the IEP/IFSP multi-disciplinary team assessment process, or more frequently if the beneficiary's condition changes or alternative treatments are recommended.

1.8 EVALUATIONS

Evaluations for medical services are covered when:

- Performed as part of the IDEA Assessment.
- The beneficiary left and is re-entering special education.
- An initial development, review or revision of the student's IEP/IFSP treatment plan will occur.
- A change or decrease in function occurs.

1.8.A. EVALUATIONS PERFORMED FOR DMEPOS MEDICAL SUPPLIERS

If an ISD physical therapist, occupational therapist, speech pathologist or audiologist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.



SECTION 2 – COVERED SERVICES

2.1 INDIVIDUALS WITH DISABILITIES EDUCATION ACT ASSESSMENT AND IEP/IFSP DEVELOPMENT, REVIEW AND REVISION

Definition	The Individuals with Disabilities Education Act (IDEA) Assessment is a formal evaluation that includes assessments, evaluations, tests and all related activities performed to determine if a beneficiary is eligible under provisions of the IDEA of 1990, as amended in 2004, and are related to the evaluation and functioning of the beneficiary. These services are reimbursable only after they result in the implementation of an IEP/IFSP treatment plan. If an IEP/IFSP treatment plan is not implemented within one year of the date of service, then none of the services provided are covered.
Provider Qualifications	<p>Qualified staff can bill for assessments, tests, and evaluations performed for the IDEA Assessment. To be covered by Medicaid, the staff must have the following Michigan current credentials:</p> <ul style="list-style-type: none"> ▪ A licensed occupational therapist (OT) ▪ A certified orientation and mobility specialist (O&M) ▪ A licensed physical therapist (PT) ▪ A fully licensed speech-language pathologist (SLP) ▪ A licensed audiologist ▪ A fully licensed psychologist ▪ A limited-licensed psychologist (under the supervision of a licensed psychologist) ▪ A licensed professional counselor ▪ A limited-licensed counselor (under the supervision of a licensed professional counselor) ▪ A licensed master’s social worker ▪ A limited-licensed master’s social worker (under the supervision of a licensed master’s social worker) ▪ A licensed physician or psychiatrist (MD or DO) ▪ A registered nurse (RN)



Procedure Codes	<p>Qualified staff can bill for three distinct types of assessments/evaluations/tests. All activities, such as meetings and written reports related to the assessment/evaluation/test, are an integral part or extension of the service and are not separately reimbursable. For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)</p> <ul style="list-style-type: none"> ▪ The HT modifier is used with the procedure code when billing for an assessment/evaluation/test performed for the IDEA Assessment. Each qualified staff bills using the appropriate procedure code below followed by the modifier HT (multi-disciplinary team). The date of service is the date of determination of eligibility for special education or early-on services. The determination date must be included in the assessment/evaluation/test. ▪ 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. ▪ The TM modifier is used with the procedure code when billing for the multi-disciplinary team assessment to develop, review and revise an IEP/IFSP treatment plan. Each qualified staff bills using the appropriate procedure code below with the modifier TM (Individualized Education Program [IEP]). The date of service is the date of the multi-disciplinary team assessment. ▪ 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. ▪ No modifier is used when assessments/evaluations/tests are provided not related to the IDEA Assessment or the IEP/IFSP treatment plan development, review and revision. Each qualified staff bills for these activities using the appropriate procedure code below with no modifier. The date of service is the date the assessment/evaluation/test is completed.
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2.2 OCCUPATIONAL THERAPY (INCLUDES ORIENTATION AND MOBILITY SERVICES AND ASSISTIVE TECHNOLOGY DEVICE SERVICES)

2.2.A. OCCUPATIONAL THERAPY SERVICES

Definition	<p>Occupational Therapy:</p> <p>Occupational therapy (OT) must be rehabilitative, active or restorative and designed to correct or compensate for a medical problem interfering with age-appropriate functional performance. Occupational therapy services must require the skills, knowledge, and education of a licensed occupational therapist, licensed occupational therapy assistant, or Orientation and Mobility specialist.</p>
Prescription	<p>Occupational therapy services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable.</p> <p>Services supported by an Individualized Education Program can precede the signed prescription by up to 90 days; however, the active period of the prescription cannot be longer than one year.</p>



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<p>Provider Qualifications</p>	<p>OT services may be reimbursed when provided by:</p> <ul style="list-style-type: none"> ▪ A licensed occupational therapist (OT); or ▪ A licensed occupational therapy assistant (OTA) under the direction of a licensed occupational therapist (OT). <p>NOTE: The OTA's services must follow the evaluation and treatment plan developed by the OT. The OT must supervise and monitor the OTA's performance with continuous assessment of the beneficiary's progress. All documentation must be reviewed and signed by the supervising OT.</p>
<p>Evaluations for Occupational Therapies</p>	<p>Evaluations are formalized testing and reports for the development of the beneficiary's treatment plan. They may be completed by a licensed occupational therapist.</p> <p>An evaluation includes:</p> <ul style="list-style-type: none"> ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function; ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary.
<p>Assessments for Durable Medical Equipment</p>	<p>If an ISD occupational therapist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.</p>



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Services	Occupational therapy services include: <ul style="list-style-type: none">▪ Group therapy provided in a group of two to eight beneficiaries;▪ Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions;▪ Wheelchair management/propulsion training;▪ Independent living skills training;▪ Coordinating and using other therapies, interventions, or services with the ATD;▪ Training or technical assistance for the beneficiary or, if appropriate, the beneficiary's parent/guardian;▪ Training or technical assistance for professionals providing other education or rehabilitation services to the beneficiary receiving ATD services;▪ Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities;▪ Evaluating the needs of the beneficiary, including a functional evaluation of the beneficiary. ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD; or▪ Selecting, providing for the acquisition of the device, designing, fitting, customizing, adapting, applying, retaining, or replacing the ATD, including orthotics.
Procedure Codes	For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)



2.2.B. ORIENTATION AND MOBILITY SERVICES

Definition	Orientation and Mobility Services: Orientation and mobility services are services provided to blind or visually impaired students by qualified personnel to enable those students to attain systematic orientation to and safe movement within their environment in the school, home and community. Services are based on the individual student's needs for assistance in compensatory skill development, visual efficiency, utilization of low vision aids/devices and technology, etc. Spatial and environmental concepts and use of information received by the senses (such as sound, temperature and vibration) to establish, maintain, or regain orientation and line of travel (for example, using sound at a traffic light to cross the street); to use the long cane, as appropriate, to supplement visual travel skills or as a tool for safely negotiating the environment for students with no available travel vision; and to understand and use remaining vision and distance low vision aids/devices, as appropriate.
Prescription	Orientation and mobility services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable. Services supported by an Individualized Education Program can precede the signed prescription by up to 90 days; however, the active period of the prescription cannot be longer than one year.
Provider Qualifications	Orientation and mobility services may be reimbursed when provided by: <ul style="list-style-type: none">▪ A certified orientation and mobility specialist with current certification from the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP); or▪ A licensed occupational therapist.



Evaluations	<p>Evaluations are formalized testing and reports for the development of the beneficiary’s treatment plan. They may be completed by an Orientation and Mobility Specialist (O&M) or a licensed occupational therapist.</p> <p>An evaluation for Orientation and Mobility services includes:</p> <ul style="list-style-type: none">▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis;▪ Medical history as it relates to the current course of therapy;▪ The beneficiary’s current functional status (functional baseline);▪ The standardized and other evaluation tools used to establish the baseline and to document progress;▪ Assessment of the beneficiary’s performance components (status of sensory skills, proficiency of use of travel tools, current age-appropriate independence, complexity or introduction of new environment, caregiver input, assessment in the home/living environment, assessment in the school environment, assessment in the residential/neighborhood environment, assessment in the commercial environment, and assessment in the public transportation environment;▪ Assessment of the beneficiary’s cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary.
Services	<p>Orientation and mobility services include:</p> <ul style="list-style-type: none">▪ Providing assistance in the development of skills and knowledge that enable the child to travel independently to the highest degree possible, based on assessed needs and the IEP;▪ Training the child to travel with proficiency, safety and confidence in familiar and unfamiliar environments;▪ Preparing and using equipment and material, such as tactile maps, models, distance low vision aids/devices, and long canes, for the development of orientation and mobility skills;▪ Evaluation and training performed to correct or alleviate movement deficiencies created by a loss or lack of vision;▪ Communication skills training (teaching Braille is not a covered benefit);▪ Systematic orientation training to allow safe movement within their environments in school, home and community;▪ Spatial and environmental concept training and training in the use of information received by the senses (such as sound, temperature and vibration) to establish, maintain, or regain orientation;▪ Visual training to understand and use the remaining vision for those with low vision;▪ Training necessary to activate visual motor abilities;▪ Training to use distance low vision aids/devices; and▪ Independent living skills training.



Procedure Codes	For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)
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2.2.C. ASSISTIVE TECHNOLOGY DEVICE SERVICES

Definition	<p>Assistive Technology Device Services General Description:</p> <p>Utilizing the description in Section 602(2) of the Individuals with Disabilities Education Act (IDEA), the term 'assistive technology device' means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of a child with a disability. Therapists should restrict their evaluations and services to those within the scope of their practice and consistent with their education and training.</p>
Prescription	Assistive technology device services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable.
Provider Qualifications	<p>Assistive technology device services may be reimbursed when provided by:</p> <ul style="list-style-type: none"> ▪ A licensed occupational therapist (OT); or ▪ A licensed occupational therapy assistant (OTA).
Evaluations for Assistive Technology Devices	<p>Evaluations are formalized testing and reports for the development of the beneficiary's treatment plan. They may be completed by a licensed occupational therapist.</p> <p>An evaluation includes:</p> <ul style="list-style-type: none"> ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function; ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary in the school environment and home.



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<p>Assessments for Durable Medical Equipment</p>	<p>If an ISD occupational therapist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.</p>
<p>Services</p>	<p>ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD. The direct acquisition of medical equipment, such as wheelchairs etc., is not a covered benefit of the SBS program; this service must be billed under the Medical Supplier program coverage. The direct acquisition of medical equipment is covered under the Medical Supplier Medicaid benefit.</p> <p>Assistive Technology Device Services include:</p> <ul style="list-style-type: none"> ▪ Coordinating and using other therapies, interventions, or services with the ATD. ▪ Training or technical assistance for the beneficiary or, if appropriate, the beneficiary’s parent/guardian. ▪ Training or technical assistance for professionals providing other education or rehabilitation services to the beneficiary receiving ATD services. ▪ Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities. ▪ Evaluating the needs of the beneficiary, including a functional evaluation of the beneficiary. ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD. ▪ Selecting, providing for the acquisition of the device, designing, fitting customizing, adapting, applying, retaining or replacing the ATD, including orthotics. ▪ Wheelchair assessment, fitting, training. If the wheelchair assessment is for equipment billed by a Medicaid medical supplier, all prior authorization and coverage policies and procedures in the Medical Supplier Chapter of this manual must be adhered to by school based providers.
<p>Procedure Codes</p>	<p>For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)</p>



2.3 PHYSICAL THERAPY SERVICES (INCLUDES ASSISTIVE TECHNOLOGY DEVICE SERVICES)

2.3.A. PHYSICAL THERAPY SERVICES

Definition	Physical therapy (PT) must be rehabilitative, active or restorative and designed to correct or compensate for a medical problem. Physical therapy services must require the skills, knowledge and education of a PT or PTA to provide therapy. Treatment is performed through the use of therapeutic exercises and rehabilitative procedures.
Prescription	Physical therapy services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable.
Provider Qualifications	PT services may be reimbursed when provided by: <ul style="list-style-type: none">▪ A licensed physical therapist (PT); or▪ A licensed physical therapy assistant (PTA) under the direction of a licensed physical therapist (PT) (i.e., the PT supervises and monitors the PTA's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and signed by the supervising PT.
Evaluations for Physical Therapies	Evaluations are formalized testing and reports to determine a beneficiary's need for services and recommend a course of treatment. They may be completed by a PT. Evaluations include: <ul style="list-style-type: none">▪ The treatment diagnosis and the medical diagnosis, if different than the treatment diagnosis;▪ Current therapy being provided to the beneficiary in this and other settings;▪ Medical history as it relates to the current course of therapy;▪ The beneficiary's current functional status (i.e., functional baseline);▪ The standardized and other evaluation tools used to establish the baseline and to document progress;▪ Assessment of the beneficiary's performance components (e.g., strength, dexterity, range of motion) directly affecting the beneficiary's ability to function;▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary.



<p>Assessments for Durable Medical Equipment</p>	<p>If an ISD physical therapist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.</p>
<p>Services</p>	<p>Physical therapy services include:</p> <ul style="list-style-type: none"> ▪ Group therapy provided in a group of two to eight beneficiaries; ▪ Gait training; ▪ Training in functional mobility skills (e.g., ambulation, transfers, and wheelchair mobility); ▪ Stretching for improved flexibility; and ▪ Modalities to allow gains of function, strength or mobility.
<p>Procedure Codes</p>	<p>For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)</p>

2.3.B. ASSISTIVE TECHNOLOGY DEVICE SERVICES

<p>Definition</p>	<p>Assistive Technology Device Services General Description:</p> <p>Utilizing the description in Section 602(2) of the Individuals with Disabilities Education Act (IDEA), the term 'assistive technology device' means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of a child with a disability. Therapists should restrict their evaluations and services to those within the scope of their practice and consistent with their education and training.</p>
<p>Prescription</p>	<p>Assistive technology device services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable.</p>
<p>Provider Qualifications</p>	<p>Assistive technology device services may be reimbursed when provided by:</p> <ul style="list-style-type: none"> ▪ a licensed physical therapist (PT); or ▪ a licensed physical therapy assistant (PTA).



Evaluations for Assistive Technology Devices	<p>Evaluations are formalized testing and reports for the development of the beneficiary's treatment plan. They may be completed by a PT.</p> <p>An evaluation includes:</p> <ul style="list-style-type: none">▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis;▪ Current therapy being provided to the beneficiary in this and other settings;▪ Medical history as it relates to the current course of therapy;▪ The beneficiary's current functional status (functional baseline);▪ The standardized and other evaluation tools used to establish the baseline and to document progress;▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function;▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary in the school environment and home.
Assessments for Durable Medical Equipment	<p>If an ISD physical therapist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.</p>



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<p>Services</p>	<p>ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD. The direct acquisition of medical equipment, such as wheelchairs, etc., is not a covered benefit of the SBS program; this service must be billed under the Medical Supplier program coverage. The direct acquisition of medical equipment is covered under the Medical Supplier Medicaid benefit.</p> <p>Assistive Technology Device Services include:</p> <ul style="list-style-type: none"> ▪ Coordinating and using other therapies, interventions, or services with the ATD. ▪ Training or technical assistance for the beneficiary or, if appropriate, the beneficiary’s parent/guardian. ▪ Training or technical assistance for professionals providing other education or rehabilitation services to the beneficiary receiving ATD services. ▪ Evaluating the needs of the beneficiary, including a functional evaluation of the beneficiary. ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD. ▪ Selecting, providing for the acquisition of the device, designing, fitting customizing, adapting, applying, retaining or replacing the ATD, including orthotics. ▪ Wheelchair assessment, fitting, training. If the wheelchair assessment is for equipment billed by a Medical Supplier, all prior authorization and coverage policies and procedures in the Medical Supplier Chapter of this manual must be adhered to by school based providers.
<p>Procedure Codes</p>	<p>For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)</p>

2.4 SPEECH, LANGUAGE AND HEARING THERAPY (INCLUDES ASSISTIVE TECHNOLOGY DEVICE SERVICES)

2.4.A. SPEECH, LANGUAGE AND HEARING THERAPY

<p>Definition</p>	<p>Speech, language and hearing therapy must be a diagnostic or corrective service to teach compensatory skills for deficits that directly result from a medical condition. This service is provided to beneficiaries with a diagnosed speech, language or hearing disorder adversely affecting the functioning of the beneficiary. 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.</p>
<p>Prescription</p>	<p>Speech, language and hearing services require an annual referral from a physician. A stamped physician signature is not acceptable.</p> <p>Services supported by an Individualized Education Program can precede the signed referral by up to 90 days; however, the active period of the referral cannot be longer than one year.</p>



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<p>Provider Qualifications</p>	<p>Speech, language and hearing services may be reimbursed when provided by:</p> <ul style="list-style-type: none"> ▪ A fully licensed speech-language pathologist (SLP); ▪ A licensed audiologist in Michigan; ▪ A speech-language pathologist (SLP) and/or audiology candidate (i.e., in his clinical fellowship year or having completed all requirements but has not obtained a license), under the direction of a qualified SLP or audiologist. All documentation must be reviewed and signed by the appropriately licensed SLP or licensed audiologist; or ▪ A limited licensed speech language pathologist, under the direction of a fully licensed SLP or audiologist. All documentation must be reviewed and signed by the appropriately licensed supervising SLP or licensed audiologist.
<p>Evaluations for Speech Pathology Services</p>	<p>Evaluations are formalized testing and reports conducted to determine the need for services and recommendation for a course of treatment. They may be completed by a licensed SLP or audiologist.</p> <p>Evaluations include:</p> <ul style="list-style-type: none"> ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary’s current communication status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; and ▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary. <p>Evaluations may also include, but are not limited to,:</p> <ul style="list-style-type: none"> ▪ Articulation - standardized tests that measure receptive and expressive language, mental age, oral motor skills, articulation skills, current diet level (including difficulties with any food consistencies), current means of communication, and a medical diagnosis. ▪ Language - standardized tests that measure receptive and expressive language, mental age, oral motor skills, current and previous means of communication, and medical diagnosis(es). ▪ Rhythm - standardized tests that measure receptive and expressive language, mental age, oral motor skills, and measurable assessment of dysfluency, current means of communication, and a medical diagnosis. ▪ Swallowing - copy of the video fluoroscopy or documentation that objectively addresses the laryngeal and pharyngeal stages, oral motor assessment that measures consistencies that have been attempted and the results, voice quality (i.e., pre- and post-feeding and natural voice), articulation assessment, and a standardized cognitive assessment. ▪ Voice - copy of the physician’s medical assessment of the beneficiary’s voice mechanism and the medical diagnosis.



<p>Speech Assessments for Durable Medical Equipment</p>	<p>If an ISD speech pathologist or audiologist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.</p>
<p>Services</p>	<p>Speech, language and hearing services include:</p> <ul style="list-style-type: none"> ▪ Group therapy provided in a group of two to eight beneficiaries ▪ Articulation, language, and rhythm ▪ Swallowing dysfunction and/or oral function for feeding ▪ Voice therapy ▪ Speech, language or hearing therapy ▪ Speech reading/aural rehabilitation ▪ Esophageal speech training therapy ▪ Speech defect corrective therapy ▪ Fitting and testing of hearing aids or other communication devices
<p>Procedure Codes</p>	<p>For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)</p>

2.4.B. ASSISTIVE TECHNOLOGY DEVICE SERVICES

<p>Definition</p>	<p>Assistive Technology Device Services General Description:</p> <p>Utilizing the description in Section 602(2) of the Individuals with Disabilities Education Act (IDEA), the term 'assistive technology device' means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of a child with a disability. Therapists should restrict their evaluations and services to those within the scope of their practice and consistent with their education and training.</p>
<p>Prescription</p>	<p>Assistive technology device services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable.</p>
<p>Provider Qualifications</p>	<p>Assistive Technology services may be reimbursed when provided by:</p> <ul style="list-style-type: none"> ▪ A licensed audiologist; ▪ A fully licensed speech-language pathologist (SLP)



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<p>Evaluations for Assistive Technology Devices</p>	<p>Evaluations are formalized testing and reports for the development of the beneficiary’s treatment plan. They may be completed by an audiologist or SLP.</p> <p>An evaluation includes:</p> <ul style="list-style-type: none"> ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary’s current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary’s performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary’s ability to function; ▪ Assessment of the beneficiary’s cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary in the school environment and home.
<p>Assessments for Durable Medical Equipment</p>	<p>If an ISD audiologist or speech-language pathologist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.</p>
<p>Services</p>	<p>ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD. The direct acquisition of medical equipment, such as wheelchairs, etc., is not a covered benefit of the SBS program; this service must be billed under the Medical Supplier program coverage. The direct acquisition of medical equipment is covered under the Medicaid Medical Supplier benefit.</p> <p>Assistive Technology Device Services include:</p> <ul style="list-style-type: none"> ▪ Coordinating and using other therapies, interventions, or services with the ATD. ▪ Training or technical assistance for the beneficiary or, if appropriate, the beneficiary’s parent/guardian. ▪ Training or technical assistance for professionals providing other education or rehabilitation services to the beneficiary receiving ATD services. ▪ Evaluating the needs of the beneficiary, including a functional evaluation of the beneficiary. ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD.



	<ul style="list-style-type: none"> Selecting, providing for the acquisition of the device, designing, fitting customizing, adapting, applying, retaining or replacing the ATD.
Procedure Codes	For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.4.C. TELEPRACTICE FOR SPEECH, LANGUAGE AND HEARING SERVICES

Definition	Telepractice is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of speech, language and hearing services. Telepractice must be obtained through real-time interaction between the patient's physical location (patient site) and the provider's physical location (provider site). Services are provided to patients through hardwire or internet connection. It is the expectation that providers, facilitators and staff involved in telepractice are trained in the use of equipment and software prior to servicing patients. Speech, language and hearing services administered by telepractice are subject to the same provisions as services provided to a patient in person.
Prescription	Speech, language and hearing services require an annual referral from a physician. A stamped physician signature is not acceptable.
Provider Qualifications	Speech, language and hearing services may be reimbursed when provided by: <ul style="list-style-type: none"> A fully licensed speech-language pathologist (SLP); A licensed audiologist in Michigan; A speech-language pathologist (SLP) and/or audiology candidate (i.e., in his clinical fellowship year or having completed all requirements but has not obtained a license) under the direction of a qualified SLP or audiologist. All documentation must be reviewed and signed by the appropriately licensed SLP or licensed audiologist; or A limited licensed speech language pathologist under the direction of a fully licensed SLP or audiologist. All documentation must be reviewed and signed by the appropriately licensed supervising SLP or licensed audiologist.
Conditions	Providers must ensure the privacy of the beneficiary and the security of any information shared via telemedicine. The technology used must meet the needs for audio and visual compliance in accordance with current regulations and industry standards. Refer to the General Information for Providers Chapter for complete Health Insurance Portability and Accountability Act (HIPAA) compliance requirements. The patient site may be located within the school, at the patient's home, or any other established site deemed appropriate by the provider. It must be a room free from distractions so as not to interfere with the telepractice session. A facilitator must be trained in the use of the telepractice technology and physically present at the patient site during the entire telepractice session to assist the patient at the direction of the SLP or audiologist.
Billing Instructions	Telepractice services are billed using the same procedure codes as services rendered to a patient who is physically present. In addition to the procedure code, billers use the "GT" modifier to identify services provided by telepractice.



2.5 PSYCHOLOGICAL, COUNSELING AND SOCIAL WORK SERVICES

<p>Definitions</p>	<p>Psychological, counseling and social work services include planning, managing and providing a program of face-to-face services for beneficiaries with diagnosed psychological conditions. Psychological, counseling and social work services must require the skills, knowledge and education of a psychologist, counselor or licensed social worker to provide treatment.</p> <p>Psychotherapy is the treatment of a mental disorder or behavioral disturbance for which the clinician provides services through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverses or changes maladaptive patterns of behavior, and encourages personality growth and development. The codes for reporting psychotherapy are divided into two broad categories: Interactive Psychotherapy, and Insight-Oriented, Behavior-Modifying and/or Supportive Psychotherapy.</p> <ul style="list-style-type: none"> ▪ Interactive psychotherapy refers to the use of physical aids and nonverbal communication to overcome barriers to therapeutic interaction between the clinician and a beneficiary who has not yet developed, or has lost, either the expressive language communication skills to explain their symptoms and response to treatment, or the receptive communication skills to understand the clinician if they would use ordinary adult language for communication. ▪ Insight-oriented, behavior-modifying and/or supportive psychotherapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, and the use of cognitive discussion of reality or any combination of the above to provide therapeutic change.
<p>Provider Qualifications</p>	<p>Psychological, counseling and social work services may be reimbursed when provided by:</p> <ul style="list-style-type: none"> ▪ A licensed physician or psychiatrist in Michigan; ▪ A fully licensed psychologist in Michigan; ▪ A limited-licensed psychologist under the supervision of a licensed psychologist; ▪ A temporary limited-licensed psychologist under the supervision of a licensed psychologist; ▪ A licensed master’s social worker in Michigan; ▪ A limited licensed master’s social worker under the supervision of a licensed master’s social worker; ▪ A licensed professional counselor in Michigan; or ▪ A limited licensed counselor under the supervision of a licensed professional counselor.
<p>Evaluations</p>	<p>Evaluations or assessments include tests, interviews and behavioral evaluations that appraise cognitive, emotional, social functioning and self-concept. These may also include interpretations of information about a beneficiary’s behavior and conditions relating to functioning. A qualified psychologist, counselor or licensed social worker must complete them.</p>



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<p>Psychological Testing</p>	<p>Psychological testing includes tests, interviews, evaluations and recommendations for treatment. This may also include interpretations of information about a beneficiary's behavior and conditions relating to functioning. A fully licensed psychologist or a limited-licensed psychologist may perform psychological testing. Medicaid covers psychological testing that is reasonable and necessary for diagnosing the beneficiary's condition. Medicaid does not cover the time that a beneficiary spends alone in testing. The beneficiary's clinical record must be signed and dated by the staff that administered the tests, and include the actual tests administered and completed reports. The protocols for testing must be available for review. Psychological testing may be billed per hour with a five-hour maximum per year, and a report must be generated from the results of the tests. In accordance with CPT guidelines, the service includes testing time only; it does not include writing a report. Writing the report is considered a part of the testing process and is a requirement for billing.</p> <p>The psychological testing report must include all of the following:</p> <ul style="list-style-type: none"> ▪ Beneficiary name and birth date; ▪ Psychological tests administered; ▪ Summary of testing results; ▪ Treatment recommendations; and ▪ Psychologist name and dated signature.
<p>Procedure Codes</p>	<p>For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)</p>
<p>Crisis Intervention</p>	<p>Crisis intervention services are unscheduled activities performed for the purpose of resolving an immediate crisis situation. Activities include crisis response, assessment, referral and direct therapy. Since these services are unscheduled activities, they are not listed in the beneficiary's IEP/IFSP treatment plan.</p> <p>Crisis intervention must be billed using the following procedure code:</p> <ul style="list-style-type: none"> ▪ S9484 – Crisis intervention mental health services, per hour.

2.5.A. TELEMEDICINE FOR BEHAVIORAL HEALTH SERVICES [SUBSECTION ADDED 10/1/20]

<p>Definition</p>	<p>Telepractice is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of behavioral health services. Telepractice must be obtained through real-time interaction between the patient's physical location (patient site) and the provider's physical location (provider site). Services are provided to patients through hardwire or internet connection. It is the expectation that providers, facilitators and staff involved in telepractice are trained in the use of equipment and software prior to servicing patients. Behavioral health services administered by telepractice are subject to the same provisions as services provided to a patient in person.</p>
<p>Provider Qualifications</p>	<p>Behavioral health services may be provided by:</p> <ul style="list-style-type: none"> ▪ a licensed physician or psychiatrist; ▪ a licensed psychologist;



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	<ul style="list-style-type: none">▪ a limited licensed master's level psychologist under the supervision of a licensed psychologist;▪ an MDE-credentialed master's level school psychologist;▪ a licensed master's level marriage and family therapist;▪ a board-certified behavior analyst (BCBA)▪ a board-certified assistant behavior analyst (BCaBA) under the supervision of a BCBA▪ a licensed master's level professional counselor;▪ a limited licensed master's level professional counselor under the supervision of a licensed master's level professional counselor;▪ a licensed master's level social worker;▪ a licensed master's level school social worker;▪ a limited licensed master's level social worker under the supervision of a licensed master's level social worker; and▪ a temporary limited licensed psychologist under the supervision of a fully licensed psychologist.
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Conditions	<p>Telepractice specifically applies to the SBS and Caring for Students (C4S) programs and has the following requirements:</p> <ul style="list-style-type: none">▪ Providers of telepractice services must be currently licensed in the state of Michigan as behavioral health providers and must act within their scope of practice when providing services. Telepractice services must be provided by a fully licensed or credentialed behavioral health professional, or by a practitioner who holds a limited license and is under the direction of an enrolled, fully licensed provider of the same profession.▪ Transmissions, including beneficiary e-mail and prescriptions, must be password protected, encrypted electronic prescriptions, or secured via other reliable authentication techniques. All student-provider e-mail, as well as other beneficiary related electronic communications, should be stored and filed in the beneficiary's record consistent with traditional recordkeeping policies and procedures. Refer to the General Information for Providers chapter for complete HIPAA compliance requirements.▪ A contingency plan, including referral to an acute care facility or emergency room (ER) for treatment as necessary for the safety of the beneficiary, is required when using telepractice technologies. This plan must include a formal protocol appropriate to the services being rendered.▪ It is the expectation that providers, facilitators and staff involved in telepractice are trained in the use of equipment and software prior to servicing beneficiaries. Behavioral health services administered by telepractice are subject to the same provisions as services provided to a beneficiary in person, including all facets of services outlined in applicable CPT/HCPCS codes. A facilitator must be physically present at the originating site during the entire telepractice session to assist the beneficiary at the direction of the behavioral health professional.▪ Allowable telepractice originating sites include the school, the beneficiary's home, or any other established site deemed appropriate by the provider. It must be a room free from distractions so as not to interfere with the telepractice session. (Refer to the Psychological, Counseling and Social Work Services subsection for complete coverage information.)
Billing Instructions	<p>Telepractice services must be submitted using the same procedure codes as services rendered to a beneficiary who is physically present. In addition to the procedure code, billers are required to use the GT - interactive telecommunication modifier to identify services provided via telepractice. Refer to the SBS fee schedule on the MDHHS website for a complete listing of procedure codes applicable to SBS and C4S beneficiaries. (Refer to the Directory Appendix for website information.) (added per bulletin MSA 20-15)</p>



2.6 DEVELOPMENTAL TESTING

Definition	Developmental testing is medically related testing (not performed for educational purposes) provided to determine if motor, speech, language and psychological problems exist or to detect the presence of any developmental delays. Testing is accomplished by the combination of several testing procedures and includes the evaluation of the beneficiary’s history and observation. Whenever possible and when age-appropriate, standardized objective measurements are to be used (e.g., Denver II) for children under the age of six. Administering the tests must generate material that is formulated into a report. Developmental testing done for educational purposes cannot be billed to Medicaid.
Documentation	The developmental testing report must include all of the following: <ul style="list-style-type: none"> ▪ Beneficiary name and birth date; ▪ Tests administered; ▪ A completed quarterly claim breakdown, produced by the claims development software; ▪ Treatment recommendations; and ▪ The dated signature, address and phone number of the person administering the tests.
Provider Qualifications	Developmental testing services may be reimbursed when provided by the following qualified staff in accordance with their professional credentials: <ul style="list-style-type: none"> ▪ A fully-licensed psychologist in the State of Michigan; ▪ A limited-licensed psychologist under the supervision of a licensed psychologist; ▪ A licensed master’s social worker in Michigan; ▪ A limited licensed master’s social worker under the supervision of a licensed master’s social worker; or ▪ A licensed physician or psychiatrist in Michigan.
Procedure Codes	For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)



2.7 NURSING SERVICES

<p>Definition</p>	<p>Nursing services are professional services relevant to the medical needs of the beneficiary provided through direct intervention. Direct service interventions must be medically based services that are within the scope of the professional practice of the Registered Nurse (RN) and Licensed Practical Nurse (LPN), provided during a face-to-face encounter, and provided on a one-to-one basis.</p> <p>Medicaid policy will follow current Michigan Public Health Code scope of practice guidelines for nursing practices.</p> <p>Services include:</p> <ul style="list-style-type: none"> ▪ Catheterizations or Catheter care ▪ Maintenance of tracheotomies ▪ Medication administration ▪ Oxygen administration ▪ Tube feeding ▪ Suctioning ▪ Ventilator care <p>Services considered observation or stand-by in nature are not covered.</p> <p>LPN services can only be billed if performed under the supervision of an RN or physician.</p>
<p>Prescription</p>	<p>Direct service interventions require a physician’s written order when the initial need for services is determined. Direct service interventions must be reviewed and revised annually or as medically necessary by the beneficiary’s attending physician. The nurse is responsible for notifying the attending physician of any change in the beneficiary’s condition which may result in a change or modification to the care plan.</p>
<p>Provider Qualifications</p>	<p>Nursing services may be reimbursed when provided by:</p> <ul style="list-style-type: none"> ▪ A licensed Registered Nurse (RN) in Michigan; or ▪ A Licensed Practical Nurse (LPN) in Michigan.
<p>Evaluations</p>	<p>A RN must complete the evaluations/assessments and prepare a nursing care plan. An evaluation/assessment may be performed when a change in the beneficiary’s medical condition occurs. LPNs cannot bill for evaluations/assessments.</p>
<p>Procedure Codes</p>	<p>For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)</p>



2.8 PHYSICIAN AND PSYCHIATRIST SERVICES

Definition	<p>Physician and psychiatrist services are services provided with the intent to diagnose, identify or determine the nature and extent of a beneficiary’s medical or other health-related condition. Physician/psychiatrist services include:</p> <ul style="list-style-type: none">▪ Evaluation and consultation with providers of covered services for diagnostic and prescriptive services; includes participation in multi-disciplinary team assessment.▪ Record review for diagnostic and prescriptive services. <p>Only the services provided by a physician or psychiatrist (MD or DO) through SBS may be billed and reimbursed through the enrolled ISD.</p> <p>Other physician or psychiatrist services, including those which may be delivered through other Medicaid-enrolled providers, are to be billed separately and may not be billed through the enrolled ISD.</p>
Provider Qualifications	<p>A licensed physician or psychiatrist (MD or DO) in Michigan.</p>
Procedure Codes	<p>For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)</p> <p>Procedure codes that replicate the services of other billed codes, either in part or in total, will not be reimbursed for the same date of service.</p> <p>If a physician order/referral is written as a result of a physician medical conference, the order/referral is considered to be a part of that service and is not separately reimbursable.</p>



2.9 PERSONAL CARE SERVICES

Definition	<p>Personal Care Services are a range of human assistance services provided to persons with disabilities and chronic conditions which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance or cueing so that the person performs the task by him/herself.</p> <p>Personal Care Services may be provided when:</p> <ul style="list-style-type: none">▪ The service is medically necessary. <p>Personal Care Services are not covered if they are:</p> <ul style="list-style-type: none">▪ Provided by a family member. A family member is described by the Centers for Medicare & Medicaid Services (CMS) to be "legally responsible relatives"; thus, spouses of beneficiaries and parents of minor beneficiaries (including stepparents who are legally responsible for minor children).▪ Not documented in the IEP/IFSP.▪ Educational in focus, such as tutoring, preparation of educational materials or Braille interpretation.▪ Performed as a group service; however, one or more students may be served one-at-a-time sequentially. <p>Personal Care Services may include, but are not limited to, assisting with the following:</p> <ul style="list-style-type: none">▪ Eating/feeding▪ Respiratory assistance▪ Toileting▪ Grooming▪ Dressing▪ Transferring▪ Ambulation▪ Personal hygiene▪ Mobility/Positioning▪ Meal preparation▪ Skin care▪ Bathing▪ Maintaining continence▪ Assistance with self-administered medications▪ Redirection and intervention for behavior▪ Health related functions through hands-on assistance, supervision and cueing
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<p>Personal Care Paraprofessional Provider Qualifications</p>	<p>The personal care paraprofessional personnel are employed in the Special Education Program and shall be qualified under the requirements established by their respective ISD plan. Providers must be trained in the skills needed to perform covered services, and must be under the direction of a qualified professional as designated in the IEP/IFSP. Paraprofessional personnel include:</p> <ul style="list-style-type: none"> ▪ Teacher Aides ▪ Health Care Aides ▪ Instructional Aides ▪ Bilingual Aides ▪ Program Assistants ▪ Trainable Aides
<p>Prescription</p>	<p>In accordance with 42 CFR 440.167, authorization for Personal Care Services (PCS) may be done by a physician or "other licensed practitioner" operating within the scope of their practice. 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). It is expected that personal care services will be authorized by the appropriate practitioner.</p>
<p>Documentation</p>	<p>Personal care services must be medically necessary and the need for the service must be documented in the student's IEP/IFSP. Each child's school clinical record must contain a completed, signed and dated monthly activity checklist. Service categories (i.e., toileting, feeding, transferring, etc.), times and frequencies must be documented either in the IEP/IFSP, in an attached document, or in the child's treatment authorization.</p>
<p>Procedure Codes</p>	<p>For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)</p>

2.10 TARGETED CASE MANAGEMENT SERVICES

<p>Definition</p>	<p>Targeted case management (TCM) services are services furnished to assist individuals in gaining access to needed medical, social, educational or other services.</p> <p>Targeted case management services include the following assistance:</p> <ul style="list-style-type: none"> ▪ A comprehensive assessment and periodic reassessment of an individual to determine the need for medical, social, educational or other services. These assessment activities include: <ul style="list-style-type: none"> ➤ Taking client history; ➤ Identifying the individual's needs and completing related documentation; and
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- Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.
- Development (and periodic revision) of a specific care plan that:
 - Is based on the information collected through the assessment;
 - Specifies the goals and actions to address the medical, social, educational or other services needed by the individual;
 - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - Identifies a course of action to respond to the assessed needs of the eligible individual.
- Referral and related activities:
 - To help an eligible individual obtain needed services, including activities that help link an individual with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual;
 - Monitoring and follow-up activities;
 - Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals, and conducted as frequently as necessary, including at least one annual monitoring, to determine whether the following conditions are met:
 - ◆ Services are being furnished in accordance with the individual's care plan;
 - ◆ Services in the care plan are adequate.

If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and service arrangements.

TCM services may be reimbursed when provided by a Designated Case Manager.

Providers must maintain case records that document, for all individuals receiving case management, the following: the name of the individual, the dates of the case management services, the person providing the case management services, and the nature, content, and units of case management services received. The case record must also reflect whether the goals specified in the care plan have been achieved, whether the individual has declined services in the care plan, the need for and occurrences of coordination with other case managers, the timeline for obtaining needed services, and a timeline for re-evaluation of the plan.



<p>Provider Qualifications</p>	<p>The Designated Case Manager is the person responsible for the implementation of the plan of care/treatment plan. The Designated Case Manager must be an individual who meets one of the following criteria:</p> <ul style="list-style-type: none"> ▪ A licensed RN in Michigan; ▪ A bachelor's degree with a major in a specific special education area; ▪ Has earned credit in coursework equivalent to that required for a major in a specific special education area; or ▪ Has a minimum of three years' personal experience in the direct care of an individual with special needs. <p>In addition to meeting at least one of the above, the Designated Case Manager must also demonstrate knowledge and understanding of all of the following:</p> <ul style="list-style-type: none"> ▪ Services for infants and toddlers who are eligible under the IDEA law as appropriate; ▪ Part C of the IDEA law and the associated regulations; ▪ The nature and scope of services covered under IDEA, as well as systems of payments for services and other pertinent information; ▪ Provisions of direct care services to individuals with special needs; and ▪ Provisions of culturally competent services within the community being served.
<p>Designated Case Manager Services</p>	<p>Targeted Case Management services include:</p> <ul style="list-style-type: none"> ▪ Assuring that standard re-examination and follow-up of the beneficiary are conducted on a periodic basis to ensure that the beneficiary receives needed diagnosis and treatment; ▪ Assisting families in identifying and choosing the most appropriate providers of care and services, scheduling appointments, and helping families to maintain contact with providers; ▪ Follow-up to ensure that the beneficiary receives needed diagnostic and treatment services; ▪ Assuring that case records are maintained and indicate all contacts with, or on behalf of, a beneficiary in the same manner as other covered services; ▪ Coordinating school based services and treatment with parents and the child; ▪ Monitoring and recommending a plan of action; ▪ Coordinating performance of evaluations, assessments and other services that the beneficiary needs; ▪ Facilitating and participating in the development, review, modification and evaluation of the multi-disciplinary team treatment plan; ▪ Activities that support linking and coordinating needed health services for the beneficiary; ▪ Providing a summary of provider, parent and student health and behavioral consultation; and ▪ Coordinating with staff/health professionals to establish continuum of health and behavioral services in the school setting.



Procedure Code	For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)
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2.11 SPECIAL EDUCATION TRANSPORTATION

Definition	<p>Special education specialized transportation services include transport to and from the beneficiary's pick-up and drop-off site where Medicaid services are provided. It includes no more than two one-way trips on a date of service.</p> <p>The need for special education transportation must be specified in the beneficiary's IEP/IFSP treatment plan. Medicaid may reimburse for special education transportation when a beneficiary receives a Medicaid-covered service on the same day.</p> <p>Medicaid does not reimburse for transportation provided in a regular or general education school bus. There is no additional payment for an attendant.</p>
Documentation	Federal requirements include documentation for transportation service claims that must be maintained for purposes of an audit trail, such as an ongoing trip log maintained by the provider of the special education transportation. Ridership must be documented for each one-way trip.
Procedure Codes	For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)



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Taxi and Private Vehicle Transportation

For a taxi or family vehicle transportation expense to be reimbursed, the following documentation must be on file at the local education agency (LEA) or intermediate school district (ISD):

- Specialized transportation must be included in the Individualized Education Program (IEP).
- A Medicaid covered medical service must be provided on the same day as the transportation.
- Dates and times of each trip must be listed on the LEA's or ISD's trip log.
- Documentation from the beneficiary's physician or a school provider treating the student, stating the reason taxi or family transportation is required must be retained in the student's file.
- For transportation by taxi, an additional statement justifying the need for a taxi and the reason other less costly means of transportation cannot be used must be retained in the student's file.
- For ongoing transportation needs, documentation is only required once per student per school year.
- For one-time or occasional use transportation, documentation is required for each trip, or trip period per beneficiary.
- The total number of trips claimed for taxi and family transportation must be included in the Special Education trip count on the Medicaid Allowable Expenditure Report (MAER).

Taxi and family vehicle cost reimbursement will be retroactive to July 1, 2012 if the proper documentation has been retained, and a claim for the trip has been approved through the Community Health Automated Medicaid Processing System (CHAMPS). Claims must be filed within one year from the date of service according to Medicaid timely filing requirements.

Transportation by stretcher car is not covered. The term "stretcher car" is defined as a vehicle capable of transporting a patient (student) in a prone or supine position (e.g., Ambucab).



SECTION 3 – QUALITY ASSURANCE AND COORDINATION OF SERVICES

3.1 QUALITY ASSURANCE

SBS providers must have a written quality assurance plan on file. SBS costs will be reviewed/audited by MDHHS for determination of medical necessity and to verify that all services were billed and paid appropriately. The purpose of the quality assurance plan is to establish and maintain a process for monitoring and evaluating the quality and documentation of covered services, and the impact of Medicaid enrollment on the school environment.

An acceptable quality assurance plan must address each of the following quality assurance standards:

- Covered services are medically necessary, as determined and documented through appropriate and objective testing, evaluation and diagnosis.
- The IEP/IFSP treatment plan identifies which covered services are to be provided and the service frequency, duration, goals and objectives.
- A monitoring program exists to ensure that services are appropriate, effective and delivered in a cost effective manner consistent with the reduction of physical or mental disabilities and assisting the beneficiary to benefit from special education.
- Billings are reviewed for accuracy.
- Staff qualifications meet current license, certification and program requirements.
- Established coordination and collaboration exists to develop plans of care with all other providers, (i.e., Public Health, MDHHS, Community Mental Health Services Programs (CMHSPs), Medicaid Health Plans (MHPs), Hearing Centers, Outpatient Hospitals, etc.).
- Parent/guardian and beneficiary participation exists outside of the IEP/IFSP team process in evaluating the impact of the SBS program on the educational setting, service quality and outcomes.

3.2 SERVICE COORDINATION AND COLLABORATION

Children with special needs have access to services available in both outpatient and school-based treatment settings. If treatment is provided in both settings, the goals and purpose for the two must be distinct. School based services are provided to assist a child with a disability to benefit from special education. Outpatient services are provided to optimize the child's functional performance in relation to needs in the home or community setting and must not duplicate those provided in the school setting. Collaboration between the school and the community providers is mandated to coordinate treatment and to prevent duplication of services. This collaboration may take the form of phone calls, written communication logs, or participation in team meetings such as the IEP/IFSP meeting.

3.3 ISD RESPONSIBILITIES

Each ISD must establish an implementation plan that includes explicit quality control review mechanisms to ensure full staff training and compliance, accuracy and completeness of the RMTS sample frame (designated employees), adherence to MDHHS-published methodology, editing of all moments for completeness and consistency, and accurate financial and staffing reports. Claiming entities must also fully cooperate with any review requested by the U.S. Department of Health & Human Services (HHS),



maintaining all necessary records for a minimum of seven (7) years after submission of each quarterly claim.

3.3.A. SANCTIONS

It is the intent of the State to pursue, when necessary, remedial action or implement a Corrective Plan if the ISDs or their vendors are not in compliance with Medicaid policy and procedures. If these actions are not successful, a payment freeze will be implemented and sanctions put in place until the matter is resolved. ISDs are responsible for the actions of their vendors.

The following are examples of causes for sanctions. The list is not all-inclusive.

- Repeated errors in completing the RMTS forms or filing of the claims.
- Providing insufficient data or incomplete reports to the State Contractor.
- Failure to use the claims development software.
- Failure to submit requested information, reports, or data to the State Contractor, CMS, MDHHS, MDE, or failure to cooperate with representatives of these agencies during site visits, reviews or audits.
- Failure to comply with the federal mandate to submit procedure-specific claims through the Community Health Automated Medicaid Processing System (CHAMPS).



SECTION 4 – PROVIDER ENROLLMENT

4.1 ENROLLMENT

The 56 Michigan Intermediate School Districts (ISDs), Detroit Public Schools Community District, and Michigan School for the Deaf are the only providers eligible to bill Medicaid for School Based Services. Providers must be enrolled and/or revalidated via the CHAMPS Provider Enrollment subsystem. Any applications or updates must be made through the CHAMPS system.

4.2 CERTIFICATION OF QUALIFIED STAFF

The Michigan Department of Education (MDE) must provide MDHHS with documentation that enrolled ISDs meet the regulatory requirements set forth for all staff providing services in the school setting.

Enrollment as a provider is predicated on certification to MDE that the educational and experiential requirements and credentials of all staff (i.e., licensure, certification, registration, etc.) who may be performing claimable activities have been met and are current. The MDE will assist any school district in this certification process and verify the status of its certification in writing, along with recommendations, with a copy sent to MDHHS.

4.3 MEDICAID ELIGIBILITY RATE

Michigan's RMTS activity codes are designed to reflect the actual direct medical services activities that occur in a school on any given day. Because these activities and services are provided for students who are both Medicaid and non-Medicaid eligible, it is necessary to develop and apply a formula that properly allocates which students are being supported and what activities and services are being provided. This is referred to as the "IEP Medicaid Eligibility Rate (MER)" for the direct medical services program.

IEP MER is determined by calculating the ratio of Medicaid eligible recipients with health-related services indicated on their IEP/IFSPs to the total number of special education population with health-related services indicated on their IEP/IFSPs.



SECTION 5 – FINANCIAL DATA REQUIREMENTS AND UNALLOWABLE COSTS

5.1 FINANCIAL DATA

The financial data reported for the Direct Medical Services (salaries, benefits, supplies, etc.) must be based on actual detailed expenditure reports obtained directly from the participating ISD's financial accounting system. The financial accounting system data is applied using generally accepted governmental accounting standards and principles or applicable administrative rules. The expenditures accumulated for calculating the Direct Medical Services allowable costs are to include actual non-federal expenditures incurred during the claiming period, except for the summer quarter. These allowable expenditures include such things as salaries, wages, fringe benefits and medically related supplies, purchased services and materials.

5.2 UNALLOWABLE COSTS

Providers are not allowed to report any costs that are federal funds, State flow-through funds, or non-federal funds that have been committed as local match for other federal or State funds or programs.

Claims for approved Medicaid School Based Service functions may not include expenditures of:

- Federal funds received by the ISD/LEA directly
- Federal funds that have been passed through a State or local agency
- Non-Federal funds that have been committed as local match for other Federal or State funds or programs

Funds received by an ISD for school based direct medical services are not Federal funds. They are reimbursement for prior expenditures and become, upon receipt, local funds.



SECTION 6 – SCHOOL BASED SERVICES REIMBURSEMENT

6.1 METHOD OF REIMBURSEMENT FOR DIRECT MEDICAL SERVICES, PERSONAL CARE SERVICES AND TARGETED CASE MANAGEMENT

Payment for Michigan’s school based services program is a cost-based, provider specific, annually reconciled and cost settled reimbursement methodology.

The Centers for Medicare & Medicaid Services (CMS) also requires Michigan SBS providers to submit procedure specific direct medical services claims for all Medicaid allowable services. These claims do not generate a payment but are required by CMS in order to monitor the services provided, the eligibility of the recipient, and provide an audit trail. Interim monthly payments are tied to the submission of the direct medical services claims. If claim volume decreases significantly or drops to zero in any two consecutive months, all interim payments will be held until the provider is contacted and the issue resolved. MDHHS will monitor provider claim volume to make sure that this mandate is followed.

Claims are submitted and processed through the Community Health Automated Medicaid Processing System (CHAMPS); however, the procedure code fee screens are set to pay zero. SBS providers receive their cash flow from the interim monthly payment process described below.

The interim monthly payments are based on prior year actual costs and reconciled on an annual basis to the current year costs. Cost reporting and reconciliation are based on the school fiscal year which is July 1 through June 30 of each year.

The reimbursement process for the direct medical services is comprised of the following parts:

- The SBS direct medical services procedure code specific billing process;
- The random moment time study (RMTS) component;
- The interim payment process; and,
- The cost reconciliation and cost settlement process.

6.1.A. DIRECT MEDICAL SERVICES PROCEDURE CODE SPECIFIC BILLING

Providers must continue to submit procedure specific claims in addition to the expenditure reports. The procedure specific process is described in the Covered Services Section of this chapter.

Claim documentation must be sufficient to identify the patient clearly, justify the diagnosis and treatment, and document the results accurately. Documentation must be adequate enough to demonstrate that the service was provided and that the service followed the "approved plan of treatment" (for school-based services, the service must be identified in the child’s IEP/IFSP).

The ISD may either purchase software for the claims submission function or it may utilize the services of a billing agent. The cost of this process is the responsibility of the ISD.



6.1.B. RANDOM MOMENT TIME STUDY

For the Random Moment Time Study, all ISDs will be required to utilize the services of the State Contractor who will conduct the statewide time studies.

The quarterly RMTS sampling results are produced by the State Contractor who converts them to percentages. This percentage is applied to program costs to determine reimbursement. Once complete, the time study results are provided to MDHHS where they are uploaded into the cost settlement program.

Costs are reported for direct medical services and specialized transportation services on the Medicaid Allowable Expenditure Report (MAER) and collected via financial worksheets for Personal Care Services and Targeted Case Management.

Electronic Data Systems (EDS) combines all cost information and the RMTS results, the indirect cost rate, and the Medicaid eligibility rate to calculate the total allowable costs. The MDHHS Hospital and Health Plan Reimbursement section performs the reconciliation and cost settlement process.

The ISD and/or State Contractor must comply with all conditions set forth by MDHHS as SBS policy.

The cost for the State Contractor is charged back to providers based on the State Contractor's projected cost per ISD (after federal match).

For detailed description and instructions regarding the Random Moment Time Study, refer to the School Based Services Random Moment Time Study chapter of this manual.

Summer Quarter Process

The summer quarter months are July, August and September. There is a break period between the end of one regular school year and the beginning of the next regular school year during which only a few staff are working. The majority of school staff work during the school year and do not work for part of the summer quarter (9-month staff). However, there are some 9-month staff that opt to receive their pay over a 12-month period. Therefore, different factors must be applied to the summer formula in order to accurately reflect the activities that are performed by the staff.

The summer quarter will be divided into two parts. The first part of the quarter will extend from July 1 to the date the students return to school. The second part of the quarter will be from the date the students return to school through September 30.

The RMTS will still be performed in the summer quarter, but will take place only after the staff start back to work and will only be applied to the costs for the second part of the summer quarter. To accurately reflect the work efforts being performed when all staff have returned to work, the RMTS will be performed during a shorter time period.



6.1.C. INTERIM PAYMENT PROCESS

Interim payments are calculated based on an estimated monthly cost formula. The monthly cost formula utilizes prior year costs plus any inflation or program changes to calculate a monthly interim reimbursement amount. After the final cost reports have been reviewed and reported to MDHHS, reconciliation will be performed and settlements will be made to make the providers whole.

Interim payments are issued on the first pay cycle of each month based on prior year costs.

To justify an increase in the interim payment, providers must submit written documentation of significant changes in coverage, service utilization or staff costs.

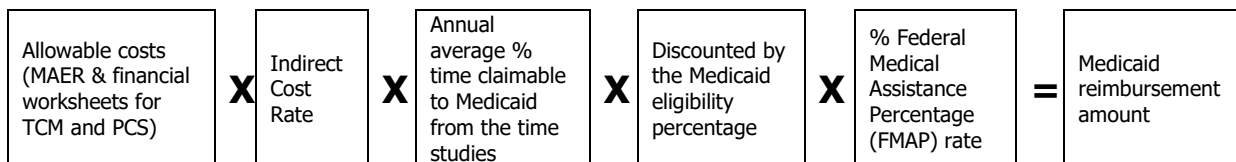
Providers may request an increase or decrease in their interim payment amount at any time throughout the year. Instructions and contact information will be included with the MAER. Any written inquiries should be addressed to the MDHHS Hospital and Clinic Reimbursement Division (HCRD). (Refer to the Directory Appendix for contact information.)

All payments and adjustments are issued by the MDHHS Hospital and Clinic Reimbursement Division. Once the payments are issued to the SBS providers (ISDs), how the interim payment revenue is distributed to the respective LEAs and how the initial and final settlements are handled is up to the discretion of the ISD.

6.1.D. COST RECONCILIATION AND SETTLEMENT

Allowable cost will be based on the following components:

- Costs from the MAER
- Targeted Case Management and Personal Care Services Financial Worksheets
- MDE Indirect Cost Rate
- Random Moment Time Study Percentage
- Health Related IEP Medicaid Eligibility Rate (IEP MER)
- Federal Medical Assistance Percentage (FMAP)



The Medicaid Allowable Expenditure Report (MAER) (modeled after the MDE SE-4096 cost report) is utilized to collect allowable costs for the medical professional staff. Costs for the staff providing targeted case management services and personal care services



that are not included in the direct medical costs are obtained from the participating ISD's financial accounting system via financial worksheets sent out by the State Contractor.

To report direct service-related costs, providers will utilize the Medicaid Allowable Expenditure Report. This cost report template may be obtained from the School Based Services Provider Specific webpage. (Refer to the Directory Appendix for website information.) An Excel printable version of the cost report is also available on the website for those providers in need of a paper version. Cost reports from the Local Educational Agencies will be submitted to their Intermediate School District for summation utilizing the Michigan Medicaid Forms (MMF) summary software (available to providers via the File Transfer Service). Providers must register and have access to the secure MILogin in order to utilize the MMF summary software. MILogin registration instructions are also available on the School Based Services Provider Specific webpage.

The filed cost data is used to calculate an initial settlement within 90 days after the receipt of the initial cost report data. The initial settlement may result in either an over or under adjustment to the provider interim payment.

Within six months after the close of the school fiscal year, the School Based Services providers will review, certify, and finalize the MAER and transmit the report to the MDHHS Medical Services Administration for reconciliation. The cost certification form (CMS-10231; Certification of Public Expenditures) must be signed and on file with MDHHS before a final settlement will be processed. The final settlement process will begin within 12-18 months after the close of the school fiscal year. Settlements may take several months for completion. (Refer to the Forms Appendix for a copy of the CMS-10231.)

ISDs/LEAs may submit revisions to the MAER until the final settlements are processed. Instructions for completing revisions are attached to the MAER.

6.2 METHOD OF REIMBURSEMENT FOR SPECIALIZED TRANSPORTATION

6.2.A. REIMBURSEMENT

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. This report does not include any federal dollars.

Medicaid-allowable specialized transportation costs include the following costs from the SE-4094:

- Salaries [Sec. 52 & Sec. 53a]
 - Bus Drivers
 - Aides
 - Employee Benefits (Bus Drivers and Aides only)
- Purchased Services – Staff (Bus Drivers and Aides only)



- Purchased Services – Vehicle Related Costs [Sec. 52 & Sec. 53a]
 - Pupil Transportation by Carrier
 - Pupil Transportation by Carrier (b/y)
 - Family Vehicle K Cost
 - Contracted Taxis
 - Pupil Transportation Fleet Insurance
 - Contracted/Leased Buses
- Supplies [Sec. 52 & Sec. 53a]
 - Gasoline/Fuel
 - Oil/Grease
 - Tires/Batteries
 - Other Expense/Adjustments, only the costs associated with adjustments to allowable costs
 - Bus Amortization

For reimbursement purposes, Bus Aides are defined as aides who ride on the bus providing care to those students being transported, assisting with the specific health concerns documented in the student's Individualized Education Program (IEP).

6.2.B. SPECIALIZED TRANSPORTATION RECONCILIATION AND SETTLEMENT

On an annual basis, the cost per trip is calculated by dividing the total Medicaid allowable costs (including indirect cost) by the total ISD-reported special education (specialized) one-way transportation trips. The cost per trip is multiplied by the quantity of Medicaid "allowable" one-way trips gleaned from CHAMPS to arrive at the Medicaid allowable cost.

An "allowable" one-way trip is one that is provided to a Medicaid beneficiary and fulfills all of the following requirements:

- Documentation of ridership is on file;
- The need for the specialized transportation service is identified in the Individualized Education Program (IEP)/Individualized Family Service Plan (IFSP); and
- A Medicaid-covered service (other than transportation) is provided on the same date of service. The Medicaid covered service must also be documented in the IEP/IFSP.

The cost settlement is accomplished by comparing the interim monthly payment totals to the annual Medicaid allowable specialized transportation cost. The cost settlement amount for the specialized transportation is combined with the cost settlement amounts for the Direct Medical Services, Targeted Case Management, and Personal Care Services; any over/under adjustments are processed as one transaction.



SECTION 7 – INDIRECT COST RATE (ICR)

7.1 INDIRECT COSTS

The ISD/LEA unrestricted indirect cost rate is calculated using the Federal Office of Management and Budget (OMB) Title 2 CFR Part 200. The methodology used to determine the indirect cost rate specific to each district is approved by the Federal cognizant agency. The indirect cost rates are updated annually by the Michigan Department of Education.



SECTION 8 – COST CERTIFICATION

8.1 COST CERTIFICATION

Once all cost reports and financial worksheets have been received by MDHHS, the summary worksheet of the Medicaid Allowable Expenditure Report (MAER) will be completed. The summary report will combine the allowable cost data submitted by the ISDs for each LEA for all four cost pools (Direct Medical, Specialized Transportation, Personal Care and Targeted Case Management). The total will be entered into the cost certification form as the "Total Computable Expenditure". The ISD is responsible for annually certifying that the total amount of expenditures for covered services has been expended and that none of the expenditures have been used as match for other programs or services. MDHHS will be utilizing the CMS-10231, "Certification of Public Expenditures (CPE)" form, for this purpose. (Refer to the Forms Appendix.)



SECTION 9 – COST ALLOCATION FACTORS

9.1 FEDERAL MEDICAL ASSISTANCE PERCENTAGE RATE

Federal regulations allow for payments to States on the basis of a Federal medical assistance percentage for part of their expenditures for services under an approved State plan. The formula for calculating this annual percentage is described in section 1905(b) of the Social Security Act. Under the formula, if a State's per capita income is equal to the national average per capita income, the Federal share is 55%. If a State's per capita income exceeds the national average, the Federal share is lower, with a statutory minimum of 50%. If a State's per capita income is lower than the national average, the Federal share is increased, with a statutory maximum of 83%.

9.2 DISCOUNTED HEALTH-RELATED MEDICAID ELIGIBILITY RATE (MER)

The discounted health-related Medicaid Eligibility Rate (MER) percentage is determined by the percentage of the special education student population that is Medicaid eligible in each ISD with a health-related support service code indicated on their December 1 Student Count Report. Support service codes are gleaned from Fields 43 and 57 of the December 1 Student Count Report. Only those codes that relate to covered school based health services are to be utilized.

Field 43	290, 310, 320, 360, 370, 400, 450, 460, 470
Field 57	801, 804, 805, 807, 808, 809, 812, 814, 816, 818

MDHHS receives the file of special education children with health-related support services indicated on their IEPs and matches the names and birthdates of those with health-related support services against the Medicaid eligibility file to identify the percentage that are Medicaid eligible. The eligibility rate is determined once each year utilizing the December 1 Student Count Report. The calculation for the eligibility rate is as follows:

$$\frac{\text{Medicaid special education students with a health-related support service in their IEP}}{\text{Total special education students with a health-related support service in their IEP}}$$

9.3 ALLOCATION OF SALARIES AND BENEFITS OF PERSONNEL PROVIDING DIRECT CARE SERVICES

Actual expenditures for salaries and benefits of all personnel are to be obtained from each participating ISD's financial accounting system. Expenditures related to the performance of approved Medicaid contracted service providers (e.g., occupational therapists, physical therapists) who also provide direct care services must also be obtained from each participating ISD's financial accounting system.



SECTION 10 – DOCUMENTATION

10.1 DIRECT MEDICAL SERVICES DOCUMENTATION

For covered services, the school clinical record must include all of the following:

- Beneficiary name and birth date;
- Date of service/treatment;
- Type (modality) of service/treatment;
- The response to the service/treatment; and
- The name and title of the person providing the service/treatment and a dated signature.

For services that have time-specific procedure codes, the provider must indicate the actual begin and end times of the service in the school clinical record. The record must indicate the specific findings or results of the diagnostic or therapeutic procedures. The student's school clinical record should include documentation of the implementation and coordination of services for the special education student.

Progress notes must be written monthly, or more frequently as appropriate, and must include:

- Evaluation of progress;
- Changes in medical or mental status; and
- Changes in treatment with rationale for change.

(Refer to the General Information for Providers Chapter of this manual for additional information regarding clinical record requirements.)

10.2 RMTS DOCUMENTATION

Each participating LEA must maintain a separate audit file for each quarter billed. The following minimum documentation is required:

- Financial data used to establish cost pools and factors.
- A copy of the quarterly sample results produced by the State Contractor.
- A copy of the warrant, remittance advice or Electronic Funds Transfer (EFT) documentation verifying that payment from MDHHS was received.

ISDs/LEAs must cooperate fully with any review requested by MDHHS and CMS, and maintain all necessary records for a minimum of seven (7) years.

Any changes in Federal regulations related to claims for administrative expenditures are incorporated by reference into this document.



SECTION 11 – AUDIT AND RECOVERY PROCEDURES

11.1 DIRECT SERVICE/TRANSPORTATION PROGRAM AUDIT ACTIVITIES TO BE PERFORMED BY MDHHS OFFICE OF AUDIT STAFF

MDHHS audit review of selected ISD/DPS and MSD cost reports for the Direct Service/Transportation Program may include the following activities:

- Verification that the Medicaid Allowable Expenditure Report (MAER) accurately reports the allowable costs incurred for the appropriate period.
- Verification that the salaries listed for employees/positions included in the RMTS staff pool match the payroll records for the same period as the time study.
- A review of the salaries of employees who changed positions during the time study period.
- If a replacement was hired/transferred, the auditor will verify that only the salary earned while working in a position on the MAER staff pool list was reported, and that salaries for both the original and replacement employees were not duplicated on the report for the same time period.
- Confirmation that none of the direct costs reported were also claimed as an indirect cost, that the proper indirect cost rate was used, and the rate was applied only to costs in the base. The employees in non-standard job categories are the most likely to be considered indirect type employees; therefore, documentation will be reviewed for these individuals.
- Verification that no federal funds were claimed on MAER cost reports and that MAER costs were not accepted for cost-sharing.
- A standard review of other areas, such as confirmation that reported costs were actually paid, support documentation was maintained as required, and costs were properly charged to the correct accounts should also be expected.
- Any other area deemed necessary.

The ISD/DPS/MSD should be prepared to direct the auditor to any document used to support and identify the reported MAER costs.

11.2 STUDENT CLAIMS AUDIT ACTIVITIES TO BE PERFORMED BY MDHHS OFFICE OF AUDIT STAFF

MDHHS audit review of selected ISD/DPS and MSD for approved SBS student claims may include the following activities:

- Verification that appropriate prescriptions/referrals/authorizations are updated annually and ordered by the appropriate individual.
- Verification that occupational, physical, and speech, language and hearing therapy address a beneficiary's medical need that affects his/her ability to learn in the classroom environment.
- Confirmation that services requiring the student to be in attendance have support documentation (i.e., attendance records) on file.
- Confirmation that the providers performing the service have the required licensure/certification.
- Verification that the providers requiring supervision both "under the direction of" and "under the supervision of" have the necessary support documentation on file.



- Verification that the beneficiary receiving special education transportation also received a Medicaid-covered service on the same day. In addition, the support documentation for specialized transportation includes an ongoing trip log maintained by the provider of the special education transportation.
- Confirmation that support documentation for personal care services includes a completed, signed and dated monthly activity checklist.
- Verification that group therapy or treatment was provided in groups of two to eight.
- A standard review of the Individualized Education Program (IEP)/Individualized Family Service Plan (IFSP) treatment plan areas, such as the inclusion of a description of the beneficiary's qualifying diagnosis and medical condition, time-related goals that are measurable and significant to the beneficiary's function and/or mobility, and anticipated frequency and duration of treatment required to meet the time-related goals.
- Any other area deemed necessary.

The ISD/DPS/MSD should be prepared to direct the auditor to any document used to support and identify the reported student claims.

11.3 AUDIT ACTIVITIES TO BE PERFORMED BY MDHHS OFFICE OF AUDIT STAFF

MDHHS audit review of selected ISD/DPS cost reports for the Administrative Outreach Program may include the following activities:

- Verification that the salaries listed for employees/positions included in the Random Moment Time Study (RMTS) staff pool match the payroll records for the same period as the time study.
- A review of the salaries of employees who changed positions during the time study period.
- If a replacement was hired/transferred, the auditor will verify that only the salary earned while working in a position on the AOP staff pool list was reported, and that salaries for both the original and replacement employees were not duplicated on the report for the same time period.
- Verification that any other salaries and costs for supplies, etc., are of direct benefit to the employees on the staff pool list, and therefore, allocable to the AOP in the same percentage as the AOP-eligible employees.
- Confirmation that none of the direct costs reported were also claimed as an indirect cost, that the proper indirect cost rate was used, and the rate was applied only to costs in the base. The employees in non-standard job categories are the most likely to be considered indirect type employees; therefore, documentation will be reviewed for these individuals.
- Verification that no federal funds were claimed on AOP cost reports and that AOP costs were not accepted for cost sharing.
- A standard review of other areas, such as confirmation that reported costs were actually paid, support documentation was maintained as required, and costs were properly charged to the correct accounts should also be expected.
- Any other area deemed necessary.

The ISD/DPS should be prepared to direct the auditor to any document used to support and identify the reported AOP costs.



11.4 AUDIT FINDINGS AND RESOLUTION

Audit findings and resolution will include the following:

- Identified overstatement of expenditures on the MAER will require the revision of the MAER and a revised final settlement for all specifically identified overstatements.
- For claim error rates in excess of the materiality threshold percentage, as established by MDHHS, the recovery will be any excess percentage greater than materiality threshold multiplied by total Medicaid paid to the ISD during the period covered by the audit.

Recoveries and re-filings are limited to fiscal years considered within three years from the last date of payment for that period.



SCHOOL BASED SERVICES ADMINISTRATIVE OUTREACH PROGRAM CLAIMS DEVELOPMENT

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SECTION 1 - CLAIMS DEVELOPMENT OVERVIEW

Using the State of Michigan's competitive bid process, MDHHS will select one Contractor to implement and administer the random moment time study. The Contractor will also provide the ISDs/DPS the option of performing certain time study responsibilities and claims development activities on behalf of those ISDs/DPS that choose to participate in this portion of the State contract and pay for these services.

1.1 CLAIMS DEVELOPMENT ENROLLED PROVIDERS

All ISDs/DPS will be required to utilize the services of the State's RMTS and Claims Development Contractor, who will conduct the statewide time studies and develop and submit claims on their behalf each quarter.

The State Claims Development Contractor will develop an implementation plan on behalf of its ISDs/DPS to conduct the statewide time studies each quarter, utilizing the claims development software, as well as complete all other key functions required for valid claim development.

The cost for the Contractor will be charged back to providers who participate in this option based on the Contractor's projected cost per ISD/DPS (after federal match).

1.2 OVERVIEW OF CLAIMS DEVELOPMENT PROCESS

Based on federal and state statutes and regulations, below is a partial list of specific functions and tasks that must be accomplished for reimbursement of Medicaid Administrative Outreach Program services. Additional details appear in subsequent sections of this chapter.

Claims will be developed by the State's Claims Development Contractor utilizing the claims development software following these basic steps:

- The quarterly RMTS sampling results are produced by the State's RMTS and Claims Development Contractor, who converts them to percentages. The percentages are applied to program costs to determine reimbursement.
- The cost/claim generation component of the claims development software uses ISD/DPS costs and other claim factors to calculate and produce the claim.
- The claim is submitted to MDHHS with verification of claim validity from each ISD/DPS.
- The ISD/DPS and/or Contractor must comply with all conditions set forth by MDHHS as SBS policy.

1.3 IMPLEMENTATION PLAN

Each ISD/DPS must submit an Implementation Plan that reflects the details of their SBS Administrative Outreach Program operation for review and approval by MDHHS and by CMS. Any subsequent changes must also be reported and receive approval.

Claims may not be submitted to MDHHS for reimbursement until MDHHS has approved the Implementation Plan that will be utilized based on this published policy.



SECTION 2 - CLAIM CALCULATIONS

2.1 IMPLEMENTATION PLAN

Each ISD/DPS must submit an implementation plan that reflects the details of their SBS Administrative Outreach Program for review and approval by MDHHS and CMS. Any subsequent changes must also receive approval.

Each implementation plan must include explicit quality control review mechanisms to ensure full staff training and compliance, accuracy and completeness of the sample frame (designated employees), adherence to the MDHHS-published methodology, editing of all moments for completeness and consistency, and accurate financial and staffing reports. Claiming entities must also fully cooperate with any review requested by the U.S. Department of Health & Human Services (HHS), maintaining all necessary records for a minimum of seven (7) years after submission of each quarterly claim.

2.2 SANCTIONS

It is the intent of the State to pursue, when necessary, remedial action or implement a Corrective Plan if the State-selected contractors, the ISD/DPS, or their vendors are not in compliance with the new SBS Administrative Outreach published policy. If this is not successful, a contract payment freeze will be implemented and sanctions put in place until the matter is resolved. Those independent ISDs/DPS not participating in the State's claims development contract will be held accountable for their vendor's actions.

The following are examples of causes for implementation of sanctions for all districts. The list is not all-inclusive.

- Repeated errors in completing the RMTS forms or filing of the claims.
- Providing insufficient data or incomplete reports to the Contractors.
- Failure to use the CLAIMS DEVELOPMENT software.
- Failure to cooperate with, or submit requested information, reports, or data to the Special Monitoring Contractor, CMS, MDHHS, MDE, and other staff involved during site visits, reviews or audits.

2.3 FACTORS FOR CLAIMS DEVELOPMENT

MDHHS will submit quarterly claims on behalf of all participating school districts to the CMS. Each claim will be based on the following factors: The cost pool, percentage of time claimable to Medicaid Outreach Program administration, the Federal Financial Participation (FFP) rate, and the discounted Medicaid eligibility percentage rate for that district. The factors for the summer quarter are described above.

2.3.A. COST POOL

This consists of the actual costs incurred for the quarter being claimed, such as salaries, overhead, etc. Each participating ISD/DPS must certify that the claim they submit to MDHHS contains sufficient non-Federal (State, county, or local) funds to match requirements and that the claim only includes actual costs.



2.3.B. FEDERAL FINANCIAL PARTICIPATION RATE

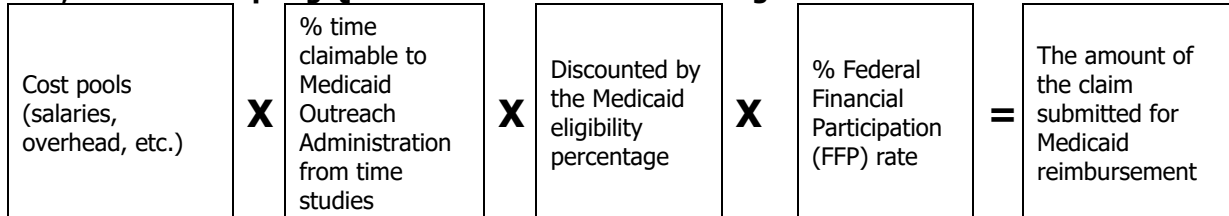
Federal regulations allow for a reimbursement rate of 50% for Medicaid administrative activities.

2.3.C. DISCOUNTED MEDICAID ELIGIBILITY PERCENTAGE

The discounted Medicaid eligibility percentage is determined by the percentage of the student population in each ISD/DPS who are actually Medicaid beneficiaries. The discounted Medicaid eligibility rates will be determined twice each year and applied to certain activities in the claim calculation formula. To calculate the discounted Medicaid eligibility rates, the claiming entity will obtain the September and February fourth Wednesday pupil count report list from the Center for Educational Performance and Information (CEPI). The pupil count list will include the student name and date of birth. MDHHS will provide a method for using the list to verify the number of Medicaid-eligible students. This number will be used in a calculation with the total pupil count to determine the discounted percentage of Medicaid-eligible students in the ISD/DPS. The September pupil count list will be used to determine discounted Medicaid eligibility rates for time studies conducted in the Fall and Winter quarters, and the February pupil count will be used for time studies conducted in the Spring and Summer quarters.

Based on the above factors, the claim that is sent to Medicaid is calculated as follows:

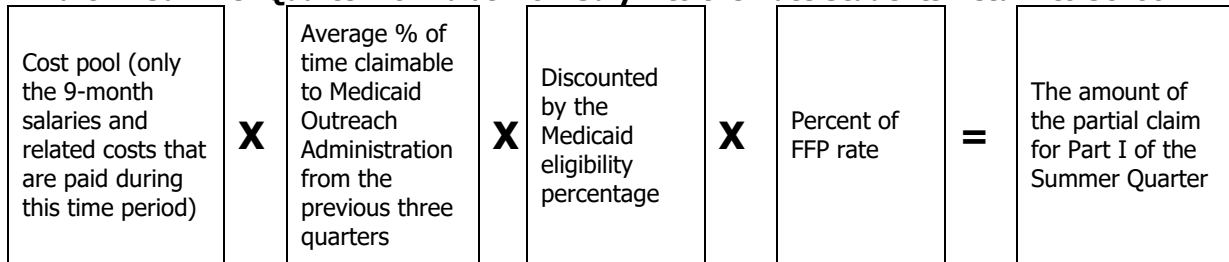
Fall, Winter and Spring Quarter Formulas for Calculating Administrative Outreach Claims



Summer Quarter Formulas

The summer quarter will be divided into two parts. The sum of both parts will be submitted to Medicaid for reimbursement. There will be two workbooks created for the summer quarter, one for each part.

Part I - Summer Quarter Formulas from July 1 to the Date Students Return to School



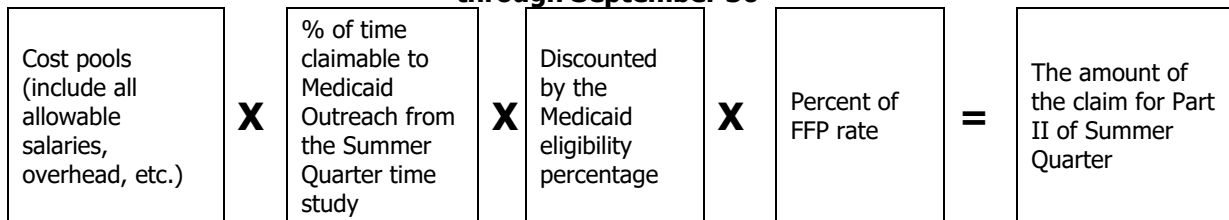


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- Salary and related costs for 9-month staff that were earned during the school year, but are paid during the summer break, will be collected in a separate cost pool. Salaries paid during this period for 12-month staff are not included in the cost pool.
- The cost pool containing the salaries and related costs of 9-month staff who are paid over 12 months will be claimed based on the average time study results and Medicaid Eligibility (MAE) rate from the previous three quarters.

Part II - Remainder of the Summer Quarter – Begins on the Date Students Return to School through September 30



- Salary and related costs of all staff eligible for the time study are included in the cost pool, along with other allowable overhead.
- An RMTS is performed and applied to determine the percent of time claimable for Outreach during Part II of the summer quarter.

The claims development software will add the Summer Quarter Part I and Part II claim amounts together to reach the dollar amount of the total Summer Quarter claim submitted to MDHHS for reimbursement.

2.4 FINANCIAL DATA

The financial data reported (salaries, benefits, supplies, etc.) must be based on actual detailed expenditure reports obtained directly from the participating ISDs'/DPS' financial accounting system. The financial accounting system data is applied using generally accepted governmental accounting standards and principles or applicable administrative rules. The expenditures accumulated for calculating the Administrative Outreach claim are to include only actual expenditures incurred during the claiming period, except for the summer quarter.

2.5 ALLOCATION OF SALARIES AND BENEFITS OF PERSONNEL PROVIDING DIRECT CARE SERVICES

Actual expenditures for salaries and benefits of all personnel included in an Administrative Outreach claim are to be obtained from each participating ISD/DPS financial accounting system. Expenditures related to the performance of approved Medicaid Administrative Outreach functions by contracted service providers (e.g., occupational therapists, physical therapists) who also provide direct care services must also be obtained from each participating ISD/DPS financial accounting system.



2.6 RMTS DOCUMENTATION AND RECORDKEEPING/AUDIT FILE REQUIREMENTS

Each participating school district will maintain a separate audit file for each quarter billed. The following minimum documentation will be required:

- Financial data used to establish cost pools and factors.
- A copy of the quarterly sample results produced by the State's RMTS and Claims Development Contractor.
- A completed quarterly claim produced by the claims development software and signed by the Chief Financial Officer of the ISD/DPS.
- A copy of the warrant, remittance advice or Electronic Funds Transfer (EFT) documentation, verifying that payment from MDHHS was received.

Districts must cooperate fully with any review requested by MDHHS and CMS, and maintain all necessary records for a minimum of seven (7) years after submission of each quarterly claim.

Any changes in Federal regulations related to claims for administrative expenditures are incorporated by reference into this document.

2.7 NON-STUDENT SPECIFIC/PRE-MEDICAID ELIGIBILITY DETERMINATION

There are some Administrative Outreach activities and expenditures that are approved by Medicaid that have not been addressed thus far. They are:

- Provided to the entire "at-risk" population,
- Not identifiable to individual students, and
- Provided before Medicaid eligibility is determined.

These activities are to be allocated to the approved Medicaid administrative outreach claim based on the results of the time study conducted during the claiming period.

2.8 STUDENT-SPECIFIC ADMINISTRATIVE FUNCTIONS EXPENDITURES

There are some Administrative Outreach functions that are identifiable to individual students after Medicaid eligibility has been determined. These functions are to be allocated in the administrative claim based on both the time study results conducted during the claiming period and the applicable discounted Medicaid eligibility rate.

2.9 NON-SALARY EXPENDITURES

Expenditures for materials and supplies related to the approved Medicaid administrative outreach activities may be included in the claim if they can be attributed directly to individuals who are claimed. The principles for claiming expenditures and cost allocation, including correct depreciation of assets as published in the Federal Office of Management and Budget (OMB) Title 2 CFR Part 200, must be followed. Examples include conference fees, registration fees, mileage, pagers, printing fees (i.e., for business cards), furniture, equipment, copy machine expenses, etc. Such expenditures are to be based on actual detailed departmental expenditure reports obtained directly from the participating ISD/DPS



financial accounting system. These expenditures may not include items identified as indirect costs, such as central business office operations, general building maintenance and repair costs, or any other costs classified as an indirect cost.

2.10 INDIRECT COSTS

Allocable indirect costs are the product of the school district aggregate, calculated, approved Medicaid administrative outreach claim amount, multiplied by the ISD/LEA unrestricted indirect cost rate, as approved annually by the Michigan State Board of Education (MSBE). The ISD/LEA unrestricted indirect cost rate is calculated using the Federal Office of Management and Budget (OMB) Title 2 CFR Part 200. The methodology used to determine the indirect cost rate specific to each district has been approved by the Federal cognizant agency. The indirect cost rates are updated annually by the Michigan Department of Education.

2.11 CLAIM CERTIFICATION

The accuracy of the submitted claims must be certified by the chief financial officer, the superintendent of the district, or the consortium's lead ISD/DPSCD designee. Such certification is accomplished when the annual cost report is submitted in CHAMPS and meets the requirements of 42 CFR 433.51. Detailed claim analyses and supporting documentation will be maintained by the ISD/DPS for audit or future reference purposes according to the terms identified in the interagency agreement between the district and MDHHS.

Reimbursement will be paid after the claim has been submitted to, reviewed by, and determined to be acceptable and accurate by MDHHS and CMS.

2.12 ANNUAL RECONCILIATION

At the end of the district's fiscal year, and after its annual financial audit is completed, a reconciliation of the filed administrative outreach claims, with the financial accounting records and supporting documentation, must be performed. Adjustments to future administrative claims must be made based on the results of the reconciliation analyses to consider any year-end adjustments to accounting entries of any items which might have impacted the claim amounts.

2.13 FISCAL PROVISIONS

School districts must use an appropriate Revenue Code to identify the Medicaid SBS Administrative Outreach Program funds within their accounting records.

2.14 SUBMISSION OF CLAIMS

All claims must be developed and submitted using the reporting format (structured spreadsheet template) and approved certification forms.

The claim package consists of completed Excel workbooks for each individual ISD/DPS and are combined and consolidated into one claim that is submitted to MDHHS.

All claims are to be submitted in accordance with the reporting requirements established by MDHHS. It is imperative that districts work closely with the Claims Development Contractor to provide pertinent



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financial, enrollment and personnel data and meet their deadlines and any other technical specifications. Claims not submitted on time must be submitted the following quarter as an adjustment to the prior missed quarter and will be processed for that following quarter. Claims not conforming to reporting requirements will not be accepted or processed.

2.15 PERIODICITY OF REPORTING

Districts must submit claims for expenditures related to approved Medicaid administrative outreach activities to MDHHS on a quarterly basis. The claim is due to MDHHS on or before 120 calendar days after the end of the reporting quarter.

Timeframes to Submit Administrative Outreach Claims to MDHHS

	REPORTING PERIOD		CLAIM DUE TO MDHHS	CLAIM SUBMITTED TO CMS BY MDHHS
	BEGIN DATE	ENDING DATE		
Summer	July 1	September 30	January 31	March 31
Fall	October 1	December 31	April 30	June 30
Winter	January 1	March 31	July 31	September 30
Spring	April 1	June 30	October 31	December 31



SCHOOL BASED SERVICES RANDOM MOMENT TIME STUDY

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SECTION 1 – GENERAL TIME STUDY INFORMATION

This chapter describes the random moment time study process for the School Based Services (SBS) direct medical services program.

In accordance with the Centers for Medicare & Medicaid Services (CMS) reimbursement policy, some activities performed by medical professionals and Intermediate School District (ISD) staff in a school-based setting are eligible for federal matching funds. These activities may be performed by staff with multiple responsibilities. CMS reimbursement requirements include the use of a random moment time study (RMTS) as a component of the Medicaid reimbursement methodology. The time study results are used to determine the amount of staff time spent on Medicaid-allowable activities. One statewide time study per staff pool is performed each quarter.

1.1 ADMINISTRATIVE OUTREACH PROGRAM ACTIVITIES

The School Based Services Administrative Outreach Program (AOP) offers reimbursement for the cost of administrative activities that support efforts to identify and enroll potentially eligible persons into Medicaid and that are in support of the state Medicaid plan.

The activities fall into several categories:

- Medicaid Outreach
- Facilitating Medicaid Eligibility Determinations
- Health-related Referral Activities
- Medical Service Program Planning, Policy Development, and Interagency Coordination
- Programmatic Monitoring and Coordination of Medical Services
- Transportation and Translation Services

1.2 DIRECT MEDICAL SERVICES

Medicaid covered services that are medically necessary and specified in the beneficiary's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) include:

- Occupational Therapy Services
- Orientation and Mobility Services
- Physical Therapy Services
- Assistive Technology Device Services
- Speech, Language and Hearing Services
- Psychological, Counseling and Social Work Services
- Developmental Testing Services
- Nursing Services
- Physician and Psychiatric Services



- Personal Care Services
- Targeted Case Management Services

1.3 STAFF POOLS AND CONFIDENCE LEVELS

The RMTS is carried out utilizing customized claims development software that automates aspects of the school district time study process. The claims development software is comprised of three components: sampling/staff pool lists, training, and cost/claim generation. All ISDs are required to utilize the services of the State's RMTS and Claims Development Contractor (hereafter referred to as the Contractor). The Contractor conducts the statewide time studies, produces the implementation plans and reports, and develops and submits the claims on behalf of the 56 ISDs, Detroit Public Schools Community District and Michigan School for the Deaf (hereafter referred to as the ISDs).

Time studies will be carried out over the following staff pools:

- AOP Only Staff – This staff pool consists of individuals who perform only administrative outreach activities. They do not perform any direct medical activities.
- AOP & Direct Medical Staff – This staff pool consists of individuals who perform both Direct Medical activities and AOP activities.
- Personal Care Services Staff – This direct medical only staff pool consists of individuals who perform direct care Personal Care Services.
- Targeted Case Management Services Staff – This direct medical only staff pool consists of individuals who perform Targeted Case Management (TCM) Services.

The RMTS results identifying the percentage of claimable time are applied to the allowable correlating cost pool. All staff pools are mutually exclusive.

The sample size of each cost pool ensures a quarterly level of precision of +/- 2% (two percent) with at least a 95% (ninety-five percent) confidence level and an annual level of precision of +/- 2% (two percent) with at least a 95% (ninety-five percent) confidence level.

Valid moments are completed moments that have been received by the Contractor and determined to be complete and accurate. Invalid moments are moments that are assigned to staff who are no longer in the position as selected, moments that are outside of paid work hours, and moments not returned for any other reason.

As long as the completed observation rate meets or exceeds 85%, missing observations will be dropped from all calculations. Should the completion rate fall below 85%, missing observations will be included as non-matchable.



SECTION 2 – CENTRALIZED CODING

The Contractor is responsible for coding the time study moments. MDHHS oversees the Contractor and ISDs participating to assure their compliance with all aspects of program policy and federal regulations.



SECTION 3 – TIME STUDY METHODOLOGY

3.1 RANDOM MOMENT TIME STUDY OVERVIEW

The time study design logs only what the participant is doing at one moment in time. A random moment consists of one minute of work done by one employee, both chosen at random, from among all such minutes of work that have been scheduled for all designated staff statewide.

The RMTS measures the work effort of each group of approved staff involved in the time study process by sampling and analyzing the work efforts of a randomly-selected cross-section of each staff pool. The RMTS methodology employs a technique of polling employees at random moments over a given time period and tallying the results of the polling over that period. The method provides a statistically valid means of determining the work effort being accomplished in each program of services. The sampling period is defined as the three-month period comprising each federal quarter of the year, except for the abbreviated sample period used in the summer quarter (July through September).

The Contractor will use the claims development software to conduct the statewide time studies each quarter. This software produces random moments concurrent with the entire reporting period which are then paired with randomly selected members of the designated staff pool population. The sampling is constructed to provide each staff person in the pool with an equal opportunity or chance to be included in each sample moment. Sampling occurs with replacement so that after a staff person and a moment are selected, the staff person is returned to the potential sampling universe. Therefore, each staff person has the same chance as any other person to be selected for each moment, which ensures true independence of sample moments.

Once the random sample of staff moments has been generated, the sample is printed in the form of master and location control lists for sample administration purposes, and as time study forms for collecting the moment data. Each sampled moment is identified on its respective control list in chronological order by the name of the staff person to be sampled and the date and time at which the recording should take place.

3.1.A. LONG-TERM SUBSTITUTES

Long-term substitute staff replacing permanent staff on leave may be added to the staff pool lists. The following criteria apply when long-term substitutes are utilized:

- A long-term substitute staff must be employed by the ISD/Local Educational Agency (LEA) for at least 30 calendar days within the quarter.
- The ISD/LEA may report the name of the long-term substitute staff any time after the sampling moments are distributed.
- The long-term substitute staff must meet all of the program requirements and provider qualifications necessary to participate in the Medicaid school based services program staff pool.
- If listed on the staff pool list, the substitute staff must complete the time study moment.
- The cost reflected should be the sum of the cost of the regular staff on leave and the long-term substitute staff.



- All audit liability for the financial data reported and the tracking of the moments is the responsibility of the ISD/LEA reporting entity.
- All staff whose costs are included in the cost pool, including long-term substitutes, must be included in the sample universe for the time study.

3.2 RANDOM MOMENT TIME STUDY FORM COMPLETION

There are two steps to completing a time study form:

- In the first step, for the designated moment, the time study participant provides the answers to the questions. These questions relate to their activities at the time of their randomly selected moment.
- In the second step, the time study forms are collected from the participants, and the Contractor assigns the appropriate activity code for that moment based on the answers to the study questions.

The Contractor conducts the statewide time studies each quarter for all ISDs and produces a report detailing the results. This involves importing clinician information from the ISDs to compile the statewide pool of all eligible time study participants for each staff pool list. There are four separate staff pools sampled for the RMTS each quarter: 1) the AOP only staff pool, 2) the AOP and Direct Medical Services staff pool, 3) the Personal Care Services staff pool, and 4) the Targeted Case Management Services staff pool. All staff pools have 800 moments randomly selected for the summer quarter (July-September). For the remaining three quarters, the Direct Medical Services and the Targeted Case Management Services staff pools have 3,000 moments randomly selected per quarter, and the Personal Care Services staff pool has 3,200 moments randomly selected per quarter. The person's name that is associated with each moment is placed on a time study form. The Contractor distributes the control lists of their selected staff and the time study forms to the ISDs prior to the beginning of the reporting period. The Contractor is also responsible for the collection of all time study forms for the ISDs.

The Contractor monitors the status of each time study form so that appropriate follow-up calls are made for delinquent moments or missing data. The ISD is responsible for ensuring that a copy of the time study form and instructions are distributed to staff just prior to the assigned moment. The completed time study forms are returned to the Contractor, generally on a weekly basis, for data entry and tabulation.

At the end of the sampling period after all data has been collected and tabulated, program precision tables will be produced by the Contractor. These tables will verify that a sufficient number of personnel were sampled to ensure time study results that have a confidence level of at least 95% quarterly with a precision level of +/- 2% annually.

3.3 TIME STUDY STAFF POOLS

To preserve the integrity of the RMTS process and to allow for timely process flow, school staff are given four weeks to review and return the staff pool lists and financials to the Contractor for those staff eligible to participate in each time study group. The staff pool lists must be returned as a complete file with all updates reflected. No partial staff pool list files will be accepted by the Contractor.



If staff pool lists and/or financials for the Personal Care Services, the Targeted Case Management, or the Administrative Outreach Program (AOP) time studies are not returned to the Contractor on or before the published deadline, the LEA staff pool lists and correlating financials will be removed from the time study and claim calculation for the affected quarter. ISD coordinators and LEA financial contact staff will be notified.

When providing the staff pool list of those eligible to participate in the time studies, school districts must certify the list of participants and activities to be claimed to ensure that all appropriate personnel are submitted and that appropriate credentials are in place for billing Medicaid.

3.3.A. AOP ONLY STAFF POOL

AOP Only Staff Pool:

- Administrators
- Counselors
- Early Identification/Intervention Personnel
- Physician Assistants
- Teacher Consultants
- School Psychologists (certified by the Michigan Department of Education but without Michigan licensure)
- Limited Licensed Speech Language Pathologists (without their American Speech-Language-Hearing Association Certificate of Clinical Competence)
- School Social Workers (certified by the Michigan Department of Education but without Michigan licensure)

3.3.B. AOP & DIRECT MEDICAL SERVICES STAFF POOL

AOP & Direct Medical Services Staff Pool:

- Fully Licensed Speech Language Pathologists
- Audiologists
- Counselors
- Licensed Practical Nurses
- Occupational Therapists
- Occupational Therapist Assistants
- Orientation and Mobility Specialists
- Physical Therapists
- Physical Therapist Assistants
- Physician and Psychiatrists
- Psychologists (not School Psychologists)
- Registered Nurses
- Social Workers



3.3.C. PERSONAL CARE SERVICES STAFF POOL

The following staff may be appropriate for inclusion in time studies if they are involved in Personal Care activities in the school setting:

- Bilingual Aides
- Health Aides
- Instructional Aides
- Paraprofessionals
- Program Assistants
- Teacher Aides
- Trainable Aides

3.3.D. TARGETED CASE MANAGEMENT SERVICES STAFF POOL

Staff with the following credentials may be appropriate for inclusion in time studies if they are involved in Targeted Case Management activities in the school setting:

- A bachelor's degree with a major in a specific special education area.
- Coursework credit equivalent to a major in a specific special education area.
- Minimum of three years' personal experience in the direct care of an individual with special needs.
- A licensed Registered Nurse (RN) in Michigan.

Targeted case managers must also demonstrate knowledge and understanding of all of the following:

- Services for infants and toddlers who are eligible under the IDEA law as appropriate;
- Part C of the IDEA law and the associated regulations;
- The nature and scope of services covered under IDEA, as well as systems of payments for services and other pertinent information;
- Provision of direct care services to individuals with special needs; and
- Provision of culturally competent services within the community being served.



SECTION 4 – ADMINISTRATIVE OUTREACH AND DIRECT MEDICAL ACTIVITY CODE SUMMARY

This section summarizes the code categories utilized for the random moment time study and indicates whether they are claimable for reimbursement under the AOP only, the AOP & Direct Medical program (including Personal Care Services and Targeted Case Management Services), allocated across all programs, or "unallowable" (not claimable). The "unallowable" activities are those that are purely educational in nature.

These codes represent activities that may be performed by any time study participants during a typical workday. Some of these activities may be claimed under Medicaid and some may not. In the following section, examples and clarifications of each code are provided to assist with the appropriate coding of the activities.

4.1 ACTIVITY CODES

Staff Activity and Codes – the indicators below, which follow each code, provide the application of the Federal Financial Participation (FFP) rate, the allowability or non-allowability designation, and the proportional Medicaid share status of the code. In order to maintain coding objectivity by time study participants, time study sheets used by employees should not include references to rates of FFP, proportional or total Medicaid, or whether such codes are allowable or unallowable under Medicaid.

Application of FFP Rate	
50 percent	Refers to an activity that is allowable as administration under the Medicaid program and claimable at the 50 percent non-enhanced FFP rate.
75 percent	Refers to an activity that is allowable as administration under the Medicaid program and claimable at the 75 percent enhanced FFP rate.
Unallowable Activities	
U	Refers to an activity that is unallowable as administration under the Medicaid program. This is regardless of whether or not the population served includes Medicaid eligible individuals.
Application of Medicaid Share	
TM	(Total Medicaid) Refers to an activity that is 100 percent allowable as administration under the Medicaid program.
PM	(Proportional Medicaid) Refers to an activity which is allowable as administration under the Medicaid program, but for which the allowable share of costs must be determined by the application of the proportional Medicaid share (the Medicaid eligibility rate [MER] or the IEP Ratio). The Medicaid share is then determined by applying the MER or the IEP Ratio to the appropriate student populations.



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Reallocated Activities	
R	Refers to those general administrative activities performed by time study participants which must be reallocated across the other activity codes on a pro rata basis. These reallocated activities are reported under Code 10 - General Administration. Note that certain functions, such as payroll, maintaining inventories, developing budgets, executive direction, etc., are considered overhead and, therefore, are only allowable through the application of an approved unrestricted indirect cost rate.

4.2 UNIFORM CODES

Staff should document time spent on each of the following coded activities:

Code 1.a.	Non-Medicaid Outreach – U
Code 1.b.	Medicaid Outreach – TM/50 Percent FFP
Code 2.a.	Facilitating Application for Non-Medicaid Programs - U
Code 2.b.	Facilitating Medicaid Eligibility Determination – TM/50 Percent FFP
Code 3.	School Related and Educational Activities – U
Code 4.a.	Direct Medical Services – Not Covered on a Medical Plan of Care (FFS – Non-IEP) - U
Code 4.b.	Direct Medical Services – Covered as IDEA/IEP Services (FFS- IEP) - IEP Ratio
Code 4.c.	Direct Medical Services – Covered on a Medical Plan of Care, Not Covered as IDEA/IEP Service – Medical Plan Ratio
Code 5.a.	Transportation for Non-Medicaid Services – U
Code 5.b.	Transportation-Related Activities in Support of Medicaid Covered Services – PM/50 Percent FFP
Code 6.a.	Non-Medicaid Translation – U
Code 6.b.	Translation Related to Medicaid Services – PM/75 Percent FFP
Code 7.a.	Program Planning, Policy Development, and Interagency Coordination Related to Non-Medical Services – U
Code 7.b.	Program Planning, Policy Development and Interagency Coordination Related to Medical/Medicaid Services – PM/50 Percent FFP
Code 8.a.	Non-Medical/Medicaid Training – U
Code 8.b.	Medical/Medicaid Related Training – PM/50 Percent FFP
Code 9.a.	Referral, Coordination, and Monitoring of Non-Medicaid Services – U



Code 9.b.	Referral, Coordination, and Monitoring of Medicaid Services – PM/50 Percent FFP
Code 10.	General Administration – R
Code 11.	Not Scheduled to Work- Not Included in the distribution or invalid

4.2.A. CODE 1.A. - NON-MEDICAID OUTREACH – U

This code should be used by all LEA staff when performing activities that inform individuals about non-Medicaid social, vocational and educational programs (including special education) and how to access them; describing the range of benefits covered under these non-Medicaid social, vocational and educational programs and how to obtain them. Both written and oral methods may be used. Includes related paperwork, clerical activities or staff travel required to perform these activities.

- Informing families about wellness programs and how to access these programs.
- Scheduling and promoting activities that educate individuals about the benefits of healthy lifestyles and practices.
- Conducting general health education programs or campaigns that address lifestyle changes in the general population (e.g. dental prevention, anti-smoking, alcohol reduction, etc.).
- Conducting outreach campaigns that encourage persons to access social, educational, legal or other services not covered by Medicaid.
- Assisting in early identification of children with special medical/dental/mental health needs through various child find activities.
- Outreach activities in support of programs that are 100 percent funded by state general revenue.
- Developing outreach materials such as brochures or handbooks for these programs.
- Distributing outreach materials regarding the benefits and availability of these programs.

4.2.B. CODE 1.B. - MEDICAID OUTREACH – TM/50 PERCENT FFP

LEA staff should use this code when performing activities that inform eligible or potentially eligible individuals about Medicaid and how to access it. Activities include bringing potentially eligible individuals into the Medicaid system for the purpose of determining eligibility and arranging for the provision of Medicaid services. LEAs may only conduct outreach for the populations served by their affiliated schools, i.e., students and their parents or guardians. Examples include:

- Informing Medicaid eligible and potentially Medicaid eligible children and families about the benefits and availability of services provided by Medicaid (including preventive treatment and screening), including services provided through the EPSDT program.
- Developing and/or compiling materials to inform individuals about the Medicaid program (including EPSDT) and how and where to obtain those benefits. Note: This activity



should not be used when Medicaid-related materials are already available to the schools (such as through the Medicaid agency). As appropriate, school-developed outreach materials should have prior approval of the Medicaid agency.

- Distributing literature about the benefits, eligibility requirements, and availability of the Medicaid program, including EPSDT.
- Assisting the Medicaid agency to fulfill the outreach objectives of the Medicaid program by informing individuals, students and their families about health resources available through the Medicaid program.
- Providing information about Medicaid EPSDT screening (e.g. dental, vision) in schools that will help identify medical conditions that can be corrected or improved by services offered through the Medicaid program.
- Contacting pregnant and parenting teenagers about the availability of Medicaid prenatal and well baby care programs and services.
- Providing information regarding Medicaid managed care programs and health plans to individuals and families and how to access that system.
- Encouraging families to access medical/dental/mental health services provided by the Medicaid program.

Activities which are not considered Medicaid outreach under any circumstances are: (1) general preventive health education programs or campaigns addressing lifestyle changes, and (2) outreach campaigns directed toward encouraging persons to access social, educational, legal or other services not covered by Medicaid.

4.2.C. CODE 2.A. - FACILITATING APPLICATION FOR NON-MEDICAID PROGRAMS – U

LEA staff should use this code when informing an individual or family about programs such as Temporary Assistance for Needy Families (TANF), Food Stamps, Women, Infants, and Children (WIC), day care, legal aid and other social or educational programs and referring them to the appropriate agency to make application. The following are examples:

- Explaining the eligibility process for non-Medicaid programs, including IDEA.
- Assisting the individual or family in collecting/gathering information and documents for the non-Medicaid program application.
- Assisting the individual or family in completing the application, including necessary translation activities.
- Developing and verifying initial and continuing eligibility for the Free and Reduced Lunch Program.
- Developing and verifying initial and continuing eligibility for non-Medicaid programs.
- Providing necessary forms and packaging all forms in preparation for the non-Medicaid eligibility determination.



4.2.D. CODE 2.B. - FACILITATING MEDICAID ELIGIBILITY DETERMINATION - TM/50 PERCENT FFP

LEA staff should use this code when assisting an individual in becoming eligible for Medicaid. Includes related paperwork, clerical activities or staff travel required to perform these activities. This activity does not include the actual determination of Medicaid eligibility. Examples include:

- Verifying an individual's current Medicaid eligibility status for purposes of the Medicaid eligibility process.
- Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective applicants.
- Assisting individuals or families in completing a Medicaid eligibility application.
- Gathering information related to the application and eligibility determination for an individual, including resource information and third party liability (TPL) information, as a prelude to submitting a formal Medicaid application.
- Providing necessary forms and packaging all forms in preparation for the Medicaid eligibility determination.
- Referring an individual or family to the local assistance office to make application for Medicaid benefits.
- Assisting the individual or family in collecting/gathering required information and documents for the Medicaid application.
- Participating as a Medicaid eligibility outreach outstation (does not include determining eligibility).

4.2.E. CODE 3. - SCHOOL RELATED AND EDUCATIONAL ACTIVITIES – U

This code should be used for any other school related activities that are not health related, such as social services, educational services and teaching services; employment and job training. These activities include the development, coordination and monitoring of a student's education plan. Includes related paperwork, clerical activities or staff travel required to perform these activities. Examples include:

- Providing classroom instruction (including lesson planning).
- Testing, correcting papers.
- Developing, coordinating, and monitoring the academic portion of the Individualized Education Program (IEP) for a student, which includes ensuring annual reviews of the IEP are conducted, parental sign-offs are obtained, and the academic portion of the actual IEP meetings with the parents. (If appropriate, this would also refer to the same activities performed in support of an Individualized Family Service Plan [IFSP].)
- Compiling attendance reports.
- Performing activities that are specific to instructional, curriculum, and student-focused areas.
- Reviewing the education record for students who are new to the school district.



- Providing general supervision of students (e.g. playground, lunchroom).
- Monitoring student academic achievement.
- Providing individualized instruction (e.g. math concepts) to a special education student.
- Conducting external relations related to school educational issues/matters.
- Compiling report cards.
- Carrying out discipline.
- Performing clerical activities specific to instructional or curriculum areas.
- Activities related to the educational aspects of meeting immunization requirements for school attendance.
- Compiling, preparing, and reviewing reports on textbooks or attendance.
- Enrolling new students or obtaining registration information.
- Conferring with students or parents about discipline, academic matters or other school related issues.
- Evaluating curriculum and instructional services, policies, and procedures.
- Participating in or presenting training related to curriculum or instruction (e.g. language arts workshop, computer instruction).
- Translating an academic test for a student.

4.2.F. CODE 4.A. - DIRECT MEDICAL SERVICES – NOT COVERED ON A MEDICAL PLAN OF CARE (FFS – Non IEP) - U

This code should be selected when LEA staff members (employees or contracted staff) are providing direct client care services for which medical necessity has not been determined. This code includes pre- and post-activities associated with the actual delivery of the direct client care services, e.g. paperwork or staff travel required to perform these services.

Examples of activities reported under this code:

- All non-IDEA and/or non-IEP direct client care services as follows:
 - Providing health/mental health services.
 - Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports.
 - Performing developmental assessments.
 - Administering first aid.

4.2.G. CODE 4.B. - DIRECT MEDICAL SERVICES – COVERED AS IDEA/IEP SERVICE (FFS – IEP) – IEP RATIO

This code should be selected when LEA staff members (employees or contracted staff) provide direct client services as covered services delivered by LEAs under the FFS



Program for students with an IEP/IFSP. These direct client services may be delivered to an individual and/or group in order to ameliorate a specific condition and are performed in the presence of the student(s). This code includes the provision of all IDEA/IEP medical (i.e. health-related) services. It also includes functions performed pre- and post-actual direct client services (when the student may not be present); for example: paperwork, or staff travel directly related to the direct client services.

Examples of activities reported under this code:

4.2.G.1. ALL IDEA/IEP DIRECT CLIENT SERVICES WITH THE STUDENT/CLIENT PRESENT

Includes:

- Providing health/mental health services as covered in the student's IEP.
- Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports as covered in the student's IEP.

4.2.G.2. DIRECT MEDICAL SERVICES COST POOL

The list of services corresponds to all of the services outlined in the State Plan. This includes:

- Audiologist services, including evaluation and therapy services (only if included in the student's IEP/IFSP).
- Physical Therapy services and evaluations (only if included in the student's IEP/IFSP).
- Occupational Therapy services and evaluations (only if included in the student's IEP/IFSP).
- Speech Language Therapy services and evaluations (only if included in the student's IEP/IFSP).
- Psychological, Counseling and Social Work services, including therapy services (only if included in the student's IEP/IFSP).
- Orientation and Mobility services and evaluations (only if included in the student's IEP/IFSP).
- Nursing services and evaluations (only if included in the student's IEP/IFSP), including skilled nursing services on the IEP/IFSP and time spent administering/monitoring medication only if it is included as part of an IEP/IFSP and documented in the IEP/IFSP).
- Physician and Psychiatrist services (only if included in the student's IEP/IFSP).
- Assistive Technology Device Services.

4.2.G.3. PERSONAL CARE SERVICES

This code is used for providing a range of human assistance services to persons with disabilities and chronic conditions which enable them to accomplish tasks that they would normally do for themselves if they did not have a disability or chronic condition.



Assistance may be in the form of hands-on assistance or cueing so that the person performs the task by him/herself. The need for services must be documented in the child's IEP/IFSP. Services are not covered when provided by a family member or if they are educational in nature.

Personal care services include related paperwork, clerical activities, or staff travel required to perform the following activities:

- Eating/feeding
- Respiratory assistance
- Toileting
- Grooming
- Dressing
- Transferring
- Ambulation
- Intervention for seizure disorder
- Personal hygiene
- Mobility/Positioning
- Meal preparation
- Skin care
- Muscle strengthening
- Bathing
- Maintaining continence
- Medical equipment maintenance
- Assistance with self-administered medications
- Re-direction and intervention for behavior
- Health-related functions through hands-on assistance, supervision and cueing

4.2.G.4. TARGETED CASE MANAGEMENT SERVICES

This code is used for providing services which are a part of the IEP/IFSP treatment plan. These services identify and address special health problems and needs that affect the student's ability to learn and assist the student to gain and coordinate access to a broad range of medically-necessary services covered under the Medicaid program.

Targeted Case Management Services include related paperwork, clerical activities, or staff travel required to perform the following activities:

- Assure that standard re-examination/follow-up of the student is periodically conducted to ensure the student receives needed diagnosis and treatment.



- Assist families in identifying/choosing appropriate care providers and services.
- Maintain case records and indicate all contact for student in the same manner as other covered services.
- Coordinate performance evaluations/assessments and other service needs for the student.
- Prevention of duplicate services.
- Facilitation/participation in development, review and evaluation of the multi-disciplinary assessment.
- Supporting activities that link or coordinate needed health services for the student.
- Meeting with teachers and other professional staff to discuss testing, planning, treatment, coordinating effective interventions, and student progress.
- Coordinating school based services and treatment with parents and student.
- Monitoring and recommending a plan of action.
- Providing modifications to the multi-disciplinary, patient-centered treatment plan.
- Coordinating with staff/health professionals to establish continuum of health and behavioral services in the school setting.
- Provide summary of provider, parent and student consultation.

This code also includes pre- and post-time directly related to providing direct client care services when the student/client is not present. Examples of pre- and post-time activities when the student/client is not present include: time to complete all paperwork related to the specific direct client care service, such as preparation of progress notes, translation of session notes, review of evaluation testing/observation, planning activities for the therapy session, travel to/from the therapy session, or completion of billing activities.

General examples that are considered pre- and post-time:

- Pre- and post-activities associated with physical therapy services; for example: time to build a customized standing frame for a student or time to modify a student's wheelchair desk for improved freedom of movement for the client.
- Pre- and post-activities associated with speech language pathology services; for example: preparing lessons for a client to use with an augmentative communicative device or preparing worksheets for use in group therapy sessions.
- Updating the medical/health-related service goals and objectives of the IEP.
- Travel to the direct service/therapy.
- Paperwork associated with the delivery of the direct care service, as long as the student/client is not present. Such paperwork could include the preparation of progress notes, translation of session notes, or completion of billing activities.
- Interpretation of the evaluation results and/or preparation of written evaluations when student/client is not present. (Assessment services are billed for testing time when the



student is present, for interpretation time when the student is not present, and for report writing when the student is not present.)

4.2.H. CODE 4.C. - DIRECT MEDICAL SERVICES – COVERED ON A MEDICAL PLAN OF CARE, NOT COVERED AS IDEA/IEP SERVICE – MEDICAL PLAN RATIO

This code should be selected when LEA staff members (employees or contracted staff) provide direct client services as covered services delivered by LEAs under the FFS program when documented on a medical plan other than an IEP/IFSP or for services in which medical necessity has been determined. These direct client services may be delivered to an individual and/or group in order to ameliorate a specific condition and are performed in the presence of the student(s). This code includes the provision of medical (i.e., health-related) services outlined on a medical plan other than an IEP/IFSP or for which medical necessity has been determined. It also includes functions performed pre- and post-actual direct client services (when the student may not be present); for example: paperwork, or staff travel directly related to the direct client services.

Examples of activities reported under this code:

4.2.H.1. ALL MEDICAL PLAN DIRECT CLIENT SERVICES WITH THE STUDENT/CLIENT PRESENT

Includes:

- Providing health/mental health services as covered in the student’s medical plan other than an IEP/IFSP.
- Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports as covered in the student’s medical plan other than an IEP/IFSP.
- Services for which medical necessity has been determined.

The list of services corresponds to all of the services outlined in the State Plan. This includes:

- Audiologist services, including evaluation and therapy services (only if included in the student’s medical plan).
- Physical Therapy services and evaluations (only if included in the student’s medical plan).
- Occupational Therapy services and evaluations (only if included in the student’s medical plan).
- Speech Language Therapy services and evaluations (only if included in the student’s medical plan).
- Counseling services, including therapy services (only if included in the student’s medical plan or when medical necessity has been determined).
- Orientation and Mobility services and evaluations (only if included in the student’s medical plan).



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- Nursing services and evaluations (only if medical necessity has been determined including skilled nursing services on the medical plan, and time spent administering/monitoring medication only if it is included as part of a medical plan of care and documented in the plan of care).
- Nutrition services include the management and counseling for students on special diets for genetic metabolic disorders, prolonged illness, deficiency disorders or other complicated medical problems. Nutritional support through assessment and monitoring of the nutritional status and teaching related to the dietary regimen.
- All EPSDT covered services, such as screenings, immunizations, etc. or services in which medical necessity has been determined.

This code also includes pre- and post-time directly related to providing direct client care services when the student/client is not present. Examples of pre- and post-time activities when the student/client is not present include: time to complete all paperwork related to the specific direct client care service such as preparation of progress notes, translation of session notes, review of evaluation testing/observation, planning activities for the therapy session, travel to/from the therapy session, or completion of billing activities.

General examples that are considered pre- and post-time:

- Pre- and post-activities associated with physical therapy services; for example: time to build a customized standing frame for a student or time to modify a student's wheelchair desk for improved freedom of movement for the client.
- Pre- and post-activities associated with speech language pathology services; for example: preparing lessons for a client to use with an augmentative communicative device or preparing worksheets for use in group therapy sessions.
- Updating the medical/health-related service goals and objectives of the medical plan of care.
- Travel to the direct service/therapy.
- Paperwork associated with the delivery of the direct care service as long as the student/client is not present. Such paperwork could include the preparation of progress notes, translation of session notes, or completion of billing activities.
- Interpretation of the evaluation results and/or preparation of written evaluations when student/client is not present. (Assessment services are billed for testing time when the student is present, for interpretation time when the student is not present, and for report writing when the student is not present.)



4.2.I. CODE 5.A. - TRANSPORTATION FOR NON-MEDICAID SERVICES – U

LEA staff should use this code when assisting an individual to obtain transportation to services not covered by Medicaid or accompanying the individual to services not covered by Medicaid. Includes related paperwork, clerical activities or staff travel required to perform this activity:

- Scheduling or arranging transportation to social, vocational, and/or educational programs and activities.

4.2.J. CODE 5.B. – TRANSPORTATION-RELATED ACTIVITIES IN SUPPORT OF MEDICAID-COVERED SERVICES – PM/50 PERCENT FFP

LEA staff should use this code when assisting an individual to obtain transportation to services covered by Medicaid. This does not include the provision of the actual transportation service or the direct cost of the transportation, but rather the administrative activities involved in providing transportation. Includes related paperwork, clerical activities or staff travel required to perform these activities. An example is:

- Scheduling or arranging transportation to Medicaid covered services.

Note: Staff that may arrange transportation that may be included in the RMTS include, but are not limited to, Program Administrators, Special Education Support or other staff at the district who are responsible for arranging specialized transportation for students to receive medical services; however, job titles of staff that provide these types of services vary by district.

4.2.K. CODE 6.A. - NON-MEDICAID TRANSLATION – U

LEA staff should use this code when providing translation services related to social, vocational or educational programs and activities as an activity separate from the activities referenced in other codes. Includes related paperwork, clerical activities or staff travel required to perform these activities. Examples include:

- Arranging for or providing translation services (oral or signing services) that assist the individual to access and understand social, educational, and vocational services.
- Arranging for or providing translation services (oral or signing services) that assist the individual to access and understand state education or state-mandated health screenings (e.g. vision, hearing, and scoliosis) and general health education outreach campaigns intended for the student population.
- Developing translation materials that assist individuals to access and understand social, educational, and vocational services.

4.2.L. CODE 6.B. - TRANSLATION RELATED TO MEDICAID SERVICES - PM/75 PERCENT FFP

Translation may be allowable as an administrative activity if it is not included and paid for as part of a medical assistance service. However, it must be provided by separate units



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or separate employees performing solely translation functions for the LEA and it must facilitate access to Medicaid covered services.

This code should be used by LEA employees who provide translation services related to Medicaid covered services as an activity separate from the activities referenced in other codes. Includes related paperwork, clerical activities or staff travel required to perform these activities. Examples include:

- Arranging for or providing translation services (oral and signing) that assist the individual to access and understand necessary care or treatment covered by Medicaid.
- Developing translation materials that assist individuals to access and understand necessary care or treatment covered by Medicaid.
- Providing translation services (oral and signing) that assist the individual to access and understand necessary care or treatment covered by Medicaid.
- Developing translated materials, including Braille transcriptions, that assist individuals to access and understand necessary care or treatment covered by Medicaid
- Translation while the school nurse provides covered services to a student whose primary language is not English.
- Sign language interpretation during provision of covered services to a deaf child.
- Transcribing into Braille the fact sheet school nurses use to explain/practice steps/proper technique for using an inhaler.
- Translation to help a school psychologist follow up with a student's non-English speaking parent on a mental health referral.

4.2.M. CODE 7.A. - PROGRAM PLANNING, POLICY DEVELOPMENT AND INTERAGENCY COORDINATION RELATED TO NON-MEDICAL SERVICES – U

LEA staff should use this code when performing activities associated with the development of strategies to improve the coordination and delivery of non-medical/non-mental health services to school age children and when performing collaborative activities with other agencies. Non-medical services may include social, educational and vocational services. Only employees whose position descriptions include program planning, policy development and interagency coordination should use this code. Includes related paperwork, clerical activities or staff travel required to perform these activities. Examples include:

- Identifying gaps or duplication of non-medical services (e.g. social, vocational, educational and state-mandated general health care programs) to school age children and developing strategies to improve the delivery and coordination of these services.
- Developing strategies to assess or increase the capacity of non-medical school programs.
- Monitoring the non-medical delivery systems in schools.
- Developing procedures for tracking families' requests for assistance with non-medical services and the providers of such services.



- Evaluating the need for non-medical services in relation to specific populations or geographic areas.
- Analyzing non-medical data related to a specific program, population, or geographic area.
- Working with other agencies providing non-medical services to improve the coordination and delivery of services and to improve collaboration around the early identification of non-medical problems.
- Defining the relationship of each agency's non-medical services to one another.
- Developing advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services and state-mandated health screenings to the school populations.
- Developing non-medical referral sources.
- Coordinating with interagency committees to identify, promote and develop non-medical services in the school system.

4.2.N. CODE 7.B. - PROGRAM PLANNING, POLICY DEVELOPMENT AND INTERAGENCY COORDINATION RELATED TO MEDICAL/MEDICAID SERVICES - PM/50 PERCENT FFP

This code should be used by LEA staff when performing activities associated with the development of strategies to improve the coordination and delivery of medical/dental/mental health services to school age children, and when performing collaborative activities with other agencies and/or providers. Employees whose position descriptions include program planning, policy development and interagency coordination may use this code. However, it is a state option whether or not the position descriptions need to be explicit with respect to these specific functions. This code refers to activities such as planning and developing procedures to track requests for services; the actual tracking of requests for Medicaid services would be coded under Code 9.b. - Referral, Coordination and Monitoring of Medicaid Services. Includes related paperwork, clerical activities or staff travel required to perform these activities. Examples include:

- Identifying gaps or duplication of medical/dental/mental health services to school age children and developing strategies to improve the delivery and coordination of these services.
- Developing strategies to assess or increase the capacity of school medical/dental/mental health programs.
- Monitoring the medical/dental/mental health delivery systems in schools.
- Developing procedures for tracking families' requests for assistance with medical/dental/mental health services and providers, including Medicaid. (This does not include the actual tracking of requests for Medicaid services.)
- Evaluating the need for medical/dental/mental health services in relation to specific populations or geographic areas.
- Analyzing Medicaid data related to a specific program, population, or geographic area.
- Working with other agencies and/or providers that provide medical/dental/mental health services to improve the coordination and delivery of services, to expand access to



specific populations of Medicaid eligible, and to increase provider participation and improve provider relations.

- Working with other agencies and/or providers to improve collaboration around the early identification of medical/dental/mental health problems.
- Developing strategies to assess or increase the cost effectiveness of school medical/dental/mental health programs.
- Defining the relationship of each agency's Medicaid services to one another.
- Working with Medicaid resources, such as the Medicaid agency and Medicaid managed care plans, to make good faith efforts to locate and develop EPSDT health services referral relationships.
- Developing advisory or work groups of health professionals to provide consultation and advice regarding the delivery of health care services to the school populations.
- Working with the Medicaid agency to identify, recruit and promote the enrollment of potential Medicaid providers.
- Developing medical referral sources, such as directories of Medicaid providers and managed care plans, which will provide services to targeted population groups, e.g. EPSDT children.
- Coordinating with interagency committees to identify, promote and develop EPSDT services in the school system.

4.2.O. CODE 8.A. - NON-MEDICAL/MEDICAID TRAINING – U

This code should be used by LEA staff when coordinating, conducting or participating in training events and seminars for school-based services staff regarding the benefit of the programs other than the Medicaid program such as educational programs; for example: how to assist families to access the services of the relevant programs and how to more effectively refer students for those services. Includes related paperwork, clerical activities or staff travel required to perform these activities. Examples include:

- Participating in or coordinating training that improves the delivery of services for programs other than Medicaid.
- Participating in or coordinating training that enhances IDEA child find programs.

4.2.P. CODE 8.B. - MEDICAL/MEDICAID RELATED TRAINING – PM/50 PERCENT FFP

This code should be used by LEA staff when coordinating, conducting or participating in training events and seminars for Michigan Direct Medical Service and AOP staff regarding the benefits of the Medicaid program, how to assist families in accessing Medicaid services, and how to more effectively refer students for services. Includes related paperwork, clerical activities or staff travel required to perform these activities. Examples include:

- Participating in or coordinating training that improves the delivery of medical/Medicaid related services.



- Participating in or coordinating training that enhances early identification, intervention, and screening of students with special health needs to such services (e.g. Medicaid EPSDT services). (This is distinguished from IDEA child find programs.)

4.2.Q. CODE 9.A. - REFERRAL, COORDINATION AND MONITORING OF NON-MEDICAID SERVICES –U

LEA staff should use this code when making referrals for coordinating and/or monitoring the delivery of non-medical, such as educational, services. Includes related paperwork, clerical activities or staff travel required to perform these activities. Examples include:

- Making referrals for and coordinating access to social and educational services such as child care, employment, job training, and housing.
- Making referrals for, coordinating, and/or monitoring the delivery of state education agency mandated child health screens (e.g. vision, hearing, and scoliosis).
- Making referrals for, coordinating, and monitoring the delivery of scholastic, vocational, and other non-health related examinations.
- Gathering any information that may be required in advance of these non-Medicaid related referrals.
- Participating in a meeting/discussion to coordinate or review a student's need for scholastic, vocational, and non-health related services not covered by Medicaid.
- Monitoring and evaluating the non-medical components of the individualized plan as appropriate.

Case Management: Note that case management as an administrative activity involves the facilitation of access and coordination of program services. Such activities may be provided under the term Case Management or may also be referred to as Referral, Coordination, and Monitoring of Non-Medicaid Services.

Case management may also be provided as an integral part of the service and would be included in the service cost. School staff should use this code when making referrals for, coordinating, and/or monitoring the delivery of non-Medicaid covered services.

4.2.R. CODE 9.B. - REFERRAL, COORDINATION AND MONITORING OF MEDICAID SERVICES – PM/50 PERCENT FFP

School staff should use this code when making referrals for, coordinating, and/or monitoring the delivery of medical (Medicaid covered) services. Referral, coordination and monitoring activities related to services in an IEP are reported in this code. Activities that are part of a direct service are not claimable as an administrative activity. Furthermore, activities that are an integral part of or an extension of a medical service (e.g. patient follow-up, patient assessment, patient counseling, patient education, patient consultation, billing activities) should be reported under Code 4.a. - Direct Medical Services - Not Covered on a Medical Plan of Care (FFS – Non-IEP); 4.b. - Direct Medical Services - Covered as IDEA/IEP Services (FFS – IEP); or 4.c. - Direct Medical Services – Covered on a Medical Plan of Care, Not Covered as IDEA/IEP Service. Examples include:



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- Identifying and referring adolescents who may be in need of Medicaid family planning services.
- Making referrals for and/or coordinating medical or physical examinations and necessary medical/dental/mental health evaluations.
- Making referrals for and/or scheduling EPSDT screens, interperiodic screens, and appropriate immunization, but NOT to include the state-mandated health services.
- Referring students for necessary medical health, mental health, or substance abuse services covered by Medicaid.
- Arranging for any Medicaid covered medical/dental/mental health diagnostic or treatment services that may be required as the result of a specifically identified medical/dental/mental health condition.
- Gathering any information that may be required in advance of medical/dental/mental health referrals.
- Participating in a meeting/discussion to coordinate or review a student's needs for health-related services covered by Medicaid.
- Developing, coordinating, and monitoring the medical portion of the Individualized Education Program (IEP) for a student which includes the medical portion of the actual IEP meetings with the parents, time spent developing the medical services plan on the IEP, and writing of the medical service goals of the IEP. (If appropriate, this would also refer to the same activities performed in support of an Individualized Family Service Plan (IFSP) or other medical plan.)
- Providing follow-up contact to ensure that a child has received the prescribed medical/dental/mental health services covered by Medicaid.
- Coordinating the delivery of community based medical/dental/mental health services for a child with special/severe health care needs.
- Coordinating the completion of the prescribed services, termination of services, and the referral of the child to other Medicaid service providers as may be required to provide continuity of care.
- Providing information to other staff on the child's related medical/dental/mental health services and plans.
- Monitoring and evaluating the Medicaid service components of the IEP and/or medical plan as appropriate.
- Coordinating medical/dental/mental health service provision with managed care plans as appropriate.

Note: A "referral" is considered appropriate when made to a provider who can provide the required service, will accept the student as a patient, and will accept the student's source of payment for services.

Case Management: Note that case management as an administrative activity involves the facilitation of access and coordination of program services. Such activities may be provided under the term Case Management or may also be referred to as Referral, Coordination, and Monitoring of Non-Medicaid Services.



Case management may also be provided as an integral part of the service and would be included in the service cost. School staff should use this code when making referrals for, coordinating, and/or monitoring the delivery of non-Medicaid covered services.

4.2.S. CODE 10. - GENERAL ADMINISTRATION – R

Time study participants, when performing activities that are not directly assignable to program activities, should use this code. Includes related paperwork, clerical activities or staff travel required to perform these activities. Note that certain functions such as payroll, maintaining inventories, developing budgets, executive direction, etc. are considered overhead and, therefore, are only allowable through the application of an approved indirect cost rate.

Below are typical examples of general administrative activities but they are not all inclusive.

- Taking lunch, breaks, leave, or other paid time not at work.
- Establishing goals and objectives of health-related programs as part of the school's annual or multi-year plan.
- Reviewing school or district procedures and rules.
- Attending or facilitating school or unit staff meetings, training, or board meetings.
- Performing administrative or clerical activities related to general building or district functions or operations.
- Providing general supervision of staff, including supervision of student teachers or classroom volunteers, and evaluation of employee performance.
- Reviewing technical literature and research articles.
- Other general administrative activities of a similar nature as listed above that cannot be specifically identified under other activity codes.

4.2.T. CODE 11. - NOT SCHEDULED TO WORK – NOT INCLUDED IN THE DISTRIBUTION OR INVALID

This code should be used if the random moment occurs at a time when a part-time, temporary or contracted employee is not scheduled to be at work. Note: Full-time school staff should not use this code.



SECTION 5 – CONFIDENTIALITY

Aggregate time study data may occasionally be useful for other administrative tasks (i.e., planning) and may be used in that way. However, any individually identifiable information must be protected as required by all applicable state and federal statutes and regulations to ensure confidentiality and protection of privacy.



SECTION 6 – TIME STUDY TRAINING

6.1 TRAINING

The approved training methods, materials, information, and instructions are tailored to each group involved in the time studies.

The Contractor, along with MDHHS, is responsible for developing training programs and materials and, along with the ISD coordinator, providing follow-up assistance as needed. For training, there are some services the Contractor will provide statewide and other services that will be provided to the individual ISDs.

6.1.A. LOCAL ISD COORDINATOR TRAINING

All ISDs have an ISD Coordinator/representative who receives training that ensures a thorough understanding of their coordinator responsibilities, the approved time study and cost reporting activities. These individuals must understand their role as the liaison between the Medicaid Program, the Contractor, and other staff. They must understand and be able to convey to others the basic purpose of the program, assist the Contractor with follow-up as needed, and serve as a facilitator for the Contractor to "navigate" the district as necessary.

6.1.B. TIME STUDY PARTICIPANT TRAINING

For time study participants, it is essential that these individuals understand the purpose of the time studies, that time is of the essence related to completion of the form, and that their role is crucial to the success of the time study. The Contractor develops and provides detailed written information and instructions for completing the time study forms as a coversheet attached to each time study form. The coversheet provides a "tutorial" with the aforementioned basics of the program as well as information about the Medicaid covered services provided in the school setting.



SECTION 7 – SUMMARY OF TIME STUDY STEPS

The Contractor duties are to:

- Import eligible school district staff information to create the RMTS staff pools.
- Randomly select staff/moments to be sampled.
- Generate printed or electronic RMTS forms for each moment.
- Generate and distribute a master list of selected moments to the ISD Coordinators as a local control list.
- Generate mailing labels addressed to randomly selected staff.
- Code the time study responses.
- Calculate activity percentages for each of the activity codes.
- Scan completed and coded time study forms.
- Transfer raw data from scanned forms to the claims development software to calculate activity percentages for each of the activity codes.
- Produce quarterly reports summarizing the results of the random moment time studies (RMTS) and RMTS compliance reporting. (Both reports are forwarded to the MDHHS Program Policy Division for posting on the MDHHS website. Refer to the Directory Appendix for website information.)
- Produce periodic and special RMTS reports that provide data and information sorted by LEA and ISD that are provided to the CMS, MDHHS, MDE, ISDs and their auditors.
- Create and verify the eligible staff pools for time studies from the quarterly information provided by the ISDs.
- Distribute time study forms and collect completed time study forms.
- Code the activity forms received from the ISDs.
- Initiate and complete the ISD claim workbooks by obtaining the financial data from each LEA and compiling data to complete the workbook.



SECTION 8 – SUMMER QUARTER TIME STUDY METHODOLOGY

8.1 AOP QUARTERLY CLAIM (OTHER THAN SUMMER QUARTER)

The claim consists of the results of the quarterly RMTS of the approved staff pool for the quarter and the correlating allowable costs applied to the reimbursement methodology.

8.2 AOP SUMMER QUARTER FORMULA AND RANDOM MOMENT TIME STUDY

The summer quarter months are July, August and September. There is a break period between the end of one regular school year and the beginning of the next regular school year during which only a few staff are working. The majority of school staff work during the school year and do not work for part of the summer quarter (9-month staff). However, there are some 9-month staff that opt to receive their pay over a 12-month period. Therefore, different factors must be applied to the summer formula in order to accurately reflect the activities that are performed by the staff.

The summer quarter is divided into two parts producing two partial claims. For the AOP process, the sum of both claims is submitted to Medicaid for reimbursement for the summer quarter. The first part of the quarter is from July 1 to the date students return to school. The second part of the quarter is from the date students return to school through September 30.

The summer time study of 800 moments is performed after students return to school and is only applied to the staff pool costs for the second part of the summer quarter (Fall staff pool costs). The RMTS is performed during a shorter time period to accurately reflect the work efforts being performed when all staff have returned to work.

The sums of Part I and Part II are utilized to calculate the claim submitted to Medicaid for reimbursement.

8.2.A. PART I - JULY 1 TO THE INDIVIDUAL ISD DATE THAT STUDENTS RETURN TO SCHOOL

Part I of the summer quarter is comprised of the following elements:

- Staff Pool – those eligible staff in the April through June staff pool
- Costs – April through June allowable staff pool costs
- A weighted average of the October-December, January-March, April-June, and the summer time study results.

8.2.B. PART II – DATE STUDENTS RETURN TO SCHOOL THROUGH SEPTEMBER 30

Part II of the summer quarter is comprised of the following elements:

- Staff Pool – the eligible new Fall staff returning to work
- Costs – the allowable cost associated with the new Fall staff pool
- RMTS – the time study for Part II is performed for a shortened period of time from the day students return to school through September 30. The start date will vary by ISD depending on the date the students return to school.



8.3 DIRECT MEDICAL SUMMER QUARTER FORMULA AND RANDOM MOMENT TIME STUDY

A weighted average of the four time study results for the staff pool periods listed below is applied to the Medicaid Allowable Expenditure Report (MAER) total costs. The MAER costs include the annual costs associated with the direct medical services, personal care services and targeted case management services.

The direct medical services time study application is comprised of the following elements:

- Staff Pools – Those individuals eligible to participate in the following four staff pool periods:
 - October through December
 - January through March
 - April through June
 - Date students return to school through September 30 (summer time study)
- Cost Pool – The costs from the annual Medicaid Allowable Expenditure Report (direct medical services, targeted case management and personal care services).
- RMTS – A weighted average of the October–December, January–March, April–June and the summer time study results as described above.

8.4 FINANCIAL REPORTING COMPLIANCE REQUIREMENTS

The financial data reported (salaries, benefits, supplies, purchased services, and other expenditures) must be based on actual detailed expenditures from LEA payroll and financial systems. Payroll and financial system data must be applied using generally accepted governmental accounting standards and principles or applicable administrative rules. The expenditures accumulated must correlate to the claiming period.



SECTION 9 – AUDIT AND QUALITY ASSURANCE

9.1 AUDIT

9.1 A. ACTIVITIES TO BE PERFORMED BY MDHHS OFFICE OF AUDIT STAFF

MDHHS audit staff review of selected ISD cost reports includes the following activities:

- Verification that the salaries listed for employees/positions included in the Random Moment Time Study (RMTS) staff pool match the payroll records for the same period as the time study.
- A review of the salaries of employees who changed positions during the time study period.
- If a replacement was hired/transferred, the auditor will verify that only the salary earned while working in a position on the staff pool list was reported, and that salaries for both the original and replacement employees were not duplicated on the report for the same time period.
- Verification that any other salaries and costs for supplies, etc., are of direct benefit to the employees on the relevant staff pool list and, therefore, allocable to that staff pool cost. For the Direct Medical program, all supplies and materials must be medically related.
- Confirmation that none of the direct costs reported were also claimed as an indirect cost, that the proper indirect cost rate was used, and the rate was applied only to costs in the base. The employees in non-standard job categories are the most likely to be considered indirect type employees; therefore, documentation will be reviewed for these individuals.
- Verification that no federal funds were claimed on the cost reports and that costs were not accepted for cost sharing.
- A standard review of other areas, such as confirmation that reported costs were actually paid, support documentation was maintained as required, and costs were properly charged to the correct accounts.
- Verification of recipient eligibility, documentation of services in the IEP/IFSP, and provider credentials.

The ISD must be prepared to direct the auditor to any document used to support and identify the reported RMTS costs.

9.1.B. SSAE 16 AUDIT REQUIREMENTS

The Contractor is required to have a Type II Statement on Standards for Attestation Engagements (SSAE) 16 audit to provide the necessary assurances that the claiming process (e.g., methodology, time studies, cost allocations, etc.) have been properly applied.

In a SSAE 16 Type II engagement, the service auditor expresses an opinion on whether the description of the service organization's system is fairly presented, whether the controls included in the description are suitably designed, whether the controls were



operating effectively, and provides a description of the service auditor's tests of operating effectiveness and the results of those tests.

The Contractor must undergo a SSAE 16 audit annually. The SSAE 16 audit must be submitted within 90 days after the end of the examination period.

Three (3) copies of the audit should be forwarded to the MDHHS Program Policy Section. (Refer to the Directory Appendix for contact information.)

9.2 QUALITY ASSURANCE, OVERSIGHT AND MONITORING

Quality assurance, oversight and monitoring activities include:

9.2.A. MDHHS PROGRAM POLICY – OVERSIGHT OF ADMINISTRATION AND OPERATIONS

MDHHS policy staff responsibilities are:

- Review quarterly time study results against historical benchmarks according to:
 - Overall results and matchable percentages
 - Benchmarks by activity code and by staff category
- Detailed investigation of anomalies in results.
- Determination of policy or procedure changes based on results of anomaly review.
- Overall statistical requirements in terms of confidence and precision levels on a quarterly basis and an annual basis.
- Sampling to review coding activities performed by the Contractor.
- Disseminate CMS guidance.
- Monitor ISDs processing of claims for compliance with State and Federal regulations and program guidelines.
- Assure that billing entities have the processes in place to correct any claims paid in error.
- Provide information and training to billing entities as needed for program compliance.
- Provide operational oversight and technical assistance.
- Assist the ISDs with quality assurance and compliance monitoring.
- Provide oversight of the ISDs quality assurance and compliance plans to insure that they provide oversight and monitoring of such things as documentation, provider credentials, record retention, parental consent, and confidentiality.



9.2.B. MDHHS OFFICE OF INSPECTOR GENERAL – POST PAYMENT REVIEW AND COMPLIANCE

MDHHS Office of Inspector General staff responsibilities are:

- Post payment review for the purpose of adherence to provider policy, provider credentials and appropriate billing practices.
- Post payment review for the purpose of reported fraud or abuse.

For more detailed information regarding the Fraud and Abuse and Post Payment Review, refer to the Post Payment Review and Fraud/Abuse Section of the General Information for Providers Chapter.

9.2.C. MDHHS RATE REVIEW SECTION – COST SETTLEMENT REVIEW

MDHHS Rate Review Section staff responsibilities are:

- Import and create a database of the cost report data submitted by the ISDs.
- Perform reviews of the data for accuracy and completeness.
- Summarize the data and forward to the ISDs for final approval.
- Compile cost settlement summaries and prepare over/under adjustments.

9.2.D. CONTRACTOR OVERSIGHT AND QUALITY ASSURANCE

There are several levels of quality assurance and validation built into the RMTS process.

- In terms of coding, the Contractor has a coding process in place in which centralized coders code all moments, and then a second coder reviews all moments coded as matchable for verification of accurate and consistent application of activity codes. The second coder also reviews a random sample of 10% of all non-matchable moments for quality assurance purposes.
- Quality assurance and validation includes the quarterly review which includes the Contractor meeting with MDHHS staff specifically to review time study results and other procedural issues. Each quarter, the team reviews detailed reports which outline the current quarter time study results benchmarked against past quarter results. The results are reviewed by activity code as well as by matchable/non-matchable categories. Comparisons are made of the variances in the overall quarterly results from the same quarter in the previous year, as well as variances of the current quarter against the average of the past four quarters. Results are reviewed and discussed in terms of results by staff category. Any anomalies identified are pursued through a detailed investigation of the moments which produced the anomaly. The Contractor, in conjunction with MDHHS, then determines how to handle any issues in terms of additional communication or training for RMTS participants, policy or procedural changes, etc.
- ISDs utilizing the web-based input process may view compliance reporting online.
- ISDs utilizing the paper methodology are sent compliance reporting on a weekly basis.



9.2.E. ISD OVERSIGHT

ISD responsibilities are to:

- have systems in place to monitor service delivery, claim documentation, claim billing, and payments received.
- verify that the credentials of all clinicians are current and appropriate for Medicaid billing and that services rendered are within the scope of the clinician's practice.



SPECIAL PROGRAMS

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SECTION 1 – GENERAL INFORMATION

This chapter applies to all providers.

The Michigan Department of Health and Human Services (MDHHS) administers the Medicaid Program, Children's Special Health Care Services (CSHCS), Maternity Outpatient Medical Services (MOMS) and other special programs described elsewhere in this manual. In addition to these traditional programs, MDHHS administers many other programs/coverages to meet the healthcare needs of Michigan's medically indigent population. Programs vary in scope and eligibility requirements and are funded through various sources, including federal, state, and/or private. Some of the programs offer comprehensive or reduced Medicaid benefits as indicated. Additional information regarding these programs may be available on the MDHHS website.

Contact information for the various programs is listed in the Directory Appendix.



SECTION 2 – PROGRAMS THAT TARGET SPECIFIC MEDICAL CONDITIONS

2.1 BREAST AND CERVICAL CANCER CONTROL PROGRAM

2.1.A. ELIGIBLE BENEFICIARIES

The Breast and Cervical Cancer Control Program (BCCCP) covers uninsured low-income women of all ages especially, but not limited to, women aged 40-64. Certain income restrictions do apply. Enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from co-pays.

- Insured women may apply if certain insurance, age, and income requirements are met.
- Women who are enrolled in a managed care program, health maintenance organization (HMO) or have Medicare Part B are not eligible.

2.1.B. COVERED SERVICES

Covered services include:

- Clinical breast exams
- Pap smears
- Pelvic exams
- Screening mammogram, and
- Appropriate referral to community providers for follow-up of abnormalities.

Breast biopsy, colposcopy-directed services, colposcopy service, diagnostic mammograms, and loop electrosurgical excision procedure (LEEP) may be provided based upon medical needs, financial and insurance status, and availability of federal grant funds or Michigan tobacco tax dollars.

2.2 TRAUMATIC BRAIN INJURY REHABILITATION PROGRAM

2.2.A. ELIGIBLE BENEFICIARIES

The Traumatic Brain Injury (TBI) Rehabilitation Program covers adults age 18 or older who are U.S. citizens and have incurred a traumatic brain injury in the past 15 months, or have experienced a significant change within the last three months but are medically stable. Individuals must be a RANCHO 5-6 and currently Medicaid eligible. There must be a documented need for comprehensive, specialized rehabilitative services.

Individuals must be bowel and bladder trained and able to actively participate in 21 hours of therapy a week. Services must be provided under a physician approved plan of care and rendered in a residential or outpatient program that is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and has an agreement with a Medicaid approved nursing facility.



2.2.B. COVERED SERVICES

In addition to regular Medicaid coverage, the TBI Rehabilitation Program provides:

- Hearing & speech/language services
- Occupational therapy
- Physical therapy
- Physician services
- Psychological services
- Social work.

Vocational and educational services are not reimbursable by Medicaid.



SECTION 3 – GENERAL COVERAGE PROGRAMS

3.1 MEDICARE SAVINGS PROGRAM

3.1.A. ELIGIBLE BENEFICIARIES

Low income Medicare beneficiaries and those individuals who are eligible for Medicare but do not enroll due to the cost may participate in the Medicare Savings Program (MSP). Financial and nonfinancial requirements and restrictions do apply.

3.1.B. COVERED SERVICES

The MSP pays Medicare coinsurance, deductible, and premiums.

3.2 SPECIAL N SUPPORT

3.2.A. ELIGIBLE BENEFICIARIES

Families that received the low-income families (LIF) Medicaid but are no longer eligible due to an increase in child support may qualify for Special N Support. Most of the health coverage is provided by Medicaid Health Plans (MHPs), and the majority of the beneficiaries are already enrolled in a MHP.

3.2.B. COVERED SERVICES

Special N Support beneficiaries receive regular Medicaid coverage for four months.

3.3 FREEDOM TO WORK

3.3.A. ELIGIBLE BENEFICIARIES

Medicaid-eligible disabled adults aged 16 through 64 years old with earned income may be eligible. SSI beneficiaries whose SSI eligibility may end due to financial factors are among those eligible to be considered for this program.

To be eligible, the beneficiary must be employed on a regular and continuing basis. There may be temporary breaks in employment up to 24 months if they are the result of involuntary layoff or are determined to be medically necessary.

For a married beneficiary, the spouse's income and assets are not considered when determining eligibility for this Medicaid category. The beneficiary's total countable unearned income cannot exceed 250 percent of the Federal Poverty Level (FPL) for ongoing eligibility. The beneficiary's countable assets are limited to \$75,000. In addition, the beneficiary is allowed to have IRS-recognized retirement accounts (including IRAs and 401Ks) of unlimited value.

3.3.B. COVERED SERVICES

Freedom To Work beneficiaries receive regular Medicaid coverage.



3.3.C. PREMIUMS

If the beneficiary's Modified Adjusted Gross Income (MAGI) is below 138 percent of the FPL, there is no premium required for coverage. If the beneficiary's MAGI is between 138 percent of the FPL and \$75,000 per year, the premium is 2.5 percent of MAGI. If the total countable earned income exceeds \$75,000 per year, the beneficiary must pay a premium equal to 100 percent of the cost of Medicaid coverage.

3.4 MEDICAID FOR SUPPLEMENTAL SECURITY INCOME BENEFICIARIES

3.4.A. ELIGIBLE BENEFICIARIES

Supplemental Security Income (SSI) covers disabled children whose families have low income, and low-income adults who are aged, disabled or blind. The Social Security Administration determines eligibility and awards monthly SSI payments based on income and assets requirements. Beneficiaries awarded SSI are automatically eligible for regular Medicaid coverage.

3.4.B. COVERED SERVICES

SSI beneficiaries are eligible for regular Medicaid. In some cases, Medicare premiums are paid by Medicaid based upon certain individual situations and previous work histories.

3.5 TRANSITIONAL MEDICAL ASSISTANCE

3.5.A. ELIGIBLE BENEFICIARIES

Transitional Medical Assistance (TMA) covers families who are U.S. citizens that are no longer eligible for the low-income family (LIF) Medicaid because the parent(s) has too much income from employment. The family must have received low-income family Medicaid for at least three months of the previous six months to be eligible for TMA. Most of the health coverage is provided by HMOs contracted by MDHHS. The majority of the beneficiaries are already enrolled in a MHP. A renewal of the application to TMA is not necessary.

3.5.B. COVERED SERVICES

TMA provides regular Medicaid coverage, or a comprehensive health care package that includes vision, dental and mental health services, if the beneficiary has been enrolled in a MHP for 12 months.



SECTION 4 – COMMUNITY-BASED LONG TERM CARE

4.1 MI CHOICE WAIVER (HOME AND COMMUNITY-BASED WAIVER FOR THE ELDERLY AND DISABLED)

The MI Choice Waiver provides services to aged and physically disabled individuals 18 years old and over who are eligible for full Medicaid and want to stay in their homes or another residential setting but, without the provision of waiver services, would require the level of care only available in a nursing facility. Income and assets requirements and restrictions apply. Applicants must also meet the Michigan Medicaid Nursing Facility Level of Care Determination criteria. Individuals must be currently Medicaid approved or be Medicaid eligible if they were to enter a nursing facility. MDHHS contracts with local agencies to administer this program. (Refer to the MI Choice Waiver Chapter for additional information.)

4.2 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

PACE is a comprehensive service delivery system for frail, elderly individuals who meet the Michigan Medicaid Nursing Facility Level of Care criteria. Refer to the PACE Chapter of this manual for additional information.



SECTION 5 – MICHILD

5.1 ELIGIBLE BENEFICIARIES

The MICHild Medicaid program provides health care coverage for children who:

- Are age 0 through 18
- Have income at or below 212% of the Federal Poverty Level under the Modified Adjusted Gross Income (MAGI) methodology
- Do not have other comprehensive medical insurance (this includes insurance that covers inpatient and outpatient hospital services, laboratory, x-ray, pharmacy and physician services)
- Do not qualify for other MAGI related Medicaid programs
- Are residents of the State of Michigan

The child's eligibility for MICHild is determined through the MAGI methodology. All criteria for MAGI eligibility must be met to be eligible for MICHild.

Families enrolled in the MICHild program are required to pay a premium of \$10 per month per family to maintain coverage for their children. Children enrolled in MICHild are exempt from copay for services.

5.2 COVERED SERVICES

Children enrolled in MICHild are considered Medicaid beneficiaries and are entitled to all Medicaid covered services.



SECTION 6 – CHILD AND ADOLESCENT HEALTH CENTERS AND PROGRAMS

Under an agreement with MDHHS, Child and Adolescent Health Centers and Programs (CAHCPs) provide medical services and outreach on behalf of the Medicaid Health Plans (MHPs) to school-aged children. (Refer to the Medicaid Health Plan Chapter of this manual for additional information.)



SECTION 7 - FLINT FAMILY SUPPORTS COORDINATION SERVICES

Family Supports Coordination services are part of a comprehensive health benefit available to pregnant women and children who were served by the Flint water system who meet the Medicaid eligibility requirements.

Family Supports Coordination services assist individuals in gaining access to appropriate medical, educational, social, and/or other services. Family Supports Coordination services include assessments, planning, linkage, advocacy, care coordination, referral, monitoring, and follow-up activities.

In addition to Family Supports Coordination services, eligible beneficiaries will receive the full array of Medicaid-covered benefits. This includes the provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children up to age 21, Non-Emergency Medical Transportation (NEMT), and Maternal Infant Health Program (MIHP) services.

7.1 ELIGIBILITY

Providers may verify beneficiary eligibility for Family Supports Coordination services through a Community Health Automated Medicaid Processing System (CHAMPS) online eligibility inquiry or via a Health Insurance Portability and Accountability Act (HIPAA) 270 transaction. The CHAMPS or 271 eligibility response for beneficiaries eligible for Family Supports Coordination services will show:

- a current MAGI category beginning with "F"; and
- a current benefit plan of "TCMF" in addition to their assigned Medicaid or Children's Health Insurance Program (CHIP)-related benefit plans.

7.2 CORE ELEMENTS OF FAMILY SUPPORTS COORDINATION

The purpose of Family Supports Coordination services is to provide a comprehensive array of services that are appropriate to the conditions of the individual. At a minimum, Family Supports Coordination services must include:

- a face-to-face comprehensive assessment, history, re-assessments, and identification of a course of action to determine the specific needs of the beneficiary and to develop an individual Plan of Care;
- planning, linking, coordinating, follow-up, and monitoring to assist the beneficiary in gaining access to services;
- coordination with the beneficiary's primary care provider (PCP), other providers, and Medicaid Health Plan (MHP), as applicable; and
- any other service approved by MDHHS.

7.2.A. INITIAL/ ANNUAL COMPREHENSIVE ASSESSMENT VISIT

All comprehensive assessment visits, including the initial face-to-face comprehensive assessment visit, must be conducted by a qualified licensed nurse or social worker with the beneficiary in the beneficiary's home or primary place of residence. The purpose of the comprehensive assessment visit is to gather sufficient information to develop an



individualized Plan of Care for the beneficiary and to ensure that all other eligible individuals in the household are identified for further screening.

It is expected that face-to-face assessments are performed annually; however, the frequency should be based on the needs and circumstances of the beneficiary and/or family. Active participation by the beneficiary and/or parent(s)/legal guardian(s) is necessary. Comprehensive assessment activities include:

- obtaining client history;
- identifying the beneficiary's needs and completing related documentation; and
- gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the beneficiary.

At a minimum, the comprehensive assessment visit shall assess:

- the growth and development of beneficiaries up to age 21;
- the behavioral profile of beneficiaries up to the age of 21, including the notation of aggressive or hyperactive behavior;
- the beneficiary's access to a PCP and other health care providers;
- whether the beneficiary's PCP has conducted a developmental and social-emotional screen(s) utilizing a standardized and validated tool, such as the Ages & Stages Questionnaire: Social-Emotional (ASQ:SE) or the Pediatric Symptom Checklist (PSC) as indicated by the American Academy of Pediatrics (AAP) Periodicity Schedule, and documenting the results of any screenings performed;
- whether the beneficiary's PCP has assessed the beneficiary for sources of toxic stress and for sources of strength using nationally recognized tools, such as the Adverse Childhood Experiences (ACEs) and Resiliency questionnaires, and documenting the results of any screenings performed;
- the beneficiary's access to prenatal care, potential for pregnancy complications, pica activities, and intent to breastfeed (pregnant beneficiaries);
- the beneficiary's educational and nutritional needs, including participation in the Women, Infants and Children (WIC) program and/or the Food Assistance Program (FAP);
- the beneficiary's environment and typical family practices that may pose a lead risk;
- lead hazards within the family's dwelling; and
- access to NEMT.

7.2.B. DEVELOPMENT OF THE PLAN OF CARE AND DOCUMENTATION

During or immediately following the face-to-face initial comprehensive assessment visit, a Plan of Care must be developed for beneficiaries who agree to participate in Family Supports Coordination services, with the active participation of the parent(s)/legal guardian(s) when applicable. The development (and periodic revision) of a specific Plan of Care that is based on the information collected through the comprehensive



assessment must specify the goals and actions to address the medical, educational, social, and/or other services needed by the beneficiary. The supports coordinator must ensure the active participation of the beneficiary, and work with the beneficiary (or the beneficiary's parent[s]/legal guardian[s]) and others to develop those goals, and to identify a course of action to respond to the assessed needs of the beneficiary. The Plan of Care is to be shared with the beneficiary's MHP and PCP, if applicable. Beneficiaries must consent to share the Plan of Care with the MHP and other providers identified in the Plan of Care. At a minimum, the Plan of Care must:

- identify a course of action to respond to the assessed needs of the beneficiary (e.g., plan for the testing of family members at risk for lead hazard exposure);
- provide education and information regarding lead hazards, including the impact of lead exposure on the developing fetus of pregnant beneficiaries; and
- facilitate blood lead testing and follow-up testing and treatment as recommended by the PCP.

Family Supports Coordination providers are required to document the following information for all beneficiaries receiving Family Supports Coordination services:

- the name of the beneficiary;
- the dates of the supports coordination services;
- the name of the Family Supports Coordination provider and the qualified professional (i.e., licensed nurse or social worker) providing the supports coordination services;
- the nature and content of the supports coordination visits received, and whether goals specified in the Plan of Care have been achieved;
- whether the beneficiary has declined services within the Plan of Care;
- the need for, and occurrences of, coordination with other providers;
- a timeline for obtaining needed services;
- a timeline for re-evaluation of the Plan of Care; and
- the beneficiary's consent to share information.

7.2.C. REFERRALS AND RELATED ACTIVITIES

In collaboration with the PCP and the MHP, it is expected that the supports coordinator will facilitate and coordinate referral and related activities to assist the beneficiary in obtaining needed services. Activities such as scheduling appointments or linking the beneficiary with medical, educational, social, and/or other programs and services to address identified needs and achieve goals specified in the Plan of Care are primary components of Family Supports Coordination services. Referral activities include, but are not limited to, the coordination of age-appropriate services such as:

- health care related services, including physical and specialty behavioral health services;
- nutritional services, such as coordinating referrals to the Special Supplemental Nutrition Program, WIC program, or FAP;



- educational services, such as age-appropriate referrals to Early On, Great Start Readiness Programs, Head Start, and school-based services;
- additional social supports (including home visiting programs) to assist the beneficiary in obtaining other assistance, such as financial, housing, and transportation assistance, and lead assessment and abatement resources; and
- blood lead testing and re-testing for family members at risk for lead exposure, and education regarding lead hazards including the impact of lead exposure on young children and the developing fetus.

7.2.D. MONITORING AND FOLLOW-UP ACTIVITIES

Monitoring and follow-up activities include activities and contacts that are necessary to ensure the Plan of Care is implemented and adequately addresses the eligible beneficiary's needs, and which may be conducted with the beneficiary, family members, service providers, or other entities or individuals. Monitoring and follow-up activities are conducted as frequently as necessary by the supports coordinator.

A maximum of five (5) face-to-face monitoring visits are billable per year for each eligible beneficiary. To be reimbursed, the visit must be face-to-face. Additional monitoring and follow-up activities are likely between face-to-face visits but are not reimbursable. At least one annual face-to-face monitoring visit should be conducted to determine whether the following conditions are met:

- services are being furnished in accordance with the beneficiary's Plan of Care;
- services in the Plan of Care are adequate; and
- changes in the needs or status of the beneficiary are reflected in the Plan of Care.

Monitoring and follow-up activities include making necessary adjustments in the Plan of Care and service arrangements with providers.

7.3 ACCESSING SERVICES

Accessing Family Supports Coordination services may occur a number of ways. If the beneficiary is an MHP member, the MHP may initiate the initial contact with the beneficiary and identify those beneficiaries that may benefit from Family Supports Coordination services. Fee-for-Service (FFS) and MHP beneficiaries may also access Family Supports Coordination services either through a referral from their PCP or through a self-referral.

7.4 COVERED SUPPORTS AND SERVICES

A maximum of six (6) face-to-face visits per year will be reimbursed for each eligible beneficiary as follows:

- one (1) visit for the initial/annual comprehensive assessment.
- a maximum of five (5) visits for monitoring and follow-up.



For additional visits, MDHHS requires the provider to obtain prior authorization before the service is rendered. (Refer to the Directory Appendix for contact information regarding prior authorizations.)

Reimbursement for assessment and monitoring visits is inclusive of all related care coordination and monitoring activities. MDHHS does not reimburse for missed appointments/visits. A beneficiary may not be billed for a missed appointment/visit.

Medicaid reimbursement for Family Supports Coordination services may not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

Supports coordination includes contacts with non-eligible beneficiaries when the contact is:

- directly related to identifying the eligible beneficiary's needs and care for the purpose of assisting the beneficiary in accessing services;
- identifying needs and supports to assist the beneficiary in obtaining services;
- providing supports coordinators with useful feedback; and
- alerting supports coordinators to changes in the beneficiary's needs.

Family supports coordination does not include activities that constitute the direct delivery of underlying medical, educational, social, and/or other services to which an eligible beneficiary has been referred, including foster care programs and services such as, but not limited to, the following:

- research gathering and completion of documentation required by the foster care program;
- assessing adoption placements;
- recruiting or interviewing potential foster care parents;
- serving legal papers;
- home investigations;
- providing transportation;
- administering foster care subsidies; and
- making placement arrangements.

7.5 TRANSFER OF CARE/ RECORDS

During the course of care, the beneficiary may require services from a different supports coordinator due to relocation of the beneficiary's primary residence or due to a request of the beneficiary to change supports coordinators. When there is a planned change of the supports coordinator, information about the new supports coordinator (e.g., contact information) should be provided to the beneficiary. The referring supports coordinator must consult with the new supports coordinator about the case and transfer all applicable information and records, including all completed assessment visits and the updated Plan of Care, to the new supports coordinator in compliance with the privacy and security requirements of federal and state laws and regulations including, but not limited to, the HIPAA and the Michigan Mental Health Code.



7.6 FAMILY SUPPORTS COORDINATION CLOSURE

Family Supports Coordination services are available to all eligible beneficiaries up to age 21, or for pregnant women up to and through 60 days post-delivery. Family Supports Coordination services will be discontinued:

- if the beneficiary is no longer eligible;
- when the beneficiary parent(s) or guardian(s) refuses the service; or
- if CMS does not extend the Flint, Michigan Section 1115 Demonstration Waiver.

When services are refused, Family Supports Coordination services may be resumed at any point during the defined period of eligibility. A discharge summary, including the services provided, outcomes, current status, and ongoing needs of the beneficiary, must be completed and provided to the PCP when the Family Supports Coordination case is closed.

7.7 PROVIDER QUALIFICATIONS

Genesee Health System, the local community mental health (CMH) serving Genesee County, serves as the Designated Provider Organization (DPO) for Family Supports Coordination services. The DPO:

- has a sufficient number of qualified staff to meet the service needs of the target population and has the administrative capacity to ensure the provision of quality services in accordance with state and federal requirements;
- has experience in the coordination and linkage of community services;
- has the willingness and capabilities to coordinate with the beneficiary's PCP and MHP as applicable; and
- must seek approval by MDHHS of all subcontractors for the provision of Family Supports Coordination services.

The DPO will provide Family Supports Coordination services primarily through the use of a supports coordinator. The supports coordinator must meet one of the following professional qualifications:

- licensure as a registered nurse by the Michigan Department of Licensing and Regulatory Affairs (LARA), and at least one year of experience providing community health, pediatric or maternal infant health nursing services; or
- licensure as a social worker by LARA, and at least one year of experience providing social work services to families.

7.8 CLAIMS SUBMISSION AND PAYMENT

All claims submitted and accepted are processed through CHAMPS. Claims must be submitted on the ASC X12N 837 5010 professional format when submitting electronic claims or on the CMS 1500 claim form for paper claims. (Refer to the Billing & Reimbursement for Professionals Chapter for additional billing information.)



7.8.A. INITIAL/ANNUAL ASSESSMENTS

Face-to-face assessment visits are to be billed using HCPCS code T2024 for an individual or family. This includes reimbursement for the development of a Plan of Care for one individual. HCPCS code T2024 with modifier TT (additional patient) should be billed for each additional individual Plan of Care that is developed from the assessment visit. For informational/reporting purposes, use modifier UN (two patients served), UP (three patients served), UQ (four patients served), UR (five patients served), or US (six or more patients served).

Assessment visits must be in the home or “home-like” environment. One face-to face initial/annual assessment visit per year per family/household is allowed. Additional assessment visits beyond one per year per family/household require prior authorization.

7.8.B. FOLLOW-UP/MONITORING

Face-to-face follow-up/monitoring visits are to be billed using HCPCS code T1017 for an individual or family. For informational/reporting purposes, use modifier UN (two patients served), UP (three patients served), UQ (four patients served), UR (five patients served), or US (six or more patients served), and enter the Medicaid beneficiary ID numbers of the family members served during the follow-up visit in the claim notes.

Follow-up visits must last at least 30 minutes and ideally take place in the home or “home-like” environment but may be performed in the office. A maximum of five face-to face follow-up/monitoring visits per year per family/household is allowed. Additional follow-up visits beyond five per year per beneficiary require prior authorization.



SECTION 8 – PEDIATRIC OUTPATIENT INTENSIVE FEEDING PROGRAM SERVICES

Pediatric Outpatient Intensive Feeding Program services are for beneficiaries with significant feeding and swallowing difficulties and are part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. (Refer to the Early and Periodic Screening, Diagnosis and Treatment Chapter for additional information.)

Pediatric Outpatient Intensive Feeding Program services may be reimbursed through Medicaid Fee-for-Service (FFS). Covered services that are carved out of the Medicaid Health Plan (MHP) delivery system will be reimbursed through FFS consistent with applicable Medicaid policy.

8.1 GENERAL INFORMATION

Pediatric feeding disorders are a complex set of feeding and swallowing problems that disrupt the acquisition of functional age-appropriate feeding habits. To resolve complex pediatric feeding issues, clinical evidence indicates that both medical and behavioral interventions are needed. Failure to address feeding issues in young children can be severe and include growth failure, susceptibility to chronic illness, and/or death.

A Pediatric Outpatient Intensive Feeding Program is an onsite day program that is delivered by a team of medical, behavioral health and other professionals who address complex feeding issues through integrated, individualized care

8.2 PROGRAM SERVICES

Medicaid covers medically necessary Pediatric Outpatient Intensive Feeding Program services for eligible beneficiaries. Pediatric Outpatient Intensive Feeding Program services primarily focus on children who have been diagnosed by a medical professional to have significant feeding difficulties that have not been resolved or treated adequately through less intensive therapies. Pediatric Outpatient Intensive Feeding Program services utilize a multi-disciplinary team to assist the beneficiary and his/her parents/guardians in improving the beneficiary's ability to eat and swallow and improve nutritional outcomes. Pediatric Outpatient Intensive Feeding Program services include an initial comprehensive assessment, individualized plan of care (POC), on-going monitoring, and incorporate appropriate behavioral modification techniques and parent/guardian education/training. Pediatric Outpatient Intensive Feeding Program services offer an intensive focus on oral-motor skill development with attention to nutritional markers for the most therapeutic outcome.

Medicaid covers medically necessary Pediatric Outpatient Intensive Feeding Program services for eligible beneficiaries. Pediatric Outpatient Intensive Feeding Program services:

- Primarily focus on children who have been diagnosed by a medical professional to have significant feeding difficulties that have not been resolved or treated adequately through less intensive therapies;
- Utilize a multi-disciplinary team to assist the beneficiary and his/her parents/guardians in improving the beneficiary's ability to eat and swallow and improve nutritional outcomes;
- Include an initial comprehensive assessment, individualized POC, ongoing monitoring, and incorporate appropriate behavioral modification techniques and parent/guardian education/training; and



- Offer an intensive focus on oral-motor skill development with attention to nutritional markers for the most therapeutic outcome.

Pediatric Outpatient Intensive Feeding Program services are designed to evaluate, diagnose and treat beneficiaries with significant feeding and swallowing difficulties. The initial comprehensive evaluation is performed by a multi-disciplinary team who meets with the beneficiary and his/her parents/guardians to assess the beneficiary's current status and potential for improvement. The initial comprehensive evaluation should include:

- Assessment of medical history and physical exam;
- Nutritional history and evaluation of growth and nutritional parameters;
- Psychological assessment of developmental, cognitive, emotional and behavioral function;
- Psychosocial evaluation;
- Evaluation of oral-motor function (may include videofluoroscopy swallow study, Fiberoptic Endoscopic Evaluation of Swallowing (FEES), clinical swallowing evaluation, and sensory evaluation);
- Standardized tests and/or objective functional baseline measures to assist with planning short- and long-term goals and to document progress;
- Observation of a simulated meal/snack time; and
- Development of an individualized POC.

Following the initial comprehensive evaluation, the beneficiary and his/her parents/guardians commit to an outpatient program which may typically be held five days per week, six to eight hours per day, for a period up to six weeks. The goals of Pediatric Outpatient Intensive Feeding Program services are to:

- Promote consistent mealtime acceptance;
- Promote good nutrition;
- Increase the variety of foods the beneficiary will eat;
- Promote development of oral-motor skills for feeding;
- Promote developmental feeding skills, such as cup drinking and self-feeding;
- Transition from tube to oral feeding; and
- Assist the beneficiary and/or parents/guardians in acquiring feeding skills through education/training.

Beneficiaries should be routinely monitored, and one-on-one consultations and/or conferences with team members should be routinely scheduled to discuss progress. Supportive services provided during this time may include speech therapy, occupational therapy, physical therapy and/or social work. Progress is assessed regularly and the POC is updated, if continuation is necessary.

8.3 INDICATIONS FOR SERVICES

Pediatric Outpatient Intensive Feeding Program services may be considered medically necessary for individuals with anatomical, physiological, congenital, or cognitive conditions and/or complications of



severe illness who experience significant feeding difficulties. Eligible beneficiaries must meet all the following criteria:

- Significant oral-motor problems and/or chronic medical condition exist;
- Normal feeding milestones have not been met through previous therapies and treatment;
- Suboptimal nutritional status has been determined; and
- Inadequate responsiveness to less intensive treatment has been clinically documented.

Examples of feeding disorders treated in these programs include, but are not limited to:

- Oral-motor dysfunction (including swallowing, oral and/or pharyngeal dysphagia);
- Severe pathology in the perception of, or response to, sensory input to the extent that it significantly limits the ability to function;
- Gastrointestinal disorders; and
- Feeding tube dependency.

Pediatric Outpatient Intensive Feeding Program services are not covered for individuals with specific eating disorders (e.g., binge eating, bulimia, anorexia or obesity-related disorders).

8.4 PROVIDER QUALIFICATIONS

Pediatric Outpatient Intensive Feeding Programs are provided under the delegation and supervision of a Medical Director and delivered by a multi-disciplinary team of medical, behavioral health and other professionals who are licensed, certified and/or registered to provide health-related services within the scope of practice for their discipline. The multi-disciplinary team should integrate and coordinate an individualized, comprehensive POC to address complex feeding issues. Each Pediatric Outpatient Intensive Feeding Program must have the following staff actively involved in the assessment process and/or development/implementation of the POC.

Provider Type	Required Qualifications
Pediatrician	A Medicaid-enrolled and CSHCS-approved physician who possesses or is eligible for Pediatric Specialty Board Certification. Physicians are expected to remain familiar with current developments and standards of treatment in their respective fields. May serve in the required role as Medical Director.
Subspecialist	A Medicaid-enrolled and CSHCS-approved physician who possesses or is eligible for Pediatric Subspecialty Board Certification, including physicians with special training and demonstrated clinical experience related to pediatric feeding clinic issues. Physicians are expected to remain familiar with current developments and standards of treatment in their respective fields. May serve in the required role as Medical Director.
Licensed Behavioral Health Professional	A Licensed Behavioral Health Professional, such as a licensed psychologist or licensed Master's Social Worker, with at least two years of professional experience in providing services to children/youth and their families.
Occupational Therapist	A Licensed Occupational Therapist with at least one year of professional pediatric experience.
Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN)	An RD or RDN in possession of a Master's degree in human nutrition, public health, or a health-related field with an emphasis on nutrition, and one year of pediatric nutrition experience in providing nutrition assessment, education and counseling.



Provider Type	Required Qualifications
Speech-Language Pathologist	A Licensed Speech-Language Pathologist in possession of a Master’s degree, and at least one year of professional pediatric experience.
Other staff	Other staff may include registered nurses, physical therapists, etc.
Parent/Guardian and/or Beneficiary	The parent/guardian and/or the beneficiary must be an active, participating team member in the development of the beneficiary’s comprehensive POC.

8.5 SERVICE PROVIDER ENROLLMENT

CSHCS-approved, Medicaid-enrolled program sites must be certified by the Michigan Department of Health and Human Services (MDHHS). MDHHS certification will be based upon adherence to the following requirements:

- Existence of a program schedule of services and supports.
- Assessment and POC services must be delivered by professional staff, as identified.
- If an aide under professional supervision delivers direct services, that supervision must be documented in the beneficiary’s medical record.

Certification of new program sites will be contingent upon submission of acceptable enrollment information to MDHHS or upon a site visit by MDHHS.

8.6 PRIOR AUTHORIZATION

Pediatric Outpatient Intensive Feeding Program services require prior authorization. Requests for prior authorization must be submitted utilizing form MSA-6544-B (Practitioner Special Services Prior Approval – Request/Authorization) and include documentation to support medical necessity such as height/weight measurements and previously attempted therapeutic interventions. (Refer to the Prior Authorization subsection of the Practitioner Chapter for additional information.) Medicaid forms can be accessed on the MDHHS website. (Refer to the Directory Appendix for website information.)

A copy of the prior authorization must be retained in the beneficiary’s medical record.

Pediatric Outpatient Intensive Feeding Program services must request prior authorization to continue intensive treatment services beyond the current authorization period, even if a beneficiary changes providers. A copy of the latest re-evaluation must be submitted with the prior authorization request.

Requests for continued treatment must be supported by all of the following:

- Summary of previous treatment period (not to exceed 90 days prior to that time period for which prior authorization is being requested), including measurable progress on each short- and long-term goal, rate of progress, statement of the beneficiary’s response to treatment, and any factors that have affected progress during the therapy period. Do not send daily treatment notes.
- Revised goals and justification for any change in the treatment plan for the requested period of treatment.
- Statement detailing any parent/guardian education and training.



8.7 BILLING AND REIMBURSEMENT

Reimbursement for Pediatric Outpatient Intensive Feeding Program services is a bundled payment rate based on the covered services provided by a multi-disciplinary team. This service is reimbursed as a daily rate comprised of all costs associated with the services provided within the day program, including: facility-related costs; medical care services provided by the physician and other licensed practitioners; services provided by clinical staff working under the delegation and supervision of a licensed medical practitioner; and diagnostic, screening and rehabilitative services. Services are billed as FFS claims through the Community Health Automated Medicaid Processing System (CHAMPS) regardless of beneficiary health plan status. Providers are to bill using Healthcare Common Procedure Coding System (HCPCS) code S0317 (disease management; per diem).



THERAPY SERVICES

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SECTION 1 – GENERAL INFORMATION

This chapter applies to enrolled Private Practice, Outpatient, Nursing Facility, and Home Health Agency therapy providers.

The term Medicaid throughout this chapter refers to all programs administered by MDHHS unless specifically stated otherwise. The primary objective of Medicaid is to ensure that essential health care services are made available to those individuals who would not otherwise have the financial resources to purchase them. Policies are aimed at maximizing medically necessary health care services available to eligible Medicaid beneficiaries.

The primary objective of the Children's Special Health Care Services (CSHCS) Program is to ensure that CSHCS beneficiaries receive medically necessary services related to a CSHCS qualifying diagnosis as recommended by a CSHCS authorized subspecialist. Providers should refer to the Children's Special Health Care Services chapter of this manual for information specific to CSHCS only beneficiaries.

1.1 SERVICE PROVISION

Therapy may be provided by Medicaid-enrolled providers when performed by properly credentialed/licensed or appropriately supervised professionals in the following settings:

- Occupational Therapy (OT) and Physical Therapy (PT)
 - Outpatient Hospital
 - Comprehensive Outpatient Rehabilitation Facility (CORF)
 - Outpatient Rehabilitation Agency (Rehab Agencies)
 - Commission on Accreditation of Rehabilitation Facilities (CARF)-Accredited Outpatient Medical Rehabilitation Program
 - Physical Therapist or Occupational Therapist in Private Practice
 - Physician's Office/Clinic
 - Optometrist's Office
 - Nursing Facility
 - Home Health Agency
- Speech-Language Therapy (ST)
 - Outpatient Hospital
 - Comprehensive Outpatient Rehabilitation Facility (CORF)
 - Outpatient Rehabilitation Agency (Rehab Agencies)
 - CARF-Accredited Outpatient Medical Rehabilitation Program
 - Council on Academic Accreditation (CAA)-Accredited University Graduate Education Program
 - Speech-Language Pathologist in Private Practice



- Physician's Office/Clinic
- Nursing Facility
- Home Health Agency

Medicaid covers medically necessary rehabilitative therapy services for beneficiaries of all ages. Rehabilitative services include teaching or training someone to perform or develop a level of reasonable functional proficiency of tasks or skills that were previously learned, with or without compensatory strategies. Examples may include, but are not limited to:

- PT to regain functional ambulation using a cane following a stroke, or to advance from ambulation with an assistive device/physical assistance to ambulation without an assistive device or physical assistance;
- OT to achieve independent dressing following a spinal cord injury, or to develop dressing independence without an assistive device or physical assistance;
- Speech-Language Pathology (SLP) to improve articulation and fluency following a traumatic brain injury or develop communication skills utilizing an augmentative communication strategy.

Medicaid beneficiaries under 21 years of age and Healthy Michigan Plan beneficiaries may be eligible for medically necessary habilitative therapy services. Habilitation therapy includes teaching/training someone to perform/develop a level of reasonable functional proficiency of a task that was not previously learned/achieved at a typically expected age or without compensatory techniques or processes. Examples may include, but are not limited to:

- PT for a child who is not walking at a typically expected age.
- OT teaching normal dressing skills beyond the typically expected age of learning.
- SLP for communication skills including articulation errors beyond the typically expected age of learning or syntax and semantics for a person with significant hearing impairment.

Documentation must objectively support the request for rehabilitative and/or habilitative therapy.

1.2 THERAPY DATABASE

For specifics regarding Medicaid coverage of the Healthcare Common Procedure Coding System (HCPCS), refer to the MDHHS Therapies Database on the MDHHS website or the Medicaid Code and Rate Reference tool in the Community Health Automated Medicaid Processing System (CHAMPS). (Refer to the Directory Appendix for website information.) The database includes covered private practice, outpatient, nursing facility, and home health therapy codes, applicable limits, and prior authorization requirements.

1.3 DOCUMENTATION IN BENEFICIARY MEDICAL RECORD

Therapy providers must retain all applicable documentation in the beneficiary's medical record for seven years. For audit purposes, the beneficiary's medical record must substantiate the medical necessity of the service performed.



1.4 PRACTITIONER SIGNATURES

In all documentation requiring a signature, the signature must be hand written by the practitioner or submitted electronically. A stamped signature, second party signature, or statement of “signature on file” will not be accepted. NOTE: An electronic signature must specifically identify and authenticate the individual practitioner. This applies to signatures for ordering, referring, and treating practitioners.

1.5 MODIFIERS

Therapy claims must be submitted using the appropriate procedure code and therapy modifier to distinguish the discipline under which the service is delivered. To differentiate between habilitative and rehabilitative therapy, when services are habilitative report with the appropriate modifier that represents the nature of the therapy being performed. Only Medicaid beneficiaries under 21 years of age and Healthy Michigan Plan beneficiaries may be eligible for medically necessary habilitative therapy services. In addition to these modifiers, maintenance therapy services should be billed with the MDHHS identified modifier to categorize the service as maintenance related.

Therapy services submitted without these modifiers may be denied. Refer to the Billing and Reimbursement chapters in this manual for additional modifier information.

1.6 REIMBURSEMENT

Reimbursement structure is based on the provider’s enrollment type. Reimbursement methodologies include the MDHHS Outpatient Prospective Payment System or the Medicaid fee screens. (Refer to the Medicaid Code and Rate Reference tool in CHAMPS or the MDHHS Therapies Database on the MDHHS website.) For Not Otherwise Classified codes or covered codes without established fee screens, the authorized reimbursement amount is indicated on the approved prior authorization request.



SECTION 2 – PROVIDER REQUIREMENTS

2.1 OUTPATIENT HOSPITALS

Outpatient OT, PT and ST services may be provided to beneficiaries of all ages in the outpatient hospital.

2.2 COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES AND OUTPATIENT REHABILITATION AGENCIES

Comprehensive Outpatient Rehabilitation Facilities (CORFs) and rehab agencies may enroll with Medicaid for reimbursement of outpatient OT, PT and ST services provided by qualified professionals. All CORFs and rehab agencies must provide proof of Medicare certification when enrolling in Medicaid.

2.3 COMMISSION ON ACCREDITATION OF REHABILITATION FACILITIES-ACCREDITED OUTPATIENT MEDICAL REHABILITATION PROGRAMS

Commission on Accreditation of Rehabilitation Facilities (CARF)-accredited outpatient medical rehabilitation programs may enroll with Medicaid for reimbursement of outpatient OT, PT and ST services provided by qualified professionals. The program must not be part of, or owned by, a hospital, CORF or rehab agency. All CARF-accredited outpatient medical rehabilitation programs must provide proof of their current CARF accreditation when enrolling in Medicaid.

2.4 NURSING FACILITY

A Medicaid-certified nursing facility (NF) is defined as a nursing home, county medical care facility, or hospital long term care unit with Medicaid certification. Nursing facilities must provide or obtain specialized rehabilitative services if required by the beneficiary's plan of care.

In situations where the therapist is not an employee of the facility, the facility must establish a valid contract with a therapist/speech-language pathologist who meets applicable licensure/certification/accreditation requirements. A valid contract allows the facility to retain professional and administrative control over the services provided. Therefore, an agreement that stipulates only the use of facility space does not constitute a valid contract.

2.5 HOME HEALTH AGENCY

A Home Health Agency (HHA) is an organization that provides home care services, such as skilled nursing care, OT, PT, ST and home health aide services. The HHA must be Medicare certified to enroll as a Medicaid provider and must comply with the Medicare/Medicaid Conditions of Participation.

OT, PT, and ST services may be provided by an HHA if Medicare/Medicaid Conditions of Participation, including medical necessity, are met. A therapist in the home health setting may be responsible for supervision of the home health aide. Refer to the Home Health chapter for additional information.

2.6 UNIVERSITY AFFILIATED SPEECH-LANGUAGE PATHOLOGY GRADUATE EDUCATION PROGRAMS

University graduate education programs accredited by the American Speech-Language-Hearing Association's (ASHA) Council on Academic Accreditation (CAA) in Audiology and Speech-Language Pathology may enroll with Medicaid for reimbursement of outpatient speech-language therapy provided



by qualified professionals. The university program must be freestanding and not part of, or owned by, a hospital, CORF or rehab agency. All university programs must provide proof of their current ASHA-CAA when enrolling in Medicaid.

2.7 PHYSICAL THERAPISTS, OCCUPATIONAL THERAPISTS, AND SPEECH-LANGUAGE PATHOLOGISTS' PRIVATE PRACTICE

PT, OT, and ST services may be provided to beneficiaries of all ages when provided by a Medicaid enrolled physical therapist, occupational therapist, or speech-language pathologist employed by an individual/sole, partnership, or group practice. These providers are eligible for direct reimbursement.

2.8 PHYSICIAN'S OFFICE OR CLINIC

PT, OT, and ST services may be provided to beneficiaries of all ages in a physician's office or one of the following clinics: Federally Qualified Health Center, Rural Health Clinic, Tribal Health Center, or Local Health Department.



SECTION 3 – PRIOR AUTHORIZATION REQUESTS [CHANGES MADE 10/1/20]

Prior authorization is required for certain therapy services before the services are rendered. To determine which therapy services require prior authorization, refer to the Standards of Coverage and Service Limitations Section of this chapter, the Medicaid Code and Rate Reference tool in CHAMPS, or the MDHHS Therapies Database on the MDHHS website. (Refer to the Directory Appendix for website information.)

Prior authorization (PA) is not required for the initiation of home health therapy services for up to a maximum of 24 visits within the first 60 consecutive days if:

- the beneficiary has not received home health therapy services within the calendar year, and
- services do not exceed the **(text deleted 10/1/20)** maximum.

If a beneficiary has previously received home health therapy services at the maximum 24 visits within the first 60 consecutive days of service for each calendar year, PA is needed. **(revised 10/1/20)**

PA is needed when therapy limits are exceeded regardless of diagnosis.

PA may be authorized for a period not to exceed six months for outpatient and private practice therapy providers and outpatient hospitals, or two months for home health agencies and nursing facilities.

Nursing facilities participating in Medicare are not required to obtain prior authorization for the deductible and/or coinsurance amounts when Medicare approves the services.

If a beneficiary is approved for ventilator care and requires therapy, prior authorization for the therapy must be obtained under the Ventilator Dependent Care Unit (VDCU) National Provider Identification (NPI).

Prior authorization requests must be submitted on the Occupational Therapy-Physical Therapy-Speech Therapy Prior Approval Request/Authorization form (MSA-115). (Refer to the Forms Appendix or the MDHHS website for a copy of the form.) Required medical documentation must accompany the form.

The information on the MSA-115 must be:

- Typed – All information must be clearly typed in the designated boxes of the form.
- Thorough – Complete information, including the appropriate HCPCS procedure codes, must be provided on the form. The form and all documentation must include the beneficiary's name and **mihealth** card ID number, provider name and address, and the provider's NPI number.

Whenever a beneficiary is admitted to a nursing facility directly from a general hospital or from another nursing facility where the beneficiary was receiving reimbursable therapy services, the name of that facility and the date of discharge from that facility should be included on the prior authorization request.

Prior authorization requests should be submitted with the appropriate therapy modifier to distinguish the discipline under which the service is being requested. When the therapy is habilitative, a modifier that represents the nature of the therapy being requested must also be reported. Requests for maintenance therapy services should also contain the appropriate maintenance modifier. Refer to the Billing & Reimbursement Chapters for additional modifier information.



For all Medicaid Fee-for-Service (FFS) beneficiaries, the MSA-115 must be mailed or faxed to the MDHHS Program Review Division. Providers can check the status of a prior authorization request in CHAMPS or by contacting the MDHHS Program Review Division via telephone. (Refer to the Directory Appendix for website and contact information.)

Prior authorization requests may also be submitted electronically via FFS Direct Data Entry (DDE) in CHAMPS. (Refer to the General Information for Providers chapter of this manual for additional information.) A copy of the MSA-115 must be attached to each electronic prior authorization request.

A copy of the prior authorization determination letter must be retained in the beneficiary's medical record.

3.1 EMERGENCY/VERBAL PRIOR AUTHORIZATION

A provider may contact MDHHS to obtain a verbal prior authorization when the prescribing practitioner (practicing within their scope of practice as defined by state law) has indicated that it is medically necessary to provide therapy services without delay. If a therapy service is required during MDHHS nonworking hours, providers must contact the Program Review Division the next working day.

To obtain verbal prior authorization, providers may call or fax a request to the Program Review Division. (Refer to the Directory Appendix for contact information. Refer to the Forms Appendix for a copy of form MSA-115 and completion instructions.) If the provider faxes a request, the request must state "verbal prior authorization required."

The following steps must be completed before a prior authorization number is issued for billing purposes:

- The verbal authorization date must be entered on the MSA-115 or electronically in CHAMPS via FFS DDE.
- The MSA-115 or FFS DDE prior authorization request must be submitted to the Program Review Division within 30 days of the verbal authorization.
- Supporting documentation must be submitted with the prior authorization request.

The verbal authorization does not guarantee reimbursement for the services if:

- The beneficiary was not eligible for Medicaid when the therapy service was provided.
- The Program Review Division does not receive the completed MSA-115 and documentation within 30 days of the verbal authorization.
- The prescription is dated after the date the verbal authorization was requested.

3.2 RETROACTIVE PRIOR AUTHORIZATION

Therapy services provided before prior authorization is requested will not be covered unless the beneficiary was not eligible on the date of service and a subsequent eligibility determination was made retroactive to the date of service. If the MDHHS eligibility file does not show that retroactive eligibility was approved, then the request for retroactive prior authorization will be denied.



- Exception for nursing facilities: When a beneficiary is admitted to a nursing facility directly from a general hospital or from another nursing facility where the beneficiary was receiving reimbursable therapy services, retroactive authorization may be requested to ensure continuity of a treatment regimen if the request is filed within ten days following admission. Retroactive authorization may be granted when the service is rendered within Program guidelines for coverage (e.g., is restorative in nature).

3.3 BENEFICIARY ELIGIBILITY

Approval of a therapy service on the prior authorization request confirms that the service is authorized for the beneficiary. Approval of a prior authorization request does not guarantee beneficiary eligibility or payment. It is the provider's responsibility to verify the beneficiary's eligibility prior to rendering the service.

3.4 BILLING AUTHORIZED SERVICES

After prior authorization is issued, the information (e.g., prior authorization number, HCPCS/ CPT procedure code, modifier, and quantity) that was approved on the prior authorization must match the information on the claim form.

Therapy rendered to a nursing facility beneficiary must be billed by the nursing facility.

Refer to the Billing & Reimbursement Chapters of this manual for complete billing instructions.



SECTION 4 – STANDARDS OF COVERAGE AND SERVICE LIMITATIONS

4.1 OCCUPATIONAL THERAPY

MDHHS uses the terms Occupational Therapy, OT, and therapy interchangeably. OT is covered when furnished by a Medicaid-enrolled therapy provider and the documentation is signed by the treating therapist. Medicaid reimburses for occupational therapy services when provided by any of the following:

- A licensed occupational therapist.
- A licensed occupational therapy assistant under the supervision of an occupational therapist (i.e., the occupational therapy assistant services must follow the evaluation and treatment plan developed by the occupational therapist, and the occupational therapist must supervise and monitor the occupational therapy assistant’s performance with continuous assessment of the beneficiary’s progress). All documentation must be reviewed and co-signed by the supervising occupational therapist.
- A student completing their clinical affiliation under the direct supervision of (i.e., in the presence of) an occupational therapist. All documentation must be reviewed and co-signed by the supervising occupational therapist.

OT is considered an all-inclusive charge. Medicaid does not reimburse for a clinic room charge in addition to therapy services unless the room charges are unrelated. MDHHS expects occupational therapists and occupational therapy assistants to utilize the most ethically appropriate therapy within their scope of practice as defined by state law or the appropriate national professional association. OT must be medically necessary, reasonable and required to achieve one or more of the following:

- Return the beneficiary to the functional level prior to illness or disability;
- Return the beneficiary to a functional level that is appropriate to a stable medical status;
- Prevent a reduction in medical or functional status had the therapy not been provided.

Therapies provided to nursing facility beneficiaries outside the nursing facility premises must be provided in the outpatient department of a general hospital or medical care facility.

Therapies provided to county medical care facility, hospital long term care unit, or hospital swing bed beneficiaries outside their respective facilities must be provided in the outpatient department of a general hospital.

Medicaid standard coverage allows the following:

Outpatient/Private Practice Occupational Therapy	Nursing Facility Occupational Therapy	Home Health Occupational Therapy
<ul style="list-style-type: none"> • Up to 144 units of OT per calendar year period. • Prior authorization is required for treatment that exceeds this unit limitation. 	<ul style="list-style-type: none"> • Prior authorization is required. 	<ul style="list-style-type: none"> • Up to 24 visits of OT in a 60-consecutive day period. • Prior authorization (PA) is required for treatment that exceeds this visit limitation or for continued treatment beyond the initial 60 days.



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OT is expected to result in measurable improvement that is significant to the beneficiary’s ability to perform daily living tasks appropriate to his/her chronological, developmental, or functional status. Functional improvements must be achieved in a reasonable, and generally predictable, amount of time as specified in the short- and long-term goals identified on the evaluation/re-evaluation and treatment plan. Functional improvements must be maintainable. Medicaid does not cover therapy if the beneficiary’s maximum functional potential has been realized, the beneficiary has plateaued, or the therapy has no impact on the beneficiary’s ability to perform age-appropriate tasks. However, medically necessary habilitative therapy services may be covered under Early and Periodic Screening, Diagnosis and Treatment (EPSDT) or Healthy Michigan Plan.

Medicaid only covers OT services that require the skills, knowledge, and education of an occupational therapist. Medicaid does not cover interventions provided by another practitioner or caregiver (e.g., registered nurse, physical therapist, family member, teacher, etc.).

<p>Occupational therapy may be covered for one or more of the following:</p>	<ul style="list-style-type: none"> ▪ Therapeutic use of everyday life activities/occupations*. ▪ Adaptation of environments and processes to enhance functional performance in occupations*. ▪ Graded tasks (performance components) in activities as prerequisites to an engagement in occupations*. ▪ Oral function (including swallowing, oral and/or pharyngeal dysphagia, and increasing nutrition/hydration). ▪ Design, fabrication, application, or training in the use of assistive technology or orthotic/prosthetic devices. ▪ Skilled services that are designed to develop, train, monitor, and modify a maintenance program to be carried out by family or caregivers. ▪ Severe pathology in the perception of, or response to, sensory input to the extent that it significantly limits the ability to function. ▪ Federal EPSDT regulations require coverage of medically necessary treatment for beneficiaries under 21 years of age, including medically necessary habilitative therapy services. (Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter for additional information.) <p>*Covered occupations include:</p> <ul style="list-style-type: none"> ▪ Activities of daily living (self-care activities). ▪ Instrumental activities of daily living (multistep activities to care for self and others, such as household management and childcare).
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Occupational therapy is not covered for the following:

- If provided solely for educational, vocational, or recreational purposes.
- If therapy services are required to be provided by another public agency (e.g., community mental health services provider, school-based services, etc.).
- If a therapy service requires prior authorization and the service is rendered before prior authorization is approved.
- Habilitative therapy designed to facilitate the normal progression of development without compensatory techniques or processes. (Refer to the Early and Periodic Screening, Diagnosis and Treatment and the Healthy Michigan Plan chapters for coverage exceptions.)
- If therapy is rote practice of achieved skills.
- Development of perceptual motor skills and sensory integrative functions to follow a normal sequence. (Refer to the Early and Periodic Screening, Diagnosis and Treatment and the Healthy Michigan Plan chapters for coverage exceptions.)
- If therapy is designed to facilitate the normal progression of development without compensatory techniques or processes. (Refer to the Early and Periodic Screening, Diagnosis and Treatment and the Healthy Michigan Plan chapters for coverage exceptions.)
- Non-diagnostic, non-therapeutic, routine, or repetitive tasks without skilled feedback (e.g., sitting with a beneficiary needing prompting to swallow or take small bites which does not require the skills of a therapist, etc.)
- Feeding for a beneficiary whose status is nothing per oral cavity (NPO), with physician orders to continue NPO, and who does not demonstrate the potential to improve oral and/or pharyngeal phases of swallowing (i.e., pleasure eating).
- Continuation of therapy that is maintenance in nature, except as described under Maintenance Visits in the Prescription Requirements subsection (below).
- If Medicare determines the service is not medically necessary.
- Additionally for nursing facility beneficiaries:
 - Therapy provided by a physician (MD or DO).
 - Services covered by the facility's per diem rate, including diversional OT, reality orientation, restorative nursing functions, routine maintenance, or the development of the therapy and treatment plan.

4.1.A. DUPLICATION OF SERVICES

Medicaid does not cover two disciplines working concurrently on similar goals/areas (e.g., dysphagia, assistive technology, sitting and standing balance/tolerance, etc.). Collaboration between treating therapists is required to coordinate therapy and prevent duplication of services. Documentation of the collaboration must be retained in the beneficiary's medical record for audit purposes.



4.1.B. ACCESS TO SERVICES FOR SCHOOL-AGED BENEFICIARIES

School based therapy services are covered by Medicaid when they assist a child/youth with a disability to benefit from special education. This includes beneficiaries up to the age of 21 who are eligible under the provisions of the Individuals with Disabilities Education Act (IDEA) of 1990 as amended, and those enrolled in programs that require an Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP). Therapy provided solely for educational purposes (e.g., pre-academic goals such as improved attention span, catching/throwing/kicking balls, etc.) is not covered by Medicaid.

Beneficiaries receiving school-based therapy may also receive medically-based therapy services in an outpatient setting, nursing facility, or through a home health agency. If therapy is provided in more than one setting, the goals and purpose for each must be distinct.

Outpatient therapy services are provided to optimize the child's/youth's maximum functional performance in relation to needs in the home or community setting and must not directly duplicate those provided in the school setting. Collaboration between the school and community providers is required to coordinate therapy and prevent direct duplication of services. Documentation of the collaboration must be retained in the beneficiary's medical record for audit purposes.

Beneficiaries receiving school-based therapy services with medically-related goals may be eligible for the continuation of services in an outpatient setting during the summer months to maintain function. Prior authorization is required if standard coverage limitations have been exceeded. (Refer to the Requirements of Continued Therapy under the Prescription Requirements subsection below for additional information.)

4.1.C. AQUATIC THERAPY

Medicaid does not cover aquatic therapy as a separately reimbursable treatment or modality. A covered therapeutic procedure performed in a pool may be reimbursed when billed using the HCPCS code describing the covered procedure if the service meets all Medicaid coverage requirements.

4.1.D. GROUP THERAPY

OT is not covered by Medicaid when provided concurrently to a group of two or more individuals by the same therapist. Covered therapeutic procedures require direct (one-to-one) contact between the beneficiary and the therapist.

4.1.E. SERIAL CASTING

Serial casting is a process in which a joint(s) that lacks full range of motion is immobilized with a rigid or semi-rigid cast. During this procedure, the affected joint(s) is gradually and progressively set in a more anatomically correct alignment to improve joint alignment, increase muscle length, or to achieve a decrease in abnormal tone, resulting in an increase in the range of motion.



Casts are applied and removed in succession, usually every week, until full range of motion, flexibility, or plateau is reached. Upon removal of each cast, the limb is stretched, and a new cast is applied to hold the limb in place.

Serial casting is a covered benefit when performed by, or under the direct supervision of, a qualified therapist and defined in a treatment plan as a medically necessary therapy service for improving range of motion or reducing abnormal tone. The referral for therapy services must specifically indicate that the beneficiary is being referred for serial casting, or the referring provider must provide written concurrence, via signature, of any treatment plan that includes serial casting.

4.1.F. PRESCRIPTION REQUIREMENTS

Outpatient and private practice therapy requires a prescription from a physician or other licensed practitioner practicing within their scope of practice as defined in State law for occupational therapy. Home health and nursing facility therapy require a prescription from a physician for occupational therapy.

A treatment plan meeting all the requirements below is considered a prescription. The prescription/treatment plan must contain all the following:

- Beneficiary's name;
- Beneficiary's date of birth;
- Prescribing practitioner's name, address, and telephone number;
- Prescribing practitioner's signature;
- The date the prescription was written;
- The frequency and duration of the therapy services;
- Diagnosis; and
- For swallowing or oral motor evaluation/treatment, the documentation must clearly specify allowance of trial feeds and/or oral intake during therapy). All documentation, including the prescription, current plan of care, and prior authorization, must consistently substantiate this allowance.

A copy of the prescription must be retained in the beneficiary's medical record. A prescription is valid for 90 days from the date that the prescription was written unless the termination date is otherwise stated by the authorized prescribing practitioner on the prescription.

If the beneficiary has another insurance plan (e.g. Medicare or commercial insurance) and the service is a covered benefit, the provider must follow the requirements of the other insurance plan(s), including but not limited to, prescription, prior authorization, and provider qualifications. (Refer to the Coordination of Benefits chapter for more information.)



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Evaluations/ Re-evaluations	<p>An evaluation is formalized testing at the initiation of the beneficiary’s treatment plan. Evaluations may be provided up to two times in a 365-day period. Evaluations of swallowing function may be provided up to four times in a 365-day period. Objective and periodic re-evaluations and reports are utilized to determine the measurable functional change resulting from the treatment plan. Re-evaluations may be provided up to two times in a 365-day period. Prior authorization is required if an evaluation or re-evaluation is needed more frequently. An evaluation/re-evaluation is required for the initiation of therapy and continued therapy.</p> <p>OT evaluations/re-evaluations must be completed and signed by the occupational therapist and include all the following:</p> <ul style="list-style-type: none">▪ Standardized tests and/or objective functional baseline measures to establish short- and long-term goals and to document progress;▪ Corresponding baseline measures for all short- and long-term goals;▪ Treatment diagnosis(es);▪ Medical diagnosis(es), if different from treatment diagnosis;▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable;▪ Medical history as it relates to the current course of therapy;▪ The beneficiary’s current functional status (functional baseline);▪ Assessment of the beneficiary’s performance components (e.g., strength, dexterity, range of motion, sensation, perception, muscle tone, etc.) directly affecting the beneficiary’s ability to function or make progress toward goals; and▪ Assessment of the beneficiary’s cognitive skill level (e.g., ability to follow directions, including auditory and visual comprehension). <p>Oral function/swallowing evaluations must also include:</p> <ul style="list-style-type: none">▪ Presence/absence of coughing;▪ History of recent respiratory illness;▪ Current diet, documenting difficulties with food consistencies;▪ Aversion/sensitivity during eating;▪ Objective oral motor assessment addressing labial, glossal, laryngeal, and pharyngeal stages;▪ Report or copy of a video fluoroscopy and any other formal testing, if available; and▪ Voice quality (i.e., pre- and post-feeding and natural voice), if applicable.
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Treatment Plan/Plan of Care	<p>The OT treatment plan that results from the evaluation must be medically necessary, signed by the occupational therapist, and include all the following:</p> <ul style="list-style-type: none">▪ Time-related short-term goals that are measurable, functional, and significant to the beneficiary's function or mobility;▪ Long-term goals that are measurable, functional, and identify specific maximum functional achievement for the requested authorization period;▪ Functional outcome measures specific to maximum functional achievement for the current course of therapy (up to 12 consecutive months);▪ Anticipated type, frequency and duration of therapy required to meet short- and long-term goals;▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable;▪ Plan for discharge from service; and▪ Signature of the prescribing practitioner confirming agreement with the treatment plan. <p>A treatment plan, including all the criteria established above, must be submitted with the prior authorization request.</p>
Initiation of Services	<p>OT may be initiated upon completion of the evaluation (current within 12 months) and development of a treatment plan that is medically necessary as documented in the beneficiary's medical record. The initiation of therapy services may begin if all the following have been met:</p> <ul style="list-style-type: none">▪ The beneficiary is Medicaid-eligible;▪ A copy of the signed and dated (no more than 90 days prior to the initiation of services) prescription for occupational therapy is retained in the beneficiary's medical record;▪ The standard coverage limitations have not been exceeded;▪ Therapy is provided by the evaluating discipline (e.g., a speech-language pathologist may not provide treatment under an occupational therapist's evaluation); and▪ There is a change in medical status resulting in decreased activities of daily living skills, oral motor skills, or functional ability.



Requirements of Continued Therapy

The occupational therapist must request prior authorization to continue therapy beyond standard coverage limitations, even if the beneficiary changes providers. A copy of the latest evaluation/re-evaluation (completed no more than 12 months prior to the prior authorization request) must be submitted with the prior authorization request.

Requests for continued therapy must be supported by all the following:

- Summary of previous treatment period (not to exceed the 90 days prior to that period for which prior authorization is being requested), including measurable progress on each short- and long-term goal, rate of progress, a statement of the beneficiary's response to treatment, and any factors that have affected progress during the therapy period. Do not send daily treatment notes.
- Revised goals and justification for any change in the treatment plan for the requested period of therapy.
- Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable.
- Statement detailing any family/caregiver services being provided in a maintenance program, if appropriate.
- A copy of the prescription indicating the date range of the requested treatment period must be provided with each prior authorization request. The prescription must meet all the requirements established under this subsection. A treatment plan meeting all the prescription requirements is considered a prescription.
- The anticipated plan of discharge for the current course of therapy (up to 12 consecutive months). If more than 12 months of therapy is anticipated, a new course of therapy with a new evaluation/re-evaluation and treatment plan is required.



Maintenance Visits	<p>The skills of an occupational therapist may be required for training, review of previously achieved skills, monitoring of a maintenance program being carried out by family or caregivers, or continued follow-up for the fit and function of orthotic, prosthetic, or assistive technology devices. Maintenance visits in an outpatient or nursing facility setting may be provided up to four times per 90-consecutive day period. If more than four maintenance visits are required in a 90-consecutive day period, the therapist must request prior authorization. Maintenance visits in a home setting may be provided up to four times per 60-consecutive day period. If more than four maintenance visits are required in a 60-consecutive day period, the therapist must request prior authorization.</p> <p>The occupational therapist must complete the MSA-115 or FFS DDE plus MSA-115 prior authorization request, and include all the following:</p> <ul style="list-style-type: none">▪ Summary of previous treatment period, including measurable progress on each short- and long-term goal. This must include the treating occupational therapist's analysis of the therapy, rate of progress, and justification for any change in the treatment plan. Documentation must relate to the 90-day period immediately prior to that period for which prior authorization is being requested.▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during the therapy period.▪ A copy or description of the maintenance program.▪ A statement detailing the reason(s) additional maintenance visits are medically necessary.▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable.▪ The anticipated frequency and duration of maintenance visits.▪ The anticipated plan of discharge for the current course of therapy (up to 12 months).▪ A treatment plan signed by the prescribing practitioner that includes all the criteria established under Treatment Plan/Plan of Care above.
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4.1.G. DISCHARGE SUMMARY

MDHHS requires the occupational therapist to document a discharge summary to identify the completion of OT services and the discharge status. The discharge summary must be retained in the beneficiary's medical record and include all the following:

- Dates of service (i.e., initial and discharge dates);
- Description of therapy services provided;
- Functional status at discharge related to treatment areas/goals/maximum functional achievement over the course of therapy;
- Analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status;
- A copy or description of the maintenance program, if appropriate;



- Identification of assistive technology devices (e.g., walker) and its current utilization, if appropriate; and
- Recommendations/referral to other services, if appropriate.

4.1.H. SUPPLIES AND EQUIPMENT

MDHHS does not allow separate reimbursement for supplies and equipment used as part of a therapy treatment or for trials/training in the use of complex durable medical equipment when required to establish competency for a prior authorization request. The cost of supplies and equipment used are included in the reimbursement for the therapy.

4.2 PHYSICAL THERAPY

MDHHS uses the terms Physical Therapy, PT, and therapy interchangeably. PT is covered when furnished by a Medicaid-enrolled therapy provider and the documentation is signed by the treating therapist. Medicaid reimburses for physical therapy services when provided by any of the following:

- A licensed physical therapist.
- A licensed physical therapy assistant under the supervision of a physical therapist (i.e., the physical therapy assistant services must follow the evaluation and treatment plan developed by the physical therapist, and the physical therapist must supervise and monitor the physical therapy assistant's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and co-signed by the supervising physical therapist.
- A student completing their clinical affiliation under the direct supervision of (i.e., in the presence of) a physical therapist. All documentation must be reviewed and co-signed by the supervising physical therapist.

PT is considered an all-inclusive charge. Medicaid does not reimburse for a clinic room charge in addition to therapy services unless the room charges are unrelated. MDHHS expects physical therapists and physical therapy assistants to utilize the most ethically appropriate therapy within their scope of practice as defined by state law or the appropriate national professional association. PT must be medically necessary, reasonable and required to achieve one or more of the following:

- Return the beneficiary to the functional level prior to illness or disability;
- Return the beneficiary to a functional level that is appropriate to a stable medical status;
- Prevent a reduction in medical or functional status had the therapy not been provided.

Therapies provided to nursing facility beneficiaries outside the nursing facility premises must be provided in the outpatient department of a general hospital or medical care facility.

Therapies provided to county medical care facility, hospital long term care unit or hospital swing bed beneficiaries outside their respective facilities must be provided in the outpatient department of a general hospital.



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Medicaid standard coverage allows the following:

Outpatient/Private Practice Physical Therapy	Nursing Facility Physical Therapy	Home Health Physical Therapy
<ul style="list-style-type: none"> Up to 144 units of PT per calendar year period. Prior authorization is required for treatment that exceeds this unit limitation. 	<ul style="list-style-type: none"> Prior authorization is required. 	<ul style="list-style-type: none"> Up to 24 visits of PT in a 60-consecutive day period. Prior authorization (PA) is required for treatment that exceeds this visit limitation or for continued treatment beyond the initial 60 days.

PT is expected to result in measurable improvement that is significant to the beneficiary’s ability to perform mobility skills appropriate to his/her chronological, developmental, or functional status. Functional improvements must be achieved in a reasonable, and generally predictable, amount of time as specified in the short- and long-term goals identified on the evaluation/re-evaluation and treatment plan. Functional improvements must be maintainable. Medicaid does not cover therapy if the beneficiary’s maximum functional potential has been realized, the beneficiary has plateaued, or the therapy has no impact on the beneficiary’s ability to perform age-appropriate tasks. However, medically necessary rehabilitative therapy services may be covered under EPSDT or Healthy Michigan Plan.

Medicaid only covers PT services that require the skills, knowledge, and education of a physical therapist. Medicaid does not cover interventions provided by another practitioner or caregiver (e.g., registered nurse, licensed occupational therapist, family member, teacher, etc.).

<p>Physical therapy may be covered for one or more of the following:</p>	<ul style="list-style-type: none"> ▪ If expected to result in the restoration or amelioration of the anatomical or physical basis for the restriction in performing age-appropriate functional mobility skills. ▪ PT service that is diagnostic. ▪ For a temporary condition that creates decreased mobility and/or function. ▪ Training in functional mobility skills (e.g., ambulation, transfers, floor mobility, transitions, wheelchair mobility, etc.). ▪ Stretching for improved flexibility. ▪ Modalities to allow gains of function, strength, or mobility. ▪ Training in the use of orthotic/prosthetic devices and assistive technology devices. ▪ Severe pathology in the perception of, or response to, sensory input to the extent that it significantly limits the ability to function. ▪ Skilled services that are designed to develop, train, monitor, and modify a maintenance program to be carried out by family or caregivers. ▪ Federal EPSDT regulations require coverage of medically necessary treatment for beneficiaries under 21 years of age, including medically necessary rehabilitative therapy services. (Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter for additional information.)
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<p>Physical therapy is not covered for the following:</p>	<ul style="list-style-type: none"> ▪ If provided solely for educational, vocational, or recreational purposes. ▪ If therapy services are required to be provided by another public agency (e.g., community mental health services provider, school-based services, etc.). ▪ If a therapy service requires prior authorization and the service is rendered before prior authorization is approved. ▪ Habilitative therapy designed to facilitate the normal progression of development without compensatory techniques or processes. (Refer to the Early and Periodic Screening, Diagnosis and Treatment and the Healthy Michigan Plan chapters for coverage exceptions.) ▪ If therapy is rote practice of achieved skills. ▪ Development of perceptual motor skills and sensory integrative functions to follow a normal sequence. (Refer to the Early and Periodic Screening, Diagnosis and Treatment and the Healthy Michigan Plan chapters for coverage exceptions.) ▪ Continuation of therapy that is maintenance in nature, except as described under Maintenance Visits in the Prescription Requirements subsection below. ▪ If Medicare determines the service is not medically necessary. ▪ Additionally for nursing facility beneficiaries: <ul style="list-style-type: none"> ➢ Therapy provided by a physician (MD or DO); ➢ Services covered by the facility’s per diem rate, including routine maintenance and the development of the therapy and treatment.
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4.2.A. DUPLICATION OF SERVICES

Medicaid does not cover two disciplines working concurrently on similar goals/areas (e.g., assistive technology, hand therapy, sitting and standing balance/tolerance, transfers, etc.). Collaboration between treating therapists is required to coordinate therapy and prevent duplication of services. Documentation of the collaboration must be retained in the beneficiary’s medical record for audit purposes.

4.2.B. ACCESS TO SERVICES FOR SCHOOL-AGED BENEFICIARIES

School-based therapy services are covered by Medicaid when they assist a child/youth with a disability to benefit from special education. This includes beneficiaries up to the age of 21 who are eligible under the provisions of the Individuals with Disabilities Education Act (IDEA) of 1990 as amended, and those enrolled in programs that require an Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP). Therapy provided solely for educational purposes (e.g., pre-academic goals such as improved attention span, catching/throwing/kicking balls, etc.) is not covered by Medicaid.

Beneficiaries receiving school-based therapy may also receive medically-based therapy services in an outpatient setting, nursing facility, or through a home health agency. If therapy is provided in more than one setting, the goals and purpose for each must be distinct.



Outpatient therapy services are provided to optimize the child's/youth's maximum functional performance in relation to needs in the home or community setting and must not directly duplicate those provided in the school setting. Collaboration between the school and community providers is required to coordinate therapy and prevent direct duplication of services. Documentation of the collaboration must be retained in the beneficiary's medical record for audit purposes.

Beneficiaries receiving school-based therapy services with medically-related goals may be eligible for the continuation of services in an outpatient setting during the summer months to maintain function. Prior authorization is required if standard coverage limitations have been exceeded. (Refer to Requirements of Continued Therapy under the Prescription Requirements subsection below for additional information.)

4.2.C. AQUATIC THERAPY

Medicaid does not cover aquatic therapy as a separately reimbursable treatment or modality. A covered therapeutic procedure performed in a pool may be reimbursed when billed using the HCPCS code describing the covered procedure if the service meets all Medicaid coverage requirements.

4.2.D. GROUP THERAPY

PT is not covered by Medicaid when provided concurrently to a group of two or more individuals by the same therapist. Covered therapeutic procedures require direct (one-to-one) contact between the beneficiary and the therapist.

4.2.E. SERIAL CASTING

Serial casting is a process in which a joint(s) which lacks full range of motion is immobilized with a rigid or semi-rigid cast. During this procedure, the affected joint(s) is gradually and progressively set in a more anatomically correct alignment to improve joint alignment, increase muscle length, or to achieve a decrease in abnormal tone, resulting in an increase in the range of motion.

Casts are applied and removed in succession, usually every week, until full range of motion, flexibility, or plateau is reached. Upon removal of each cast, the limb is stretched, and a new cast is applied to hold the limb in place.

Serial casting is a covered benefit when performed by, or under the direct supervision of, a qualified therapist and defined in a treatment plan as a medically necessary therapy service for improving range of motion or reducing abnormal tone. The referral for therapy services must specifically indicate that the beneficiary is being referred for serial casting, or the prescribing provider must provide written concurrence, via signature, of any treatment plan that includes serial casting.



4.2.F. PRESCRIPTION REQUIREMENTS

Outpatient and private practice therapy requires a prescription from a physician or other licensed practitioner practicing within their scope of practice as defined in State law for physical therapy. Home health and nursing facility therapy require a prescription from a physician for physical therapy.

A treatment plan meeting all of the requirements below is considered a prescription. The prescription/treatment plan must contain all the following:

- Beneficiary's name;
- Beneficiary's date of birth;
- Prescribing practitioner's name, address, and telephone number;
- Prescribing practitioner's signature;
- The date the prescription was written;
- The frequency and duration of the therapy services; and
- Diagnosis.

A copy of the prescription must be retained in the beneficiary's medical record. A prescription is valid for 90 days from the date that the prescription was written unless the termination date is otherwise stated by the authorized prescribing practitioner on the prescription.

If the beneficiary has another insurance plan (e.g. Medicare or commercial insurance) and the service is a covered benefit, the provider must follow the requirements of the other insurance plan(s), including but not limited to, prescription, prior authorization, and provider qualifications. (Refer to the Coordination of Benefits chapter for more information.)



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<p>Evaluations/ Re-evaluations</p>	<p>An evaluation is formalized testing at the initiation of the beneficiary’s treatment plan. Evaluations may be provided up to two times in a 365-day period. Objective and periodic re-evaluations and reports are utilized to determine the measurable functional change resulting from the treatment plan. Re-evaluations may be provided up to two times in a 365-day period. Prior authorization is required if an evaluation or re-evaluation is needed more frequently. An evaluation/re-evaluation is required for the initiation of therapy and continued therapy.</p> <p>PT evaluations/re-evaluations must be completed and signed by the physical therapist and include all the following:</p> <ul style="list-style-type: none"> ▪ Standardized tests and/or objective functional baseline measures to establish short- and long-term goals and to document progress; ▪ Corresponding baseline measures for all short-and long-term goals; ▪ Treatment diagnosis(es); ▪ Medical diagnosis(es), if different from treatment diagnosis; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary’s current functional status (functional baseline); ▪ Assessment of the beneficiary’s performance components (e.g., strength, dexterity, range of motion, sensation, perception, muscle tone, etc.) directly affecting the beneficiary’s ability to function or make progress toward goals; and ▪ Assessment of the beneficiary’s cognitive skill level (e.g., ability to follow directions, including auditory and visual comprehension).
<p>Treatment Plan/Plan of Care</p>	<p>The PT treatment plan that results from the evaluation must be medically necessary, signed by the physical therapist, and include all the following:</p> <ul style="list-style-type: none"> ▪ Time-related short-term goals that are measurable, functional, and significant to the beneficiary’s function or mobility; ▪ Long-term goals that are measurable, functional, and identify specific maximum functional achievement for the requested authorization period; ▪ Functional outcome measures specific to maximum functional achievement for the current course of therapy (up to 12 consecutive months); ▪ Anticipated type, frequency, and duration of therapy required to meet short- and long-term goals; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ Plan for discharge from service; and ▪ Signature of the prescribing practitioner confirming agreement with the treatment plan. <p>A treatment plan, including all the criteria established above, must be submitted with the prior authorization request.</p>



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Initiation of Services	<p>PT may be initiated upon completion of the evaluation (current within 12 months) and development of a treatment plan that is medically necessary as documented in the beneficiary’s medical record. The initiation of therapy services may begin if all the following have been met:</p> <ul style="list-style-type: none">▪ The beneficiary is Medicaid-eligible;▪ A copy of the signed and dated (no more than 90 days prior to the initiation of services) prescription for physical therapy is retained in the beneficiary’s medical record;▪ The standard coverage limitations have not been exceeded;▪ Therapy is provided by the evaluating discipline (e.g., occupational therapist cannot provide treatment under a physical therapist’s evaluation); and▪ There is a change in medical status resulting in decreased mobility skills or functional ability.
Requirements of Continued Therapy	<p>The physical therapist must request prior authorization to continue therapy beyond standard coverage limitations, even if the beneficiary changes providers. A copy of the latest evaluation/re-evaluation (completed no more than 12 months prior to the authorization request) must be submitted with the prior authorization request.</p> <p>Requests for continued therapy must be supported by all the following:</p> <ul style="list-style-type: none">▪ Summary of previous treatment period (not to exceed the 90 days prior to that period for which prior authorization is being requested), including measurable progress on each short- and long-term goal, rate of progress, a statement of the beneficiary’s response to treatment, and any factors that have affected progress during the therapy period. Do not send daily treatment notes;▪ Revised goals and justification for any change in the treatment plan for the requested period of therapy;▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable;▪ Statement detailing any family/caregiver services being provided in a maintenance program, if appropriate;▪ A copy of the prescription indicating the date range of the requested treatment period must be provided with each prior authorization request. The prescription must meet all the requirements established in this subsection. A treatment plan meeting all the prescription requirements is considered a prescription; and▪ The anticipated plan of discharge for the current course of therapy (up to 12 months). If more than 12 months of therapy is anticipated, a new course of therapy with a new evaluation/re-evaluation and treatment plan is required.



Maintenance Visits	<p>The skills of a physical therapist may be required for training, review of previously achieved skills, monitoring of a maintenance program being carried out by family or caregivers, or continued follow-up for the fit and function of orthotic, prosthetic, or assistive technology devices. Maintenance visits in an outpatient or nursing facility setting may be provided up to four times per 90-consecutive day period. If more than four maintenance visits are required in a 90-consecutive day period, the therapist must request prior authorization. Maintenance visits in a home setting may be provided up to four times per 60-consecutive day period. If more than four maintenance visits are required in a 60-consecutive day period, the therapist must request prior authorization.</p> <p>The physical therapist must complete the MSA-115 or FFS DDE plus MSA-115 prior authorization request, and include all the following:</p> <ul style="list-style-type: none">▪ Summary of previous treatment period, including measurable progress on each short- and long-term goal. This must include the treating physical therapist's analysis of the therapy, rate of progress, and justification for any change in the treatment plan. Documentation must relate to the 90-day period immediately prior to that period for which prior authorization is being requested;▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during the therapy period;▪ A copy or description of the maintenance program;▪ A statement detailing the reason(s) additional maintenance visits are medically necessary;▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable;▪ The anticipated frequency and duration of the maintenance visits;▪ The anticipated plan of discharge for the current course of therapy (up to 12 consecutive months);▪ A treatment plan signed by the prescribing practitioner that includes all the criteria established under Treatment Plan/Plan of Care (above).
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4.2.G. DISCHARGE SUMMARY

MDHHS requires the physical therapist to document a discharge summary to identify the completion of PT services and the discharge status. The discharge summary must be retained in the beneficiary's medical record and include all the following:

- Dates of service (i.e., initial and discharge dates);
- Description of therapy services provided;
- Functional status at discharge related to treatment areas/goals/maximum functional potential over the course of therapy;
- Analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status;
- A copy or description of the maintenance program, if appropriate;



- Identification of assistive technology devices (e.g., walker) and its current utilization, if appropriate; and
- Recommendations/referral to other services, if appropriate.

4.2.H. SUPPLIES AND EQUIPMENT

MDHHS does not allow separate reimbursement for supplies and equipment used as part of a therapy treatment or for trials/training in the use of complex durable medical equipment when required to establish competency for a prior authorization request. The cost of supplies and equipment used are included in the reimbursement for the therapy.

4.3 SPEECH-LANGUAGE THERAPY

MDHHS uses the terms speech therapy, SLP, speech-language pathology, speech-language therapy (ST), and therapy to mean speech and language services and speech-language therapy. Speech-language therapy is covered when furnished by a Medicaid-enrolled therapy provider and the documentation is signed by the treating therapist. Medicaid reimburses services for speech-language therapy when provided by any of the following:

- A speech-language pathologist with a current license and who is authorized by ASHA to use Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP) credentials.
- An appropriately supervised speech-language pathologist candidate (i.e., in their clinical fellowship year) or having completed all requirements but has not obtained a license. All documentation must be reviewed and co-signed by the appropriately credentialed supervising speech-language pathologist.
- A student completing their clinical affiliation under the direct supervision of (i.e., in the presence of) a licensed speech-language pathologist. All documentation must be reviewed and co-signed by the appropriately credentialed supervising speech-language pathologist.

ST is considered an all-inclusive charge. Medicaid does not reimburse for a clinic room charge in addition to therapy services unless the room charges are unrelated. MDHHS expects speech-language pathologists to utilize the most ethically appropriate therapy within their scope of practice as defined by state law or the appropriate national professional association. ST must be medically necessary, related to a medical diagnosis, reasonable, and required to achieve one or more of the following:

- Return the beneficiary to the functional level prior to illness or disability;
- Return the beneficiary to a functional level that is appropriate to a stable medical status; and
- Prevent a reduction in medical or functional status had the therapy not been provided.

Speech-Language therapy is limited to services for:

- Articulation
- Language
- Fluency



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- Oral function (including swallowing, oral and/or pharyngeal dysphagia, and increasing nutrition/hydration)
- Training in the use of a speech-generating device (SGD)/Augmentative and Alternative Communication (AAC) device/Augmentative Communication Device (ACD)
- Evaluation and instruction in the use of an oral-pharyngeal prosthesis
- Voice
- Rehabilitation of executive skills function status post neurological insult (examples may include reasoning, decision making, judgement, and language)
- Audiologic/Aural Rehabilitation

Speech-Language Therapies (ST) provided to nursing facility beneficiaries outside the nursing facility premises must be provided in the outpatient department of a general hospital or medical care facility.

Therapies provided to county medical care facility, hospital long term care unit, or hospital swing bed beneficiaries outside their respective facilities must be provided in the outpatient department of a general hospital.

Medicaid standard coverage allows the following:

Outpatient/Private Practice Speech-Language Therapy	Nursing Facility Speech-Language Therapy	Home Health Speech-Language Therapy
<ul style="list-style-type: none"> • Up to 36 visits of ST per calendar year period. • Prior authorization is required for treatment that exceeds this unit limitation. 	<ul style="list-style-type: none"> • Prior authorization is required. 	<ul style="list-style-type: none"> • Home Health ST is covered for CSHCS beneficiaries only. • Prior authorization is required.

ST is expected to result in a measurable improvement that is significant to the beneficiary’s ability to demonstrate communication and/or oral motor function appropriate to his/her chronological, developmental, cognitive, or functional status. Functional improvements must be achieved in a reasonable, and generally predictable, amount of time as specified in the short- and long-term goals identified on the evaluation/re-evaluation and treatment plan. Functional improvements must be maintainable. Medicaid does not cover therapy if the beneficiary’s maximum functional potential has been realized, the beneficiary has plateaued, or the therapy has no impact on the beneficiary’s ability to perform age-appropriate tasks. However, medically necessary habilitative therapy services may be covered under EPSDT or Healthy Michigan Plan.

Medicaid only covers ST services that require the skills, knowledge, and education of a speech-language pathologist. MDHHS does not cover interventions provided by another practitioner or caregiver (e.g., registered nurse, licensed physical therapist, family member, teacher, etc.).



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Speech-Language therapy that is related to a medical diagnosis may be covered for one or more of the following:

- It is expected to result in the restoration or amelioration of the beneficiary's ability to communicate wants, needs, and desires to their previous level of function following illness or injury.
- A temporary condition that results in decreased comprehension and expression, fluency, and/or oral function.
- Training to improve articulation.
- Training to improve receptive and expressive language.
- Training to improve fluency.
- Training to improve oral and/or pharyngeal phases of swallowing.
- Training in the use of a SGD/AAC/ACD device.
- Training in the use of an oral-pharyngeal prosthesis.
- Training in voice disorders.
- Training in the use of compensatory communication strategies.
- Training in restoration of executive skill functions.
- Skilled services that are designed to develop, train, monitor, and modify a maintenance program to be carried out by family or caregivers.
- Federal EPSDT regulations require coverage of medically necessary treatment for beneficiaries under 21 years of age, including medically necessary habilitative therapy services. (Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter for additional information.)



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<p>Speech-Language therapy is not covered for the following:</p>	<ul style="list-style-type: none"> ▪ If provided solely for educational, vocational, social/emotional, or recreational purposes. ▪ If therapy services are required to be provided by another public agency (e.g., community mental health services provider, school-based services, etc.). ▪ If a therapy service requires prior authorization and the service is rendered before prior authorization is approved. ▪ Habilitative therapy designed to facilitate the normal progression of development without compensatory techniques or processes. (Refer to the Early and Periodic Screening, Diagnosis and Treatment and the Healthy Michigan Plan chapters for coverage exceptions.) ▪ If therapy is rote practice of achieved skills. ▪ Feeding for a beneficiary whose status is NPO, with physician orders to continue NPO, and who does not demonstrate the potential to improve oral and/or pharyngeal phases of swallowing (i.e., pleasure eating). ▪ Non-diagnostic, non-therapeutic, routine, or repetitive tasks without skilled feedback (e.g., sitting with a beneficiary needing prompting to swallow or take small bites which does not require the skills of a therapist, etc.). ▪ Continuation of therapy that is maintenance in nature, except as described under Maintenance Visits in the Prescription Requirements subsection (below). ▪ If Medicare determines the service is not medically necessary. ▪ Additionally for nursing facility beneficiaries: <ul style="list-style-type: none"> ➢ Therapy provided by a physician (MD or DO) is not a covered benefit for beneficiaries in a nursing facility. ➢ Services covered by the facility’s per diem rate including routine maintenance and the development of the therapy and treatment.
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4.3.A. DUPLICATION OF SERVICES

Medicaid does not cover two disciplines working concurrently on similar goals/areas (e.g., dysphagia, assistive technology, etc.). Collaboration between treating therapists is required to coordinate therapy and prevent duplication of services. Documentation of the collaboration must be retained in the beneficiary’s medical record for audit purposes.

4.3.B. ACCESS TO SERVICES FOR SCHOOL-AGED BENEFICIARIES

School-based therapy services are covered by Medicaid when they assist a child/youth with a disability to benefit from special education. This includes beneficiaries up to the age of 21 who are eligible under the provisions of the Individuals with Disabilities Education Act (IDEA) of 1990 as amended, and those enrolled in programs that require an Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP). Therapy provided solely for educational purposes (e.g., pre-academic goals such as improved attention span, catching/throwing/kicking balls, etc.) is not covered by Medicaid.



Beneficiaries receiving school-based therapy may also receive medically-based therapy services in an outpatient setting, nursing facility, or through a home health agency. If therapy is provided in more than one setting, the goals and purpose for each must be distinct.

Outpatient therapy services are provided to optimize the child's/youth's functional performance in relation to needs in the home or community setting and must not directly duplicate those provided in the school setting. Collaboration between the school and community providers is required to coordinate therapy and prevent direct duplication of services. Documentation of the collaboration must be retained in the beneficiary's medical record for audit purposes.

Beneficiaries receiving school-based therapy services with medically-related goals may be eligible for the continuation of services in an outpatient setting during the summer months to maintain function. Prior authorization is required if standard coverage limitations have been exceeded. (Refer to Requirements of Continued Therapy under the Prescription Requirements subsection below for additional information.)

4.3.C. GROUP THERAPY

Group therapy requires documentation justifying the benefit of group therapy in addition to, or in place of, individual therapy. No more than one session of individual speech-language therapy and one session of group speech-language therapy may be provided on the same date of service. Group therapy is not covered in the home setting.

4.3.D. PRESCRIPTION REQUIREMENTS

Outpatient and private practice therapy requires a prescription from a physician or other licensed practitioner practicing within their scope of practice as defined in State law for speech-language therapy. Home health and nursing facility therapy require a prescription from a physician for speech-language therapy.

A treatment plan meeting all the requirements below is considered a prescription. The prescription/treatment plan must contain all the following:

- Beneficiary's name;
- Beneficiary's date of birth;
- Prescribing practitioner's name, address, and telephone number;
- Prescribing practitioner's signature;
- The date the prescription was written;
- The frequency and duration of the therapy services;
- Diagnosis; and
- For swallowing or oral motor evaluation/treatment, the documentation must clearly specify allowance of trial feeds and/or oral intake during therapy. All documentation, including the prescription, current plan of care, and prior authorization, must consistently substantiate this allowance.



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A copy of the prescription must be retained in the beneficiary's medical record. A prescription is valid for 90 days from the date that the prescription was written unless the termination date is otherwise stated by the authorized prescribing practitioner on the prescription.

If the beneficiary has another insurance plan (e.g. Medicare or commercial insurance) and the service is a covered benefit, the provider must follow the requirements of the other insurance plan(s), including but not limited to, prescription, prior authorization, and provider qualifications. (Refer to the Coordination of Benefits chapter for more information.)



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Evaluations/ Re-evaluations	<p>An evaluation is formalized testing at the initiation of the beneficiary's treatment plan. Evaluations may be provided up to two times in a 365-day period. Oral function or swallowing evaluations may be provided up to four times in a 365-day period. Objective and periodic re-evaluations and reports are utilized to determine the measurable functional change resulting from the treatment plan. Re-evaluations may be provided up to two times in a 365-day period. Prior authorization is required if an evaluation or re-evaluation is needed more frequently. An evaluation/re-evaluation is required for the initiation of therapy and continued therapy.</p> <p>Speech-Language therapy evaluations/re-evaluations must be completed and signed by the speech-language pathologist and include all the following:</p> <ul style="list-style-type: none">▪ Standardized tests and/or objective functional baseline measures used to establish short- and long-term goals and to document progress;▪ Corresponding baseline measures for all short-and long-term goals;▪ Treatment diagnosis(es);▪ Medical diagnosis(es), if different from treatment diagnosis;▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable;▪ Medical history as it relates to the current course of therapy;▪ Assessment of the beneficiary's performance components (e.g., functional communication, receptive, expressive, articulation, fluency, voice, oral function, muscle tone, etc.) directly affecting the beneficiary's ability to function or make progress toward goals;▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual comprehension). <p>Oral function/swallowing evaluations must also include:</p> <ul style="list-style-type: none">▪ Presence/absence of coughing;▪ History of recent respiratory illness;▪ Current diet, documenting difficulties with food consistencies;▪ Aversion/sensitivity during eating;▪ Report or copy of a video fluoroscopy and any other formal testing, if available;▪ Objective oral motor assessment addressing labial, glossal, laryngeal, and pharyngeal stages;▪ Voice quality (i.e., pre- and post-feeding and natural voice), if applicable.
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<p>Treatment Plan/Plan of Care</p>	<p>The ST treatment plan that results from the evaluation must be medically necessary, signed by the speech-language pathologist, and include all the following:</p> <ul style="list-style-type: none"> ▪ Time-related short-term goals that are measurable, functional, and significant to the beneficiary's communication needs; ▪ Long-term goals that are measurable, functional, and identify specific maximum functional achievement for the requested authorization period; ▪ Functional outcome measures specific to maximum functional achievement for the current course of therapy (up to 12 consecutive months); ▪ Anticipated type, frequency and duration of therapy required to meet short- and long-term goals; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ Plan for discharge from service; and ▪ Signature of the prescribing practitioner confirming agreement with the treatment plan. <p>A treatment plan, including all the criteria established above, must be submitted with the prior authorization request.</p>
<p>Initiation of Services</p>	<p>Speech-Language therapy may be initiated upon completion of the evaluation (current within 12 months) and development of a treatment plan that is medically necessary as documented in the beneficiary's medical record. The initiation of therapy services may begin if all the following have been met:</p> <ul style="list-style-type: none"> ▪ The beneficiary is Medicaid eligible; ▪ A copy of the signed and dated (no more than 90 days prior to the initiation of services) prescription for speech-language therapy is retained in the beneficiary's medical record; ▪ The standard coverage limitations have not been exceeded; ▪ Therapy is provided by the evaluating discipline (e.g., an occupational therapist cannot provide treatment under a speech-language pathologist's evaluation); and ▪ If there is a change in medical status resulting in decreased communication skills, oral motor skills, or functional ability.



Requirements of Continued Therapy

The speech-language pathologist must request prior authorization to continue therapy beyond standard coverage limitations, even if the beneficiary changes providers. A copy of the latest evaluation/re-evaluation (completed no more than 12 months prior to the prior authorization request) must be submitted with the prior authorization request.

Requests for continued therapy must be supported by all the following:

- Summary of previous treatment period (not to exceed the 90 days prior to that period for which prior authorization is being requested), including measurable progress on each short- and long-term goal, rate of progress, a statement of the beneficiary's response to treatment, and any factors that have affected progress during the therapy period. Do not send daily treatment notes.
- Revised goals and justification for any change in the treatment plan for the requested period of therapy.
- Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable.
- Statement detailing any family/caregiver services being provided in a maintenance program, if appropriate.
- A copy of the prescription indicating the date range of the requested treatment period must be submitted with each prior authorization request. The prescription must meet all the requirements established under this subsection. A treatment plan meeting all the prescription requirements is considered a prescription.
- The anticipated plan of discharge for the current course of therapy (up to 12 months). If more than 12 months of therapy is anticipated, a new course of therapy with a new evaluation/re-evaluation and treatment plan is required.



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Maintenance Visits	<p>The skills of a speech-language pathologist may be required for training, review of previously achieved skills, monitoring of a maintenance program being carried out by family or caregivers, or continued follow-up for the fit and function of orthotic, prosthetic, or assistive technology devices. Maintenance visits in an outpatient or nursing facility setting may be provided up to four times per 90-consecutive day period. If more than four maintenance visits are required in a 90-consecutive day period, the speech-language pathologist must request prior authorization. Maintenance visits in a home setting may be provided up to four times per 60-consecutive day period. If more than four maintenance visits are required in a 60-consecutive day period, the speech-language pathologist must request prior authorization.</p> <p>The speech-language pathologist must complete the MSA-115 or FFS DDE plus MSA-115 prior authorization request, and include all the following:</p> <ul style="list-style-type: none"> ▪ Summary of previous treatment period, including measurable progress on each short- and long-term goal. The summary must include the treating speech-language pathologist's analysis of the therapy, rate of progress, and justification for any change in the treatment plan. Documentation must relate to the 90-consecutive day period immediately prior to that period for which prior authorization is being requested. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during the therapy period. ▪ A copy or description of the maintenance program. ▪ A statement detailing the reason(s) additional maintenance visits are medically necessary. ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable. ▪ The anticipated frequency and duration of the maintenance visits. ▪ The anticipated discharge plan for the current course of therapy (up to 12 consecutive months). ▪ A treatment plan signed by the prescribing practitioner that includes all the criteria established under Treatment Plan/Plan of Care (above).
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4.3.E. DISCHARGE SUMMARY

MDHHS requires the speech-language pathologist to document a discharge summary to identify the completion of speech-language therapy services and the discharge status. The discharge summary must be retained in the beneficiary's medical record and include all the following:

- Dates of service (i.e., initial and discharge dates);
- Description of therapy services provided;
- Functional status at discharge related to treatment areas/goals/maximum functional achievement over course of therapy;
- Analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status;
- A copy or description of the maintenance program, if appropriate;



- Identification of assistive technology devices provided (e.g., SGD/AAC, switches) and its current utilization, if appropriate; and
- Recommendations/referrals to other services, if appropriate.

4.3.F. SUPPLIES AND EQUIPMENT

MDHHS does not allow separate reimbursement for supplies and equipment used as part of a therapy treatment or for trials/training in the use of complex durable medical equipment when required to establish competency for a prior authorization request. The cost of supplies and equipment used are included in the reimbursement for the therapy. Refer to the Speech Generating Devices subsection of the Medical Supplier Chapter for additional information regarding SGDs, including trial periods.

4.3.G. EVALUATIONS AND FOLLOW-UP FOR SPEECH-GENERATING DEVICES/VOICE PROSTHESES [CHANGE MADE 7/1/20]

An evaluation by the speech-language pathologist for recommendation of a SGD may be billed once in three years. Prior authorization is required for evaluations exceeding standard coverage limitations. The results of this evaluation must be shared with the provider submitting the SGD prior authorization request.

SGD set-up, programming, and modification services that require the skills of a speech-language pathologist (beyond those provided by the SGD vendor) are covered as part of the beneficiary's ST benefit and may be billed up to 36 visits per calendar year. (revised 7/1/20)

Prior authorization is required for all SGDs. The Special Services Prior Approval-Request/Authorization form (MSA-1653-B) must be submitted for all original, replacement, upgrade, or repair of SGDs. (Refer to the Forms Appendix for additional information.)

Refer to the Speech Generating Devices subsection of the Medical Supplier Chapter for additional information regarding SGDs.

An evaluation for the use and/or fitting of a voice prosthetic device to supplement oral speech may be billed only if the evaluation was done to determine the need for an electro-larynx. The evaluation may be provided once in three years.



TRIBAL HEALTH CENTERS

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SECTION 1 – GENERAL INFORMATION

Under the Indian Self-Determination and Education Assistance Act (Public Law 93-638), tribal facilities, including Tribal Health Centers (THCs), are those owned and operated by American Indian/Alaska Native tribes and tribal organizations under contract or compact with the Indian Health Service (IHS).

The Michigan Department of Health and Human Services (MDHHS), which administers the State Medicaid Agency (SMA), has the authority to enter into reimbursement agreements with THCs to establish a payment mechanism for Medicaid beneficiaries receiving outpatient services through a THC.

Under the Michigan Medicaid State Plan, THCs have the option of choosing from one of three reimbursement mechanisms. The THC may elect to be reimbursed under only one of the options listed below, and the selected option applies to all beneficiaries receiving services at the THC. The options are:

- A THC may choose to be certified as an IHS facility and receive the IHS outpatient all-inclusive rate (AIR) for eligible encounters. The AIR applies to encounters for both native and non-native Medicaid beneficiaries. THCs are reimbursed at the AIR unless the THC chooses a different payment option and informs MDHHS of this choice in writing.
- If a THC chooses to be reimbursed as a FQHC, the entity would be required to adhere to the same requirements specified in the Federally Qualified Health Centers Chapter.
- A THC may be reimbursed as a fee-for-service provider. THCs choosing this option receive payment for covered services. No additional reimbursement or settlement is made.

Upon federal approval by the Health Resources and Services Administration, THCs may be reimbursed as a Federally Qualified Health Center (FQHC) by signing the FQHC Memorandum of Understanding (MOU). THCs choosing this option will receive the FQHC encounter rate set by the State in accordance with the Michigan Medicaid State Plan and federal regulations. The FQHC encounter rate applies to encounters for both native and non-native Medicaid beneficiaries. A THC electing to be reimbursed as an FQHC is not required to have a contract with the managed care entity.



SECTION 2 – MEDICAID ENROLLMENT

2.1 PROVIDER ENROLLMENT [CHANGE MADE 7/1/20]

MDHHS requires all THC's to have a Group (Type 2 - Organization) National Provider Identification (NPI) number in order to receive the enhanced THC reimbursement. For THC's with multiple locations and multiple rates, an NPI number for each location may be necessary so that the proper reimbursement rate of all encounters can be determined. If the THC fails to obtain and/or use the correct NPI number, the THC reimbursement will be determined under fee for service rules. The NPI number must be reported to MDHHS before billing Medicaid services.

Individual providers (doctors, dentists, optometrists, etc.) are required to obtain a Provider (Type 1 - Individual) NPI number and report the number to MDHHS.

In accordance with 42 CFR 455.104 and the Provider Ownership and Control Disclosures subsection of the General Information for Providers chapter of this Manual, clinics are required to disclose ownership information to MDHHS within 35 days of a change of ownership. Failure to notify MDHHS of any change in identification information may result in the loss of Medicaid enrollment, lapse of provider eligibility, or nonpayment of services. **(text added 7/1/20)**

2.1.A. NON-PHYSICIAN BEHAVIORAL HEALTH SERVICES

Licensed psychologists (Master's Limited or Doctoral level), social workers (Master's level), professional counselors (Master's or Doctoral level), and marriage and family therapists who serve Medicaid beneficiaries are required to enroll as Medicaid providers. Services must be billed using the appropriate evaluation and management (E/M) codes listed in the American Medical Association's Current Procedural Terminology (CPT) Book or Healthcare Common Procedure Coding System (HCPCS) codes. Providers should refer to the Non-Physician Behavioral Health provider database on the MDHHS website for the current list of covered procedure codes. The list of allowable services is reviewed annually and updated as applicable. Refer to the Additional Code/Coverage Resource Materials Section of the General Information for Providers Chapter for additional information regarding coverage parameters.

2.2 NONENROLLED PROVIDERS

Professional services performed by limited licensed psychologists (except as noted in Section 333.18223 of the Public Health Code), social workers, professional counselors, marriage and family therapists or student interns must be performed under the supervision of an enrolled, fully-licensed provider of the same profession. Since MDHHS does not directly enroll these providers, claims for their services must be billed using the NPI of the supervising provider responsible for ensuring the medical necessity and appropriateness of the services. Claims submitted with the non-enrolled provider's NPI in the rendering provider field will reject.



SECTION 3 – BENEFITS

3.1 COVERED SERVICES

THC services are reimbursed at the current Medicaid fee screens and reconciled annually, if applicable, for services provided to Medicaid fee-for-service (FFS) or managed care beneficiaries. THC Medicaid services include:

- Physician (MD, DO) services
- Podiatrist (DPM) services
- Chiropractor (DC) services
- Optometrist (OD) services
- Dental (DDS) services
- Advanced practice registered nurse (APRN) services
- Physician assistant (PA) services
- Services and supplies incident to the services rendered by the provider:
 - Pharmacy services administered by the provider and billed under the provider’s NPI number
 - Laboratory services billed under the provider’s NPI number
 - Diagnostic services billed under the provider’s NPI number
- Therapies (i.e., Occupational, Physical, and Speech, Hearing, and Language Evaluation and Therapy) rendered under the physician’s NPI number

The services listed may be modified in accordance with benefits covered under the Medicaid State Plan. MDHHS notifies providers of changes (additions/deletions) in Medicaid covered services through the Medicaid bulletin process. Providers should refer to these documents to verify that benefits are covered prior to rendering services.

For clarification of covered services:

Physician Services	Physician services must comply with coverages and limitations published in the Practitioner Chapter of this manual and in MDHHS Bulletins.
Podiatrist Services	Podiatrist services must comply with coverages and limitations published in the Practitioner Chapter of this manual and in MDHHS Bulletins.
Chiropractor Services	Chiropractor services must comply with the coverages and limitations published in the Chiropractor Chapter of this manual and MDHHS Bulletins.



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<p>Maternal Infant Health Program (MIHP)</p>	<p>THCs providing Maternal Infant Health Program (MIHP) services must be certified through MDHHS. Information specific to the coverages and limitations for MIHP services are detailed in the Maternal Infant Health Program Chapter of this manual. MIHP related services rendered to fee-for-service beneficiaries must be billed on the ASC X12N 837 5010 professional format. Refer to the Billing & Reimbursement for Professionals Chapter of this manual for specific billing guidelines.</p> <p>If the THC subcontracts any MIHP services, no duplicate billing is permitted.</p>
<p>Physician’s Assistant</p>	<p>Physician’s assistant services must comply with coverages and limitations published in the Practitioner Chapter of this manual and in MDHHS Bulletins.</p>
<p>Advanced Practice Registered Nurse (APRN)</p>	<p>APRN services must comply with the coverages and limitations published in the Practitioner Chapter of this manual and in MDHHS Bulletins.</p>
<p>Pharmacy Services</p>	<p>Pharmacy services billed under the practitioner NPI number are included in the encounter rate but do not constitute a separate encounter as they are considered part of the office visit.</p> <p>Practitioner pharmacy services do not include drugs provided by a pharmacy. THCs with enrolled pharmacy providers may continue to bill prescription claims to the MDHHS Pharmacy Benefits Manager (PBM).</p> <p>Medication Therapy Management (MTM) services are face-to-face consultations provided by pharmacists to optimize drug therapy and improve therapeutic outcomes for beneficiaries. MTM services provided according to Medicaid policy may be eligible to receive the encounter rate. (Refer to the Pharmacy Chapter of this manual for additional information.)</p> <p>MDHHS contracts with a PBM for processing of all fee-for-service (FFS) pharmacy claims for Medicaid. (Refer to the Pharmacy Chapter of this manual for an explanation of coverages and limitations.)</p>
<p>Laboratory Services</p>	<p>The Practitioner Chapter of this manual explains the coverages and limitations of the Medicaid laboratory benefit. Laboratory services billed under the practitioner’s NPI number are included in the THC encounter rate but do not constitute a separate encounter for reimbursement purposes as they are considered part of the office visit.</p> <p>THCs cannot bill for any services rendered by an outside laboratory provider or for an outside laboratory’s employees performing tests.</p>
<p>Diagnostic Services</p>	<p>Diagnostic testing performed as part of an office visit must be directly related to the presenting condition and substantiated in the medical records. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for billing information.)</p> <p>Diagnostic testing services do not constitute a separate encounter. These services are regarded as part of the office visit and are included in the encounter reimbursement. Examples of diagnostic tests are allergy testing, audiologic function tests, x-rays, and EKGs.</p>



Telemedicine	<p>A THC can be either an originating or distant site for telemedicine services. Refer to the Billing & Reimbursement for Institutional Providers Chapter for specific billing instructions. Refer to the Telemedicine Section of the Practitioner Chapter for additional information regarding telemedicine services.</p> <p>Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.</p>
Therapies	<p>Physical therapy, speech therapy, and occupational therapy are covered when performed at the THC. Refer to the appropriate chapter of this manual and MDHHS Bulletins for an explanation of current coverages and limitations. The Billing & Reimbursement for Professionals Chapter of this manual describes the billing requirements for services provided. Therapies provided on the same date of service as a physician visit are included in the encounter reimbursement.</p>

3.2 DENTAL COVERAGES AND LIMITATIONS

THC dental services are covered if provided in the THC and must comply with coverages and limitations for dental services as specified in the Dental Chapter of this manual. Dental benefits covered for beneficiaries under the age of 21 differ from those covered for beneficiaries age 21 and over.

Information for billing dental services is published in the Billing & Reimbursement for Dental Providers Chapter of this manual.

MDHHS contracts with Dental Health Plans (DHPs) for the administration of dental services for *Healthy Kids Dental* (HKD) beneficiaries. Claims for services provided to beneficiaries enrolled in the HKD program should be submitted to the beneficiary’s DHP. Payment is made based on the DHP fee schedule. No additional reimbursement is made by MDHHS.

(Refer to the Directory Appendix for DHP contact information.)

3.3 VISION COVERAGES AND LIMITATIONS

Vision services are covered if provided at the THC. Vision providers are ophthalmologists and optometrists. The vision services provided by an ophthalmologist or optometrist must comply with coverages and limitations published in the Vision Chapter of this manual.

MDHHS contracts for the volume purchase of frames and lenses from an optical house. Frames and lenses covered by the program must be ordered through the contractor and are listed in the Vision Chapter of this manual.

Some vision services require prior authorization (PA) before they can be rendered. The Vision Services Approval/Order Form (DCH-0893) is used to obtain PA. (Refer to the Vision Chapter for information on services that require PA and to the Forms Appendix for a copy of the form.)

3.4 SERVICES PROVIDED TO MEDICAID HEALTH PLAN ENROLLEES

For Medicaid-covered services provided to Medicaid beneficiaries enrolled in a Medicaid Health Plan (MHP), THCs receive payment from the MHP based on an agreement or contract with the MHP. In the absence of an agreement or contract, payment is based on the Medicaid fee-for-service (FFS) rates in



effect on the date of service (DOS). Approved services provided to MHP enrollees are then recognized as encounters.

3.5 MEDICARE AND MEDICAID BENEFICIARIES

For dually eligible Medicare and Medicaid beneficiaries, Medicaid reimburses coinsurance and deductible amounts on Medicare-approved claims up to Medicare's IHS encounter rate.



SECTION 4 – SUBSTANCE ABUSE

Outpatient substance abuse services provided by physicians, clinical social workers, clinical psychologists, and substance abuse treatment specialists are reimbursed. These services may include:

- Initial complete physical
- Medical history
- Social history
- Psychiatric history
- Individual, family, and group counseling
- Outpatient substance abuse treatment
- Intensive outpatient counseling
- Therapies (i.e., Psychiatric occupational/recreational therapy) in a Tribal-operated substance abuse treatment center are covered services provided they are active, restorative, and designed to prevent, correct, or compensate for a specific medical problem.
- Methadone

4.1 REQUIREMENTS FOR PARTICIPATION

All programs must meet the following criteria to bill Medicaid for services:

- Licensed by the state licensing agency to provide each type of substance abuse service; and
- Accredited as an alcohol and/or drug abuse program by one of the five national accreditation bodies:
 - The Joint Commission
 - Commission on Accreditation of Rehabilitation Facilities (CARF)
 - American Osteopathic Association (AOA)
 - Council on Accreditation of Services for Families and Children (CASFC)
 - National Committee on Quality Assurance (NCQA)

4.2 AUTHORIZATION

Services provided at the THC to American Indian and Alaska Native beneficiaries do not require the authorization of the regional Prepaid Inpatient Health Plan (PIHP).

4.3 AMERICAN INDIAN AND ALASKA NATIVE SERVICES

American Indians and Alaska Natives who are Medicaid beneficiaries can obtain substance abuse services directly from the THC. These services are not included in the MDHHS §1915(b) Managed Specialty Services and Supports Waiver for PIHPs and substance use disorder services. THCs should contact their regional PIHP to determine the appropriate process for accessing other funding sources or other service providers for those individuals requiring substance abuse services not covered by the THC.



4.4 SERVICES PROVIDED TO NON-AMERICAN INDIANS AND ALASKA NATIVES

The MDHHS Prepaid Inpatient Health Plan (PIHP) for Specialty Developmental Disabilities, Mental Health and Substance Abuse services assumes responsibility for certifying admission/continuing stays and reimbursing claims for the specialized substance abuse services of non-American Indians and Alaska Natives. Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of this manual for further information on PIHPs, Mental Health and Substance Abuse Services. Substance abuse services for non-American Indians and Alaska Natives must not be billed under CPT and HCPCS codes.

4.5 SERVICE LIMITS

THCs may exceed the substance abuse treatment limits for American Indian and Alaska Native beneficiaries as long as the medical record and plan of care documents the medical necessity.

4.6 NONCOVERED SERVICES

The following substance abuse services are not covered when provided through THCs:

- Emergency and non-emergency transportation
- Initial emergency screening and medical stabilization
- Acute medical detoxification services
- Medications prescribed in the management or treatment of methadone
- Room and Board



SECTION 5 – MENTAL HEALTH

Outpatient mental health services provided by physicians, clinical social workers, and clinical psychologists are covered. These services may include:

- Health assessment
- Psychiatric evaluation
- Psychological testing
- All other assessments and testing
- Case management
- Child therapy
- Crisis interventions
- Crisis residential services
- Intensive crisis stabilization services
- Individual psychotherapy
- Family psychotherapy
- Group psychotherapy
- Interpretation or explanation of data to family
- Medication administration
- Medication review
- Therapies (i.e., psychiatric occupational/recreational therapy) in a mental health treatment center are a covered service provided they are active, restorative, and designed to prevent, correct, or compensate for a specific medical problem.

5.1 NONENROLLED PROVIDERS

Professional services provided by limited licensed psychologists (except as noted in Section 333.18223 of the Public Health Code), social workers, professional counselors, marriage and family therapists or student interns are covered but must be performed under the supervision of an enrolled, fully-licensed provider of the same profession. Individuals who meet Michigan licensure/certification requirements for social workers and psychologists may provide services.

5.2 AUTHORIZATION

Mental health services provided at the THC to American Indian and Alaska Native beneficiaries do not require the authorization of PIHPs/CMHSPs.



5.3 AMERICAN INDIAN AND ALASKA NATIVE SERVICES

American Indians and Alaska Natives who are Medicaid beneficiaries can obtain mental health services directly from the THC. THC services are not included in the MDHHS §1915(b) Managed Specialty Services and Supports Waiver for PIHPs and substance use disorder services. THCs may refer tribal members to the PIHP/CMHSP for mental health services not provided at the THC.

5.4 NON-AMERICAN INDIAN SERVICES

PIHPs/CMHSPs assume responsibility for community-based mental health and developmental disability services covered through Medicaid for non-American Indians. Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of this manual for policies and procedures. Non-American Indian mental health services must not be billed under CPT or HCPCS codes.

5.5 NONCOVERED SERVICES

Mental Health services that are **not** the responsibility of the THC are as follows:

- Home-based mental health services
- Nursing facility (NF) mental health monitoring
- Emergency and non-emergency transportation



SECTION 6 – ENCOUNTERS

THCs are eligible to receive an encounter (per visit) rate as reimbursement for Medicaid covered services provided at the THC for native and non-native Medicaid beneficiaries.

The IHS outpatient all-inclusive rate (AIR) is determined by the Centers for Medicare & Medicaid Services (CMS) and is published in the Federal Register. The FQHC encounter rate under the FQHC MOU is an alternative methodology that was based on the prospective payment system (PPS) outlined in section 1902(bb) of the Social Security Act.

6.1 DEFINITION

An encounter is a face-to-face visit between a Medicaid beneficiary and the THC provider of health care services who exercises independent judgment in the provision of Medicaid-covered services. The THC provider may be credited with no more than one face-to-face encounter with a given beneficiary per day, except when the beneficiary, after the first encounter, suffers a separate or different illness or injury requiring additional diagnosis or treatment.

For a service to be defined as an encounter, the Medicaid-covered service must be recorded in the patient's record.

6.2 SERVICES BUNDLED IN THE ENCOUNTER

Ancillary Medicaid services (e.g., labs, x-rays, injections, etc.) are included in the per visit encounter. These ancillary services are described as being provided incident to the office visit. For example, lab services billed under the physician's NPI number would not be considered a separate encounter.

Ancillary services provided at another facility are not bundled under the office visit encounter. For example, services provided by the local hospital are not included in the encounter.



SECTION 7 – BILLING

The Group (Type 2 - Organization) NPI number must be used as the billing provider on all electronic and paper claims submitted to Medicaid. Do not use Provider (Type 1 - Individual) as the billing provider. The billing provider loop or field is mandatory to complete.

The NPI (Type 1 – Individual) number is the individual who has overall responsibility for the patient’s medical care and treatment reported in the claim or encounter. The attending provider field is mandatory to complete. Additionally, the NPI (Type 1 – Individual) number of the practitioner who performed the service should be entered as the rendering provider. Do not enter a Group (Type 2) NPI number as the attending or rendering provider.

MDHHS will use the billing provider NPI field (Type 2 - Organization) to determine the number of encounters and calculate the settlement for the year-end reconciliation.

7.1 OTHER INSURANCE

Billing instructions related to coordination of benefits are published in the Coordination of Benefits Chapter of this manual. Other insurance and all other payments received for services rendered to a Medicaid beneficiary must be reported. If payment received from other insurance exceeds the amount Medicaid would have paid, the THC must still submit a claim to Medicaid with the appropriate procedure code in order for the visit to be counted as an encounter.

7.2 MEDICARE AND MEDICAID CLAIMS

Refer to the Billing & Reimbursement Chapters of this manual for specific instructions regarding Medicare and Medicaid claims. If the Medicare payment exceeds the Medicaid fee screen, the appropriate procedure code should still be billed to Medicaid for encounter and reconciliation purposes.

7.3 PAYER OF LAST RESORT

The IHS is the payer of last resort for persons defined as eligible for contract health services under the regulations in 42 CFR, Part 36a, Subpart G, Section 36.61, notwithstanding any State or local law or regulation to the contrary.

7.4 COPAYMENTS

Medicaid copayments for chiropractic, dental, physician, podiatry and vision services are waived under the THC benefit as part of the reconciliation. (Refer to the General Information for Providers chapter for a list of services requiring copayments.)

Refer to the Billing Beneficiaries Section of the General Information for Providers Chapter of this manual for additional information regarding copayment requirements. Beneficiaries may not be denied care or services based on inability to pay a copayment, except as outlined in that section.



7.5 TIMELY FILING BILLING LIMITATION

The same timely filing billing limitations explained in the General Information for Providers Chapter of this manual pertain to encounters as well as claim submission.

7.6 PLACE OF SERVICE

Place of service codes are not applicable to institutional billing. However, if the THC performs a service that must be billed on the professional claim form within the clinic, THC's must use place of service (POS) code 07. For services provided outside the THC, bill with the appropriate POS code noted in the Billing & Reimbursement for Professionals Chapter of this manual.

THC services provided to beneficiaries at the THC are reconciled annually, if applicable.

The THC may bill for covered services that are not provided at the THC. These services must be billed with the appropriate Place of Service (POS) code in compliance with the coverages and limitations specified in the Practitioner Chapter of this manual. A complete list of POS codes can be found in the Billing & Reimbursement for Professionals Chapter of this manual.

Services billed to Medicaid are subject to audit and verifications.



SECTION 8 – MEDICAID PAYMENTS, ANNUAL RECONCILIATION AND APPEALS

8.1 QUARTERLY PAYMENTS

Quarterly payments are made to the THC at the beginning of each quarter. The payment is based on an estimate of the difference between the amount the THC receives for Medicaid services from FFS claims, managed care encounters, and other third party payments (including Medicare) during the year and the amount due the center based on the THC encounter rate.

8.2 INITIAL RECONCILIATION AND SETTLEMENT

An annual reconciliation, if applicable, ensures that reimbursement is made according to the payment option selected by the THC. The initial reconciliation and settlement is calculated approximately six months after the THC's fiscal year end. The number of encounters is determined from Medicaid fee-for-service (FFS) and managed care approved claims. Any difference between the THC rate and the amount paid to the THC from FFS and managed care payments, other insurance and quarterly payments is paid to or recovered from the THC. Future quarterly payments are adjusted based on the information in the initial reconciliation.

8.3 FINAL RECONCILIATION AND SETTLEMENT

A final reconciliation and settlement is calculated approximately one year after the THC's fiscal year end. This will allow time for all claims to clear the payment system.

8.4 APPEALS

A Medicaid provider has the right to appeal any adverse action taken by MDHHS unless that adverse action resulted from an action over which MDHHS had no control (e.g., Medicare termination, license revocation). The appeals process is outlined in MDHHS Medicaid Provider Reviews and Hearings rules, Michigan Administrative Code R400.3402 through R400.3425, amended, and filed with the Secretary of State on May 19, 2016. Any questions regarding this appeal process should be directed to the Michigan Office of Administrative Hearings and Rules (MOAHR). (Refer to the Directory Appendix for contact information.)



URGENT CARE CENTERS

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SECTION 1 – GENERAL INFORMATION

An Urgent Care Center (UCC) is a medical clinic or office, not located in a hospital emergency department, whose purpose is to provide unscheduled diagnosis and treatment of illnesses for ambulatory beneficiaries requiring immediate medical attention for non-life-threatening conditions. It is expected that UCCs will provide access to a place of service (POS) more appropriate than a hospital emergency department for addressing non-emergency medical needs when a beneficiary's primary care provider (PCP) is not available.

1.1 Staff Credentials

The UCC medical director must be a Michigan-licensed physician. The UCC medical director is responsible for the medical management of the UCC. All Medicaid-covered physician services must be performed by the physician, the physician's employee, or an employee of the same legal entity that employs the physician under the physician's delegation and supervision. Only persons currently licensed/certified in an appropriate health occupation/profession (e.g., physician assistant, nurse practitioner), as authorized by Public Act 368 of 1978 as amended, may provide direct patient care under the delegation and supervision of a physician when the physician is not physically present on the premises.

1.2 Hours of Operation

UCCs must be open seven days a week, and include evening hours, weekends and holidays. Hours of operation must be posted in the facility. UCCs must accept walk-in patients of all ages during all hours the facility is open to see patients.



SECTION 2 - COVERED SERVICES

Unscheduled, non-emergency, medically necessary services that are a non-life threatening condition or injury or illness that can be treated appropriately in a UCC are Medicaid covered services.

Michigan Department of Health and Human Services (MDHHS) covered services are based on the level of care that can be appropriately rendered in an urgent care place of service.

MDHHS will not cover separate facility charges.

Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

All facilities must provide clinical documentation for services rendered and complete a discharge summary which must be sent to the appropriate PCP. If a beneficiary does not have a PCP, the facility must document assistance with arranging a medical home for follow-up care.



SECTION 3 – PROVIDER ENROLLMENT

Providers must be enrolled with Medicaid and have a valid Type 2 (Group) National Provider Identifier (NPI) for MDHHS claim adjudication.

Claims must also include the appropriate Type 1 (Individual) NPI of the specific provider performing the service(s) as the rendering provider. A valid MDHHS-enrolled rendering provider number is required for claim adjudication. Providers must not enter a Type 2 (Group) NPI as the rendering provider. The Group NPI must be reported as the billing provider.

3.1 NPI Edits

MDHHS NPI claim editing will be applied to attending, billing, referring, rendering and supervising providers, as applicable. A claim cannot be paid if the NPI is missing or the reported NPI is invalid as it does not check digit and/or correctly crosswalk to the Provider Enrollment files for these provider loops or fields.



SECTION 4 – BILLING & REIMBURSEMENT

UCC providers must follow uniform billing guidelines using the professional CMS-1500 claim format or electronic Health Care Claim Professional (837) ASC X12N Version 5010 information. All providers are encouraged to bill electronically. Refer to the Billing & Reimbursement for Professionals chapter for additional CMS-1500 or 837P Professional claims submission and billing information.

If ancillary services are provided by UCC staff using hospital-owned equipment (i.e., done in the same building where urgent care is located), the hospital may bill that service on the institutional claim format for the technical service.

Reimbursement is based on the practitioner fee schedule. Services performed in a UCC are reimbursed at the non-facility rate based on the non-facility relative value unit (RVU). MDHHS utilizes the Medicaid National Correct Coding Initiative (NCCI) coding policies and edits as developed by the Centers for Medicare & Medicaid Services (CMS) to promote national correct coding methodologies. To avoid duplicate payments, UCC providers must submit only one non-facility service claim per beneficiary per DOS. Separate physician service claims should not be submitted.

4.1 Copay Requirements

A copayment may be required for office evaluation and management (E&M) visits for beneficiaries age 21 years and older.

Refer to the General Information for Providers Chapter for information about copayments. Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)



VISION

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SECTION 1 – GENERAL GUIDELINES AND REQUIREMENTS

The Michigan Department of Health and Human Services (MDHHS) contracts for the volume purchase of frames and lenses from an optical laboratory, referred to in this chapter as the contractor.

Vision providers (e.g., opticians, dispensing ophthalmologists, optometrists) must order frames and lenses from the contractor. A list of lenses is available in the MDHHS Vision Services Fee Schedule located on the MDHHS website. A list of available frames is available from the contractor, currently Classic Optical Laboratories. (Refer to the Directory Appendix for contact information.)

Orders placed with the contractor must be postmarked no later than 30 days after the date of order. If orders are placed beyond the 30 days, the contractor returns the order to the provider, who must explain to Medicaid why submission was delayed and request an exception from the time limit.

Procurement of contact lenses, low vision aids, and prosthetic eyes must be obtained from the vision provider's own source and are subject to prior authorization (PA) requirements as described in this chapter.

1.1 BENEFICIARY ELIGIBILITY AND COPAYMENTS

Providers must verify beneficiary eligibility prior to rendering services or ordering materials. If a beneficiary's eligibility expires prior to the date the material is delivered, reimbursement is made **only** if the beneficiary was eligible on the date the material was ordered by the vision provider and the date of order is used when billing. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.)

A copayment may be required for Medicaid beneficiaries age 21 and older for each separately reimbursable:

- Ophthalmological service performed by an optometrist or ophthalmologist; and
- Dispensing service for glasses or contact lenses billed by dispensing ophthalmologists or optometrists.

Refer to the General Information for Providers Chapter for information about copayments. Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)

1.2 PRIOR AUTHORIZATION

Some vision services and materials require PA before they can be rendered. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

The Vision Services Approval/Order Form (DCH-0893) is used to obtain PA. A copy of the DCH-0893 and completion instructions can be found in the Forms Appendix of this manual. Complete and mail or fax the DCH-0893 to the MDHHS Program Review Division. (Refer to the Directory Appendix for contact information.) PA requests must be postmarked no later than 30 calendar days after the date of order. If



beyond the 30 days, the provider must include a detailed explanation of why the submission was delayed.

When requesting prior approval, providers should make a photocopy of the completed form for the beneficiary file. Upon completion of the PA process, MDHHS returns one copy of the DCH-0893 to the provider.

An electronic copy of the DCH-0893 is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

1.3 CODING OF SERVICES

The American Medical Association's (AMA) Current Procedural Terminology (CPT) is the national coding standard for health care professional services. Vision providers must use CPT codes in effect on the date of service to describe and identify the services and procedures performed. Optometrists must be Therapeutic Pharmaceutical Agent certified in order to use many of these codes. All prescriptions or prescription orders must comply with state and federal laws. (Refer to the Pharmacy Chapter of this manual for additional information.)

Providers must use the International Classification of Diseases (ICD) for diagnostic coding of diseases, injuries, and conditions. Codes must be used at the highest level of specificity.

Healthcare Common Procedure Coding System (HCPCS) is a system developed by the Centers for Medicare & Medicaid Services (CMS) to report materials, supplies, and certain services not covered by the CPT codes. HCPCS codes are to be used when applicable.

1.4 MEDICARE

All vision services are subject to editing for Medicare coverage. MDHHS reimburses vision providers for coinsurance and deductible amounts on Medicare-approved claims up to Medicaid's reimbursement limit.

If a service requires PA by Medicaid and is covered by Medicare, vision providers do not have to obtain PA, nor does the vision provider have to obtain lenses or frames through the volume purchase program.

(Refer to the Billing & Reimbursement for Professionals Chapter of this manual for additional information.)

1.5 CONTRACTOR GUARANTEE

Frames and lenses furnished by the contractor are guaranteed for 90 days. If any material is found to be unsatisfactory due to contractor error or defective workmanship or materials, the materials and work order form should be returned to the contractor. The contractor is required to correct, adjust, or replace the materials.

If the vision provider supplies the contractor with incorrect specifications that results in eyeglasses being fabricated which the beneficiary cannot use, the vision provider is responsible for payment to the contractor for the remake. The contractor may not charge the vision provider more than what they would charge MDHHS for the remake. MDHHS does not pay for the remake (e.g., eyeglasses, lenses, or frames) due to vision provider error.



1.6 COMPLAINT PROCESS

To resolve problems (such as an overdue shipment, error in an order, or defective workmanship), vision providers should first contact the contractor.

If the lenses and/or frames are not received from the contractor within 21 days from the date they were ordered, vision providers are responsible for contacting the contractor to determine the cause of the delay.

If difficulties are encountered with the contractor in resolving a problem, vision providers should call the Vision Contract Manager. (Refer to the Directory Appendix for contact information.) Vision providers must be prepared to report the beneficiary's name and Medicaid ID number, and a detailed explanation of the problem(s) they have experienced.

MDHHS reviews the complaint, takes necessary action to correct the problem, and notifies the vision provider of the resolution.



SECTION 2 – DIOPTR CRITERIA

2.1 INITIAL LENSES

Initial lenses are considered to be the first prescription lenses ever worn by a person regardless of how they were obtained (e.g., through Medicaid, other insurance, or private pay). Initial lenses are a Medicaid benefit and do not require PA if the following minimum diopter criteria are met:

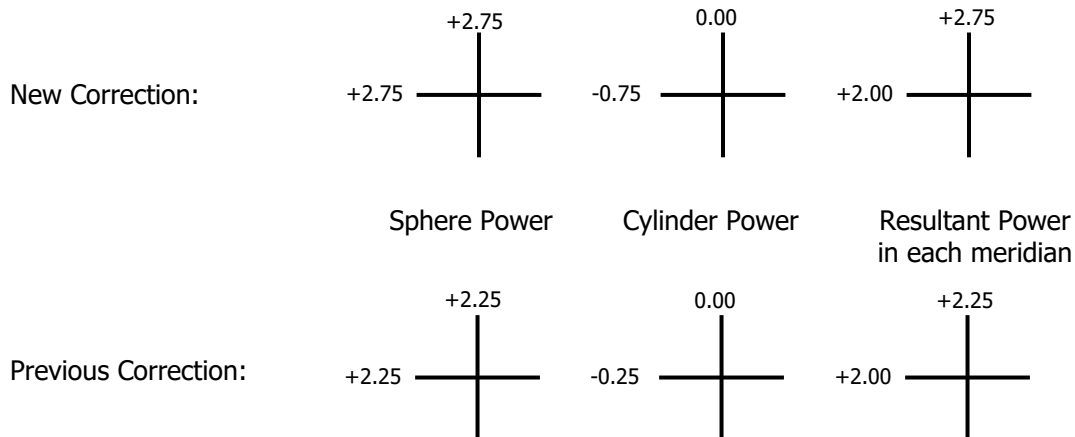
Age Group 42 Years and Younger	
▪ 0.50D myopia	▪ 0.75D anisometropia
▪ 0.50D astigmatism	▪ 0.75D hyperopia

Age Group 43 Years and Older	
▪ 0.50D myopia	▪ 0.50D hyperopia
▪ 0.50D astigmatism	▪ 0.50D presbyopia
▪ 0.75D anisometropia	

2.2 SUBSEQUENT LENSES

Regardless of age group, subsequent lenses are medically necessary lenses that are provided after initial lenses. Subsequent lenses are a Medicaid benefit and do not require PA if there is a change in the refractive error of 0.75D or more in the meridian of greatest change, or a change in the cylinder axis of at least 10 degrees for cylinders of 1.00D or more. These lenses must also meet minimum dioptric criteria as specified above. The change need only be present in one eye.

The following example illustrates how this requirement is assessed for a new correction (+2.75-0.75 ax 092) and a previous correction (+2.25-0.25 ax 090). The dioptric power in each meridian can be portrayed in the form of cross diagrams.



This is an example of where the change in dioptric power for subsequent lenses has not been met. Note that the resultant powers in the vertical meridians of the "new" and "previous" correction are +2.75 and +2.25 respectively. There is only a 0.50D change in the vertical meridian and no change in the horizontal.

For periods greater than 24 months from the date of the previous prescription, subsequent lenses may be ordered for diopter changes less than those specified above.



SECTION 3 – SERVICES

This section provides information on both Medicaid covered and noncovered services.

3.1 DIAGNOSTIC SERVICES

In providing services, it is the responsibility of the optometrist or ophthalmologist to determine that the services are medically necessary, appropriate, and within the scope of current medical practice and Medicaid limitations. The prescribing optometrist or ophthalmologist is held responsible if he orders excessive or unnecessary services, regardless of who actually renders the services. The prescribing optometrist or ophthalmologist may be subject to corrective action related to these services, including recovery of funds.

Documentation Guidelines for Evaluation and Management Services, 1995, 1997, or latest version thereof, developed jointly by CMS and the AMA, must be adhered to when using the CPT/HCPCS procedure codes.

Eye Examinations	<ul style="list-style-type: none"> ▪ A routine eye examination once every two years is a Medicaid benefit and does not require PA. Examinations include, but are not limited to, case history, determination of visual acuity (each eye), ophthalmoscopy, biomicroscopy, ocular motility, tonometry, refraction, diagnosis, treatment program and disposition. (Use appropriate CPT/HCPCS procedure codes for routine eye exam and applicable ICD diagnosis codes. ▪ Nonroutine eye examinations are a Medicaid benefit for the purpose of evaluation and treatment of chronic, acute, or sudden onset of abnormal ocular conditions. (Use appropriate CPT/HCPCS procedure codes.)
Glaucoma Screenings	<p>Glaucoma screenings are covered without PA on an annual basis for beneficiaries who:</p> <ul style="list-style-type: none"> ▪ Have no ocular complaints or prior history of glaucoma and who have diabetes; ▪ Have a family history of glaucoma; or ▪ Are African-American, age 50 or older. <p>This screening entails a dilated eye examination, tonometry, and direct ophthalmoscopy or slit lamp examination. If this screening is provided as part of another billable service, separate reimbursement for this screening is not allowed. Use the appropriate CPT/HCPCS procedure code for glaucoma screening and the applicable ICD diagnosis code.</p> <p>If the beneficiary presents with a visual or ocular complaint, the glaucoma screening code should not be used. The procedure code which best describes the visit should be selected from the CPT Evaluation and Management (E/M) codes or General Ophthalmological procedure codes.</p>



3.2 DISPENSING SERVICES

Dispensing services are a Medicaid benefit and do not require PA. Vision providers may bill a dispensing fee for dispensing prescription lenses, prescription lenses with frames, or replacing a complete frame.

Reimbursement for the dispensing service includes the vision provider's services in selecting, ordering, verifying, and aligning/fitting of eyeglasses as described above. Routine follow-up and post-prescription visits (e.g., for minor adjustments) are considered part of the dispensing service and are not separately reimbursable.

3.3 NURSING FACILITY BENEFICIARIES

Covered and noncovered vision services, as well as PA requirements, apply to vision services provided to beneficiaries residing in a nursing facility (NF).

Performance of vision services (except replacement of a frame part for eyeglass repair) must be upon the written request of the beneficiary, a member of the beneficiary's family, or other beneficiary representative and upon the written order of the beneficiary's attending physician (MD, DO) prior to the date of the vision provider's visit.

If service is provided in the NF, a copy of the request and written order must be retained by the facility as part of the beneficiary's record.

Vision services are not considered a part of the facility's per diem rate. The vision provider or contractor must bill MDHHS for vision services rendered.

No additional payments are made to vision providers for a visit(s) to the NF. Appropriate procedure codes must be utilized.

3.4 OPHTHALMIC FRAMES AND LENSES

A complete pair of eyeglasses is a Medicaid benefit and does not require PA when:

- The eyeglasses being prescribed are the beneficiary's first pair of eyeglasses ever worn. These eyeglasses are considered to be initial eyeglasses and must meet minimum diopter criteria for initial lenses.
- The beneficiary's correction meets diopter criteria for subsequent lenses and the frames are unusable.
- A previously used frame requires oversized lenses. (Oversized lenses are not a Medicaid benefit, therefore, a complete pair of eyeglasses must be ordered.)
- Prescription lenses remain usable, but the original frame is broken beyond repair and the original frame is not a Medicaid benefit.
- The beneficiary's correction meets diopter criteria for subsequent lenses and the frames remain usable, but the vision provider or beneficiary elects not to send the frames to the contractor or the contractor feels that the previously used frames will break or otherwise be damaged during lens insertion.



- The beneficiary's eyeglasses have been lost, stolen, or broken beyond repair and the number of replacements have not exceeded Medicaid limits which are:
 - For beneficiaries age 21 and over, one pair of replacement eyeglasses per year.
 - For beneficiaries under age 21, two pair of replacement eyeglasses per year.One year is defined as 365 days from the date the first pair of eyeglasses (initial or subsequent) was ordered.

The DCH-0893 must be used when ordering frames and/or lenses. A copy of the form and instructions for completing the form are available in the Forms Appendix of this manual and on the MDHHS website. (Refer to the Directory Appendix for website information.) These orders must be sent directly to the contractor. Orders may be mailed, faxed, or entered directly online at the contractor's website. (Refer to the Directory Appendix for contact information. The contractor must be contacted directly to register for on-line access.) The contractor fills the vision provider's order in accordance with the lens and frame specifications indicated on the DCH-0893. The order form is returned to the provider if the eligibility information is not completed.

Procedures identified as requiring PA must first receive approval from the MDHHS Program Review Division. (Refer to the Prior Authorization subsection in this chapter for instructions on obtaining PA.)

The contractor monitors orders to assure that Medicaid replacement limitations, diopter criteria, and PA requirements are being maintained. The contractor returns an order if the order exceeds the replacement limits, does not meet diopter criteria, or requires PA.

The contractor bills MDHHS for the frames and/or lenses ordered by vision providers. Vision providers subsequently bill for a dispensing service for dispensing the frames and/or lenses.

If the beneficiary has other insurance that covers frames and/or lenses, the material may still be obtained through the contractor. (Refer to the Billing & Reimbursement for Professionals and the Coordination of Benefits Chapters of this manual when billing for the dispensing service if other insurance is involved.)

3.4.A. LENSES

Lenses must conform to the latest edition of the *American National Standard Recommendations for Prescription Ophthalmic Lenses*.

Plastic and glass lenses are a Medicaid benefit. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

- Plastic and glass bifocals are available in Round 22, FT-28, FT-35, and Executive style.
- Plastic and glass trifocals are available in FT-7x28 segments.



Photochromic, Tinted and Dyed Lenses	PA is required for these lens features. Appropriate documentation of medical necessity must be attached to the DCH-0893 when submitted to the MDHHS Program Review Division.
Polycarbonate Lenses	For beneficiaries age 21 and over, polycarbonate lenses are a Medicaid benefit when diopter criteria is met and the lenses are inserted into a safety frame marked "Z 87" or "Z 87-2". For beneficiaries under age 21, polycarbonate lenses may be inserted into any covered Medicaid frame and do not require PA.

Oversized lenses, no-line, progressive style multi-focals, or transitions are not Medicaid benefits.

3.4.B. OPHTHALMIC FRAMES

Frames must conform to the latest edition of the *American National Standard Requirements for the Dress Ophthalmic Frames*.

Ophthalmic frame styles that are a Medicaid benefit are available from the contractor. Vision providers may order sample frames directly from the contractor. The vision provider is charged for sample frames at the same price stated in the current contract. Neither the provider nor the contractor may charge Medicaid for sample frames.

Vision providers must offer a beneficiary the opportunity to select a frame from at least 80 percent of the total authorized frame styles. A vision provider who fails to comply with this requirement is subject to termination of enrollment in Medicaid.

If a frame manufacturer discontinues production of a frame that is listed as a benefit, vision providers may utilize the discontinued frame from their sample kit. If lenses are required, they must be ordered from the contractor. Submit the DCH-0893 to the MDHHS Program Review Division for approval. (Refer to the Directory Appendix for contact information.)

Safety Frames	Safety frames are a Medicaid benefit. A list of authorized safety frame styles is available from the contractor. These frames conform to ANSI Z87.1-2003 standards, and samples can be purchased from the contractor at contract prices. Only polycarbonate lenses of 2 millimeter minimum thickness shall be used in frames marked "Z 87" or "Z 87-2".
Frame Repairs	Frame repairs (e.g., aligning temples, insertion of screws, adjusting frames) are not a separately reimbursable service and cannot be billed.

3.4.C. SUBSEQUENT LENSES PLACED IN PREVIOUSLY USED FRAMES

Subsequent lenses that are to be placed in a beneficiary's previously used frame are a Medicaid benefit and do not require PA. Previously used frames are defined as ophthalmic frames in which the beneficiary has had previous corrective lenses incorporated and which were previously worn.

All noncontract previously used frames require PA.



To order subsequent lenses for insertion into a previously used frame, vision providers must complete the DCH-0893, indicating all information necessary for proper fabrication. Vision providers have the option of having the contractor insert the lenses, in which case the provider must supply the previously used frame to the contractor, or inserting the newly fabricated lenses into the frames in their office.

If the previously used frames are sent to the contractor for lens insertion, the contractor is required to fabricate the lenses and mail the frames and lenses to the vision provider within nine working days after receiving the frames. If a special prescription requires more than nine working days to complete, the contractor must notify the vision provider. If the provider does not receive the materials within three weeks from the date the order was sent, he should contact the contractor.

If the vision provider or beneficiary elects not to send the previously used frames as might be requested by the contractor, or if the contractor feels that the previously used frames may break or otherwise be damaged during lens insertion, the vision provider is requested to order a complete pair of eyeglasses.

If frames are sent to the contractor, either at the contractor’s request or the vision provider’s preference, the vision provider is responsible for paying the postage necessary to ship the frames. Also, vision providers are responsible for paying for frames lost or damaged in transit.

If a previously used frame requires lenses that are not a Medicaid benefit (e.g., oversized lenses), a complete pair of eyeglasses that are a benefit must be ordered.

3.4.D. REPLACEMENT OR REPAIR

Eyeglasses	<p>Eyeglass repairs are a separately reimbursed service when the repair is considered major (e.g., reinsertion of a lens, repair of a sheared screw, shortening or replacing temples, etc.) and when the glasses are deemed repairable. Minor repairs (e.g., insertion of screw, adjustments of nose pads or temples, etc.) that occur as a result of the beneficiary’s typical wear patterns are not separately reimbursed. The appropriate HCPCS code(s) must be reported for the component part that is being replaced. The reason for the repair must be documented in the beneficiary’s file and made available upon request.</p> <p>If a provider determines that eyeglasses are repairable, the provider must guarantee the repair for a minimum of 30 days. Subsequent repair for the same issue within 30 days is the responsibility of the provider. If replacement eyeglasses are needed within the 30 day time frame following a repair, the provider must return the reimbursement received for the repair to MDHHS.</p> <p>Eyeglasses that are broken beyond repair may be eligible for replacement by the contractor. Eyeglass replacement requires prior authorization if replacement limits have been exceeded.</p>
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Lenses Only	<p>Replacement of a corrective lens(es), without frames, for one that is damaged or broken is a benefit if that lens(es) is covered by Medicaid and the replacement limits have not been exceeded. A replacement lens(es) must be an identical copy of the damaged or broken lens. It does not require PA. Vision providers must order the lens(es) directly from the contractor.</p> <p>For periods greater than 24 months from the date of the previous prescription when ordering subsequent lenses or complete eyeglasses, see Subsequent Lenses subsection above for appropriate diopter criteria.</p>
Frames Only	<p>Replacement of a complete frame (front and temples) is a Medicaid benefit only when the original frame is broken beyond repair, the prescription lenses remain usable, and the replacement limits have not been exceeded. The replacement frame must be an identical replacement. If an identical frame is not listed as a Medicaid benefit, the beneficiary must select a frame that is a covered benefit.</p> <p>The contractor bills Medicaid for the complete frame. The vision provider inserts the lenses into the frame and bills Medicaid for the dispensing service.</p>

3.4.E. TWO PAIRS OF EYEGLASSES

Two pairs of single vision eyeglasses (one for near visual tasks and the other for distance visual tasks) are a Medicaid benefit in either of the following instances:

- When the beneficiary has clearly demonstrated the inability to adjust to bifocals after a reasonable trial period.
- When the beneficiary’s physical condition does not allow bifocal usage.

PA is required when requesting two pairs of eyeglasses. Appropriate documentation must be attached to the DCH-0893 and submitted to the MDHHS Program Review Division.

Providing both multi-focal and single vision eyeglasses for interchangeable usage is not a Medicaid benefit.

3.4.F. NONDELIVERABLE EYEGLASSES

If a beneficiary fails to return to the vision provider for dispensing of eyeglasses, the vision provider should make every effort to locate the beneficiary, including contacting the local MDHHS office in the beneficiary’s area.

If the beneficiary still cannot be located, the eyeglasses should be sent to the local MDHHS office (or local nonprofit agency if the MDHHS office refuses to accept them) in the beneficiary’s area within 90 days of placing the order with the contractor. Do not send the nondelivered lenses and/or frames to MDHHS unless requested to do so by MDHHS.

To bill for dispensing, the provider must use the date of order for the lenses and/or frames.

Medicaid does not reimburse vision providers for postage and handling.



3.4.G. EYEGLOSS CASE

One eyeglass case for every complete pair of eyeglasses ordered is a Medicaid benefit and must be provided by the contractor. Vision providers cannot bill for eyeglass cases.

3.5 LOW VISION SERVICES

Evaluation	<p>A low vision evaluation is a benefit when the beneficiary presents with moderate visual impairment, severe visual impairment, or profound visual impairment. Under these conditions, a low vision evaluation does not require PA.</p> <p>This evaluation includes, but is not limited to, a detailed case history, effectiveness of any low vision aids in use, visual acuity in each eye with best spectacle correction, steadiness of fixation, assessment of aids required for distance vision and near vision, evaluation of any supplemental aids, evaluation of therapeutic filters, development of treatment, counseling of beneficiary, and advice to family (if appropriate).</p> <p>The CPT E/M or General Ophthalmological procedure code which best describes this service should be utilized.</p>
Aids	<p>High add bifocals do not require PA. For high add bifocals, complete the DCH-0893 and submit to the contractor.</p> <p>The prescription and fitting of low vision optical aids (such as telescopes, microscopes, and certain other low vision aids) require PA. Only basic and essential low vision aids are a Medicaid benefit.</p> <p>The Provision of Low Vision Services and Aids Support Documentation (MSA-0891) form outlines the information required when requesting PA for low vision services and aids. A sample of this form is provided in the Forms Appendix. It can also be obtained through the MDHHS website. (Refer to the Directory Appendix for website information.)</p> <p>This form must be attached to DCH-0893 and submitted as part of the PA process. (Refer to the Prior Authorization subsection above.)</p> <p>Reimbursement for a low vision aid is based on the manufacturer’s charge for the aid plus a professional fee. Procurement of the low vision aid is done through the vision provider’s own source. The professional fee includes procurement, verification, and fitting of the aid.</p> <p>Only an enrolled optometrist or a dispensing ophthalmologist can bill for a low vision aid.</p>
Rehabilitative Services	<p>Low vision rehabilitative services include instructions, training, and assistance to the beneficiary in the most effective use of the low vision aid. Documentation for these services should be included when requesting the low vision aid.</p>



3.6 CONTACT LENSES

3.6.A. EVALUATION

A comprehensive contact lens evaluation is a Medicaid benefit when the beneficiary presents with one of the following conditions (use appropriate HCPCS comprehensive contact lens evaluation code):

- Aniridia
- Anisometropia or Antimetropia (of two diopters or greater that results in Aniseikonia)
- Aphakia
- Irregular cornea
- Keratoconus (if vision cannot be improved to 20/40 or better with eyeglasses)
- Other conditions which have no alternative treatment (e.g., Aniseikonia with documentation and severe Keratoconjunctivitis sicca)

3.6.B. PRESCRIPTION AND FITTING

The prescription and fitting of contact lenses is a Medicaid benefit and requires PA, except for beneficiaries who are under six years of age with a diagnosis of aphakia.

3.6.B.1. PRESCRIPTION

The prescription for contact lenses requires the complete description of contact lens specifications. The following must be included on a prescription for contact lenses:

- complete description of the contact lens(es) parameters
- material of the contact lens(es)
- manufacturer of the contact lens(es)
- material discard and replacement schedule
- number of lenses required to provide a one-year supply
- prescription expiration date

3.6.B.2. FITTING

The fitting of the contact lens(es) must include:

- determination of appropriate initial contact lens parameters based on clinical observation, and measurements of the eye with or without a trial (sample) contact lens.



- a trial or adaption period of one to three months, including a fitting warranty that provides for adjustments in the contact lens parameters either by exchange or by modification of existing materials.

Note: Certain custom contact lens designs may not be warranted by the manufacturer. This type of custom contact lens design will be considered on a case-by-case basis. The provider must provide a detailed explanation of need, initial cost, and potential re-fitting cost.

- instruction of proper insertion, removal, disinfection, and care of the contact lens(es).
- initial supply of contact lenses, storage case, and solutions sufficient to last until the fitting is complete.

3.6.C. REPLACEMENT AND SUPPLIES

Procurement of contact lenses is to be done through the vision provider’s own source.

The Documentation of Medical Necessity for the Provision of Contact Lenses form (MSA-0892) outlines the information required when requesting contact lens PA. A sample of this form is provided in the Forms Appendix and can also be obtained through the MDHHS website. (Refer to the Directory Appendix for website information.)

This form must be attached to the Vision Services Approval/Order form (DCH-0893) and submitted to MDHHS as part of the PA process. (Refer to the Prior Authorization subsection in this chapter for additional information.)

Requests for contact lens replacements due to loss or damage will require PA and will be reviewed on an individual basis.

Except as previously indicated, contact lens supplies (e.g., wetting and cleaning solutions, carrying cases) are not Medicaid benefits.

3.7 STRABISMUS AND AMBLYOPIA EXAMINATION

Strabismus and amblyopia examinations (sensorimotor examination) are Medicaid benefits and do not require PA.

3.8 ORTHOPTICS AND PLEOPTICS TRAINING

<p>Orthoptics and Pleoptics Training</p>	<p>Orthoptics and Pleoptics (O & P) training is a Medicaid benefit only when there is a diagnosis of one of the following conditions:</p> <ul style="list-style-type: none"> ▪ Amblyopia ▪ Esotropia ▪ Exotropia ▪ Heterotropia ▪ Strabismus
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	<ul style="list-style-type: none"> ▪ Ocular Motor and Fusion Dysfunction <p>PA is not required for O & P training for beneficiaries under age 21. PA is required for beneficiaries age 21 and older for O & P training.</p> <p>When requesting PA, the following documentation must be attached to the DCH-0893 and submitted to the Program Review Division:</p> <ul style="list-style-type: none"> ▪ Visual acuity, each eye, with best spectacle correction; ▪ Magnitude and direction of the subjective and objective angle of strabismus at distance and near; ▪ Refractive error of each eye; ▪ Degree of fusion; ▪ History of strabismus, including onset, duration, prior treatment; and ▪ Other relevant information. <p>In addition to the above documentation, a detailed plan indicating the training procedures and equipment to be employed, frequency of office visits, home training aids, and prognosis must be attached to the DCH-0893. This training plan may be authorized for a period of up to three calendar months.</p> <p>O & P training is limited to a maximum of 13 visits within the first three calendar months of therapy without PA. PA will be required for additional necessary visits.</p> <p>If continued training beyond the period that was authorized is necessary, a new request for PA must be submitted with the following information:</p> <ul style="list-style-type: none"> ▪ Update of the above-listed items; ▪ Report of the results of previous training; and ▪ Indication for further treatment with a detailed plan.
Orthoptic Training Aids	<p>Orthoptic training aids are a Medicaid benefit when incorporated in an orthoptics or pleoptics training plan (as described above) and require PA. The following documentation must be included with the vision provider’s detailed plan when requesting the purchase of an aid:</p> <ul style="list-style-type: none"> ▪ How the aid is to be used; ▪ Complete description of the aid; ▪ Name of the manufacturer; and ▪ Manufacturer’s charge. <p>Reimbursement for a training aid is based on the manufacturer’s charge to the vision provider plus a professional fee. The professional fee includes procurement, instruction in use, and fitting when applicable. Procurement of the training aid is done through the vision provider’s own source.</p> <p>Purchase of orthoptic training aids must be billed only by an enrolled optometrist or dispensing ophthalmologist.</p>



3.9 PROSTHETIC EYES

A prosthetic eye (plastic/custom) or shell is a Medicaid benefit and does not require PA.

For an enlargement or reduction of an ocular prosthesis, PA is required. PA is also required when requesting a prosthesis other than a plastic/custom eye. When requesting PA, the DCH-0893 should be completed, with documentation attached, and submitted to the MDHHS Program Review Division. Procurement of the prosthesis should be obtained from the provider's own source.

Reimbursement for a prosthesis is made on a per case basis which includes, but is not limited to:

- Trial fitting
- Supply of prosthesis
- Solutions
- Training in insertion and removal
- Instruction in care
- Subsequent office visits to achieve maximum wearing time and optimal cosmetic fit
- Any necessary modification during the adaptation period of six months



ACRONYM APPENDIX

Acronym	Meaning
AA	Anesthesiologist Assistant
AAAHC	Accreditation Association for Ambulatory Health Care
AADE	American Association of Diabetes Educators
AAP	American Academy of Pediatrics
AAR	Access Assessment and Referral
AASA	Aging and Adult Services Agency)
ABA	Applied Behavior Analysis
ABAS-III	Adaptive Behavior Assessment System-III
ABC	American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc.
ABI	Applied Behavioral Intervention
ABLLS-R	Assessment of Basic Language and Learning Skills - Revised
ABR	Auditory Brainstem Response
ACA	Affordable Care Act
ACEs	Adverse Childhood Experiences
ACHC	Accreditation Commission for Health Care
ACIP	US Public Health Service Advisory Committee on Immunization Practices
ACRC	Admissions and Certification Review Contractor
ACT	Assertive Community Treatment
ADA	American Dental Association; Americans with Disabilities Act; American Diabetes Association
ADI-R	Autism Diagnostic Interview - Revised
ADL	Activities of Daily Living
ADOS-2	Autism Diagnostic Observation Schedule - Second Edition
AER	Administrative Expense Report
AFC	Adult Foster Care
AFC/HFA	Adult Foster Care Facility/Home for the Aged



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Acronym	Meaning
AFLS	Assessment of Functional Living Skills
AFO	Ankle-Foot Orthosis
AHI	Apnea-Hypopnea Index
AI	Assessment Indicator
AIMS	Attachment-Interaction-Mastery-Support
AIR	All-Inclusive Rate
ALD	Alternative Listening Device
ALMB	Additional Low Income Medicare Beneficiary
ALS	Advanced Life Support
ALTE	Apparent Life Threatening Event
AMA	American Medical Association; against medical advice
ANSI	American National Standards Institute
AO	Accreditation Organization (text added per bulletin MSA 19-37)
AOA	American Osteopathic Association
AOD	alcohol and other drug
APA	American Psychological Association
APC	Ambulatory Payment Classification
API	Active Pharmaceutical Ingredients (text added per bulletin MSA 20-03)
APR-DRG	All Patient Refined Diagnosis Related Grouper
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
APTA	American Physical Therapy Association
AQAR	Administrative Quality Assurance Review
ARD	Assessment Reference Date
ARR	Annual Resident Review
ASAM	American Society of Addiction Medicine
ASC	Ambulatory Surgical Center



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Acronym	Meaning
ASD	Autism Spectrum Disorder
ASHA	American Speech-Language-Hearing Association
ASM	American Society for Microbiology
ASQ	Ages and Stages Questionnaire
ATD	Assistive Technology Device
ATP	Assistive Technology Professional
ATR-BC	Registered Art Therapist – Board Certified
AUAM	Ambulatory Uterine Activity Monitor
BACB	Behavioral Analyst Certification Board
BAHD	Bone Anchored Hearing Device
BCaBA	Board Certified Assistant Behavior Analyst
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctoral
BCCCP	Breast and Cervical Cancer Control Program
BHDDA	Behavioral Health Developmental Disabilities Administration (MDHHS)
BHT	Behavioral Health Treatment
BICROS	Bilateral Contralateral Routing of Signals
BIPA	Section 702 of the Medicare, Medicaid, and CHIP Benefits Improvement and Protection Act of 2000. Section 702 of BIPA created a new section 1902(bb) in the Social Security Act.
BLS	Basic Life Support
BMI	Body Mass Index
BMP	Benefits Monitoring Program
BSBP	Bureau of Services for Blind Persons
BSN	Bachelor of Science in Nursing
BSW	Bachelor of Social Work
BY	Base Year
CAA	Council on Academic Accreditation; Care Area Assessment



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Acronym	Meaning
CADC	Certified Alcohol and Drug Counselor
CAFAS	Child and Adolescent Functional Assessment Scale
CAH	Critical Access Hospitals
CAHCP	Child and Adolescent Health Center and Program
CALOCUS	Child and Adolescent Level of Care Utilization System
CAMTS	Commission on Accreditation of Medical Transport Systems
CAP	College of American Pathologists
CAPD	Continuous Ambulatory Peritoneal Dialysis (hospital)
CARF	Commission on Accreditation of Rehabilitation Facilities
CBC	Complete Blood Count
CBSA	Core Based Statistical Area
CCA	Care Coordination Agreement
CCI	Child Caring Institution
CDC	Centers for Disease Control and Prevention
CDL	Commercial Driver's License
CDT	Current Dental Terminology
CENA	Competency Evaluated Nurse Aide
CF	Cystic Fibrosis
CFR	Code of Federal Regulations
CFY	Clinical Fellowship Year
CHAMPS	Community Health Automated Medicaid Processing System
CHAP	Community Health Accreditation Program
CHIP	Children's Health Insurance Program
CHPL	Certified Health IT Product List (text added per bulletin MSA 19-37)
CIP	Capital Interim Payment
CKD	Chronic Kidney Disease
CLIA	Clinical Laboratory Improvement Amendments



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Acronym	Meaning
CLS	Community Living Supports
CMCF	County Medical Care Facilities
CMCFSP	County Medical Care Facilities Special Payments
CMHC	Community Mental Health Center
CMHSP	Community Mental Health Services Program
CMN	Certificate of Medical Necessity
CMP	Civil Money Penalty
CMS	Centers for Medicare & Medicaid Services
CNA	Certified Nurse Aide
CNM	Certified Nurse Midwife
CNP	Certified Nurse Practitioner
CNS	Clinical Nurse Specialist
COA	Council on Accreditation of Services for Families and Children
COB	Coordination of Benefits
CON	Certificate of Need
CORF	Comprehensive Outpatient Rehabilitation Facility
CPAP	Continuous Positive Airway Pressure
CPH	Community Public Health
CPS	Children's Protective Services
CPT	Current Procedural Terminology
CQAR	Clinical Quality Assurance Review
CR	Cardiac Rehabilitation
CRN	Claim Reference Number
CRNA	Certified Registered Nurse Anesthetist
CROS	Contralateral Routing of Signals
CRP	Collaborative Remediation Project
CRTS	Certified Rehabilitation Technology Supplier



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Acronym	Meaning
CSHCS	Children's Special Health Care Services
CSW	Certified Social Worker
CT	Computerized Axial Tomography
CTLSO	Cervical-Thoracic-Lumbar-Sacral Orthosis
CTS	Community Transition Services
CWP	Children's Home and Community Based Services Waiver Program
CY	Current Year
DABS	Diagnostic Adaptive Behavior Scale
DAS-II	Differential Ability Scales-II
DD	Developmental Disabilities
DDS	Dentist
DEA	Drug Enforcement Administration
DEAP	Diabetes Education Accreditation Program
DECA	Devereux Early Childhood Assessment
DEG	Data Exchange Gateway
DESI	Drug Efficacy Study Implementation
DHP	Dental Health Plan
DIFS	Department of Insurance and Financial Services
DIT	Directed In-Service Training
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics & Supplies
DMP	Document Management Portal
DPNA	Denial of Payment for New Admissions
DO	Doctor of Osteopathy
DOB	Date of Birth
DOS	Date of Service
DPM	Doctor of Podiatric Medicine



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Acronym	Meaning
DPO	Designated Provider Organization
DPOA	Durable Power of Attorney
DPOC	Directed Plan of Correction
DPSCD	Detroit Public Schools Community District
DPT/CSAT	Division of Pharmacologic Therapies/Center for Substance Abuse Treatment
DQ	Developmental Quotient
DRG	Diagnosis Related Group
DSH	Disproportionate Share Hospital
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSME	Diabetes Self-Management Education
DTMB	Department of Technology, Management & Budget
DTT	Discrete Trial Training
DUB	Designated Unavailable Beds
DUR	Drug Utilization Review
E/M	Evaluation and Management
EAA	Environmental Accessibility Adaptations
EBG	Evidence-Based Guidelines
ECG	Electrocardiogram
ECR	Electronic Cost Report
ED	Emergency Department
EEG	Electroencephalogram
EFT	Electronic Funds Transfer
EGrAMS	Electronic Grants Administration and Management System
EH	eligible hospital (NOTE: Term applies to EHR Incentive Program only.)
EHR	Electronic Health Record



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Acronym	Meaning
EIBI	Early Intensive Behavioral Intervention
EIN	Federal Employee ID number
EMT	Emergency Medical Technician
EMTALA	Emergency Medical Treatment and Active Labor Act
EOAE	Evoked Otoacoustic Emissions
EOB	Explanation of Benefit
EP	eligible professional (NOTE: Term applies to EHR Incentive Program only.)
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
ERP	Education Recognition Program
ESO	Emergency Services Only
ESRD	End Stage Renal Disease
ESR	Erythrocyte Sedimentation Rate
EVS	Eligibility Verification System
F/T	Full Time
FAP	Food Assistance Program
FDA	Food and Drug Administration
FFP	Federal Financial Participation
FFS	Fee-for-Service
FNP	Family Nurse Practitioner
FOC	Freedom of Choice
FPL	Federal Poverty Level B67
FQHC	Federally Qualified Health Center
FSR	Financial Status Report
FTE	Full-Time Equivalent
FYE	Fiscal Year End
GAAS	Generally Accepted Auditing Standards
GAF	Global Assessment of Functioning



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Acronym	Meaning
GED	General Educational Development
GME	Graduate Medical Education
HAA	Hospital Access Agreement
HBP	Hospital Based Provider
HCAC	Health Care Acquired Condition
HCPCS	Healthcare Common Procedure Coding System
HCRD	Hospital and Clinic Reimbursement Division (Michigan Department of Health and Human Services)
HDM	Home Delivered Meals
HELP	Hawaii Early Learning Profile
HFA	Home for the Aged
HFCWO	High Frequency Chest Wall Oscillation
HHA	Home Health Agency
HHS	Health & Human Services (U.S. Department of)
HICN	Health Insurance Claim Number
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPPS	Health Insurance Prospective Payment System
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health Act
HKAFO	Hip-Knee-Ankle-Foot Orthosis
HLTCU	Hospital Long Term Care Unit
HMO	Health Maintenance Organization
HRSA	Health Resources and Services Administration
HSW	Habilitation Supports Waiver
HUAM	Home Uterine Activity Monitor
IBCLC	Internationally Board Certified Lactation Consultant
IBCLE	International Board of Lactation Consultant Examiners
ICA	Indigent Care Agreement



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Acronym	Meaning
ICCD	International Center for Clubhouse Development (d/b/a Clubhouse International)
ICD	International Classification of Diseases
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities [previously known as Intermediate Care Facility for the Mentally Retarded (ICF/MR)]
ICO	Integrated Care Organization
ICR	Intensive Cardiac Rehabilitation
ID	Identification
IDA	Infant-Toddler Developmental Assessment
IDEA	Individuals with Disabilities Education Act
IDG	Interdisciplinary Group
IDTF	Independent Diagnostic Testing Facilities
IE	Independent Employment
IEP	Individualized Education Program
IFDSH	Indigent Fund Disproportionate Share Hospital
IFSP	Individualized Family Service Plan
IGT	Intergovernmental Transfer
IHCP	Individualized Health Care Plan
IME	Indirect Medical Education
INS	Immigration and Naturalization Services (INS)
IOP	Intensive outpatient
IPOS	Individual Plan of Service
IQ	Intelligence Quotient
IRA	Imminent Risk Assessment
IS	Intensity of Service
ISD	Intermediate School District
ISEP	Implementation, Sustainability and Exit Plan
ITFI	Infant-Toddler Family Instrument
IV	Intravenous; Indigent Volume



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Acronym	Meaning
KAFO	Knee-Ankle-Foot Orthosis
KDE	Kidney Disease Education
LARA	Licensing and Regulatory Affairs (Department of)
LARC	Long Acting Reversible Contraceptive
LCD	Local Code Determination
LEEP	Loop Electrosurgical Excision Procedure
LHD	Local Health Department
LIF	Low-Income Families
LLP	Limited Licensed Psychologist
LOA	Leave of Absence
LOC	Level of Care
LOCD	(Michigan Medicaid Nursing Facility) Level of Care Determination
LOCM	Low Osmolar Contrast Material
LP	Licensed Psychologists
LPC	Licensed Professional Counselor
LPN	Licensed Practical Nurse
LRD	Lifetime Reserve Days
LSD	Local School District
LSO	Lumbar-Sacral Orthosis
LTACH	Long Term Acute Care Hospital
LTC	Long Term Care
LTE	Less Than Effective
MA	Medicaid
MAC	Monitored Anesthesia Care; Maximum Allowable Cost; Master Addictions Counselor
MACI	Medicaid Access to Care Initiative
MAER	Medicaid Allowable Expenditure Report
MBI	Medicare Beneficiary Identifier



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Acronym	Meaning
MCBAP	Michigan Certification Board of Addiction Professionals
MCC	Managed Care Carriers
MCF	Medical Care Facility
MCI	Michigan Children's Institute
MCIR	Michigan Care Improvement Registry
MCL	Michigan Compiled Law
MCLFS	Medicare Clinical Laboratory Fee Schedule
MCM	Medicare Carrier's Manual
MCO	Managed Care Organization
MD	Medical Doctor
MDCN	Medicare Data Communication Network
MDE	Michigan Department of Education
MDHHS	Michigan Department of Health and Human Services (formerly Michigan Department of Community Health [MDCH] and Michigan Department of Human Services [DHS])
MDS	Minimum Data Set
MDS-HC	Minimum Data Set for Home Care
MERF	Medical Eligibility Report Form
MHP	Medicaid Health Plan
MI	Mental Illness
MI Choice	Home and Community Based Waiver for the Elderly and Disabled
MI Enrolls	Michigan Enrolls
MIHP	Maternal Infant Health Program
MIP	Medicaid Interim Payment
MI-VRP	Michigan Vaccine Replacement Program
MMA	Magellan Medicaid Administration, Inc.
MMAP	Michigan Medicare/Medicaid Assistance Program
MMF	Michigan Medicaid Forms
MNT	Medical Nutrition Therapy



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Acronym	Meaning
MOA	Memorandum of Agreement
MOAHR	Michigan Office of Administrative Hearings and Rules
MOMS	Maternity Outpatient Medical Services
MOU	Memorandum of Understanding
MPH	Masters of Public Health
MPHI	Michigan Public Health Institute
MPPL	Michigan Pharmaceutical Product List
MPRO	Michigan Peer Review Organization
MRADL	Mobility Related Activities of Daily Living
MRS	Michigan Rehabilitation Services
MSA	Metropolitan Statistical Area
MSHDA	Michigan State Housing Development Authority
MSP	Medicare Savings Program
MSW	Master of Social Work
MT-BC	Music Therapist - Board Certified
MTF	Military Treatment Facility
MTU	Miscellaneous Transaction Unit
MUE	Medically Unlikely Edit
NAC	National Autism Center
NADAC	National Average Drug Acquisition Cost
NCC	National Certified Counselor
NCCA	National Commission for Certifying Agencies
NCCI	Medicaid National Correct Coding Initiative
NCD	National Coverage Determination
NCPDP	National Council for Prescription Drug Program
NCQA	National Committee on Quality Assurance
NCTRC	National Council for Therapeutic Recreation Certification



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Acronym	Meaning
NDC	National Drug Code
NEMT	Non-Emergency Medical Transportation
NF	Nursing Facility
NHC	Nursing Home Compare
NICU	Neonatal Intensive Care Unit
NLR	National Level Repository
NMTR	National Music Therapy Registry
NOC	Not Otherwise Classified
NP	Nurse Practitioner
NPI	National Provider Identifier
NPP	Non-Physician Practitioner
NPPES	National Plan and Provider Enumeration System
NRC	Nuclear Regulatory Commission
NREPP	National Registry of Evidence-based Programs and Practices
NTA	Non-therapy ancillary (text added per bulletin MSA 19-24)
NUBC	National Uniform Billing Committee
OASIS	Outcome and Assessment Information Set
OB Profile	Routine prenatal laboratory services
OBRA 90	Omnibus Budget Reconciliation Act of 1990
OCE	Outpatient Code Editor
OCR	Office of Civil Rights; Optical Character Reader
OFIR	Office of Financial and Insurance Regulation
OMA	Office of Medical Affairs
OMB	Office of Management and Budget
ONC	Office of the National Coordinator for Health Information Technology
OPH	Outpatient Hospital
OPPC	Other Provider Preventable Condition



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Acronym	Meaning
OPPS	Outpatient Prospective Payment System
OR	Operating Room
OSA	Obstructive Sleep Apnea
OT	Occupational Therapy; Occupational Therapist
OTA	Occupational Therapy Assistant
OTC	Over the Counter
OTP	Opioid Treatment Program
P&O	Prosthetics and Orthotics
P&T	Pharmacy & Therapeutics
P/T	Part Time
PA	Prior Authorization; Physician's Assistant
PACE	Program of All-Inclusive Care for the Elderly
PACER	Prior Authorization Certification Evaluation Review
PAHP	Prepaid Ambulatory Health Plan
PAS	Pre-admission Screening
PASARR	Pre-admission Screening/Annual Resident Review
PBM	Pharmacy Benefits Manager
PBRHC	Provider Based Rural Health Clinic
PC	Professional Component
PC Pool	Primary Care Pool
PCP	Primary Care Physician; Person-Centered Planning
PDAC	Pricing, Data Analysis, and Coding
PDD-NOS	Pervasive Developmental Disorder - Not Otherwise Specified
PDN	Private Duty Nursing
PDPM	Patient Driven Payment Model (text added per bulletin MSA 19-24)
PECFAS	Preschool and Early Childhood Functional Assessment Scale
PECOS	Provider Enrollment, Chain and Ownership System



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Acronym	Meaning
PEDS	Parent's Evaluation of Developmental Status
PEME	Pre-Eligibility Medical Expenses
PERS	Personal Emergency Response System
PET	Program Enrollment Type
PHI	Protected Health Information
PHS	Public Health Service
PIHP	Prepaid Inpatient Health Plan
PNP	Pediatric Nurse Practitioner
POA	Present on Admission
POC	Plan of Care; Plan of Correction
POL	Physician's Office Laboratory
POS	Point of Service; Plan of Service; Place of Service
PPA	Patient Pay Amount
PPACA	Patient Protection and Affordable Care Act
PPC	Provider Preventable Condition
PPI	Proton Pump Inhibitor
PPO	Preferred Provider Organizations
PPR	Prospective Payment Rate
PPS	Prospective Payment System
PR	Pulmonary Rehabilitation
ProDUR	Prospective Drug Utilization Review
PSC	Pediatric Symptom Checklist
PT	Physical Therapy; Physical Therapist
PTA	Physical Therapy Assistant
PTAN	Provider Transaction Access Number
PTCA	Percutaneous Transluminal Coronary Angioplasty
PXRS	Portable X-ray Suppliers



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Acronym	Meaning
Q/U/RM	Quality, Utilization and Risk Management
QAAF	Quality Assurance Assessment Factor
QAAP	Quality Assurance Assessment Program
QAS	Quality Assurance Supplement
QBHP	Qualified Behavioral Health Professionals
QDWI	Qualified Disabled Working Individual
QIDP	Qualified Intellectual Disabilities Professional [previously known as Qualified Mental Retardation Professional (QMRP)]
QMB	Qualified Medicare Beneficiary
QMHP	Qualified Mental Health Professional
QMI	Quality Measure Initiative
RA	Remittance Advice
RAI	Resident Assessment Instrument
RAP	Refugee Assistance Program
RARSS	Reimbursement and Rate Setting Section
RBRVS	Resource Based Relative Value Scale
RBT	Registered Behavior Technician
RD	Registered Dietitian
RDA	Recommended Dietary Allowance
RDRP	Rapid Dispute Resolution Process
RetroDUR	Retrospective Drug Utilization Review
RF	Reduction Factor
RFP	Request for Proposal
RHC	Rural Health Clinic
RN	Registered Nurse
RNR	Registered Nurse Reviewer
RSV	Respiratory Syncytial Virus
	(text removed per bulletin MSA 19-24)



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Acronym	Meaning
RVU	Relative Value Units
SADMERC	Statistical Analysis DME Regional Carrier
SARF	Screening, Assessment, Referral, and Follow-up
SBS	School Based Services
SCI	Spinal Cord Injury (text added 4/1/20)
SCQ	Social Communication Questionnaire
SDF	Silver Diamine Fluoride
SE	Supported Employment
SED	Serious Emotional Disturbance
SEDW	Children's Serious Emotional Disturbance Home and Community Based Services Waiver
SFF	Special Focus Facility
SGA	Substantial Gainful Activity
SGD	Speech Generating Device
SHS	Short Hospital Stay
SI	Severity of Illness; Status Indicator
SI/IS	Severity of Illness and Intensity of Service
SIDS	Sudden Infant Death Syndrome
SLMB	Specified Low Income Medicare Beneficiary
SLP	Speech-Language Pathologist
SMA	State Medicaid Agency
SMP	State Medical Plan
SNF	Skilled Nursing Facility
SNNU	Special Newborn Nursery Unit
SOM	State Operations Manual
SQC	Substandard Quality of Care
SRS-II	Social Responsiveness Scale-II
SS	Social Security



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Acronym	Meaning
SSA	Social Security Administration; State Survey Agency
SSG	Service Selection Guidelines
SSI	Supplemental Security Income
SSN	Social Security Number
ST	Speech-Language Therapy
STD	Sexually Transmitted Disease
SUBC	State Uniform Billing Committee
SVDCU	Sub-acute Ventilator-Dependent Care Unit
TABS	Temperament and Atypical Behavior Score
TB	Tuberculosis
TBI	Traumatic Brain Injury
TC	Technical Component
TCM	Targeted Case Management
TCN	Transaction Control Number
TE	Transitional Employment
TEFRA	Tax Equality and Fiscal Responsibility Act of 1982
TENS	Transcutaneous Electrical Nerve Stimulator
TEP	Temporary Eligibility Period
THC	Tribal Health Center
TIG	Telephone Intake Guidelines
TIN	Tax Identification Number
TIP	Temporarily Ineligible Participant
TJC	The Joint Commission
TLSO	Thoracic-Lumbar-Sacral Orthosis
TMA	Transitional Medical Assistance
TOB	Type of Bill
TPA	Therapeutic Pharmaceutical Agent



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Acronym	Meaning
TPL	Third-Party Liability
TPN	Total Parenteral Nutrition
TTP	Thrombotic Thrombocytopenic Purpura
U&C	Usual and Customary
UMICAD	Upper Midwest Indian Council on Addiction Disorders
UPL	Upper Payment Limit
USPHS	U.S. Public Health Service
USPS	United States Postal Service (text added per bulletin MSA 19-37)
USPSTF	United States Preventive Services Task Force
USTF	Uniform Service Treatment Facility
VABS-2	Vineland Adaptive Behavior Scales - Second Edition
VB-MAPP	Verbal Behavior-Milestones Assessment and Placement Program
VBP	Value Based Purchasing
VFC	Vaccine for Children
VPI	Virginia Polytechnic Institute
WAC	Wholesale Acquisition Cost
WBC	White Blood Cell
WIC	Women, Infants and Children Program
WISC-IV	Wechsler Intelligence Scale for Children-IV
WISC-V	Wechsler Intelligence Scale for Children-V
WPPSI-III	Wechsler Preschool and Primary Scale of Intelligence-III
WPPSI-IV	Wechsler Preschool and Primary Scale of Intelligence-IV
YTD	Year-to-Date



DIRECTORY APPENDIX

This directory provides contact information referenced in the various chapters of the Medicaid Provider Manual, and is divided into the following topic areas:

[Provider Assistance](#)
[Beneficiary Assistance](#)
[Eligibility Verification](#)
[Prior Authorization](#)
[Billing Resources](#)
[Claim Submission/Payment](#)
[Policy/Forms/Publications](#)
[Appeals](#)
[Health Plan Information](#)
[Healthy Michigan Plan](#)
[Provider Resources](#)

[Hospice Resources](#)
[Maternal-Child Educational Resources](#)
[Maternal Infant Health Program Resources](#)
[MH/SA Resources](#)
[MI Choice Waiver Resources](#)
[MI Health Link](#)
[Non-Emergency Medical Transportation](#)
[Nursing Facility Level of Care Determination](#)

[Nursing Facility Resources](#)
[Pharmacy Resources](#)
[Private Duty Nursing Resources](#)
[School Based Services](#)
[Vision Services Resources](#)
[Reporting Fraud, Abuse, or Misuse of Services](#)
[Other Health Care Resources/Programs](#)
[Miscellaneous Contact Information](#)

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
PROVIDER ASSISTANCE			
Provider Inquiry M-F 8 am to 5 pm EST	800-292-2550	MDHHS /Provider Inquiry PO Box 30731 Lansing, MI 48909-8231 providersupport@michigan.gov	Provider resource for billing assistance including out-of-state and non-enrolled provider claims).
Atypical Providers M-F 8 am to 5 pm EST	800-979-4662	MDHHS/Provider Inquiry PO Box 30731 Lansing, MI 48909-8231 providersupport@michigan.gov	Provider and client resource for Home Help/Adult Foster Care/Non-Emergency Transportation services that involve questions of approved authorizations and payment information, along with submission of claims for personal care services.
CHAMPS Provider Enrollment On-Line System	1-800-292-2550	providersupport@michigan.gov	On-line provider enrollment application and information, on-line update of provider information, billing agent authorizations, etc.



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CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Provider Enrollment Unit	1-800-292-2550 Fax 517-241-8233	MDHHS /Medicaid Payments Division Provider Enrollment Unit PO Box 30238 Lansing, MI 48909 email address: providerenrollment@michigan.gov website: www.michigan.gov/medicaidproviders >> Provider Enrollment	Change provider Pay To address. Use the CHAMPS PE contact information for all questions related to the enrollment process.
CHAMPS	Helpline: 1-800-292-2550	www.michigan.gov/medicaidproviders >> CHAMPS	Resources for information; training
Children's Special Health Care Services (CSHCS)	517-241-7186 Fax 517-241-8970	CSHCS Program 320 S. Walnut Lansing, MI 48913 www.michigan.gov/cshcs	General information regarding CSHCS program
CSHCS Customer Support	517-335-8986 Fax 517-335-9491 (submission of medical reports, applications, and all other information)	CSHCS Customer Support PO Box 30734 Lansing, MI 48909	Information about medical eligibility determinations, application process, coverage, requests for retroactive coverage, hospice, respite, or submission of client information updates.
MI Care Team		email address: MDHHS-MICareTeam@michigan.gov website: www.michigan.gov/micareteam	General information. Provider Resources, including: <ul style="list-style-type: none"> • MI Care Team Handbook • MSA-1030 • MDHHS-5515 • sample of Beneficiary Enrollment letter Consumer Resources <ul style="list-style-type: none"> • MI Care team sites • Map of participating counties
		email address: MDHHS-BHConsent@michigan.gov website: www.michigan.gov/bhconsent	form MDHHS-5515 and supporting resources, including FAQ
		email address: automatedbilling@michigan.gov website: www.michigan.gov/medicaidproviders >> Provider Enrollment >> Billing Agent -User Guide	Billing agent information
		email address: MDHHSEncounterData@michigan.gov	questions related to encounter file submission and FTS issues for MI Care Team organizations



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CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
		website: www.michigan.gov/tradingpartners >> HIPAA - Companion Guides >> Electronic Submissions Manual	information and instructions relating to submitting data electronically and the File Transfer Service (FTS)
BENEFICIARY ASSISTANCE			
Beneficiary Help Line M-F 8 am to 7 pm	800-642-3195	MDHHS Enrollment Services Section PO Box 30479 Lansing, MI 48909-7979	Beneficiary resource for all programs administered by MDHHS, billing problems, mihealth card replacements, etc.
Beneficiary Pharmacy Help Line 24/7/365	877-681-7540	Magellan Medicaid Administration, Inc.	Beneficiaries can receive answers to general pharmacy questions.
MI Enrolls (Michigan Enrolls) M-F 8 am to 7 pm	888-367-6557 TTY: 888-263-5897	Michigan Enrolls PO Box 30412 Lansing, MI 48909	Health plan enrollment, provider participation information, and health plan change.
MiChild/MOMS	888-988-6300 TTY: 888-263-5897	Michigan Enrolls PO Box 30412 Lansing, MI 48909 On-line application www.michigan.gov/mibridges	MiChild health plan enrollment, MiChild provider participation information, and MiChild health plan change.
Family Center for Children and Youth with Special Needs Family Phone Line M-F 8 am to 5 pm	800-359-3722 fax 313-456-4379	CSHCS Family Center Cadillac Place, Suite 3-350 3056 W. Grand Blvd. Detroit, MI 48202 email: cschscf@michigan.gov	For parent use only. Information regarding CSHCS, statewide Family Support Network, other resource information, transferring calls to CSHCS staff and providers.
Medicare Buy-In Unit	517-335-5488 Fax 517-335-0478	MDHHS /Buy-In Unit Elliott-Larsen Bldg. (revised 10/1/20) 320 S. Walnut St. Lansing, MI 48913 BuyInUnit@michigan.gov	Reviews Medicare/Medicaid dual eligible beneficiary information to determine if they qualify for the Medicare Buy-In/Medicare Savings Program.
ELIGIBILITY VERIFICATION			
CHAMPS Eligibility Inquiry	MDHHS Provider Inquiry Helpline 1-800-292-2550 for questions/issues related to the eligibility response.	email: providersupport@michigan.gov Website: Log into CHAMPS using MIlogin at https://milogintp.michigan.gov . Go to the Eligibility Inquiry hyperlink located on the 'Provider Portal' page under the 'Member' section. Benefit Plan Information: www.michigan.gov/mdhhs >> Resources >> Beneficiary Eligibility Verification >> Benefit Plans >> Benefit Plan ID table	For Medicaid providers to verify eligibility for the Medicaid, CSHCS, MOMS, and MiChild programs. Refer to the Benefit Plan ID table in the Beneficiary Eligibility Chapter for a complete list of Benefit Plan IDs that are provided in the eligibility response. Providers need to utilize the Benefit Plan ID(s) indicated in the eligibility response to determine coverage for a specific DOS.



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CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
CHAMPS 270/271 Batch Transaction		email: AutomatedBilling@michigan.gov Web Address: www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Electronic Billing >> HIPAA - Companion Guides	A HIPAA 270/271 Batch option is available in CHAMPS for providers and/or their contracted clearinghouse vendors to verify eligibility. Refer to the HIPAA 5010 270/271 Inquiry Response Companion Guide for more information and/or the Electronic Submission Manual for upload availability.
Web-DENIS	1-877-BLUE-WEB (1-877-258-3932) fax 248-486-2214	Blue Cross Blue Shield of MI Electronic Business Interchange Group, L830 53200 Grand River New Hudson, MI 48165 www.bcbsm.com For more information, including access information, refer to the MDHHS website at www.michigan.gov/medicaidproviders >> Beneficiary Eligibility Verification	Web-DENIS is BCBSM's secure browser-based internet site for eligibility verification. Medicaid providers can verify eligibility for the Medicaid, CSHCS, MOMS, and MICHild programs at no cost. Eligibility response data is provided from CHAMPS. Providers need to utilize the Benefit Plan ID(s) indicated in the eligibility response to determine coverage for a specific DOS.
Newborn ID Numbers	Fax 517-373-1437	MDHHS Enrollment Services Section PO Box 30479 Lansing, MI 48909-7979 MSA-ESS@michigan.gov	Fax or e-mail requests to obtain newborn ID numbers for billing Medicaid only when an eligibility inquiry does not locate the newborn. Eligibility information must be obtained using the CHAMPS Eligibility Inquiry with the ID number provided by MDHHS. When submitting a request, include newborn's name, gender, date of birth, mother's name, and mother's Medicaid ID number.
MOMS Eligibility	Fax 517-241-8556	Customer Services Division Attn: MOMS Program	ONLY if MOMS ID number is not available through the CHAMPS Eligibility Inquiry or mihealth card. Request must be on provider letterhead and include provider's phone number and contact person.
Eligibility Verification (out-of-state providers)	1-800-292-2550		For out-of-state providers without internet access to verify eligibility for Medicaid, CSHCS, MOMS, and MICHild programs within the last 12 months.
Michigan Public Health Institute (MPHI)		email: MedicaidEligibility@mphi.org Web Address: https://healthplanbenefits.mihealth.org	For Medicaid providers to verify eligibility for the Medicaid, CSHCS, MOMS, and MICHild programs at no cost. Eligibility response data provided from CHAMPS. Providers need to utilize the Benefit Plan ID(s) indicated in the eligibility response to determine coverage for a specific DOS.



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CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
			MPHI offers: Web-based system called MI Health Plan Benefits. To obtain access, go to https://healthplanbenefits.mihealth.org >> Enrollment Form HIPAA X12 270/271 Realtime/batch transaction. For information, Enrollment Form, and Companion Guide, go to www.mihealth.org >> HIPAA 270/271 Transactions for Michigan Medicaid <ul style="list-style-type: none"> MSA-1038 status tool: Search by Member ID or Name/DOB to determine the status of a submitted MSA-1038. Database is updated on a daily basis.
Medicare DSH Audits - Eligibility Verification for Dates Of Service Over 12 Months for Hospital Providers	Michigan Public Health Institute (MPHI): (877) 816-0737 CHAMPS = MDHHS Provider Inquiry: 800-292-2550	MPHI: Website: HIPAA X12 270/271 Realtime/batch Transaction website = http://www.mihealth.org/#HIPAA >> HIPAA 270/271 Transactions for Michigan Medicaid email: MedicaidEligibility@mphi.org CHAMPS: Website: www.michigan.gov/tradingpartners >> HIPAA –Companion Guides Mailing Address: MDHHS /Provider Inquiry P.O. Box 30731 Lansing, MI 48909-8231 email: providersupport@michigan.gov	The following options are available for hospital providers to verify eligibility for DOS over 12 months for Medicare DSH audits: <ul style="list-style-type: none"> MPHI = 270/271 Realtime/Batch Transactions CHAMPS = Member Eligibility Inquiry CHAMPS = 270/271 Batch Transaction Hospital providers that contract with clearinghouse vendors to submit/receive their DSH inquiries must have the vendor listed as one of their approved billing agents on CHAMPS (PE subsystem).
PRIOR AUTHORIZATION (Authorization of Services)			
Program Review Division, Benefits Monitoring Program	855-808-0312 fax 517-335-0075	MDHHS Program Review Division P.O. Box 30170 Lansing, MI 48909-7979	Inquiries by beneficiaries and providers regarding the Benefits Monitoring Program
Program Review Division (FFS Medicaid & CSHCS)	800-622-0276 fax 517-335-0075	MDHHS Program Review Division PO Box 30170 Lansing, MI 48909	Prior authorization for all services except hospital, specified durable medical equipment, and pharmacy
Prior Authorization (MHP)	See Health Plan list on MDHHS website	Obtain specific health plan contact information at: www.michigan.gov/medicaid >> Program Resources >> Medicaid Health Plans	For beneficiaries enrolled in a health plan, providers are to contact the plan for authorization of services
Prior Authorization - Dental	800-622-0276 fax 517-335-0075	MDHHS Dental Prior Authorization PO Box 30154 Lansing, MI 48909	Prior authorization of dental services for Medicaid and CSHCS



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CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Prior Authorization - Specified DME and Medical Supplies (MDHHS Medicaid Telephone Prior Authorization Contractor)	800-727-7223	Michigan Peer Review Organization 22670 Haggerty Rd., Ste. 100 Farmington Hills, MI 48335-2611	Telephone prior authorization of specified DME and medical supplies (applies to applicable procedure codes requiring telephone prior authorization noted on the MDHHS Medical Supplier/Orthotists/Prosthetists/DME Dealers page on the MDHHS website)
Prior Authorization (PACER) – Med/Surg Inpatient Admissions (Admissions & Certification Review Contractor)	800-727-7223	Michigan Peer Review Organization 22670 Haggerty Rd., Ste. 100 Farmington Hills, MI 48335-2611	Prior authorization for Medicaid and CSHCS admissions
Prior Authorization (PACER) Acute Care Hospital to Long Term Acute Care Hospital (LTACH)	800-727-7223	Michigan Peer Review Organization 22670 Haggerty Rd., Ste. 100 Farmington Hills, MI 48335-2611	Prior authorization for Medicaid, Healthy Michigan Plan, and CSHCS admissions.
Prior Authorization – Psychiatric Inpatient Admissions	Refer to local Community Mental Health Services Program		
Prior Authorization – Private Duty Nursing FFS Medicaid	800-622-0276 fax 517-241-7813	MDHHS Program Review Division PO Box 30170 Lansing, MI 48909	Prior authorization for FFS Medicaid PDN services.
Prior Authorization – Private Duty Nursing Children’s Waiver & Habilitation Supports Waiver		Contact beneficiary’s case manager/ supports coordinator at their local Community Mental Health Services Program (CMHSP)	Prior authorization for Children’s Waiver and Habilitation Supports Waiver PDN services.
Prior Authorization – Ventilator-Dependent Care Units (MDHHS Medicaid Prior Authorization Contractor)	800-727-7223	Michigan Peer Review Organization 22670 Haggerty Rd., Ste. 100 Farmington Hills, MI 48335-2611	Authorization for Medicaid reimbursement in contracted ventilator dependent care units
Prior Authorization – NF Complex Care	800-622-0276 fax 517-241-7813	MDHHS Program Review Division PO Box 30170 Lansing, MI 48909	Authorization for increased NF per diem for complex care
Prior Authorization – Pharmacy (PBM Technical Call Center) 24/7/365	877-624-5204 fax 877-888-6370	Magellan Medicaid Administration, Inc. 4300 Cox Rd. Glen Allen, VA 23060	Non-clinical prior authorization and early refills
Pharmacy Clinical Call Center (PBM Clinical Call Center) 7 am – 7 pm EST, M – F After hours calls rollover to the PBM Technical Call Center	877-864-9014 fax 887-888-6370 fax 800-250-6950	Magellan Medicaid Administration, Inc. 4300 Cox Rd. Glen Allen, VA 23060	Prescribers call for prior authorization clinical reasons and non-preferred drug products. Pharmacies call for dollar amount limits and Medicare Part B coinsurance.



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CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
BILLING RESOURCES			
Automated Billing Unit/ Electronic Billing Resources	fax 517-335-3766	Automated Billing Unit PO Box 30731 Lansing, MI 48909 AutomatedBilling@michigan.gov	Information regarding becoming an electronic biller and submitting electronic claims to MDHHS. 835 & 837 Companion Guides, Testing Instructions, and MDHHS Electronic Submission Manual are available at www.michigan.gov/tradingpartners
Beneficiary Co-Payments		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Co-Payment Requirements www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Co-Payment FAQ Healthy Michigan Plan: www.michigan.gov/healthymichiganplan >> Healthy Michigan Plan Provider Information	Beneficiary co-payment requirements; frequently asked questions
CDT Coding Manual (American Dental Assoc.)	800-947-4746		Procedure codes required for dental claims.
Centers for Medicare & Medicaid Services (CMS)		www.cms.gov	Provider resource for CMS guidelines, HCPCS Codes, and National Physician Fee Schedule Relative Value Files
CPT Coding Manual HCPCS Coding Manual ICD Coding Manual			Procedure and diagnosis coding required for professional and institutional claims. Available for purchase from a variety of vendors.
Electronic Healthcare Transactions		Web Address: www.michigan.gov/5010ICD10	Information regarding X12 version 5010 transactions and ICD-10 code sets
MDHHS Procedure Code Databases/Fee Screens, Documentation Requirements, Readmission Example, etc.	517-284-1245 fax 517-335-5136	www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information	MDHHS -covered procedure codes, parameters, fee screens, 15-day readmission example, OPSS Wraparound Code Lists for each provider type available on-line.
MDHHS Institutional Billing Resource		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information (>> "Inpatient Hospital" or "Outpatient")	Billing updates.



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MDHHS Sanctioned Providers List		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> List of Sanctioned Providers U.S. Department of Health & Human Services (HHS) Sanctioned Providers: https://exclusions.oig.hhs.gov MDHHS Licensing Actions: www.michigan.gov/healthlicense and www.michigan.gov/bchs MDHHS Licensing Actions: www.michigan.gov/mdhhs >> Doing Business with MDHHS >> Licensing	List of providers that are excluded from participation in Michigan Medicaid, CSHCS, etc.
Medicaid Code and Rate Reference Tool		Log into CHAMPS using MILogin at https://milogintp.michigan.gov . Go to the External Links menu located on the 'Provider Portal' page. Select 'Medicaid Code and Rate Reference' from the dropdown list.	Real-time information regarding MDHHS -covered procedure codes, parameters, and fee screens.
Medicare Crossover Claims		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Medicare Crossover	Information regarding Medicare Crossover billing and exclusions
Medicaid National Correct Coding Initiative (NCCI)	fax 317-571-1745	Medicaid National Correct Coding Initiative Correct Coding Solutions, LLC P.O. Box 907 Carmel, IN 46082-0907 https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html	Information regarding Medicaid NCCI. Questions regarding NCCI coding policies and edits may be directed to the CMS NCCI Contractor: Correct Coding Solutions, LLC.
National Uniform Billing Committee (NUBC) Manual		American Hospital Association National Uniform Billing Committee PO Box 92247 Chicago, IL 60675-2247 www.nubc.org	To obtain a NUBC manual.
National Uniform Claim Committee		www.nucc.org	To obtain CMS-1500 (02-12) claim forms or NUCC standard claim completion instructions.
Medicare Pricing, Data Analysis, and Coding (PDAC); Contractor: Noridian Administrative Services, LLC	877-735-1326 (9:00 a.m.-4:00 p.m. EST)	http://www.dmepdac.com	Enteral Product Classification List; DME information
Washington Publishing Co.		PMB 161 5284 Randolph Rd Rockville, MD 20852-2116 www.wpc-edi.com	Information regarding HIPAA compliant claim formats and code sets



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CLAIM SUBMISSION/PAYMENT			
Document Management Portal		www.michigan.gov/medicaidproviders >> Document Management Portal	Document Management Portal information and tutorials
Vendor Registration and Electronic Funds Transfer		State Budget Office www.michigan.gov/SIGMAVSS	Register provider SSN or EIN/TIN, initiate receipt of electronic Medicaid payments
Friend of the Court	517-373-5975 Fax 517-373-8740	Friend of the Court Bureau State Court Administrative Office Michigan Hall of Justice PO Box 30048 Lansing, MI 48909 FOCB@courts.mi.gov	Qualifying medical support orders
MDHHS Cashier's Unit		MDHHS Cashier's Unit 235 S. Grand Ave., Ste. 801 PO Box 30437 Lansing, MI 48909	Refund payments to MDHHS, purchase Medicaid manual subscription
		MDHHS - Cashier's Unit Attn.: Bureau of Finance - MCU 235 S. Grand Ave., Ste. 801 PO Box 30437 Lansing, MI 48909	Provider returning overpayments
Paper Claim Submission		MDHHS PO Box 30043 Lansing, MI 48909	CMS-1500 (02-12), CMS-1450 (UB-04), and ADA 2012 claims are to be mailed to the address indicated. No other paper claim formats are accepted.
Pharmacy Paper Claim Submission		Magellan Medicaid Administration, Inc. Michigan Paper Claims Processing Unit PO Box C-85042 Richmond, VA 23261-5042	Address to submit paper pharmacy claims.
Sterilization & Hysterectomy Forms Submission	Fax 866-229-6675		Fax completed form according to Document Management Portal instructions. Form may be downloaded from the MDHHS website at: www.michigan.gov/medicaidproviders >> Policy, Letters & Forms
Third Party Liability Section	800-292-2550 (option #4) fax 517-346-9817	MDHHS /TPL PO Box 30479 Lansing, MI 48909-7979 TPL_Health@michigan.gov	Coordination of benefits issues



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POLICY/FORMS/PUBLICATIONS			
Medicaid Policy Division		MDHHS /Medicaid Policy PO Box 30479 Lansing, MI 48909 MSAPolicy@michigan.gov	Policy questions, etc. Billing questions/problems and general policy questions should be directed to Provider Inquiry at 1-800-292-2550.
Draft Medicaid Policy	517-284-1245	MSADraftPolicy@michigan.gov	Proposed policies are distributed for a 30-day public comment period. Copies of proposed policies may be requested via e-mail or obtained from the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms
ListServ Communications		www.michigan.gov/medicaidproviders >> Listserv Instructions (under Resources)	Subscription instructions
Medicaid Forms Distribution		MDHHS Medicaid Program Policy Division PO Box 30479 Lansing, MI 48909 E-mail: MSA-Forms@michigan.gov	Many required forms are available in the Forms Appendix of this manual and on-line at: www.michigan.gov/medicaidproviders >> Policy, Letters & Forms
Medicaid Policy Manuals and Bulletins	517-284-1245 fax 517-335-5136	MSAPolicy@michigan.gov	Copies of policy bulletins. This information is also available on-line at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms
Michigan Medicaid Provider Manual (CD version)	Fax 517-335-5136	MDHHS /Medicaid Program Policy Division PO Box 30479 Lansing, MI 48909 MSA-Forms@michigan.gov	Michigan Medicaid Provider Manual on compact disc (CD)
Medicaid Publications		MDHHS Health Promotions & Publications 320 S. Walnut Lansing, MI 48933 www.michigan.gov/medicaidproviders >> Policy, Letters & Forms	Medicaid brochures and other publications
Numbered Letters		www.michigan.gov/medicaidproviders >> Policy, Letters & Forms	Copies of numbered letters
U.S. Department of Health & Human Services (HHS)		http://www.hhs.gov/opa/order-publications/#pub_sterilization-pubs	Consent for Sterilization form (HHS-687)



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APPEALS			
Appeals/Administrative Hearings (Beneficiary)	800-648-3397 or (517) 335-7519 Fax (517) 763-0146	Michigan Office of Administrative Hearings and Rules Michigan Department of Health and Human Services PO Box 30763 Lansing, MI 48909	For questions about sending in a hearing request or on the administrative hearings process, once a MDHHS action has been taken or adverse benefit determination has been appealed through the managed care entity.
Appeals/Administrative Hearings/Department Reviews (Beneficiary)	877-833-0870	MDHHS Appeals Section PO Box 30807 Lansing, MI 48909	For questions about a MDHHS action with rights for an administrative hearing or department review.
Appeals/Administrative Hearings (Provider)	800-648-3397 or 517-335-7519 Fax 517-763-0146	Michigan Office of Administrative Hearings and Rules Michigan Department of Health and Human Services PO Box 30763 Lansing, MI 48909 www.michigan.gov/medicaidproviders >> (under 'Resources') Michigan Office of Administrative Hearings and Rules for Michigan Department of Health and Human Services http://www.michigan.gov/lara >> Bureau List >> Michigan Office of Administrative Hearings and Rules >> Administrative Rules >> Publications >> Michigan Administrative Code >> Select Department: Health and Human Services >> Medical Services Administration >> MSA Provider Hearings http://www.michigan.gov/lara >> Bureau List >> Michigan Office of Administrative Hearings and Rules >> Benefit Services Hearings >> MDHHS Medicaid Provider and Women, Infants and Children Vendor (WIC)	For questions about requesting an administrative hearing with Michigan Office of Administrative Hearings and Rules (MOAHR) or the hearings process for provider appeals.
Appeals/Administrative Hearings/Informal Conferences (Provider)	877-833-0870	MDHHS Appeals Section PO Box 30807 Lansing MI 48909 www.michigan.gov/medicaidproviders >> (under 'Resources') Michigan Office of Administrative Hearings and Rules for Michigan Department of Health and Human Services	For questions about MDHHS actions with rights for informal conferences or administrative hearings with MOAHR.



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		http://www.michigan.gov/lara >> Bureau List >> Michigan Office of Administrative Hearings and Rules >> Administrative Rules >> Publications >> Michigan Administrative Code >> Select Department: Health and Human Services >> Medical Services Administration >> MSA Provider Hearings http://www.michigan.gov/lara >> Bureau List >> Michigan Office of Administrative Hearings and Rules >> Benefit Services Hearings >> MDHHS Medicaid Provider and Women, Infants and Children Vendor (WIC)	
State Hospital Appeals Panel Coordinator		State Hospital Appeals Panel Coordinator Michigan Office of Administrative Hearings and Rules PO Box 30763 Lansing, Michigan 48909	Hospitals wishing to waive right to appeal through the administrative rules, R400.3406 through R400.3424, may elect to request a hearing before the State Hospital Appeals Panel
HEALTH PLAN INFORMATION			
Dental Health Plans		Web Address: www.michigan.gov/healthykidsdental	Information related to <i>Healthy Kids Dental</i> enrollees, services, claims, and Dental Health Plans.
Medicaid Health Plans	517-284-1162	www.michigan.gov/medicaid >> Program Resources >> Medicaid Health Plans	Information regarding Medicaid Health Plans
Medicaid Health Plan Carveout		<u>Medicaid Health Plan Pharmacy Program Carve-out</u> https://michigan.magellanrx.com/ >> Provider >> Documents >> Carveout Coverage >> Medicaid Health Plan Carveout <u>Medicaid Health Plan Injectable Drugs and Biologicals Carve-out</u> www.michigan.gov/medicaid >> Providers >> Billing & Reimbursement >> Provider Specific Information >> Medicaid Health Plan Carve-out	Drugs in the categories listed on the MHP carveout list are excluded from the MHP contract.
Pre-paid Inpatient Health Plan Contract Managers	517-241-5066	www.michigan.gov/mdhhs >> Keeping Michigan Healthy >> Behavioral Health and Developmental Disability >> Mental Health >> Community Mental Health Services	Information regarding Mental Health and Substance Use Disorder treatment services available through the Pre-paid Inpatient Health Plans
Delta Dental Customer & Claims Services Department	800-482-8915		Information related to <i>Healthy Kids Dental</i> enrollees, services, and claims



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PIHP Contact Information, Service Areas		www.michigan.gov/mdhhs >> Keeping Michigan Healthy >> Behavioral Health and Developmental Disability >> Mental Health >> Community Mental Health Services	Contact information for Mental Health & Substance Abuse
HEALTHY MICHIGAN PLAN			
Preventive and Wellness Services		United States Preventive Services Task Force grade A and B services http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ Advisory Committee on Immunization Practices recommended vaccines http://www.cdc.gov/vaccines/hcp/acip-recs/index.html Institute of Medicine recommended preventive services for women http://www.iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx Current periodicity schedule by the American Academy of Pediatrics http://brightfutures.aap.org/clinical_practice.html	Resources for covered preventive and wellness services.
Healthy Michigan Plan Provider Webpage		www.michigan.gov/healthymichiganplan	Healthy Michigan Plan information and resources for providers
PROVIDER RESOURCES			
MDHHS Bureau of Epidemiology and Population Health; Division of Communicable Diseases	517-335-8165 517-335-9030 (After Hours) Fax 517-335-8263	MDHHS Bureau of Epidemiology and Population Health Division of Communicable Diseases 333 S. Grand Ave., 3rd Floor Lansing, MI 48909 www.michigan.gov/mdhhs >> Keeping Michigan Healthy >> Communicable & Chronic Diseases >> Communicable Disease Information and Resources	Disease reporting, commonly used forms, press releases and other useful information.
MDHHS Bureau of Family Health Services; Division of Immunization	517-335-8159 517-335-9030 (After Hours)	MDHHS Bureau of Family Health Services Division of Immunization 333 S. Grand Ave., 3rd Floor Lansing, MI 48909 www.michigan.gov/mdhhs >> Adult & Children's Services >> Children & Families >> Immunization Info for Families & Providers	Immunization schedules, commonly used forms, press releases and other useful information.



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MDHHS Bureau of Purchasing, Grants Division/Electronic Grants Section	517-241-8764	MDHHS Bureau of Purchasing Grants Division Electronic Grants Section 235 S. Grand Ave., Ste. 1201 Lansing, MI 48933	Local Health Department Agreements
MDHHS Healthy Homes Section	517-335-9390 Fax 517-335-8800	MDHHS Healthy Homes Section P.O. Box 30195 Lansing, MI 48909 Web address: www.michigan.gov/leadsafe	Obtain Protocol for Environmental Investigations for Children with Elevated Blood Lead Levels, a list of certified risk assessors, applications for training and certification, and education materials
MDHHS Hospital 15-Day Readmission Guidelines		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Inpatient Hospitals	Readmission guidelines for hospitals and Medicaid Health Plans
MDHHS Infant Oral Health Training	517-335-8879 Fax 517-346-9862	Education/Fluoride Coordinator Oral Health Program Michigan Department of Health and Human Services P.O. Box 30195 Lansing, MI 48909 oralhealth@michigan.gov www.michigan.gov/oralhealth www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Dental	Assistance for medical providers on training programs and other resource materials. Provides certification for, and monitoring of, medical providers on infant oral health.
MDHHS Injury and Violence Prevention Section	517-335-9518 Fax 517-335-9669	MDHHS Injury and Violence Prevention Section P.O. Box 30195 Lansing, MI 48909 www.michigan.gov/mdhhs >> Safety & Injury Prevention >> Injury & Violence Prevention	Public health prevention resources to reduce morbidity, mortality, and risk behaviors related to unintentional and intentional injuries
MDHHS Mobile Dentistry		www.michigan.gov/oralhealth >> Mobile Dentistry	Mobile Dental Facility Application
MDHHS Newborn Screening Section	517-335-8095	MDHHS Bureau of Laboratories Newborn Screening Section 3350 N. Martin Luther King Jr. Blvd. Lansing, MI 48906 www.michigan.gov/mdhhs >> Adult & Children's Services >> Hereditary Disorders	Blood samples and each newborn's pulse oximetry screening results are to be reported to the MDHHS Newborn Screening Section. Complete list of newborn blood screening disorders.



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MDHHS OIG Post-Payment Audits	614-801-0495	AdvanceMed Midwestern 1530 E. Parham Rd. Henrico, VA 23228 www.michigan.gov/medicaidproviders >> Resources >> MDHHS OIG Post-Payment Audits	Audit resources for providers.
MDHHS Oral Health Program		Email: OralHealth@michigan.gov Web Address: www.michigan.gov/oralhealth	Education and technical assistance on oral health resources regarding oral screenings, caries risk assessment, and fluoride varnish applications.
Advisory Committee on Immunization Practices (ACIP)		www.cdc.gov/vaccines/acip	Information regarding immunization and vaccine recommendations and standards of practice
American Academy of Pediatric Dentistry (AAPD)		http://www.aapd.org >> Policies and Guidelines >> Infant Oral Health Care (under Clinical Guidelines)	Guidelines on periodicity of examination, preventive dental services, anticipatory guidance and oral treatment
		http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf	Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling
		http://www.aapd.org/media/Policies_Guidelines/G_CariesRiskAssessment.pdf	Caries Risk Assessment Tool
American Academy of Pediatrics (AAP)		www.aap.org >> About the AAP >> Committees, Councils & Sections >> Section Websites >> Oral Health >> Resources	Oral health resources
		http://www.aap.org >> Professional Resources >> Clinical Support >> Connected Kids >> Materials >> Connected Kids Clinical Guide	Connected Kids: Safe, Strong, Secure clinical guide on youth violence and injury prevention
		http://brightfutures.aap.org >> Materials >> Practice Guides and Other Resources	Practice guides on oral health, mental health, and physical activity
		http://www.aap.org >> Professional Resources >> Red Book Resources	Tuberculosis information regarding risk and testing.
Clinical Laboratory Improvement Amendments (CLIA)		https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/waivetbl.pdf	List of CLIA-waived lab tests.
Community Health Centers/Federally Qualified Health Centers		www.michigan.gov/mdhhs >> Assistance Programs >> Health Care Coverage >> Help Finding Health Care >> Free or Low Cost Primary Care from a Doctor or Nurse	Source for Free or Low Cost Primary Care



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Consent to Share Behavioral Health Information form (MDHHS-5515)		email address: MDHHS-BHConsent@michigan.gov website: www.michigan.gov/bhconsent	Form MDHHS-5515 and supporting resources, including FAQ.
Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit		www.gladpc.org >> GLAD-PC Toolkit	Information, recommendations, educational resources, and tools to aid in the management of adolescent depression in primary care.
Hospital Post-Payment Reviews (MDHHS Post-Payment Review Hospital Audit Contractor)	800-727-7223	Michigan Peer Review Organization 22670 Haggerty Rd., Ste. 100 Farmington Hills, MI 48335-2611	Inpatient and outpatient hospital post-payment reviews
Medicaid Health Plan Carve-out		www.michigan.gov/medicaid >> Providers >> Billing & Reimbursement >> Provider Specific Information >> Medicaid Health Plan Carve-out	A list of outpatient physician-administered drugs and biological products carved-out from the Michigan Medicaid Health Plans (MHPs)
Medicaid State Plan		Web Address: www.michigan.gov/medicaid >> Program Resources	
Mental Health Screening and Assessment Tools for Primary Care		www.aap.org >> Advocacy & Policy >> AAP Health Initiatives >> Clinical Resources >> Mental Health >> Key Resources >> Primary Care Tools >> Mental Health Screening and Assessment Tools for Primary Care	Listing of mental health screening and assessment tools.
Michigan Care Improvement Registry (MCIR)		http://www.mcir.org	All immunizations must be reported to the MCIR
Michigan's Great Start Trauma Informed System		www.michigan.gov/traumatoxicstress	To add a trauma informed approach into the comprehensive early childhood system known as Great Start.
OASIS		www.cms.hhs.gov/OASIS	Mandated assessment for Home Health services
OASIS HelpDesk	888-324-2647 or 517-241-2628		Assistance in transmitting OASIS data to the state repository
Office of Medical Affairs	517-335-5181	MDHHS /Office of Medical Affairs PO Box 30479 Lansing MI 48909	
Reimbursement & Audit	517-335-5330	MDHHS /Hospital and Clinic Reimbursement Division PO Box 30479 Lansing, MI 48909-7979 www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Inpatient Hospitals	Information on hospital and health plan rates and audits



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Smiles for Life		www.smilesforlifeoralhealth.org	Comprehensive oral health curriculum designed to enhance the role of primary care clinicians in promoting oral health. Providers and staff are encouraged to complete the online Children's Oral Health Smiles for Life Course 6: Caries Risk Assessment, Fluoride Varnish and Counseling training module at www.smilesforlifeoralhealth.org and obtain certification prior to providing oral health screenings and fluoride varnish applications.
State Survey Agency (Non-Long Term Care Facilities)	517-335-1980 fax 517-241-3354	Department of Licensing and Regulatory Affairs Bureau of Community and Health Systems Federal Survey and Certification Division 611 W. Ottawa Street PO Box 30664 Lansing, MI 48909 www.michigan.gov/bchs	Hospital, ESRD, OPT/CORF, RHC, Hospice, Home Health Agencies, Clinical Labs, FSOF/ASC, Psychiatric hospitals
United States Preventive Services Task Force (USPSTF)		www.uspreventiveservicestaskforce.org	Information regarding preventive service recommendations.
Women, Infants, and Children (WIC) Program	800-262-4784	www.michigan.gov/wiccc	Michigan WIC Client Portal site connects beneficiaries with a local WIC agency and provides additional resources regarding supplemental healthy foods, nutrition counseling and education, breastfeeding support, immunization screening, and referrals to other helpful services to pregnant, breastfeeding, and post-partum women, infants, and children younger than five years of age.
HOSPICE RESOURCES			
MDHHS Hospice Enrollment Coordinator	517-335-5567		Contact only if hospice services began prior to a health plan enrollment.
MATERNAL-CHILD EDUCATIONAL RESOURCES			
Infant Sleep Positioning	1-800-331-7437	www.tomorrowschildmi.org	Information/brochures related to infant sleep positioning.
		www.mihealth.org	Training for professionals, CEUs



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MATERNAL INFANT HEALTH PROGRAM RESOURCES			
Early On Michigan	1-800-EarlyOn Fax 517-668-2505	https://1800earlyon.org/index.php	Early intervention services for infants and toddlers, birth to three years of age with developmental delay (s) or disabilities.
Great Start Collaborative		http://greatstartforkids.org/content/great-start-network	Helps parents find the best early learning settings for their children and helps providers and educators improve the care they give to their children.
LogistiCare Solutions	866-569-1902		Non-emergency medical transportation for qualifying beneficiaries in Wayne, Oakland, and Macomb counties
Maternal Infant Health Program	Phone #: 1-833-644-6447 Fax #: 517-763-0366	website: http://www.michigan.gov/mihp e-mail address: mihp@michigan.gov	Information regarding MIHP enrollment and operations, including the MIHP Operations Guide, forms, and contact information.
Text4baby		https://www.text4baby.org	Service providing information for pregnant and postpartum women
MENTAL HEALTH/SUBSTANCE ABUSE RESOURCES			
Children's Waiver Program	517-241-5757	Children's Waiver Program MDHHS -BHDDA Division of Quality Management & Planning Elliott-Larsen Bldg., 5th Floor (revised 10/1/20) 320 S. Walnut St. Lansing, MI 48913	Submission of Prior Review and Approval Request (PRAR) form and documentation
International Center for Clubhouse Development (ICCD)		http://www.iccd.org/certification.html	Information regarding Clubhouse International accreditation
		http://www.iccd.org/images/employment_guidelines_2012.pdf	Clubhouse International standards and guidelines
MDHHS-BHDDA Community Practices and Innovation Section, Division of Quality Management & Planning	517-335-0499	MDHHS-BHDDA Community Practices and Innovation Section Division of Quality Management & Planning 320 S. Walnut St. Lansing, MI 48913	Requests for approval of Clubhouse services
National Registry of Evidence-based Programs and Practices (NREPP)		www.samhsa.gov/nrepp	Clubhouse model
Network Adequacy Standards		website: https://www.michigan.gov/mdhhs/0,588,5,7-339-71550_2941_38765---,00.html	Policy and procedural document.



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PIHP Provider Registry	517-373-2568	MDHHS -BHDDA Division of Program Development, Consultation & Contracts 320 S. Walnut Street Lansing, MI 48913	Information regarding how to register a new service provider, delete a service provider or change information about the service provider.
PIHP Special Program Approval	517-335-0499	MDHHS -BHDDA Community Practices and Innovation Section Division of Quality Management & Planning 320 S. Walnut St. Lansing, MI 48913	Information regarding how to obtain approval of new special programs: ACT, PSR, crisis residential, day program site, and intensive crisis stabilization.
MI CHOICE WAIVER RESOURCES			
Critical Incident Reporting	Phone: 517-241-8474 Fax: 517-241-7816	Home and Community-Based Services Section 400 S. Pine St. Lansing, MI 48909 https://webapp.ciminc.com/CompassMI	Information on critical incident reporting.
MDHHS Audit Reports	Phone: 517-241-7599	email: MDHHS-AuditReports@michigan.gov	Required audit and any other related submissions.
MI Choice Contract	Phone: 517-241-8474 Fax: 517-241-7816	Home and Community-Based Services Section 400 S. Pine St. Lansing, MI 48909 https://egramsmi.com/dch/user/home.aspx >> Medicaid/Long Term Care	MI Choice contract template and attachments.
MI Choice Intake Guidelines		View documents: www.michigan.gov/medicaidproviders >> MI Choice Vendor access for Waiver Agencies: https://webapp.ciminc.com/CompassMI	MI Choice Intake Guidelines documents and on-line access
MI Choice Waiver		www.michigan.gov/mdhhs >> Assistance Programs >> Health Care Coverage >> Services for Seniors >> MI Choice Waiver Program	Information regarding waiver services and regional contact information
MI Choice Waiver Diversions	Phone: 517-241-8474 Fax: 517-241-7816	Home and Community-Based Services Section 400 S. Pine St. Lansing, MI 48909 https://webapp.ciminc.com/CompassMI	Information for requesting diversion status for an applicant



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MI Choice Waiver Program Provider Monitoring Plan	Phone: 517-241-8474 Fax: 517-241-7816	Home and Community-Based Services Section 400 S. Pine St. Lansing, MI 48909 https://egrams-mi.com/dch/user/home.aspx >> Medicaid/Long Term Care	Document defining procedures and standards used by MDHHS in reviewing agencies and providers.
MI Choice Waiver – Provider Information		www.michigan.gov/medicaidproviders >> MI Choice	Information for MI Choice providers
MDHHS Quality Management Plan	Phone: 517-241-8474 Fax: 517-241-7816	Home and Community-Based Services Section 400 S. Pine St. Lansing, MI 48909	Document addressing waiver agency quality assurance and improvement for MI Choice.
Minimum Data Set (MDS) - Section Q - Local Contact Agency (LCA)		www.michigan.gov/mdhhs >> Assistance Programs >> Health Care Coverage >> Services for Seniors >> MI Choice Waiver Program	A list of Local Contact Agencies that nursing facilities must contact when residents indicate a desire to return to the community.
Nursing Facility Transition	Phone: 517-241-8474 Fax: 517-241-7816	Home and Community-Based Services Section 400 S. Pine St. Lansing, MI 48909 https://webapp.ciminc.com/CompassMI	Information for intent to transition a nursing facility resident to MI Choice.
Waiting List Removal – Adequate Action Notice		www.michigan.gov/medicaidproviders >> MI Choice	MI Choice Waiting List Removal Adequate Action Notice template
Waiting List Reporting		https://webapp.ciminc.com/CompassMI	Submit data for the waiting list.
MI HEALTH LINK			
Home and Community-Based Services Final Rule (CMS-2249F, CMS-2296F)		http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html	For providers or other interested individuals to access the HCBS Final Rule.
Medicaid State Plan Personal Care Services Individual and Agency County Rates		http://www.michigan.gov/documents/mdch/Individual_and_Agency_Hourly_Rates_Per_County_476167_7.pdf	Information regarding county rates for individual and agency providers of personal care services.
Medicaid State Plan Personal Care Services Payment Schedule		www.michigan.gov/homehelp	Table indicating the minimum schedule when payments should be made for personal care services during the MI Health Link continuity of care period for individuals who were receiving Adult Home Help services through MDHHS.
MI Health Link		www.michigan.gov/mihealthlink >> Providers	Information regarding how providers may participate in MI Health Link.



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CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
NON-EMERGENCY MEDICAL TRANSPORTATION			
MDHHS NEMT Database		www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Non-Emergency Medical Transportation (NEMT)	This database includes current information pertaining to NEMT reimbursement rates and services.
LogistiCare Solutions	866-569-1902		Non-emergency medical transportation for qualifying beneficiaries in Wayne, Oakland and Macomb counties.
NURSING FACILITY LEVEL OF CARE DETERMINATION			
Community Health Automated Medicaid Processing System (CHAMPS) Level of Care Determination (LOCD)		https://milointp.michigan.gov	
Level of Care Determination of Field Definitions		www.michigan.gov/medicaidproviders >> Michigan Medicaid Nursing Facility Level of Care Determination (under Resources)	
MDHHS County Offices		www.michigan.gov/mdhhs >> Inside MDHHS >> County Offices	
Michigan Medicaid Nursing Facility LOCD Exception Process		www.michigan.gov/medicaidproviders >> Michigan Medicaid Nursing Facility Level of Care Determination (under Resources)	
NURSING FACILITY RESOURCES			
Certificate of Need Commission	517-241-3344 fax 517-241-2962	MDHHS Certificate of Need Evaluation Section South Grand Building, 4th Floor 333 S. Grand Ave. Lansing, MI 48933 www.michigan.gov/providers >> Certificate of Need	
Complaints	Hotline: 800-882-6006 517-284-9798 fax 517-335-7167	Department of Licensing and Regulatory Affairs Bureau of Community and Health Systems Facility Complaint Intake Section PO Box 30664 Lansing, MI 48909 Delivery: 611 W. Ottawa, 1st Floor Lansing, MI 48933 www.michigan.gov/bchs	To file a complaint against a health care facility. Complaints on quality of care by nursing facilities, hospitals, home health agencies.
LTC Ombudsman	866-485-9393		Advocacy for nursing facility residents



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CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
MDHHS, LTC Services	517-241-4079	LTC Services PO Box 30479 Lansing, MI 48909-7979 E-mail: MDHHS-bedcerts@michigan.gov	Medicaid NF bed certification
MDS		www.cms.hhs.gov/medicaid/mds3.0/	Mandated assessment for NF residents
MDS RAI Manual		www.cms.gov >> Medicare >> Nursing Home Quality Initiative >> MDS 3.0 RAI Manual	Instruction manual for the MDS
Minimum Data Set (MDS) - Section Q - Local Contact Agency (LCA)		www.michigan.gov/mdhhs >> Assistance Programs >> Health Care Coverage >> Services for Seniors >> MI Choice Waiver Program	A list of Local Contact Agencies that nursing facilities must contact when residents indicate a desire to return to the community.
Medicare Part D	1-800-633-4227 TTY: 1-877-486-2048	www.medicare.gov	Questions regarding a beneficiary's eligibility for Medicare Part D, specific Medicare Part D drug coverage, or retroactive enrollment in Medicare Part D.
	1-800-803-7174	Michigan Medicare/Medicaid Assistance Program (MMAP)	Provides free education and personalized assistance to people with Medicare and Medicaid, their families, and caregivers (including the nursing facility).
Nurse Aide Customer Service	800-752-4724	www.michigan.gov/lara >> Community and Health Systems >> Nurse Aide Training Program	Questions regarding nurse aide training and testing
Nurse Aide Registry	517-284-8961 Fax 517-241-3354	www.michigan.gov/bchs >> Nurse Aide Registry	List of certified nurse aides
Nursing Facility Forms & Instructions, Calculation Examples, Rate Relief Worksheet		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Nursing Facilities	New Provider Information Packet, cost reporting forms, NF provider list, nurse aide testing reimbursement for facility and individual CNA, Cost-Settled Provider Detail Report (FD-622)



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CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Nursing Facility Rate Setting	517-335-5356 fax 517-335-5443	MDHHS /LTC Reimbursement & Rate Setting Section PO Box 30815 Lansing, MI 48909-7979 Delivery: Elliott-Larsen Building, 4th floor (revised 10/1/20) 320 S. Walnut St. Lansing, MI 48933 email address: DARS@michigan.gov website: www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Nursing Facilities	Nursing facility rate setting and cost reporting information. New Provider Information Packet. Nursing Facility reimbursement.
Michigan Medicaid Nursing Facility Level of Care Determination		www.michigan.gov/medicaidproviders >> Michigan Medicaid Nursing Facility Level of Care Determination	Information and forms necessary to complete the Michigan Medicaid Nursing Facility Level of Care Determination to determine eligibility for NF level of care.
Patient Driven Payment Model (PDPM)		www.cms.gov >> Medicare >> Skilled Nursing Facility PPS (under Medicare Fee-for-Service Payment) >> Patient Driven Payment Model	Resources including PDPM overview, fact sheets, and available training. (text added per bulletin MSA 19-24)
Payee Registration Helpline	888-734-9749 or 517-373-4111	www.michigan.gov/SIGMAVSS	Enroll with SIGMA Vendor Self Service (VSS) for payment issued outside claims processing
Pre-Eligibility Medical Expenses (PEME)	517-241-4302 fax 517-241-8556	MDHHS Medical Services Administration Attention: PEME P.O. Box 30479 Lansing, MI 48909-9634 Martina2@michigan.gov	MDHHS review of offsetting unpaid PEME
Quality Measure Initiative (QMI)		Email: MDHHS-NFQMI@michigan.gov Website: www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Nursing Facilities >> Nursing Facility Quality Measure Initiative	Additional resources and contact information related to the nursing facility QMI.



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CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
RAI Coordinator	517-335-2086 fax 517-241-2635	Department of Licensing and Regulatory Affairs Bureau of Community and Health Systems Federal Survey and Certification Division RAI Coordinator 611 W. Ottawa St. PO Box 30664 Lansing, MI 48909 E-mail: najafih@michigan.gov Website: www.michigan.gov/bchs	Assistance with nursing facility MDS
State Survey Agency (Nursing Facilities)	517-335-1980 fax 517-241-2635	Department of Licensing and Regulatory Affairs Bureau of Community and Health Systems Federal Survey and Certification Division 611 W. Ottawa PO Box 30664 Lansing, MI 48909 www.michigan.gov/bchs	NH/SNF federal survey and certification
Informal Dispute Resolution (IDR) and Independent Informal Dispute Resolution (IIDR)	517-335-1980	Department of Licensing and Regulatory Affairs Bureau of Community and Health Systems Workforce Background Check PO Box 30664 Lansing, MI 48909 Delivery: 611 W. Ottawa, 1st Floor Lansing, MI 48933 Email: bchs-enforcement@michigan.gov www.michigan.gov/bchs >> Covered Providers >> Nursing Homes >> Dispute Resolution (IDR/IIDR)	For questions regarding completion or timeliness of IDR/IIDR process for long term care facilities.
MDHHS OBRA Office	517-241-5881	MDHHS /OBRA Office 5 th Floor, Elliott-Larsen Building (revised 10/1/20) 320 S. Walnut Lansing, MI 48933	PASARR information, follow-up on submitted DCH-3878 (Level II evaluation)
Department of Technology, Management & Budget (DTMB)		www.michigan.gov/dtmb >> Agency Services >> Travel >> Travel Rates	Approved private vehicle mileage rate information.



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Centers for Medicare & Medicaid Services	1-800-633-4227	Centers for Medicare & Medicaid Services 7500 Security Blvd Baltimore, Maryland 21244 http://www.cms.hhs.gov/Manuals/PBM/list.asp	Medicare Principles of Reimbursement (42 CFR 413), CMS Provider Reimbursement Manual (PRM-15 or Pub 15)
Beneficiary Benefit Plan ID(s) for the DOS including Patient Pay Amount, and MA Redetermination date (if on file)		Michigan Public Health Institute (MPHI) X12 270/271 Transaction testing information and companion guide: http://mihealth.org >> Trading Partners >> Medicaid Healthplan 270/271 Companion Guide v3.0 >> MPHI Companion Document v3.0 20070312.pdf MI Healthplan Benefits website access enrollment form: https://healthplanbenefits.mihealth.org >> Enrollment Form	Electronic Data Interchange (EDI) alternatives are available at no cost through MPHI for nursing facilities to verify Medicaid beneficiary eligibility
Nursing Home Compare (NHC)		https://www.medicare.gov/nursinghomecompare/search.html	NHC website information used for nursing facility QMI payments.
Special Focus Facility (SFF) List		https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/SFFList.pdf	Website information for the SFF list.
United States Department of Labor Consumer Price Index		https://www.bls.gov/cpi/	United States Department of Labor Consumer Price Index website information to find the cost-of-living changes for the Owner/Administrator compensation limits.
PHARMACY RESOURCES			
MDHHS Pharmacy Benefit Manager (PBM) 24/7/365	877-624-5204	Magellan Medicaid Administration, Inc. 4300 Cox Road Glen Allen, Virginia 23060 Web address: https://michigan.magellanrx.com	General information, MPPL, claim submission instructions, etc. See Prior Authorization Section of this Directory for additional PBM contact information.
MDHHS Pharmacy Benefit Manager (PBM)	888-868-9219 Fax: 804-965-7647	Magellan Medicaid Administration, Inc. Michigan Medicaid – Pharmacy Provider Relations Unit 4300 Cox Rd. Glenn Allen, VA 23060 Website address: https://michigan.magellanrx.com	Pharmacy remittance advice, EFT requests, and other services/inquiries
Medicaid Health Plan Pharmacy Benefit		www.michigan.gov/MCOpharmacy	Medicaid Health Plan Common Formulary



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MAC Pricing Information 9 am - 5 pm EST, M – F	800-327-6226 Fax 888-656-1951	Magellan Medicaid Administration, Inc. Attn.: MAC Department 4300 Cox Rd. Glenn Allen, VA 23060 email address: StateMacProgram@magellanhealth.com Website address: https://michigan.magellanrx.com	Maximum allowable cost (MAC) pricing information.
MDHHS Drug Dispensing Fees		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Pharmacy	
Refunds, Overpayments	877-624-5204 fax 887-888-6370	Magellan Medicaid Administration, Inc. 4300 Cox Rd. Glen Allen, VA 23060	Instruction regarding how to submit claims, refunds and overpayments.
List of Chronic Conditions for Medication Therapy Management Eligibility		www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider-Specific Information >> Pharmacy	
List of Drugs Past CMS Termination Dates		http://www.medicare.gov/medicaid-chip-program-information/by-topics/benefits/prescription-drugs/medicaid-drug-rebate-program-data.html	
List of Rebate-Participating Labelers		https://www.medicare.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/index.html	List of approved labelers who have signed rebate agreements with CMS.
List of Participating Entities in 340B Program		https://340bopais.hrsa.gov/coveredentitysearch	
Drug Rebate Specialist	Fax 517-241-7816	MDHHS Pharmacy Program Bureau of Medicaid Operations & Quality Assurance PO Box 30479 Lansing, MI 48909-7979 email address: MDHHSPharmacyServices@michigan.gov	PHS and DSH hospitals that bill the 340B prices on their drug claims are excluded from the drug rebates.
National Average Drug Acquisition Cost		https://data.medicare.gov	
Provider Liaison Meeting Calendar		https://michigan.magellanrx.com	Schedule of liaison meetings and contact information for questions and submission of agenda items.
Centers for Medicare & Medicaid Services		https://www.cms.gov/medicare-medicare-coordination/fraud-prevention/fraudabuseforprofs/trp.html	Information on Tamper Resistant Prescription Pad policy



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PRIVATE DUTY NURSING RESOURCES			
Other Insurance for PDN	Fax 517-335-9422		Submit letters of explanation or EOB when required.
SCHOOL BASED SERVICES			
SBS Administrative Outreach Program Policy Specialist	517-284-1197 Fax 517-335-5136	SBS Administrative Outreach Specialist MDHHS Medicaid Policy Division PO Box 30479 Lansing, MI 48909-7979 MSAPolicy@michigan.gov	Submission of SSAE 16 audit.
SBS Fee for Service Program Policy Specialist	517-284-1197 Fax 517-335-5136	SBS Administrative Outreach Specialist MDHHS Medicaid Policy Division PO Box 30479 Lansing, MI 48909-7979 MSAPolicy@michigan.gov	Submission of SSAE 16 audit (Fee For Service)
School Based Services		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> School Based Services	Databases, FAQs, cost reporting & training, software information, Random Moment Time Study Results
VISION SERVICES RESOURCES			
Vision Contract Manager		Vision Contract Manager MDHHS /Program Review Division PO Box 30170 Lansing MI 48909	Submit copy of DCH-0893
Vision Contractor (Classic Optical Laboratories)	888-522-2020 Fax 330-759-8300	Classic Optical 3710 Belmont Ave. PO Box 1341 Youngstown, OH 44501-1341 www.classicoptical.com	Contractor for provision of eyewear frames and lens
REPORTING FRAUD, ABUSE, OR MISUSE OF SERVICES			
Benefits Monitoring Program (BMP)	855-808-0312	MDHHS Program Review Division Benefits Monitoring Program P.O. Box 30170 Lansing, MI 48909-7979 email: MDHHS-MSA-BMP@michigan.gov	Report potential misutilization of services by Medicaid beneficiaries
MDHHS Office of Inspector General	1-855-MI-FRAUD (1-855-643-7283)	Michigan Department of Health and Human Services Office of Inspector General PO Box 30062 Lansing, MI 48909-7979 www.michigan.gov/fraud	Report suspected Medicaid provider fraud and/or abuse



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Health Care Fraud Unit	800-242-2873 fax 517-241-6515	Health Care Fraud Division Department of the Attorney General Medicaid Fraud Control Unit PO Box 30218 Lansing, MI 48909 email: HCF@michigan.gov website: www.michigan.gov/ag >> Complaints	Report Medicaid provider fraud
MDHHS OBRA Office	517-373-8091	MDHHS /OBRA Office 5 th Floor, Elliott-Larsen Building (revised 10/1/20) 320 S. Walnut St. Lansing, MI 48933	Complaints/concerns about local CMHSP services to nursing facility residents
Bureau of Community and Health Systems, Allegation Unit (MI Dept. of Licensing and Regulatory Affairs)	517-373-9196	www.michigan.gov/bpl >> File a Complaint	Complaints about licensed healthcare professionals (e.g. physicians, nurses, therapists, NF administrators)
Michigan Department of Civil Rights	800-482-3604		Report violations of handicapper rights.
Michigan Disability Rights Coalition	800-760-4600		
Office of Inspector General of the U.S. Department of Health & Human Services (HHS)	313-226-4258	Office of Inspector General of the U.S. Department of Health & Human Services (HHS) Room 512 – Federal Courthouse Detroit, MI 48226	Report violations of federal law
Welfare Fraud Hotline	800-222-8558 517-335-3900	MDHHS Office of Inspector General 235 S. Grand, Ste. 218 Lansing, MI 48933	Report suspected beneficiary fraud.
U.S. Department of Justice, Office of Civil Rights	800-552-6843		Report violations of handicapper rights.
OTHER HEALTH CARE RESOURCES/PROGRAMS			
Breast & Cervical Cancer Control Program	800-922-6266		Information regarding program services, eligibility, and enrollment
Children in Foster Care		<ol style="list-style-type: none"> www.michigan.gov/mdhhs >> Adult & Children's Services >> Foster Care >> Forms and Publications http://www.brightfutures.org/men-talhealth/pdf/tools.html >> Pediatric Symptom Checklist http://www.massgeneral.org/psychiatry/services/psc_forms.aspx http://agesandstages.com 	<ol style="list-style-type: none"> MDHHS Well Child Exam forms and Psychotropic Medication Informed Consent (DHS-1643) Pediatric Symptom Checklist Pediatric Symptom Checklist in other languages Ages and Stages Questionnaire: Social-Emotional (ASQ:SE)



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Children's Waiver Program	517-241-5757	MDHHS -BHDDA Division of Quality Management & Planning 320 S. Walnut Street Lansing, MI 48913	Information regarding the Children's Waiver program
Freedom to Work	Local MDHHS office	Local MDHHS office	Information regarding program eligibility
Habilitation Supports Waiver for Persons with Developmental Disabilities	517-335-1134	MDHHS - BHDDA Division of Quality Management & Planning 320 S. Walnut St. Lansing, MI 48913	Information regarding certification and re-certification of HSW enrollees; and HSW coverages.
Medicare Savings Program	local MDHHS office		Information regarding program eligibility and enrollment.
Medicare	1-800-633-4227 TTY: 1-877-486-2048	www.medicare.gov	Questions regarding a beneficiary's eligibility for Medicare, specific Medicare Part D drug coverage, or retroactive enrollment in Medicare Part D.
	1-800-803-7174	Michigan Medicare/Medicaid Assistance Program (MMAP)	Provides free education and personalized assistance to people with Medicare and Medicaid, their families, and caregivers (including the nursing facility).
Mental Health Home-based Program	517-241-5772	MDHHS - BHDDA Division of Mental Health Services to Children and Families 320 S. Walnut St. Lansing, MI 48913	Information regarding how to obtain approval of new Mental Health Home-based Programs for children and families
MIChild	888-988-6300	www.michigan.gov/michild application at: www.michigan.gov/mibridges	Apply at local MDHHS office or online through MI Bridges
MDHHS Prenatal Smoking Cessation Program	517-335-9750		Information regarding the Smoke-Free Baby and Me intervention model.
National Autism Center (NAC)		www.nationalautismcenter.org	Information regarding Autism Spectrum Disorder
Program of All-Inclusive Care for the Elderly (PACE)	517-373-7493	MDHHS Long Term Care and Operations Support Section PO Box 30479 Lansing, MI 48909 www.michigan.gov/medicaidproviders >> Program for All-Inclusive Care for the Elderly (Under Additional Programs & Waivers)	
Special N Support	Local MDHHS office	Local MDHHS office	Information regarding program eligibility and enrollment
Supplemental Security Income (SSI)	Local MDHHS office	Local MDHHS office	Information regarding program eligibility and enrollment



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Transitional Medical Assistance	Local MDHHS office	Local MDHHS office	Information regarding program eligibility and enrollment
Traumatic Brain Injury Program	800-642-3195	Local MDHHS office	Information regarding program eligibility and enrollment
MISCELLANEOUS CONTACT INFORMATION			
Centers for Disease Control and Prevention (CDC)		www.cdc.gov/growthcharts	Growth charts/graphing documents
Electronic Health Record (EHR) Incentive Program		www.michiganhealthit.org www.cms.gov/EHRIncentivePrograms	Information regarding the EHR Incentive Program
Federal Registers		http://www.ecfr.gov	
Sickle Cell Detection and Information	313-864-4406 800-842-0973 Fax 313-864-9980	Sickle Cell Disease Association of America - Michigan Chapter 18516 James Couzens Detroit, MI 48235 http://scdaami.org	Obtain sickle cell tests, tubes, forms, and envelopes A capillary blood sample may be mailed to SCDA-MI
SS and SSI Information Line	800-772-1213		
State of Michigan Operator	517-373-1837		Telephone numbers for State of Michigan offices/employees.
DMEPOS Liaison Meetings		www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Medical Suppliers/Orthotists/ Prosthetists/DME Dealers	Information on scheduled DMEPOS liaison meetings
Medical Care Advisory Council (MCAC) Meetings		www.michigan.gov/medicaid >> Program Resources >> Medical Care Advisory Council	MCAC roster, meeting agendas and minutes, and meeting dates



GLOSSARY APPENDIX

Glossary Term	Definition
Acquisition Costs	The manufacturer's invoice price, minus primary discount, plus a percentage over cost, plus actual shipping costs. Acquisition cost does not include handling fees. (For the specific percentage over cost, refer to the archived MDHHS Medical Supplier/DME/Prosthetics and Orthotics Database Instructions posted on the MDHHS website.)
Ambulatory Payment Classification (APC)	The Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classification (APC) is a reimbursement method representing groups of outpatient visits according to clinical characteristics and costs associated with the diagnoses and the procedures rendered known as APCs.
Borderland	A county that is contiguous to the Michigan border and includes several major cities beyond the contiguous county lines.
Durable Medical Equipment (DME)	Equipment that can withstand repeated use, is reusable or removable, is suitable for use in any non-institutional setting in which normal life activities take place, is primarily and customarily used to serve a medical purpose and is generally not useful to an individual in the absence of illness, injury or disability.
The Emergency Medical Treatment and Active Labor Act (EMTALA)	42 USC 1395dd, that requires a Hospital to perform a medical screening examination of any individual presenting in its emergency department to determine if an emergency medical condition exists and to stabilize the individual's medical condition.
Encounter	A face-to-face contact between a patient and the provider of health care services who exercises independent judgment in the provision of health care services.
Hospital	Hospital means the licensed entity that executed the Hospital Access Agreement, which has the inpatient capacity necessary to provide covered services.
Hospital Based Provider (HBP)	A hospital-employed MD, DO, Certified Registered Nurse Anesthetist (CRNA), dentist, podiatrist, optometrist, or nurse-midwife.
Medicaid Deductible	Beneficiary must incur medical expenses each month equal to, or in excess of, an amount determined by the local MDHHS worker to qualify for Medicaid. Previously referred to as Medicaid Spend-down.
Medicaid Health Plan (MHP)	A Medicaid managed care plan that provides medical assistance through the delivery of Covered Services to Beneficiaries and that holds a Comprehensive Health Care Program Medicaid Contract with the State of Michigan.



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Glossary Term	Definition
Medical Supplies	Health care related items that are required to address an individual's illness, injury or disability; are consumable, disposable or have a limited life expectancy, cannot withstand repeated use, and are suitable for use in any non-institutional setting in which normal life activities take place. Examples are: hypodermic syringes/needles, ostomy supplies, and dressings necessary for the medical management of the beneficiary.
Mobility Related Activities of Daily Living (MRADL)	Daily activities (e.g., grooming, dressing, etc.) the beneficiary is capable of performing with the aid of mobility equipment.
Noncompliance	Failure or refusal to follow instructions related to improving or stabilizing a condition.
Noncovered Service	A medical or health care service that is: <ul style="list-style-type: none"> ▪ Not covered by Medicaid; ▪ Not medically necessary; ▪ Not described in a MHP's Certificate of Coverage; ▪ Provided before or after a beneficiary is an Enrollee in a MHP; or ▪ Non-emergency services for which the Hospital did not secure PA.
Nursing Facility	A nursing home, county medical care facility, State Veterans' Home, or hospital long-term care unit, with Medicaid certification.
Orthotics	Orthotics assist in correcting or strengthening a congenital or acquired physical anomaly, or malfunctioning portion of the body.
Outpatient Hospital	A portion of a hospital, which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require inpatient hospitalization or institutionalization.
Outpatient Prospective Payment System (OPPS)	A Prospective Payment System (PPS) is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (i.e., DRGs for inpatient hospital services, APCs for outpatient hospital services). All services paid under the PPS are classified into groups called Ambulatory Payment Classifications (or APCs). Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC.
Physician (MD or DO)	An individual licensed under the Michigan Public Health Code (1978 P.A. 368) to engage in the practice of medicine or osteopathic medicine and surgery.
Practitioner	An MD, DO, Podiatrist, Dentist, Oral-Maxillofacial Surgeon, Physician's Assistant, Advanced Practice Registered Nurse (Certified Nurse Practitioner, Certified Clinical Nurse Specialist, Certified Nurse-Midwife), Certified Registered Nurse Anesthetist, Anesthesiologist Assistant, Physical Therapist, Psychologist, Occupational Therapist, Optometrist, Speech Therapist, and Audiologist.



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Glossary Term	Definition
Prosthetics	Prosthetics artificially replace a portion of the body to prevent or correct a physical anomaly or malfunctioning portion of the body.
Provider	An individual, firm, corporation, association, agency, institution, or other legal entity which is providing, has formerly provided, or has been approved to provide medical assistance to a beneficiary pursuant to the medical assistance program.
Public Facility	A public facility is defined at one of the following sections of the Michigan Public Health Code (PA 368 of 1978, as amended): Section 333.2413, Section 333.2415, or Section 333.2421.
Rapid Dispute Resolution Process	The process implemented by MDHHS to administer and resolve claim disputes.
Readmission	Any admission/hospitalization of a beneficiary within 15 days of a previous discharge, whether the readmission is to the same or different hospital.
Reference Laboratory	An enrolled laboratory that receives a specimen from another referring laboratory for testing and that actually performs the test.
Referring Laboratory	A laboratory that receives a specimen to be tested and that refers the specimen to another laboratory for performance of the laboratory test.
Sanctioned Provider	A provider who has been suspended, terminated or excluded from furnishing, ordering, or prescribing items or services to Medicaid beneficiaries.
Spend-down	See Medicaid Deductible.
Sterilization	Any medical procedure, treatment, or operation for the sole purpose of rendering an individual (male or female) permanently incapable of reproducing.
Third Party Liability	A payment resource available from both private and public insurance and other liable third parties that can be applied toward the beneficiary's health care expense.
Transfer Trauma	Any adverse psychological and/or physical effects occasioned by the transfer of a nursing home patient who would be materially detrimental to the physical or mental health of the patient.
U & C Charge	The usual and customary charge to the general public. Customary charge means the amount the provider charges another third party payer or the general public (except in cases where the general public receives free or reduced charges) for the same or a similar service. This definition does not include negotiated or contracted payment rates. If the provider renders a covered service to a beneficiary that the provider offers for free or for a reduced fee to the general public, the provider may only bill Medicaid up to that customary charge as long as all other Medicaid requirements are met.



FORMS APPENDIX

INTRODUCTION

The Forms Appendix contains all MDHHS forms referenced within the Michigan Medicaid Provider Manual. Detailed instructions are provided for forms that are not self-explanatory (refer to the table below). The bookmarks link to each form. The Forms field in the table below also links to the appropriate forms. Hold the cursor over form number (the hand cursor will turn into a pointing finger). Double click the cursor to access the form directly from the table. Use the navigation arrows to move from page to page and form to appendix.

All forms are also available on the MDHHS website (refer to the Directory Appendix for website information). Most forms are available in PDF format as well as in a downloadable Word-enabled format.

Form Number	Form Name
MSA-2218	Acknowledgment of Receipt of Hysterectomy Information
MSA-1302	Benefits Monitoring Program Referral
MSA-1550	Beneficiary Verification of Coverage
MSA-4240	Certification for Induced Abortion
CMS-10231	Certification of Public Expenditure
MSA-1326	Certified Nurse Aide Training Reimbursement
MSA-1576	Complex Care Prior Approval-Request/Authorization for Nursing Facilities
MSA-1653-D	Complex Seating and Mobility Device Prior Approval-Request/Authorization
MSA-1959	Consent for Sterilization



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Form Number	Form Name
MSA-0725	CSHCS Application for Payment of Health Insurance Premiums (revised 4/1/20)
MSA-1680-B	Dental Prior Approval Authorization Request
MSA-0892	Documentation of Medical Necessity for the Provision of Contact Lenses
DCH-1401	Electronic Signature Agreement
MSA-181	Home Health Aide Prior Approval Request/Authorization
MSA-2565-C	Hospital Newborn Notice
DCH-1164	Guarantee of Payment Letter for Pregnancy Related Services
MSA-1755	Medicaid Enrolled Birthing Hospital Agreement for Elective, Non-Medically Indicated Delivery Prior to 39 Weeks Completed Gestation
MSA-4114	Medical Eligibility Report (MERF)
DCH-3878	Mental Illness/Intellectual/Developmental Disability/Related Condition Exemption Criteria Certification (For Use in Claiming Exemption Only)
MSA-1656	Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices
MSA-1656 – Addendum A	Mobility/Seating
MSA-1656 – Addendum B	Strollers, Gait Trainers, Stenders, Car Seats, and Children’s Positioning Chairs
MSA-1324	Nurse Aide Training and Testing Program Interim Reimbursement Request
MSA-115	Occupational Therapy – Physical Therapy – Speech Therapy Prior Approval Request/Authorization



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Form Number	Form Name
MSA-6544-B	Practitioner Special Services Prior Approval – Request/Authorization
DCH-3877	Preadmission Screening (PAS)/ Annual Resident Review (ARR) (Mental Illness/ Intellectual/Developmental Disability/Related Conditions Identification)
MSA-0732	Private Duty Nursing Prior Authorization – Request for Services
MDHHS-5405	Provider Electronic Signature Agreement Cover Sheet
MSA-0891	Provision of Low Vision Services and Aids Support Documentation
MSA-1580	Request for Authorization of Private Room Supplemental Payment for Nursing Facility
DCH-0078	Request to Add, Terminate or Change Other Insurance
SAMPLE 1	(Sample of) Continued Stay Notice of Non-Coverage
SAMPLE 2	(Sample of) Notice of Non-Coverage for Inpatient Hospital Admission
SAMPLE 3	(Sample of) Care Coordination Agreement
SAMPLE 4	(Sample of) Paper Remittance Advice
MSA-1653-B	Special Services Prior Approval – Request/Authorization
DCH-0893	Vision Services Approval/Order

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

Michigan Department of Health and Human Services

RECIPIENT STATEMENT:

I, _____, was told before the
(Print or Type Recipient Name)
hysterectomy was done that after the hysterectomy I would not be able to become pregnant.

(Recipient or Representative Signature)

(Date)

(Interpreter Signature, if required to inform the recipient of the above information)

(Date)

PHYSICIAN STATEMENT:

The hysterectomy for the above named recipient is solely for medical indications. This hysterectomy is not primarily or secondarily for family planning reasons, to render the above named recipient permanently incapable of reproducing, i.e. sterilization. It was explained to the above named recipient prior to the hysterectomy that the hysterectomy will render her permanently incapable of reproducing.

(Physician Signature)

(Date)

Authority: Title XIX of the Social Security Act Completion: Is Voluntary, but is required if Medical Assistance program payment is desired.	The Department of Health and Human Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to your local MDHHS office.
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BENEFITS MONITORING PROGRAM REFERRAL

SECTION 1 – Purpose of Submission

PCP Designation Specialty Referral Discharge from Practice

SECTION 2 – Beneficiary Information

Beneficiary Name (Last, First, Middle)			mihealth Card Number
Street Address			Home Telephone Number
City	State	ZIP Code	Work or Other Telephone Number

SECTION 3 – Referring Provider Information

Provider Name			Individual NPI Number	Specialty
Group Name (If applicable)			Group NPI Number	
Business Address			Are you the PCP? <input type="checkbox"/> YES <input type="checkbox"/> NO	
City	State	ZIP Code	Telephone Number	Fax Number

SECTION 4 – Referred Provider Information

Provider Name			Individual NPI Number	Specialty
Group Name (If applicable)			Group NPI Number	
Business Address			Telephone Number	Fax Number
City	State	ZIP Code	Anticipated Duration of Need <input type="checkbox"/> Acute/Short-Term <input type="checkbox"/> Chronic/Long-Term	

SECTION 5 – Drugs Subject to Abuse

MDHHS must authorize all prescribers of drugs subject to abuse for BMP-enrolled beneficiaries. Do you anticipate a need for the referred provider to prescribe medications in these classes?

YES NO Unable to determine

Include the beneficiary's current medication list with form submission.

SECTION 6 – Additional Information/Comments (including diagnoses)

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Provider Signature	Date of Authorization
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Benefits Monitoring Program Referral (MSA-1302) Instructions for Completion and Submission

General Instructions

This form should ONLY be used for beneficiaries enrolled in the Benefits Monitoring Program (BMP).^{*} Enrollment may be verified through the CHAMPS Eligibility Inquiry response as additional information. The form is to be completed by the beneficiary's BMP Authorized Provider(s). For additional program information, refer to the Michigan Medicaid Provider Manual (Beneficiary Eligibility Chapter, Benefits Monitoring Program Section) available on the MDHHS website.

MDHHS requests that the MSA-1302 be typewritten to facilitate processing.

Form Completion

Section 1	Check the appropriate box to communicate purpose of the submission.
Section 2	Beneficiary Information.
Section 3	Referring (or Primary Care) Provider Information.
Section 4	Referred Provider Information. Note: This section may be left blank when making a PCP designation only.
Section 5	Check the appropriate box to communicate the anticipated need for MDHHS to authorize the referred provider to write prescriptions for drugs subject to abuse for this beneficiary. Include the beneficiary's current list of medications with form submission.
Section 6	Fill in the reason for referral, including diagnosis. Include any additional information that would assist in MDHHS review. When using this form to communicate a discharge from practice, include a copy of the communication from your office to the patient for MDHHS records.

Copy Distribution

- Original – Referring Provider File
- Copy – Referred Provider
- Copy – Michigan Department of Health and Human Services (MDHHS), Medical Services Administration, Benefits Monitoring Program

Form Submission

The MSA-1302 and any supplemental information (e.g. medication list, medical records, forged prescriptions, etc.) must be mailed or faxed to:

**MDHHS – Medical Services Administration
Benefits Monitoring Program
PO Box 30170
Lansing, MI 48909**

Fax Number: (517) 335-0075

The MDHHS Program Review Division may be reached via telephone at (800) 622-0276.

^{*} Previously known as Beneficiary Monitoring Program.

The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.
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AUTHORITY: Title XIX of the Social Security Act.

COMPLETION: Is Voluntary, but is required if Medical Assistance program payment is desired.

BENEFICIARY VERIFICATION OF COVERAGE

Michigan Department of Health and Human Services
Medical Services Administration

I understand that Medicaid, Healthy Michigan Plan, or MIChild only covers payment for elective abortions under limited circumstances.

These are:

- Elective abortion to terminate a pregnancy to save the life of the mother,
- Elective abortion to terminate a pregnancy that was the result of rape, or
- Elective abortion to terminate a pregnancy that was the result of incest.

I certify that I am eligible for Medicaid, Healthy Michigan Plan, or MIChild coverage for an elective abortion based upon the circumstance that I have checked above. I understand that if I have given false information to obtain coverage for an elective abortion I can be prosecuted for fraud. I also understand that a copy of this verification will be sent to the local Michigan Department of Health and Human Services (MDHHS) office or to a police agency when appropriate.

Beneficiary Name (typed or printed)			Beneficiary Signature	
Beneficiary Address				
City	State	ZIP Code		

WITNESSED BY:

Witness Name (typed or printed)			Witness Signature	
Witness Address				
City	State	ZIP Code		

<p>Authority: Title XIX and Title XXI of the Social Security Act.</p> <p>Completion: Is Voluntary, but is required if payment from the Medicaid, Healthy Michigan Plan, or MIChild programs is sought.</p>	<p>The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.</p>
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CERTIFICATION FOR INDUCED ABORTION
Michigan Department of Health and Human Services
Medical Services Administration

Medicaid, Healthy Michigan Plan, or MIChild payments for abortion services are limited to cases in which the life of the mother would be endangered if the pregnancy were continued or cases in which the pregnancy was the result of rape or incest. To receive payment for abortion services, a physician must determine and certify that the abortion is necessary to save the life of the mother or is to terminate a pregnancy that resulted from rape or incest.

INSTRUCTIONS:

- TYPE or PRINT ALL Information below.
- The Physician completing this form is responsible for providing a copy of the completed form to any other provider assisting in this procedure (e.g., hospital, anesthesiologist, laboratory) for billing purposes.
- Send a copy of the completed form with the claim. (Refer to the Medicaid Provider Manual, Directory Appendix, Claim Submission/Payment.)

Any questions regarding this form should be referred to Provider Inquiry at 800-292-2550 or e-mail ProviderSupport@michigan.gov.

Beneficiary Name		mihealth Number		Date of Service	
Beneficiary Address (no. & street, apt./lot #, etc.)		City		State	ZIP Code
<p>Appropriate box must be checked for payment to be made.</p> <p>By signing below, I certify that:</p> <p><input type="checkbox"/> the life of the mother would be endangered if the pregnancy were continued. (List the medical condition(s) that exists.)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> the pregnancy terminated through this procedure was the result of rape or incest. Information included in the medical record supports this claim.</p>					
<p>In cases of rape or incest, was a police report filed?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO (If NO, explain)</p>					
<p>If appropriate, was a report filed with the local MDHHS office?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO (If NO, explain)</p>					
NOTE Payment for service is not dependent upon a report being filed with the police or the local MDHHS office.					
Physician Name (Type or Print)			Handwritten Signature of Physician		
Address (No. & Street, Ste., etc.)					
City	State	ZIP Code	Date Signed	Provider NPI Number	

<p>Authority: Title XIX and Title XXI of the Social Security Act. Completion: Is voluntary, but is required if payment from Medicaid, Healthy Michigan Plan, or MIChild programs is sought.</p>	<p>The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.</p>
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CERTIFICATION OF PUBLIC EXPENDITURE (CPE)

GOVERNMENTAL PROVIDER USE ONLY: CERTIFICATION OF TOTAL COMPUTABLE PUBLIC EXPENDITURE

1 Governmental Provider Name and Address:

Provider Name
1234 Health Services Drive
Anytown, USA 99999

2 Reporting Period (School Fiscal Year):

From: _____
To: _____

Medicaid Provider Number:
(National Provider
Identifier (NPI) Number)

3 a. Type of Report:

- Partial Period Report
- Quarterly Cost Report
- Full Year Cost Report

b. Total Computable Certified Public Expenditure by Component:

Medicaid
Medical Services

Total Computable Expenditure
(From Exhibit 11, Line 23)

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED HEREIN
MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.

CERTIFICATION STATEMENT BY OFFICER OF THE PROVIDER

I HEREBY CERTIFY that:

1. I have examined this statement, the accompanying supporting exhibits, the allocation of expenses, services and activities, and the attached worksheets for the period from _____ to _____ and that to the best of my knowledge and belief they are true and correct statements prepared from the books and records of the governmental provider in accordance with applicable instructions.
2. The expenditures included in this statement are based on the actual cost of recorded expenditures and reflect the reporting provider's cost of serving Medicaid recipients.
3. I am the officer authorized by the referenced governmental provider to submit this form and I have made a good faith effort to assure that all information reported is true and accurate.
4. The required amount of State and/or local funds were used to pay for total computable allowable expenditures included in this statement, and such State and/or local funds were in accordance with all applicable Federal requirements for the non-Federal share match of expenditures (including that the funds were not Federal funds in origin, or are Federal funds authorized by Federal law to be used to match other Federal funds, and that the claimed expenditures were not used to meet matching requirements under other Federally funded programs).
5. The total computable expenditures identified herein are submitted in accordance with 42 CFR 433.51.
6. I understand that this certification of public expenditures serves as the basis for Federal matching funds; that such expenditures were allowable to the State Medicaid program in accordance with all procedures, instructions, and guidance issued by and to the single state agency during the reporting period; and that falsification or concealment of a material fact may be prosecuted under Federal or State civil or criminal law.

SIGNATURE (officer of the governmental provider)

DATE

TITLE

PHONE NUMBER

Michigan Department of Health and Human Services
Nurse Aide Training and Competency Evaluation Program
Certified Nurse Aide Training Reimbursement

PURPOSE: The Certified Nurse Aide (CNA) must present this information to his/her Medicaid and/or Medicare certified nursing facility employer to apply for reimbursement of eligible CNA training and testing costs. Reimbursement is not available to CNAs working in other residential or patient care settings.

CNA:

Last Name	First Name	Middle Initial
Social Security Number	Birthdate	Driver License/Identification

I incurred the following expenses to become a CNA (Certified Nurse Aide).

TRAINING: *(Attach receipts)*

Approved Program Name: _____	Amount: \$ _____
Location: _____	Date of Payment: _____
Completion Date of Training: _____	

COMPETENCY EVALUATION: *(Attach receipts)*

Clinical Skills Test

Site: _____	Date: _____	Amount: \$ _____
Site: _____	Date: _____	Amount: \$ _____
Site: _____	Date: _____	Amount: \$ _____

Knowledge Test

Site: _____	Date: _____	Amount: \$ _____
Site: _____	Date: _____	Amount: \$ _____
Site: _____	Date: _____	Amount: \$ _____

Rescheduling Fee (No-Show)

Date: _____	Amount: \$ _____
Date: _____	Amount: \$ _____
Date: _____	Amount: \$ _____

Initial Registration Fee

Date: _____	Amount: \$ _____
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Registration Document Renewal

Date: _____	Amount: \$ _____
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Check appropriate box, sign and date:

- I have not received any payment for any of these expenses from another source, such as another nursing home, a vocational training program, etc.
- I have received payment from another source for the listed expenses:

Amount: \$ _____	Date: _____	Source: _____
Amount: \$ _____	Date: _____	Source: _____
Amount: \$ _____	Date: _____	Source: _____

I understand that the information I have provided may be audited.

CNA Signature: _____ Date: _____

NURSING FACILITY: (Retain this information for documentation of NATCEP costs.)

Facility Name: _____

Provider NPI Number: _____ LARA - BCCHS License Number: _____

Michigan Department of Health and Human Services
**COMPLEX CARE PRIOR APPROVAL – REQUEST/AUTHORIZATION
 FOR NURSING FACILITIES**

PRIOR AUTHORIZATION NUMBER

Fax: MDHHS Program Review Division (517) 241-7813

The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.

SECTION I:

Provider's Name	NPI Number	Phone Number
Provider's Address (Number, Street, Ste., City, State, Zip)		Fax Number
Beneficiary's Name (Last, First, Middle Initial)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date
		mihealth Card Number

SECTION II: CARE STAFFING AND SUPPLIES

List the average number of nursing hours and supplies, vent, etc. required for this beneficiary's care that EXCEED the standard level of care and the corresponding rate of pay. *Attach additional information if necessary.*

Excess Nursing Hours	Charges Per Hour/Day	Total
RN _____ Hours Per Day	\$ _____ Per hour	\$ _____
LPN _____ Hours Per Day	\$ _____ Per hour	\$ _____
Aide _____ Hours Per Day	\$ _____ Per hour	\$ _____
Excess Daily Supplies		
Medical Supplies (e.g., vent)		
1.	\$ _____ Per day	\$ _____
2.	\$ _____ Per day	\$ _____
3.	\$ _____ Per day	\$ _____
4.	\$ _____ Per day	\$ _____
TOTAL		\$ _____

SECTION III: ADDITIONAL COMMENTS

(250-Character Limit)

SECTION IV: PROVIDER CERTIFICATION

The patient named above (parent or guardian if applicable) understands the necessity to request prior approval for the services indicated. I understand that services requested herein require prior approval and, if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of a material fact may lead to prosecution under applicable Federal or State law.

 Provider Signature

 Date

MDHHS USE ONLY

Review action: APPROVED <input type="checkbox"/> INSUFFICIENT DATA <input type="checkbox"/> DENIED <input type="checkbox"/> NO ACTION <input type="checkbox"/> APPROVED AS AMENDED <input type="checkbox"/>	Consultant remarks
Start Date	End Date
	Units – Number of Days
	Total Daily Rate
	\$ _____

 Consultant Signature

 Date

Authority: Title XIX of the Social Security Act.
 Completion: Completion is required for Medicaid reimbursement.
 MSA-1576 (5/15) - Previous editions are obsolete.

Michigan Department of Health and Human Services is an equal opportunity employer, services, and programs provider.

Complex Seating and Mobility Device Prior Approval - Request/Authorization Completion Instructions

The MSA-1653-D must be used by Medicaid enrolled DME Providers. Note: Requests for new complex seating or mobility devices submit with a completed Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices" form (MSA-1656).

MDHHS requests that the MSA-1653-D be typewritten to facilitate processing. A Word fill-in enabled version of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms. The form is generally self-explanatory. For complete information on required modifiers, documentation, and appropriate quantity amounts, refer to the following documents:

- Standards of Coverage portion of the provider-specific chapters of the Medicaid Provider Manual.
- Billing & Reimbursement for Professionals Chapter of the Medicaid Provider Manual.
- Provider-specific databases on the MDHHS website. www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.

Completion of this form is as follows:

Box 1	MDHHS Use Only
Box 11	Beneficiary address. If beneficiary resides in Nursing Facility include the Nursing Facility name, address and phone number.
Box 17	Complete this box ONLY for wheelchair requests. <ul style="list-style-type: none"> • For repairs or parts, complete MSA-1653-D. (Do not include MSA-1656.) • For new or replacement (due to a change in beneficiary basic medical functional status requests), stop at this point and complete MSA-1656. Both forms must be submitted for Prior Authorization consideration.
Box 20	Enter brand name, model catalog or part number. DME, orthotics and prosthetics, must provide the brand name, model, and catalog or part number.
Box 21	Enter a complete description of the item requested.
Box 22	Enter the HCPCS Procedure Code.
Box 23	Enter the applicable HCPCS Modifier.
Box 28	Enter the beneficiary's primary and secondary diagnoses or the CSHCS qualifying diagnosis (list both the code and description). DME/POS providers must submit the prescription/CMN with this form.
Box 29	Any additional remarks regarding the request should be listed in this box such as verbal authorization date, retroactive date of service if being requested. Provide other insurance coverage for services requested.
Box 31	Must be completed for all requests.

Form Submission

PA request forms and required documentation for all eligible Medicaid beneficiaries must be mailed or faxed to:

**MDHHS - Medical Services Administration
Program Review Division
P.O. Box 30170
Lansing, Michigan 48909**

Fax Number: (517) 335-0075

To check the status of a PA request, contact the MDHHS - Medical Services Administration, Program Review Division via telephone at **1-800-622-0276**.

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable programs is sought.

The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.

Michigan Department of Health and Human Services
Complex Seating and Mobility Device
Prior Approval - Request/Authorization

1. PRIOR AUTHORIZATION NUMBER (MDHHS USE ONLY)
--

The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.

2. PROVIDER'S NAME (LAST, FIRST, MIDDLE INITIAL)		3. NPI NUMBER		4. PHONE NUMBER	
5. PROVIDER'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)				6. FAX NUMBER	
7. BENEFICIARY'S NAME (LAST, FIRST, MIDDLE INITIAL)		8. SEX <input type="checkbox"/> M <input type="checkbox"/> F	9. BIRTH DATE	10. MIHEALTH CARD NUMBER	
11. BENEFICIARY'S ADDRESS (NUMBER, STREET, APT./LOT NUMBER, CITY, STATE, ZIP). IF RESIDES IN NURSING FACILITY INDICATE NAME OF FACILITY, ADDRESS AND PHONE NUMBER.					
12. NAME OF DESIGNATED CONTACT PERSON (E.G., BENEFICIARY, PARENT, GUARDIAN, ETC.)				13. PHONE NUMBER	
14. OTHER INSURANCE NAME		15. POLICY NUMBER		16. FAX NUMBER	
17. AUTHORIZATION TYPE: <input type="checkbox"/> NEW WHEELCHAIR/REPLACEMENT <input type="checkbox"/> REPAIR <input type="checkbox"/> RENTAL ONLY				18. MSA-1656 SUBMITTED ON	

19. LINE	20. BRAND NAME, MODEL CATALOG OR PART NUMBER	21. DESCRIPTION OF SERVICE	22. PROCEDURE CODE	23. MODIFIER	24. QUANTITY	25. CHARGE	26. COVERED BY OTHER INSURANCE?		27. DATE LAST REPLACED (MM/DD/YYYY)
							YES	NO	
01							<input type="checkbox"/>	<input type="checkbox"/>	
02							<input type="checkbox"/>	<input type="checkbox"/>	
03							<input type="checkbox"/>	<input type="checkbox"/>	
04							<input type="checkbox"/>	<input type="checkbox"/>	
05							<input type="checkbox"/>	<input type="checkbox"/>	
06							<input type="checkbox"/>	<input type="checkbox"/>	
07							<input type="checkbox"/>	<input type="checkbox"/>	
08							<input type="checkbox"/>	<input type="checkbox"/>	
09							<input type="checkbox"/>	<input type="checkbox"/>	

FOR ADDITIONAL ITEMS ADD PAGE WITH DESCRIPTION, PROCEDURE CODE(S), MODIFIER(S), QUANTITY, CHARGE, IF COVERED BY OTHER INSURANCE, AND IF APPLICABLE DATE OF LAST REPLACED.

28. DIAGNOSES (CODES AND DESCRIPTIONS) REQUIRING THE ABOVE SERVICES.	29. ADDITIONAL REMARKS, INCLUDING OTHER INSURANCE COVERAGE, FOR SERVICES REQUESTED.
--	---

30. INDICATE ANY OTHER SERVICES PROVIDED TO THIS BENEFICIARY DURING THE PAST YEAR.

31. DME PROVIDER CERTIFICATION: THE PATIENT NAMED ABOVE (PARENT OR GUARDIAN IF APPLICABLE) UNDERSTANDS THE NECESSITY TO REQUEST PRIOR APPROVAL FOR THE SERVICES INDICATED. I UNDERSTAND THAT SERVICES REQUESTED HEREIN REQUIRE PRIOR APPROVAL AND, IF APPROVED AND SUBMITTED ON THE APPROPRIATE INVOICE, PAYMENT AND SATISFACTION OF APPROVED SERVICES WILL BE FROM FEDERAL AND/OR STATE FUNDS. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY LEAD TO PROSECUTION UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

DME'S SIGNATURE _____	DATE _____
ADDITIONAL DME'S SIGNATURE _____	DATE _____

MDHHS USE ONLY

32. REVIEW ACTION: APPROVED DENIED RETURN NO ACTION APPROVED AS AMENDED

33. CONSULTANT REMARKS

CONSULTANT SIGNATURE AND DATE

Michigan Department of Health and Human Services
Complex Seating and Mobility Device
Prior Approval - Request/Authorization

Additional Page (Use only if requesting additional mobility items)

Beneficiary
Name: _____

Mihealth
Number: _____

19. LINE	20. BRAND NAME, MODEL CATALOG OR PART NUMBER	21. DESCRIPTION OF SERVICE	22. PROCEDURE CODE	23. MODIFIER	24. QUANTITY	25. CHARGE	26. COVERED BY OTHER INSURANCE?		27. DATE LAST REPLACED (MM/DD/YYYY)
							YES	NO	
10							<input type="checkbox"/>	<input type="checkbox"/>	
11							<input type="checkbox"/>	<input type="checkbox"/>	
12							<input type="checkbox"/>	<input type="checkbox"/>	
13							<input type="checkbox"/>	<input type="checkbox"/>	
14							<input type="checkbox"/>	<input type="checkbox"/>	
15							<input type="checkbox"/>	<input type="checkbox"/>	
16							<input type="checkbox"/>	<input type="checkbox"/>	
17							<input type="checkbox"/>	<input type="checkbox"/>	
18							<input type="checkbox"/>	<input type="checkbox"/>	
19							<input type="checkbox"/>	<input type="checkbox"/>	
20							<input type="checkbox"/>	<input type="checkbox"/>	
21							<input type="checkbox"/>	<input type="checkbox"/>	
22							<input type="checkbox"/>	<input type="checkbox"/>	
23							<input type="checkbox"/>	<input type="checkbox"/>	
24							<input type="checkbox"/>	<input type="checkbox"/>	
25							<input type="checkbox"/>	<input type="checkbox"/>	
26							<input type="checkbox"/>	<input type="checkbox"/>	
27							<input type="checkbox"/>	<input type="checkbox"/>	
28							<input type="checkbox"/>	<input type="checkbox"/>	
29							<input type="checkbox"/>	<input type="checkbox"/>	
30							<input type="checkbox"/>	<input type="checkbox"/>	
31							<input type="checkbox"/>	<input type="checkbox"/>	
32							<input type="checkbox"/>	<input type="checkbox"/>	
33							<input type="checkbox"/>	<input type="checkbox"/>	
34							<input type="checkbox"/>	<input type="checkbox"/>	

FOR ADDITIONAL ITEMS ADD PAGE WITH DESCRIPTION, PROCEDURE CODE(S), MODIFIER(S), QUANTITY, CHARGE, IF COVERED BY OTHER INSURANCE, AND IF APPLICABLE DATE OF LAST REPLACED.

CONSENT FOR STERILIZATION

Michigan Department of Health and Human Services

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____
(Doctor or Clinic). When I first asked for the

information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT AND NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____
(Month / Day / Year)

I, _____
(Name of Individual Being Sterilized)

hereby consent of my own free will to be sterilized by _____

(Name of Doctor and Professional Degree)

by a method called _____.

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:
Representatives of the Department of Health and Human Services OR Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

(Signature of Person Giving Consent) Date: _____
(Month / Day / Year)

You are requested to supply the following information, but it is not required: *Ethnicity and race designation (please check)*

- Ethnicity:* Hispanic or Latino American Indian or Alaska Native
 Not Hispanic or Latino Asian
 Black or African American
 Native Hawaiian or Other Pacific Islander
 White

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____

language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

(Interpreter's Signature) Date: _____
(Month / Day / Year)

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed the
(Name of Individual)

consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

(Signature of person obtaining consent) _____
(Date)

(Facility)

(Facility Address)

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____

_____ on _____
(Name of individual to be sterilized) (Date of sterilization)

I explained to him/her the nature of the sterilization operation _____, the fact that it is intended

(specify type of operation) _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- Premature delivery
Individual's expected date of delivery: _____
 Emergency abdominal surgery: _____
(describe circumstances)

(Signature of Physician and Professional Degree) Date: _____
(Month / Day / Year)

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is Voluntary, but is required if Medical Assistance program payment is desired.

The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.

INSTRUCTIONS TO COMPLETE CONSENT FOR STERILIZATION FORM

1. Name of the physician or clinic giving information to the beneficiary. The "M.D." or "D.O." designation must be included.
2. Name of the sterilization procedure to be performed (e.g., Tubal Ligation or Vasectomy).
3. Beneficiary's complete birth date (month, day, and year). The beneficiary must be 21 years of age at the time they sign the form.
4. Beneficiary's full name. If a name change is indicated on the Medicaid card by the time surgery is performed, both names must be indicated.
5. Name of physician performing the sterilization. If the physician is unknown, "doctor on call" may be indicated.
6. Name of surgery to be performed (e.g., Tubal Ligation or Vasectomy).
7. Beneficiary's handwritten signature. A beneficiary who cannot write should sign with an "X." The "X" signature must be witnessed. The witness' handwritten signature must appear below item 7.
8. Date the consent form was signed (month, day and year). This date must be more than 30 days and less than 180 days before the date the sterilization is performed. If it is less than 30 days, see instructions for "alternative final paragraphs."
9. Race and ethnicity designation is optional.
10. Interpreter's Statement. This information is only required if the beneficiary is unable to understand English. The language used for interpretation must be specified (e.g., Spanish). The interpreter's handwritten signature and date must appear. The date must be the same date the beneficiary signed the form.
11. Name of beneficiary.
12. Name of sterilization procedure (e.g., Tubal Ligation or Vasectomy).
13. The handwritten signature of the person obtaining consent.
14. Date consent is taken (month, day and year). This date must be before the date sterilization is performed (#18).
15. Name of provider or clinic (e.g., office of John Doe, M.D., doctor's office, ABC Clinic, XYZ Hospital).
16. Street address, city, state, and zip code. No P.O. boxes allowed.
17. Beneficiary's full name.
18. Date of sterilization (month, day, and year). The surgery date must be the same as indicated on the claim.
19. Name of sterilization procedure (e.g., Tubal Ligation, Vasectomy).
20. Instructions for use of alternative final paragraphs.
21. If at least 30 days have passed since the date the beneficiary signed the consent form and the date of sterilization, paragraph "1" applies and paragraph "2" should be crossed out.
22. If the date the sterilization was performed is less than 30 days and more than 72 hours of the beneficiary signing the consent form, paragraph "2" applies and paragraph "1" should be crossed out. The applicable box should be checked.
23. For premature delivery, the expected date of delivery must be given.
24. Physician's signature. This can be a stamped signature if counter initialed.
25. Date physician signed the consent form. This date must be on or after the date of surgery. This can be typed or stamped.

If abdominal surgery was performed, the circumstances must be explained and operative notes submitted with the claim.

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is Voluntary, but is required if Medical Assistance program payment is desired.

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Application for Payment of Health Insurance Premiums

SECTION ONE – CSHCS Identifying Information

1. Name of Client (Last, First MI)		2. CSHCS ID Number	
3. Client's Contact Phone Number - -		4. Client's Date of Birth (MM/DD/YYYY) / /	
5. Does Client have Medicare Part B? <input type="checkbox"/> YES <input type="checkbox"/> NO	6. Does Client have Medicare Part D? <input type="checkbox"/> YES <input type="checkbox"/> NO	7. Does Client have MIChild? <input type="checkbox"/> YES <input type="checkbox"/> NO	

SECTION TWO – Insurance Information

Is this case for:

- COBRA** - Answer questions 8-24
- Insurance Premium (new or continuing coverage)** - Answer questions 13-24

8. Reason COBRA was offered OR may be available:	
9. Date of qualifying event / /	10. Date of COBRA notice to employee / /
11. Date COBRA election form was signed (if applicable) / /	12. Has first COBRA payment been made? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, list date / /
13. Is insurance coverage through employer? <input type="checkbox"/> YES <input type="checkbox"/> NO	14. Name of employee (if applicable)
15. Name of employer (if applicable)	16. Name of insurance contact person
17. Phone number of insurance contact person ()	18. Name of insurance company
19. Insurance contract number/group number	20. Premium cost per month for client's coverage \$.
21. Date next premium is due / /	22. Date of contract renewal (<i>when rate could change</i>) / /
23. Name and address of company where premium payments are to be sent:	
24. Reason family is unable to pay premium:	

SECTION THREE – Health and Medical Information

25. What is the client's CSHCS covered diagnosis?			
26. What does the health insurance cover:			
<input type="checkbox"/> HOSPITAL	<input type="checkbox"/> DOCTOR VISITS	<input type="checkbox"/> PRESCRIPTIONS	
<input type="checkbox"/> VISION	<input type="checkbox"/> DENTAL		
27. What are the expected future medical needs for the CSHCS client?			

28. Is it likely the client's insurance will cover these medical needs? Explain.

29. What special health care needs are **not** covered by the client's health insurance?

30. Are there other health insurance coverages for which the client might be eligible (e.g. Medicare Part B, Medicare Part D, other private health insurance, etc)? YES NO
 Explain:

31. Additional Comments:

- Attach the following information:
- Copy of the billing statement from the insurance carrier or a statement from the employer verifying the cost of the insurance premium.
 - Copies of Explanation of Benefit (EOB) statements or expenditure summaries from the private health insurance carrier or Medicare.
 - Copy of the completed COBRA election form if health insurance coverage is to be maintained under the provisions of COBRA.
 - Pharmacy report documenting the cost of the prescriptions and the amount paid by the private health insurance carrier or Medicare if the coverage includes a prescription benefit.

Mail this application and attachments to:
 MDHHS/CSHCS
 Insurance Specialist
 PO Box 30734
 Lansing, MI 48909

OR

Fax: 517-335-8055

For questions call:
 Family Phone Line: 1-800-359-3722 and ask for the Insurance Specialist

SECTION FOUR – Verification and Signature

- **By signing this application form, I am certifying that the information is accurate and complete to the best of my ability.**
- **I understand that I may need to show proof of this information.**
- **I understand that the information shared might relate to HIV, ARC, or AIDS if the Client has those conditions.**

Signature of Legally Responsible Party or Adult Client **Date Signed**

MDHHS USE ONLY

MDHHS Action <input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED	<div style="border-bottom: 1px solid black; height: 20px; margin-bottom: 5px;"></div> <div style="display: flex; justify-content: space-between;"> MDHHS Signature Date </div>
--	--

Copy Distribution:
 Client/Family
 LHD

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.

AUTHORITY: Title V of the Social Security Act.
COMPLETION: Is Voluntary but is required if CSHCS program services are desired.

DENTAL PRIOR APPROVAL AUTHORIZATION REQUEST

Instructions for MSA-1680-B

The Dental Prior Approval Authorization Request form (MSA-1680-B) is to be used for persons with Medicaid coverage in the Fee for Service dental benefit and persons enrolled in Children's Special Health Care Services (CSHCS). For beneficiaries enrolled in **Healthy Kids Dental, Healthy Michigan Plan Health Plans, Integrated Care Organizations and pregnant women enrolled in a Medicaid Health Plan**, providers should contact the assigned plan for authorization requirements.

The MSA-1680-B must be completed by private dentists or community-based dental clinics (e.g., local health departments, Federally Qualified Health Centers (FQHC)). MDHHS requires that the MSA-1680-B be typewritten, handwritten forms will not be accepted.

The status of a prior authorization request may be reviewed in CHAMPS. Additionally, providers will receive a Prior Authorization determination letter. Approved services are required to be completed before the end of the Prior Authorization. To request an extension, the provider must submit a copy of the determination letter and required documentation within 15 days prior to the end date of the current authorization. If the original prior authorization is over one year old, a new prior authorization request must be submitted.

For further information on the prior authorization of dental services, please see the Prior Authorization Section, Dental Chapter of the Medicaid Provider Manual.

Dental providers treating CSHCS beneficiaries are required to submit the beneficiary's CSHCS qualifying diagnosis related to the services being requested. For authorization of orthodontics and/or crown and bridge services for beneficiaries enrolled in CSHCS, please see the Children's Special Health Care Services Dental Services Section, Dental Chapter of the Medicaid Provider Manual.

The completed MSA-1680-B may be mailed, faxed, or submitted via CHAMPS, depending whether Radiograph films are necessary, to:

Michigan Department of Health and Human Services
Dental Prior Authorization
P.O. Box 30154
Lansing, MI 48909
Fax: (517) 335-0075

Questions should be directed to Dental Prior Authorization at 1-800-622-0276.

If submitting electronically, the completed MSA-1680-B and all radiographs must be attached, as required by policy.

Radiographs will only be returned upon request, as indicated in box 17.

Michigan Department of Health and Human Services
DENTAL PRIOR APPROVAL AUTHORIZATION REQUEST
www.michigan.gov/mdhhs

FAX: 517-335-0075

1. Prior Authorization Number (MDHHS use only)			

Medicaid CSHCS

Note: The provider is responsible for eligibility verification. Authorization does not guarantee beneficiary eligibility or payment. MDHHS requires that the MSA-1680-B be typewritten, handwritten forms will not be accepted.

2. Provider Name (Last, First, Middle Initial)				9. Beneficiary Name (Last, First, Middle Initial)								
3. Provider Street Address				10. Birth Date / /		11. Sex <input type="checkbox"/> M <input type="checkbox"/> F						
4. City		State	ZIP Code	12. MI Health Card Number		13. Phone Number () -						
5. Provider Fax Number () -		6. Provider Phone Number () -		14. Does patient live in a nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Facility Name								
7. Provider NPI No.		8. Group NPI No.		15. Is Patient Covered by Any Other Dental Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Plan Name								
16. CSHCS Diagnosis – ICD Diagnosis Code and Description				20. Indicate missing teeth with an "X" - teeth to be extracted with a "/". 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 A B C D E F G H I J ----- T S R Q P O N M L K 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17								
17. Are Radiographs Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Number of Radiographs and Date Taken / / Radiographs will only be returned upon request. Check here for return of Radiographs <input type="checkbox"/>				21. Indicate teeth extracted since Radiographs:								
18. Is Treatment for Orthodontics? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is Treatment Plan Enclosed? <input type="checkbox"/> Yes <input type="checkbox"/> No										
19. Is this Initial Placement of Prosthesis? <input type="checkbox"/> Max. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Mand. <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", please document Reason for Replacement:												
22. Status of Current Prosthesis:				EXAMINATION AND TREATMENT REQUESTED								
	Part	Full	Date Inserted	Can Be		Used Now		L I N E	23. Tooth	24. Procedure Code	25. Consultant Use Only	26. Description of Service
				Worn?	Repaired?	Yes	No					
Max				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	1			
Mand				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	2			
27. Address 5 Year Prognosis for Partial Dentures				3								
				4								
				5								
				6								
				7								
				8								
				9								
28. Other Pertinent Dental or Medical History												
29. PROVIDER CERTIFICATION: The patient named above (parent, if minor, or authorized representative) understands the necessity to request prior approval for the services indicated above. I understand the services requested herein require prior approval and if submitted on the proper invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of material fact may be prosecuted under applicable Federal and State Law.												
Provider's Name (printed/typed):				Provider Signature:				Date:				
For MDHHS Consultant Use Only												
30. Consultant Remarks				31. Review Action				32. Consultant Signature				
				Approved <input type="checkbox"/>				Denied <input type="checkbox"/>				
				Returned <input type="checkbox"/>				No Action <input type="checkbox"/>				
				Approved as amended <input type="checkbox"/>								
								Date				



Documentation of Medical Necessity for the Provision of Contact Lenses

(This form is to be completed and attached to DCH-0893 when requesting prior authorization for the provision of contact lenses. Prior authorization is NOT required for beneficiaries with aphakia who are under six years of age.)

Beneficiary's Name _____

Medicaid ID Number _____

Indicate the diagnosis(es) which best describes the beneficiary's condition:

- Anirida
- Anisometropia or Antimetropia
- Aphakia
- Irregular Corneas *
- Keratoconus * (If vision can not be improved to 20/40 or better with eyeglasses.)
- Other conditions with no alternative treatment (e.g., Aniseikonia (with documentation), Keratoconjunctivitis Sicca)

Diagnosis(es) Code: _____

Current spectacle correction:

R _____ VA _____

L _____ VA _____

ADD _____

Best spectacle correction:

R _____ VA _____

L _____ VA _____

ADD _____

Has the beneficiary previously worn contact lenses? YES NO

If yes, explain:

Is the beneficiary currently wearing contact lenses? YES NO

If yes, indicate reason for new lenses:

Keratometry (diopters)

R _____ @ _____ ; _____ @ _____

L _____ @ _____ ; _____ @ _____

Mire Quality

R _____

L _____

* A corneal topography for Keratoconus and Irregular Cornea diagnoses may be requested.

Type of contact lens requested:

A. Hydrogels

- Power
- Series (Brand Name)
- Additional Specifications
- Manufacturer
- Manufacturer's wholesale cost

R	L

B. Rigid Gas Permeable or Hybrid

- Base Curve
- Power
- Diameter
- Additional Specifications
- Complete description of contact lens parameters
- Material of the contact lens
- Manufacturer of the contact lens
- Brand Name
- Manufacturer's wholesale cost
- Number of lenses required to provide one-year supply
- Prescription expiration date

R	L

Expected obtainable visual acuity with contact lenses at distance:

R _____ L _____

Approximate wearing time per day (specify number of hours): _____

Are eyeglasses to be worn simultaneously, as an over-correction, with the contact lenses? Yes No

Provide your assessment of beneficiary's ability to insert, remove, maintain, and wear contact lenses:

Provider's Signature

Provider's Name (Print)

Date: _____

ELECTRONIC SIGNATURE AGREEMENT
Michigan Department of Health and Human Services

Employer or Employing Entity Name	Employer Identification Number	NPI
Individual Name (Doctor, Dentist, Nurse, etc.)		NPI
<p>The undersigned Individual and Employing Entity attest that they have entered into an agreement effective on the date indicated below. Both parties agree an authorized representative of the Employing Entity has the authority to sign and submit the electronic Michigan Department of Health and Human Services Medical Assistance Provider Enrollment Trading Partner Agreement and to maintain enrollment information through the MDHHS CHAMPS Provider Enrollment Subsystem. Both parties also agree that the Employing Entity listed above is liable and bound by all information submitted on his or her behalf as if the Employing Entity had submitted changes to CHAMPS directly.</p>		
Individual Signature		Date
Employing Entity Signature		Date
Individual MILogin User ID		Date

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

**Michigan Department of Health and Human Services
Completion Instructions for MSA-181
Home Health Aide Prior Approval Request/Authorization**

General Instructions

The MSA-181 must be used by Medicaid enrolled and home health agencies to request Prior Authorization (PA) for home health aide services. MDHHS requires that the MSA-181 be typewritten; handwritten forms will not be accepted. A Word fill-in enabled version of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Forms.

This form must be used to request Prior Authorization (PA) for home health aide services for beneficiaries with Medicaid. A request to begin services may be submitted by a person other than the home health agency such as the hospital Discharge Planner or physician. When this is the case, the person submitting the request must do so in consultation with the beneficiary (parent or guardian if applicable), and home health agency who will be assuming responsibility for the care of the beneficiary.

PA may be authorized for a period not to exceed ninety days. If need for home health aide services are medically necessary, a subsequent request for PA must be submitted. The provider should retain a copy of the PA form until the approval or denial is returned.

Refer to the Medicaid Provider Manual, Home Health Chapter, Prior Authorization Subsection, for the listing of required documentation to accompany each request.

Completion of this form is as follows:

Item#	Instructions
1	Prior Authorization Number. MDHHS use only.
2	The Home Health Agency Provider Name.
3	The Medicaid enrolled provider's name and National Provider Identifier (NPI).
4-9	The Home Health Agency provider's telephone number (including area code), address and fax number (including area code).
10	Initial: The authorization request is the initial prior authorization request for the beneficiary under this treatment plan. Continuing: The treatment authorization request is to continue treatment for additional calendar month(s) of service under this treatment plan.
11-19	Beneficiary information. Provide complete name, sex, mi health card number, date of birth, complete address (including city, state, and zip code), and phone number.
20-21	Enter the beneficiary's diagnosis(es) code(s) and onset date that relate to the service being requested.
22	The beneficiary's most recent hospital discharge date for the requesting prior authorization period.
23-25	Hospital information including complete address and phone number, anticipated discharge date, and name and contact information of Discharge Planner, if beneficiary is currently hospitalized.
26	The start date of the last approved authorization period.
27	The previous total number of home health aide visits rendered (since services were first started).
28	The date home health services were first started.
29	For this current request being submitted, indicate requested start and end dates, total quantity of procedure code G0156 (i.e. visits) requested, and the planned visit frequency during the requested authorization period.
30	Indicate if the current authorization request is an increase or decrease from previous authorization, or if a change is being requested for the currently approved authorization period.
31	List the beneficiary's current medications relevant to the medical diagnosis.
32	Documentation of the beneficiary's cognitive status.
33	Identify the beneficiary's ability to complete range of motion for upper and lower extremities.

34	<p>Evaluation includes OASIS coding of the beneficiary.</p> <p>OASIS Coding</p> <p>06 Independent – Patient completes the activity by him/herself with no assistance from a helper.</p> <p>05 Setup or clean-up assistance – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.</p> <p>04 Supervision or touching assistance – Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.</p> <p>03 Partial/moderate assistance – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.</p> <p>02 Substantial/maximal assistance – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.</p> <p>01 Dependent – Helper does ALL the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.</p> <p>If activity was not attempted, code reason:</p> <p>07 Patient refused</p> <p>09 Not applicable</p> <p>88 Not attempted due to medical condition or safety concerns</p>
35	Indicate the service and frequency of the service for this authorization request.
36	Identify the medical need for additional services. Service request must be specific, include supportive documentation of the beneficiary's current level of function and the medical necessity of requested service(s).
37	List all other services in the home. Must include the frequency of the service(s) and payer(s). Failure to disclose all services in the home may result in recoupment of Medicaid dollars for home health aide reimbursement.
38	Signature certifies that Parent/Guardian of beneficiary attests that information provided on this form is accurate and complete to the best of their ability. All unsigned requests will be returned for signature.
39	The Physician's signature certifies that (1) the Home Health agency requesting the services understands the medical necessity for obtaining prior authorization for Home Health services and; (2) the information provided on this form is accurate and complete. All unsigned requests will be returned for signature.
40	The licensed supervising professional's signature certifies that (1) the licensed, registered nurse, physical therapist, occupational therapist, or speech/language therapist provides supervision of the home health aide; (2) the services are medically necessary for obtaining prior authorization for Home Health aide services and; (3) the information provided on this form is accurate and complete. All unsigned requests will be returned for signature.
41-42	MDHHS use only

RETURN COMPLETED FORM AND REQUIRED DOCUMENTATION TO:

MDHHS
Program Review Division
PO Box 30170
Lansing, MI 48909

OR

Fax to: 517-335-0075

Questions should be directed to MDHHS - Medical Services Administration, Program Review Division via telephone at **1-800-622-0276**.

Authority: Title XIX of the Social Security Act.	Completion: Is voluntary but is required if payment from applicable programs is sought.
<p>The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.</p>	

**HOME HEALTH AIDE
PRIOR APPROVAL REQUEST/AUTHORIZATION**
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
The provider is responsible for eligibility verification.
Approval does not guarantee beneficiary eligibility or payment.

1. Prior Authorization Number (MDHHS USE ONLY)
--

MDHHS requires this form to be typewritten; handwritten forms will not be accepted.

2. Home Health Agency Provider Name		3. Provider NPI Number		4. Provider Phone Number		5. Provider Fax Number	
6. Home Health Agency Provider Address (Number, Street, Building, Suite Number, etc.)		7. City		8. State		9. Zip Code	
10. Home Health Aide Authorization Request <input type="checkbox"/> Initial <input type="checkbox"/> Continuing							
11. Beneficiary Name (Last, First, Middle Initial)		12. Beneficiary Date of Birth	13. Sex <input type="checkbox"/> M <input type="checkbox"/> F	14. mihealth ID Number		15. Beneficiary Telephone Number	
16. Beneficiary Address (Number, Street, Apt/Lot, etc.)				17. City		18. State	19. ZIP Code
20. Medical ICD Diagnosis(es) Code(s) Requiring Home Health Services				21. Onset Date		22. Most Recent Hospital Discharge Date	
23. Primary Caregiver(s)		24. Relationship(s) to Beneficiary		25. Primary Caregiver(s) Phone Number(s)			
				- -			
				- -			
26. Date of Last Authorization	27. Number of Previous Visits	28. Date Home Health Aide Service(s) Started	29. Current Request Requested Start Date: Requested End Date: Requested Qty Code G0156: Visit Frequency:			30. Number of Visits Requested compared to Last Authorization <input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> Change to current authorization	

Beneficiary's Current Functional Level and Services

31. List Current Medications:										
32. Cognitive: <input type="checkbox"/> Alert/oriented <input type="checkbox"/> Able to Direct Care <input type="checkbox"/> Impaired/Developmental Delay <input type="checkbox"/> Disoriented <input type="checkbox"/> Unresponsive										
33. Range of Motion Exercises: Upper Extremity: <input type="checkbox"/> Independent <input type="checkbox"/> Requires Assistance / Dependent										
Lower Extremity: <input type="checkbox"/> Independent <input type="checkbox"/> Requires Assistance / Dependent										
34. SCORE: (see instructions)	06	05	04	03	02	01	07	09	88	35. Services & frequency to be performed by aide
Bathing/Skin Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Positioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ambulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Management, if applicable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vital Signs										<input type="checkbox"/>
36. Other Services (Must specify service(s) include documentation of current level of function and medical necessity for each)										

Beneficiary Name: _____ mihealth ID Number: _____

37. Other Services Currently Received By Beneficiary (Check All)	Frequency	Payer
Skilled Nursing Visits <input type="checkbox"/> No <input type="checkbox"/> Yes		
Private Duty Nursing <input type="checkbox"/> No <input type="checkbox"/> Yes		
Physical Therapy <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Outpatient		
Occupational Therapy <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Outpatient		
Speech Therapy <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Outpatient		
Home Help <input type="checkbox"/> No <input type="checkbox"/> Yes		
Community Living Services (CLS) <input type="checkbox"/> No <input type="checkbox"/> Yes		
Other Behavioral Health Services <input type="checkbox"/> No <input type="checkbox"/> Yes Specify:		
Waiver Services <input type="checkbox"/> No <input type="checkbox"/> Yes Specify:		
Hospice <input type="checkbox"/> No <input type="checkbox"/> Yes		
Other Services <input type="checkbox"/> No <input type="checkbox"/> Yes Specify:		

- Home Health Agency Plan of Care Attached (Most Recent Plan Of Care Must Accompany Request)
- Copy of Oasis Must Be Attached With Initial Request And Annually Thereafter

<p>38. PATIENT (PARENT / GUARDIAN IF APPLICABLE) CERTIFICATION</p> <p>I, the patient (parent/guardian) named above, understand the necessity to request prior authorization for the medically necessary services indicated. I understand that services requested herein require prior authorization and, if approved and submitted by the agency on the appropriate invoice, payment of authorized services will be from general and/or state funds. I understand that any false claims, statements or documents, or concealment of a material fact may lead to prosecution under applicable federal and/or state law. I hereby attest that information provided on this form is accurate and complete to the best of my ability.</p>	<p>39. PHYSICIAN CERTIFICATION</p> <p>I certify that I have examined the patient named above and have determined that home health aide services are medically necessary, as supervised by a licensed, registered nurse or other authorized licensed professional. I understand that home health aide services require prior authorization to validate that such services are deemed medically necessary in accordance with Michigan Medicaid Provider Manual policy. I understand that any false claims, statements or documents, or concealment of a material fact may lead to prosecution under applicable federal and/or state law. I hereby attest that information provided on this form is accurate and complete to the best of my ability.</p>	<p>40. LICENSED SUPERVISING PROFESSIONAL CERTIFICATION</p> <p>I hereby attest as a licensed professional (registered nurse, physical therapist, occupational therapist, or speech/language pathologist) that supervision of the home health aide is under my authority and deemed medically necessary. I understand that services requested herein require prior approval and, if approved and submitted on the appropriate invoice, payment of approved services will be from federal and/or state funds. I understand that any false claims, statements or documents, or concealment of a material fact may lead to prosecution under applicable federal and/or state law. I hereby attest that information provided on this form is accurate and complete to the best of my ability.</p>
--	--	--

<p>PATIENT NAME (PARENT / GUARDIAN)</p> <p>PRINTED</p> <p>SIGNATURE _____ DATE _____</p>	<p>PHYSICIAN NAME</p> <p>PRINTED</p> <p>SIGNATURE _____ DATE _____</p>	<p>SUPERVISING PROFESSIONAL NAME</p> <p>PRINTED</p> <p>SIGNATURE _____ DATE _____</p>
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MDHHS USE ONLY

<p>41. REVIEW ACTION:</p> <p><input type="checkbox"/> APPROVED <input type="checkbox"/> DENIED <input type="checkbox"/> RETURN <input type="checkbox"/> NO ACTION <input type="checkbox"/> APPROVED AS AMENDED</p>	<p>42. CONSULTANT REMARKS AND AUTHORIZATION PERIOD IF APPROVED:</p> <p><input type="checkbox"/> See CHAMPS <input type="checkbox"/> KEEP IN FILE</p> <p>_____ <input type="checkbox"/> KEEP IN FILE</p> <p>_____ <input type="checkbox"/> KEEP IN FILE</p> <p>_____</p> <p>CONSULTANT SIGNATURE / DATE</p>
---	--

HOSPITAL NEWBORN NOTICE

INSTRUCTIONS

The MSA-2565-C serves as notice of birth of a newborn for the purposes of obtaining a Medicaid ID number. It must be completed only if the hospital is unable to submit notice of the birth through the Michigan Electronic Birth Certificate system.

- The hospital must retain **THE ORIGINAL** of the Hospital Newborn Notice in the beneficiary's file. A copy **MUST** be sent to the local MDHHS office.
- A copy of the MSA-2565-C will be returned to the hospital, noting the eligibility status of the newborn.
- Item 6 must state the name of the mother.
- A copy of the CHAMPS Eligibility Inquiry or HIPAA 271 transaction response with the mother's Benefit Plan ID information should be attached to the form; or the form must contain the county, district, unit, worker, and case number data from the eligibility response separated by slashes (e.g., 33/01/01/08/1234567890).

The Michigan Department of Health and Human Services does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.

AUTHORITY: P.A. 280 of 1939 and Federal 42 CFR of 435
Title XIX of the Social Security Act

COMPLETION: Is voluntary

HOSPITAL NEWBORN NOTICE

1. Newborn Name (Last, First, Middle)		2. Newborn Gender <input type="checkbox"/> M <input type="checkbox"/> F	3. Newborn Birth Date / /	4. Newborn Social Security No. (If Available) - -	
5. Home Address (No. & Street, including apartment number)		City		State	Zip Code
6. Name of Newborn's Mother (Last, First, Middle)		7. Phone No. () -			
8. Mother Social Security No. (If Available) - -		9. Mother Birth Date / /			
10. Home Address (No. & Street, including apartment number)		City		State	Zip Code
11. Name of Provider		12. National Provider ID Number			
13. Provider Address (No. & Street)		City		State	Zip Code
14. Attending Physician Name		15. Hospital Case No. (If Applicable)			
16. Present Status of Patient (Check ONE) <input type="checkbox"/> Still a Patient <input type="checkbox"/> Discharged (Date): / / <input type="checkbox"/> Deceased (Date): / /					
17. Indicate Medicare or Private Health Insurance coverage available to patient and complete the following as applicable <input type="checkbox"/> Medicare <input type="checkbox"/> No Other Insurance Coverage Available <input type="checkbox"/> Private Health Insurance (Complete items 18 thru 23 below)					
18. Name of Policyholder (Private Health Ins.)			19. Policyholder's SS No. - -		
20. Name of Insurance Company					
21. Location (City)		State		Zip Code	
22. Group / Policy Number			23 Cert. / Contract No.		
PATIENT CERTIFICATION					
I certify that the information furnished by me in applying for hospital services under Michigan Public Acts 321 of 1966, 280 of 1939, and 368 of 1978 is correct. Further, I declare and hereby affirm that I have disclosed to the facility named in section 9 above, the name(s) and address (es) of all parties liable or who may be liable, in whole or in part, for payment of care received in the named facility. By accepting services, I hereby authorize the named facility to release all information and records for purposes of determining the respective liability and / or liabilities of all parties responsible, in whole or in part, for the payment of services received in this facility. I hereby authorize and assign directly to the named facility any or all benefits I may be entitled to and otherwise payable to me for the period of service in this facility.					
24. Signature of Patient's Representative		Date Signed / /		25. Signature of Person Completing This Form	
				Date Signed / /	

STATEMENT OF ELIGIBILITY (To be completed by MDHHS for MA eligibility)

Eligibility is: <input type="checkbox"/> DENIED (Contact Patient Representative for Explanation) <input type="checkbox"/> APPROVED (see the Billing Information below)					
Eligible Person's Name		Program	Grantee Name		
Recipient ID No.	MA Eligibility Effective Date		Grantee Client ID No.		MDHHS Case No.
Patient Pay Amount \$	Patient Pay Amt. Effective Date		County	District	Section
			Unit	Worker Name	
Insurance, Medicare, Third Party Name			Signature of Worker		



I - XXXXXX

RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

NICK LYON
DIRECTOR

GUARANTEE OF PAYMENT FOR PREGNANCY-RELATED SERVICES

**NOTICE TO PRENATAL CARE PROVIDERS
PHARMACY, LABORATORY AND DIAGNOSTIC SERVICES AGENCIES**

Today's Date		Expected Date of Confinement / Due Date	
Beneficiary's Name		Beneficiary's Date of Birth	
Address (Number and Street)	Apt. No.	Medicaid Case Number (if available)	
City, State, ZIP Code		Medicaid Beneficiary ID Number (if available)	

IMPORTANT: All of the above information MUST be completed.

The Michigan Department of Health and Human Services (MDHHS) **GUARANTEES PAYMENT** of the pregnancy-related services listed below for 45 days from the date listed above. This document should be considered as proof of coverage until the beneficiary receives a **mihealth card or a beneficiary ID number**. Michigan Medicaid-covered maternity services and fee screens apply.

Subsequent to the 45 days, MDHHS will continue to provide medical coverage for eligible women through the Maternity Outpatient Medical Services (MOMS) Program or the Michigan Medicaid Program for prenatal care, delivery, and other pregnancy-related services for the duration of the pregnancy. Medically necessary ambulatory postpartum care will be covered for 60 days after the pregnancy ends. Inpatient hospital coverage is limited to delivery-related services only.

Pregnancy-related covered services during the eligibility period include:

- | | |
|---|--|
| 1. Prenatal care | 6. Radiology and Ultrasound |
| 2. Pharmaceuticals and prescription vitamins | 7. Maternal Infant Health Program (MIHP) services until delivery |
| 3. Laboratory | 8. Outpatient hospital care |
| 4. Labor and Delivery – will cover both professional fees and inpatient hospitalization | 9. Childbirth education |
| 5. Postpartum Care through 60 days after the pregnancy ends | 10. Other pregnancy-related care with prior authorization |

If you have questions regarding billing or you are providing a medical service that is not listed above, please refer to page 2 of this letter for instructions on billing and prior authorization procedures.

*If you require this document for your files, please make a copy and return the original to the beneficiary.
Guarantee of payment applies only for providers enrolled in the Michigan Medicaid Program.*

Name of Contact Person		Signature		Date
Phone Number ()				
Name of Issuing Agency				
Agency's Mailing Address (Number and Street)	(Suite)	City	MI	ZIP Code

DISTRIBUTION:

Original: Beneficiary
Copy: Issuing Agency File Copy

Chris Priest, Director
Medical Services Administration

PROVIDER BILLING INSTRUCTIONS

for

GUARANTEE OF PAYMENT FOR PREGNANCY-RELATED SERVICES (DCH-1164)

ELIGIBILITY:

MOMS eligibility may be obtained through the Community Health Automated Medicaid Processing System (CHAMPS) (Eligibility Inquiry and/or 270/271 transaction). MDHHS will issue a beneficiary ID number to be used when billing for services. If the beneficiary receives full Medicaid and enrolls in a Medicaid Health Plan, the health plan's policies and procedures will apply. If you are not a participating provider with the health plan, the beneficiary should be referred to the health plan before services are rendered.

BILLING INSTRUCTIONS:

- Electronic submission of claims is the preferred method for quick and accurate claim reimbursement.
- All services must be billed within one year of the date of service. Pharmacy services should be billed within six months of the date of service.
- Claims must be completed following standard Medicaid billing and reimbursement guidelines contained in the Billing and Reimbursement Chapters of the Medicaid Provider Manual. Claims must be submitted to the same location where you submit your Medicaid Claims.
- Private insurance must be billed first, if applicable.
- This Guarantee of Payment insures the MDHHS will provide coverage for pregnancy related services. You must hold your claim for services provided until the beneficiary receives her **mihealth** card or a beneficiary ID number can be identified in CHAMPS (Eligibility Inquiry and/or 270/271 transaction) with MOMS eligibility, identified with Benefit Plan ID MOMS, for the date of service. You must provide the beneficiary ID number on the claim to receive payment. Do not use the "I" number that appears in the upper right hand corner of the Guarantee of Payment letter.
- MOMS claim adjudication information will be included in the weekly remittance advice, merged alphabetically with Medicaid and other MDHHS-administered programs. The remittance advice is your claim status. If a claim does not appear on a remittance advice within 45 days, the account should be resubmitted for processing. Should you have other questions about your claim, you may contact the Medicaid Provider Inquiry line at 1-800-292-2550 or by e-mail at providersupport@michigan.gov.

All MOMS covered services are subject to the published policies and procedures applicable under the Medicaid program as they relate to health care and claim submission requirements.

PRIOR AUTHORIZATION:

If your service does not meet the definition of pregnancy-related services listed on page one of this letter, or if the service normally requires prior authorization by the Medicaid program, submit your request for authorization, by mail or by fax. Refer to the Directory Appendix in the Medicaid Provider Manual for contact information.

PHARMACY SERVICES:

Pharmacy services provided to MOMS beneficiaries must be billed to the Pharmacy Benefits Manager. Refer to the Michigan Pharmaceutical Product List to identify products that may require prior authorization. To obtain prior authorization, you may write, call or fax your request to the Pharmacy Benefits Manager. Refer to the Directory Appendix in the Medicaid Provider Manual for contact information.

Pharmacies who provide MOMS services, when presented with this Guarantee of Payment letter (DCH-1164), have the option of billing the Pharmacy Benefits Manager as indicated below:

- A. Pharmacies will need to hold the electronic claim (electronic preferred) until MOMS eligibility, identified with Benefit Plan ID MOMS, is in CHAMPS (Eligibility Inquiry and/or 270/271 transaction) for the date of service. Then bill the Pharmacy Benefits Manager via the on-line system, if the electronic claim is used.
- B. Submit the appropriate HIPAA compliant National Council for Prescription Drug Programs (NCPDP) electronic claim or submit a Universal Claim Form, along with a copy of the Letter, to the Pharmacy Benefits Manager per the instructions in their manual.
- C. Pharmacies will need to hold the electronic claim until MOMS eligibility, identified with Benefit Plan ID MOMS, is in CHAMPS (Eligibility Inquiry and/or 270/271 transaction) for the date of service and obtain a copy of the Guarantee of Payment letter (DCH-1164) as proof of coverage in order to fill the prescription(s).

<p>AUTHORITY: Title XIX of the Social Security Act COMPLETION: Is Voluntary, but is required if Medical Assistance program payment is desired.</p>	<p>The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.</p>
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**MEDICAID ENROLLED BIRTHING HOSPITAL AGREEMENT FOR
ELECTIVE, NON-MEDICALLY INDICATED DELIVERY PRIOR TO 39 WEEKS COMPLETED GESTATION**

Instructions for MSA-1755

The Medicaid Enrolled Birthing Hospital Agreement for Elective, Non-Medically Indicated Delivery Prior to 39 Weeks Completed Gestation form (MSA-1755) is to be completed by all Medicaid enrolled birthing hospitals in the State of Michigan.

The purpose of this form is to serve as an attestation that each Medicaid enrolled birthing hospital utilizes evidence-based guidelines (EBGs) to address elective, non-medically indicated delivery prior to 39 weeks completed gestation for Medicaid beneficiaries.

To complete the form, hospitals must indicate whether they have elective delivery EBGs in place. If the hospital utilizes guidelines that are not listed on the form, hospitals may use the space provided on the form to explain. Hospitals may also submit copies of their elective delivery policies.

The form must be signed by both the Chief Executive Officer (CEO) and the Chief Medical Officer (CMO) of the facility.

The completed MSA-1755 must be mailed or faxed to:

Attn: Inpatient Hospital Policy
Michigan Department of Health and Human Services
Medical Services Administration, Program Policy Division
PO Box 30479
Lansing, Michigan 48909-7979
Fax: (517) 335-5136

Questions should be directed to Provider Support at ProviderSupport@michigan.gov.

MEDICAID ENROLLED BIRTHING HOSPITAL AGREEMENT FOR ELECTIVE, NON-MEDICALLY INDICATED DELIVERY PRIOR TO 39 WEEKS COMPLETED GESTATION

The purpose of this agreement is to certify that Medicaid enrolled birthing hospitals utilize evidence-based guidelines (EBGs) to address elective, non-medically indicated delivery prior to 39 weeks completed gestation for Medicaid beneficiaries.

NOTE: This agreement must be signed by both the Chief Executive Officer (CEO) and the Chief Medical Officer (CMO) of the facility.

Complete the following:

Hospital Name

National Provider Identifier

attests that the following elective delivery EBGs are utilized:

- | <u>Yes</u> | <u>No</u> | (Indicate Yes or No for each statement) |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Medical indications for elective, non-medically indicated delivery prior to 39 weeks completed gestation are defined in hospital policy. |
| <input type="checkbox"/> | <input type="checkbox"/> | Hospital staff is not authorized to schedule an elective, non-medically indicated delivery prior to 39 weeks completed gestation. |
| <input type="checkbox"/> | <input type="checkbox"/> | Providers are required to obtain permission from physician leadership (e.g., the head of the obstetrics department) before performing an elective, non-medically indicated delivery prior to 39 weeks completed gestation. |
| <input type="checkbox"/> | <input type="checkbox"/> | Provider education materials are used to educate providers on the risks of elective, non-medically indicated delivery prior to 39 weeks completed gestation. |
| <input type="checkbox"/> | <input type="checkbox"/> | Patient education materials are used to educate patients on the risks of elective, non-medically indicated delivery prior to 39 weeks completed gestation. |
| <input type="checkbox"/> | <input type="checkbox"/> | Hospital involvement in an initiative that addresses elective, non-medically indicated delivery prior to 39 weeks completed gestation (e.g., Michigan Health & Hospital Association [MHA] Keystone Center's initiative in obstetrics, Trinity Health System's Perinatal Patient Safety Initiative [PPSI], Ascension Health System's Handling All Neonatal Deliveries Safely [HANDS]). |
| <input type="checkbox"/> | <input type="checkbox"/> | Other. Explain in the space provided below. If more space is needed, attach explanation on a separate document. |

Along with this completed agreement, MDHHS will also accept a copy of each facility's elective delivery policy.

I certify that the responses in this attestation agreement are accurate, complete and current as of the date signed.

Signature of Chief Executive Officer

Signature of Chief Medical Officer

PRINT Name of CEO

PRINT Name of CMO

Telephone Number

Date

Telephone Number

Date

AUTHORITY: Title XIX of the Social Security Act	Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.
COMPLETION: Is Required.	

CSHCS MEDICAL ELIGIBILITY REPORT

Instructions for Form MSA-4114

Purpose:

This form is used to determine if an individual is medically eligible for the Children's Special Health Care Services (CSHCS) program. The condition must require the services of a medical and/or surgical sub-specialist at least annually, as opposed to being managed exclusively by a primary care physician. A current list of covered diagnoses is maintained on the MDHHS website at www.michigan.gov/mdhhs. In addition, some diagnoses must meet severity or chronicity criteria (e.g. asthma).

This form should be completed for the following persons:

- Anyone **UNDER 21** years of age with a potentially eligible condition. Psychiatric, emotional and behavioral disorders, attention deficit disorder, developmental delay, intellectual disability, autism, or other mental health diagnoses are **not** conditions covered by the CSHCS program.
- Anyone, regardless of age, with cystic fibrosis or hereditary coagulation defects commonly known as hemophilia.

Completion Instructions:

- Read this instruction page thoroughly. Then separate attached forms.
- **TYPE** or **PRINT** clearly in INK.
- The **Physician's Signature** (or the Attending Physician if a Hospital) and the **Date Signed** are **REQUIRED**.
- Attach supporting medical documentation.
- If desired, make a photocopy for your records.
- **FAX** the completed form to **the CSHCS Division at 517-335-9491**.

Other Information:

- If this request is approved, the client is medically eligible for the CSHCS program.
- For actual program coverage, the client or the client's family **MUST APPLY** to join the CSHCS program by completing form **MSA-0737, APPLICATION FOR CHILDREN'S SPECIAL HEALTH CARE SERVICES**.
- If the family does **NOT** receive an application after notification of approval, call **1-800-359-3722**.

For questions and/or problems, or help to translate, call the Beneficiary Help Line at 1-800-642-3195 (TTY 1-866-501-5656).
Spanish: Si necesita ayuda para traducir o entender este texto, por favor llame al telefono **1-800-642-3195** (TTY 1-866-501-5656)
Arabic: 1-800-642-3195 (TTY 1-866-501-5656)

إذا كان لديكم أي سؤال، يرجى الإتصال بخط المساعدة على الرقم المجاني ١-٨٠٠-٦٤٢-٣١٩٥

AUTHORITY: Title V of the Social Security Act
COMPLETION: Completion is voluntary, but is required if coverage under the Children's Special Health Care Services program is desired.

The Department of Health and Human Services is an equal opportunity employer, services and programs provider.

MEDICAL ELIGIBILITY REPORT

CLIENT INFORMATION:

CLIENT'S Name (Last, First, Middle)			Date of Birth	Sex <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
CLIENT'S Address (Number, Apt. No., Lot No.)			Social Security Number	HOME Phone Number () -
City	State	ZIP Code	County	WORK Phone Number () -
Does client have other health insurance? (Co. Name): <input type="checkbox"/> NO <input type="checkbox"/> YES			Is client enrolled in Medicaid? (Medicaid ID No.): <input type="checkbox"/> NO <input type="checkbox"/> YES	
Racial/ Ethnic Heritage (Check all that apply) (You are not required to complete this information.) <input type="checkbox"/> Alaska Native <input type="checkbox"/> American Indian <input type="checkbox"/> Arabic <input type="checkbox"/> Asian <input type="checkbox"/> African American/Black <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Multi-racial/Ethnic <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other:				

PARENT(S) OR LEGALLY RESPONSIBLE PARTY INFORMATION: (Check appropriate boxes and complete information.)

<input type="checkbox"/> FATHER or <input type="checkbox"/> LEGALLY RESPONSIBLE PARTY Name			<input type="checkbox"/> MOTHER or <input type="checkbox"/> LEGALLY RESPONSIBLE PARTY Name		
Street Address (if different from client's)			Street Address (if different from client's)		
City	State	ZIP Code	City	State	ZIP Code
Social Security Number	Relationship to Client		Social Security Number	Relationship to Client	
HOME Phone Number () -	WORK Phone Number () -		HOME Phone Number () -	WORK Phone Number () -	

CLIENT MEDICAL NEEDS INFORMATION:

DIAGNOSIS (If Newborn, give birth weight) Primary:	Other:	
SEVERITY/COMPLICATIONS/CHRONICITY		
HISTORY		
TREATMENT PLAN (Include names of specialists involved, and any special needs such as surgery, medications, supplies, therapies, equipment)		
What care will this client need? <input type="checkbox"/> HOSPITAL <input type="checkbox"/> HOME CARE <input type="checkbox"/> Other (explain) -	Requested Coverage Begin Date	
PROGNOSIS:		
HOSPITAL Name	Hospital Case Record Number	
Hospital Contact Person (Name and Title)	Hospital Phone Number () -	
PHYSICIAN'S Name (Print)	Physician's Phone Number () -	
Physician's Address (Number and Street)	Physician's Signature (REQUIRED)	Date Signed
City	State	ZIP Code

For CSHCS Use Only

<input type="checkbox"/> APPROVED - The client must now complete enrollment process for coverage. This client is medically eligible for the CSHCS Program for diagnosis code(s): _____	
<input type="checkbox"/> DISAPPROVED - This client is NOT medically eligible for the CSHCS Program. Reason: _____	
<input type="checkbox"/> Eligible for diagnostic evaluation at: _____	
<input type="checkbox"/> Pending / Other:	CSHCS Signature _____ Date _____

MENTAL ILLNESS/INTELLECTUAL/DEVELOPMENTAL DISABILITY/RELATED CONDITION EXEMPTION CRITERIA CERTIFICATION

Michigan Department of Health and Human Services
(For Use in Claiming Exemption Only)
Level II Screening

INSTRUCTIONS:

- Must be completed, signed and dated by a nurse practitioner, physician's assistant or physician.
- The patient being screened shall require a comprehensive LEVEL II evaluation UNLESS any of the exemption criteria below is met and certified by a physician's assistant, nurse practitioner or physician. Indicate which exemption applies.

Patient Name	Date of Birth	
Name of Referring Agency	Referring Agency Telephone Number	
Referring Agency Address (Number, Street, Building, Suite Number, etc.)		
City	State	Zip Code

Exemption Criteria

- COMA:** **Yes,** I certify the patient under consideration is in a coma/persistent vegetative state.
- DEMENTIA:** **Yes,** I certify the patient under consideration has dementia as established by clinical examination and evidence of meeting ALL 5 criteria below.
- Yes,** I certify the patient under consideration does not have another primary psychiatric diagnosis of a serious mental illness.
- Yes, I certify the patient under consideration does not have an intellectual disability, developmental disability or a related condition.**

Specify the type of dementia:

1. Has demonstrable evidence of impairment in short-term or long-term memory as indicated by the inability to learn new information or remember three objects after five minutes, and the inability to remember past personal information or facts of common knowledge.
2. Exhibits at least one of the following:
 - Impairment of abstract thinking, as indicated by the inability to find similarities and differences between related words; has difficulty defining words, concepts and similar tasks.
 - Impaired judgment, as indicated by inability to make reasonable plans to deal with interpersonal, family and job-related issues.
 - Other disturbances of higher cortical function, i.e., aphasia, apraxia and constructional difficulty.
 - Personality change: altered or accentuated premorbid traits.
3. Disturbances in items 1 or 2 above significantly interfere with work, usual activities or relationships with others.
4. The disturbance has NOT occurred exclusively during the course of delirium.

Patient Name	Date of Birth
--------------	---------------

5. **EITHER:**

- a. Medical history, physical exam and/or lab tests show evidence of a specific organic factor judged to be etiologically related to the disturbance, **OR**
- b. An etiologic organic factor is presumed in the absence of such evidence if the disturbance cannot be accounted for by any non-organic mental disorder.

HOSPITAL EXEMPTED DISCHARGE:

Yes, I certify that the patient under consideration:

1. is being admitted after an inpatient medical hospital stay, **AND**
2. requires nursing facility services for the condition for which he/she received hospital care, **AND**
3. is likely to require less than 30 days of nursing services.

Physician/Physician Assistant/Nurse Practitioner Signature and Credentials	Date
--	------

Name (Typed or Printed)	Telephone Number
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AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, however, if NOT completed, Medicaid will not reimburse the nursing facility.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

COPY DISTRIBUTION: **ORIGINAL-** Nursing Facility retains in Patient file
COPY - Attach to form DCH-3877 and send to Local Community Mental Health Services Program (CMHSP)
COPY - Patient Copy or Legal Representative

INSTRUCTIONS FOR COMPLETING LEVEL II SCREENING

The **DCH-3878** is to be used ONLY when the individual identified on a **DCH-3877, Preadmission Screening (PAS)/Annual Resident Review (ARR)** as needing a LEVEL II evaluation meets one of the specified exemptions from LEVEL II screening. If the individual under consideration meets one of the following exemptions, he/she may be admitted or retained at a nursing facility without additional evaluation. However, a completed copy of the DCH-3878 must be attached to the **DCH-3877** and sent to the local Community Mental Health Services Program (CMHSP).

Must be completed, signed and dated by a nurse practitioner, physician's assistant or physician.

Complete the following information to match the **DCH-3877**: Patient Name, DOB, and Referring Agency (including agency address and telephone number).

Use an "X" to indicate which exemption applies to the individual under consideration.

DEMENTIA:

- Review the 5 criteria listed under the dementia exemption category. Do NOT check this exemption unless the individual meets all 5 criteria. Any individual who meets some, but not all 5 criteria will be subject to a LEVEL II evaluation. If the individual under consideration meets this exemption category, specify the type of dementia.
- Do not mark the Dementia Exemption if there is a primary diagnosis of a serious mental illness. Do not mark Dementia Exemption if there is a diagnosis of intellectual disability, developmental disability or a related condition.

Dementia diagnoses include the following:

1. Dementia of the Alzheimer's Type
2. Vascular Dementia
3. Dementia due to Other General Medical Conditions
4. Substance - Induced Persisting Dementia
5. Dementia Not Otherwise Specified
6. Lewy Body Dementia

Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices Completion Instructions

This form should be completed for **NEW** or **REPLACEMENT** mobility device(s) and seating systems. It must be submitted with the **Complex Seating and Mobility Device Prior Approval - Request/Authorization (MSA-1653-D)**. The evaluation and justification must be submitted within **90 days** of the date the evaluation was completed.

The appropriate Addendum(s) must accompany the **MSA-1656 & MSA-1653-D**.

BENEFICIARY INFORMATION: Complete beneficiary name, date of birth, sex, **mihealth** number, ordering physician and physician specialty. The beneficiary name and **mihealth** number must be entered at the top of each subsequent page.

SECTIONS 1 THROUGH SECTION 11 MUST BE COMPLETED BY A LICENSED/CERTIFIED MEDICAL PROFESSIONAL.

NOTE: A licensed/certified medical professional means an occupational or physical therapist, a physiatrist or rehabilitation RN who has at least two years' experience in rehabilitation seating; and is not an employee of, or affiliated in any way with, the Medical Supplier with the exception of hospitals with integrated delivery models that include the supplier of the equipment and the provider of the clinical evaluation. A PTA or OTA may not evaluate for, complete or sign this document.

SECTION	INSTRUCTIONS														
1	Indicate the beneficiary name, mihealth number, ordering/referring physician name, specialty and National Provider Identifier (NPI).														
2	Medical history is used to gather information in regards to the beneficiary's physical status and progression of disease. Estimate weight if unable to weigh at time of evaluation. The acronym "WFL" means "within functional limits."														
3	Home Environment questions reflect the current setting in which the beneficiary lives.														
4	Community Activities of Daily Living (ADL) reflects the beneficiary's transportation situation to the community and/or school, if applicable. Indicate if the mobility equipment fits into the vehicle and if the family can lift the mobility equipment into a vehicle.														
5	This information reflects the need for pressure relief. If the beneficiary has current decubiti, the evaluator should indicate the stage as defined by the National Pressure Ulcer Advisory Panel (NPUAP) at www.npuap.org .														
6	Mandatory for all requests. Describes the beneficiary's ADL functional ability without mobility devices. The acronym "UE" means "upper extremity." Answer the items regarding visual perception, problem solving and comprehension only if requesting a power mobility item.														
7	<p>Evaluation includes measurements of the beneficiary. Relevant measures include adjustments for clothing. Complete the Manual Muscle Test (MMT) for hand only if requesting a power mobility item. This measurement should be of the appropriate hand/digits that will be used to operate specialty controllers.</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; width: 50%;">Modified Ashworth Scale</th> <th style="text-align: left; width: 50%;">Manual Muscle Evaluation</th> </tr> </thead> <tbody> <tr> <td>0 No increase in muscle tone</td> <td>100% 5 N Normal Complete ROM against gravity with full resistance</td> </tr> <tr> <td>1 Slight increase in muscle tone, manifested by a catch and release or by minimal resistance at the end of the range of motion when the attached part is moved in flexion or extension</td> <td>75% 4 G Good Complete ROM against gravity with some resistance</td> </tr> <tr> <td>1+ Slight increase in muscle tone, manifested by a catch, followed by minimal resistance throughout the remainder (less than half) of the ROM</td> <td>50% 3 F Fair Complete ROM against gravity</td> </tr> <tr> <td>2 More marked increase in muscle tone through most of the ROM, but affected part easily moved</td> <td>25% 2 P Poor Complete ROM with gravity eliminated</td> </tr> <tr> <td>3 Considerable increase in muscle tone, passive movement difficult</td> <td>10% 1 T Trace Evidence of contractibility but no joint motion</td> </tr> <tr> <td>4 Affected part rigid in flexion or extension</td> <td>0% 0 O Zero No evidence of contractility</td> </tr> </tbody> </table> <p style="text-align: center;">C = Complete; IC = Incomplete; * = Pain</p> <p>H = Hypotonia O = Observation</p>	Modified Ashworth Scale	Manual Muscle Evaluation	0 No increase in muscle tone	100% 5 N Normal Complete ROM against gravity with full resistance	1 Slight increase in muscle tone, manifested by a catch and release or by minimal resistance at the end of the range of motion when the attached part is moved in flexion or extension	75% 4 G Good Complete ROM against gravity with some resistance	1+ Slight increase in muscle tone, manifested by a catch, followed by minimal resistance throughout the remainder (less than half) of the ROM	50% 3 F Fair Complete ROM against gravity	2 More marked increase in muscle tone through most of the ROM, but affected part easily moved	25% 2 P Poor Complete ROM with gravity eliminated	3 Considerable increase in muscle tone, passive movement difficult	10% 1 T Trace Evidence of contractibility but no joint motion	4 Affected part rigid in flexion or extension	0% 0 O Zero No evidence of contractility
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SECTION	INSTRUCTIONS	
	If evaluator is not able to test beneficiary due to cognition, age, etc., then information for MMT can be based on observation (not on self-report).	
8	Check all items that apply for mobility goals. Section is to be used if evaluator has any other comments to establish medical need, functional goals, etc.	
9	Evaluator should list all equipment the beneficiary currently owns or uses. Include brand, model, serial number, description and date of purchase/rental.	
10	To be completed if beneficiary is in a nursing facility. This section should be completed and signed by the Director of Nursing, Facility Administrator or Ordering/referring Physician. This page must accompany the MSA-1653-D and appropriate Addendum(s) when submitting to the MDHHS Program Review Division.	
11	To be completed by the evaluator and, if applicable, all team members involved in the evaluation. Enter date of evaluation, evaluator's name, title, telephone number, place of employment and address. If team evaluation, in Section 11, list all participants and titles (attach additional pages if necessary). The attestation page must accompany the MSA-1653-D and appropriate Addendum(s) when submitting to the Michigan Department of Health and Human Services (MDHHS) Program Review Division.	
Notes	The applicable addendums must accompany the MSA-1656 & MSA-1653-D when requesting the authorization. Failure to include the appropriate addendum(s) may cause a delay in the authorization process.	
	Addendum A: To be completed when requesting new or replacement manual wheelchairs with accessories, power mobility devices, and/or seating systems.	Addendum B: To be completed when requesting new or replacement strollers, standers, gait trainers and children's positioning chairs.
	Note: For beneficiaries residing in a nursing facility, return the completed MSA-1656, addendum(s) and MSA-1653-D to the requesting nursing facility. For beneficiaries in the community, the MSA-1656, addendum(s) and MSA-1653-D are forwarded to the ordering physician for their review.	

SUBMIT TO:

**Michigan Department of Health and Human Services
Program Review Division
PO Box 30170
Lansing, Michigan 48909**

Fax: (517) 335-0075

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable.

The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.

Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices

This form must be completed by physical therapist, occupational therapist, physiatrist, or rehabilitation registered nurse. Incomplete information will result in the form being returned to the evaluator for completion.

SECTION 1: BENEFICIARY INFORMATION

Beneficiary Name: _____	mihealth Number: _____
Ordering/Referring Physician: _____	NPI: _____
Physician Specialty: _____	

SECTION 2: MEDICAL HISTORY

Primary Diagnosis: _____	Secondary Diagnosis: _____
Onset date: _____	Onset date: _____
If spinal cord injury or spina bifida indicate the level of injury/impairment: _____	
Relevant past and future surgeries: _____	
Bowel Mgmt: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Colostomy (Indicate type): _____	
Bladder Mgmt: <input type="checkbox"/> Continent <input type="checkbox"/> Incontinent <input type="checkbox"/> Catheter (Indicate type): _____	
Cardio Status: <input type="checkbox"/> WFL <input type="checkbox"/> Impaired Neuro Status: Seizures <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, Frequency/Duration: _____ / _____	Respiratory Status: <input type="checkbox"/> WFL <input type="checkbox"/> Impaired
Baclofen pump present? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, date Implanted: _____ Botox? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, date of last injection: _____ Other explain: _____	Sip 'N Puff controller requested? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, additional information maybe be required: _____
Height: _____ Weight: _____ Explain recent changes or trends in weight: _____	
List medication(s) currently prescribed: _____	
How does the management or severity of the above conditions/impairments affect the need for the equipment requested? _____	

SECTION 3: HOME ENVIRONMENT

Beneficiary resides in: House Condo/town home Apartment Assisted Living /AFC/Group Home Nursing Facility

Does beneficiary live alone? YES NO If NO, does beneficiary have a caregiver? YES NO

If YES, who provides the care? Family member RN LPN Other (explain) _____

How many hours per day are provided by the caregiver? _____

SECTION 4: COMMUNITY ADL (Transportation)

What is the beneficiary's mode of transportation? (Check all that apply.)

Car Van/SUV Van w/ Lift Truck Taxi Cab Bus School Bus Ambulance Other _____

Does the beneficiary attend school or work? YES NO

Is the beneficiary transported in the current or requested wheelchair? YES NO If NO, explain why the beneficiary cannot be transported in the current or requested chair? _____

Explain: _____

SECTION 5: SENSATION AND SKIN ISSUES

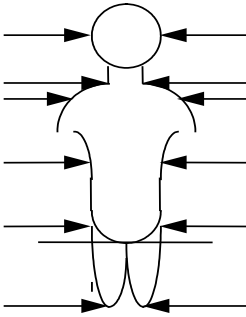
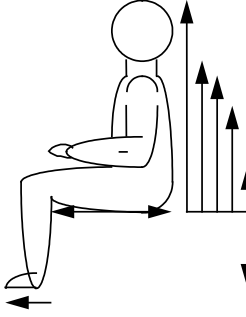
Sensation <input type="checkbox"/> Intact <input type="checkbox"/> Impaired <input type="checkbox"/> Absent <input type="checkbox"/> Hypersensitive	Pressure Relief <input type="checkbox"/> Dependent <input type="checkbox"/> Independent <input type="checkbox"/> Type of assistance needed How does the beneficiary perform pressure relief? _____	Does beneficiary have a history of skin decubiti and/or flap surgery? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, indicate location: _____
Does beneficiary have a current decubiti? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, describe: _____	Does beneficiary have other skin issues? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, describe: _____	

SECTION 6: MOBILITY ASSESSMENT (Mandatory for all requests)

Functional Ability Without Mobility Device(s)																																																								
Sitting: <table style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">Static</td> <td style="text-align: center;">Dynamic</td> </tr> <tr> <td>WFL</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Uses UE for balance</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Contact guard assist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Standby assist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Minimum assist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Moderate assist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Maximum assist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Dependent/unable</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		Static	Dynamic	WFL	<input type="checkbox"/>	<input type="checkbox"/>	Uses UE for balance	<input type="checkbox"/>	<input type="checkbox"/>	Contact guard assist	<input type="checkbox"/>	<input type="checkbox"/>	Standby assist	<input type="checkbox"/>	<input type="checkbox"/>	Minimum assist	<input type="checkbox"/>	<input type="checkbox"/>	Moderate assist	<input type="checkbox"/>	<input type="checkbox"/>	Maximum assist	<input type="checkbox"/>	<input type="checkbox"/>	Dependent/unable	<input type="checkbox"/>	<input type="checkbox"/>	Standing: <table style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">Static</td> <td style="text-align: center;">Dynamic</td> </tr> <tr> <td>WFL</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Uses UE for balance</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Contact guard assist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Standby assist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Minimum assist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Moderate assist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Maximum assist</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Dependent/unable</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		Static	Dynamic	WFL	<input type="checkbox"/>	<input type="checkbox"/>	Uses UE for balance	<input type="checkbox"/>	<input type="checkbox"/>	Contact guard assist	<input type="checkbox"/>	<input type="checkbox"/>	Standby assist	<input type="checkbox"/>	<input type="checkbox"/>	Minimum assist	<input type="checkbox"/>	<input type="checkbox"/>	Moderate assist	<input type="checkbox"/>	<input type="checkbox"/>	Maximum assist	<input type="checkbox"/>	<input type="checkbox"/>	Dependent/unable	<input type="checkbox"/>	<input type="checkbox"/>	Transfers: <input type="checkbox"/> Independent <input type="checkbox"/> Type of assistance needed: How does beneficiary transfer: <input type="checkbox"/> Pivot <input type="checkbox"/> Sliding <input type="checkbox"/> Mechanical Lift <input type="checkbox"/> Other: (Explain)
	Static	Dynamic																																																						
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Ambulation within 1 minute: <input type="checkbox"/> Independent > or = 150 ft. <input type="checkbox"/> Unable to ambulate <input type="checkbox"/> Ambulates with assist > or = 150 ft. <input type="checkbox"/> Limited due to endurance - Explain: Explain type of assistance: <input type="checkbox"/> Ambulates with device > or = 150 ft. <input type="checkbox"/> Ambulates short distance only ____ ft. Explain how this affects equipment ordered?																																																								
Complete only if power mobility item is requested (e.g., power wheelchair, scooter, power assisted wheels, etc.)																																																								
Visual perception: Has visual acuity and perception that permits safe and independent operation of the equipment requested. <input type="checkbox"/> YES <input type="checkbox"/> NO																																																								
Problem solving: Has problem solving skills appropriate to operate requested power mobility item. If beneficiary is unable, who will complete? Explain: <input type="checkbox"/> YES <input type="checkbox"/> NO																																																								
Comprehension: Understands and is able to follow directions and conversations that are complex or abstract; understands either spoken or written language. If NO, explain: <input type="checkbox"/> YES <input type="checkbox"/> NO																																																								

SECTION 7: MODIFIED ASHWORTH SCALE AND MANUAL MUSCLE EVALUATION INFORMATION

See Form Completion Instructions for Modified Ashworth Scale and Manual Muscle Evaluation.

Width at the: 	Height: 	<table style="width:100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;">L</td> <td style="text-align: center;">R</td> </tr> <tr> <td>Crown:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Occiput:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Shoulder:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Axilla:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Elbow:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Seat Depth:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Leg Length:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Foot Length:</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </table>		L	R	Crown:	_____	_____	Occiput:	_____	_____	Shoulder:	_____	_____	Axilla:	_____	_____	Elbow:	_____	_____	Seat Depth:	_____	_____	Leg Length:	_____	_____	Foot Length:	_____	_____
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Foot Length:	_____	_____																											
Primitive reflexes present: <input type="checkbox"/> Asymmetrical Tonic Neck Reflex <input type="checkbox"/> Symmetrical Tonic Neck Reflex <input type="checkbox"/> Startle Reflex <input type="checkbox"/> Other; Explain:	Explain how this relates to equipment ordered:																												

Head & Neck	<input type="checkbox"/> Maintains upright without support <input type="checkbox"/> Rotated	<input type="checkbox"/> Maintains upright with support <input type="checkbox"/> Laterally Flexed	<input type="checkbox"/> Flexed <input type="checkbox"/> Cervical Hyperextension	<input type="checkbox"/> Extended <input type="checkbox"/> Absent head control
	ROM (Range of Motion) <input type="checkbox"/> AROM <input type="checkbox"/> AAROM <input type="checkbox"/> PROM	MMT/O (Manual Muscle) <input type="checkbox"/> Test <input type="checkbox"/> Observation	TONE	Explain how this affects equipment ordered:
	Left Right	Left Right		
Shoulder	_____ Flexion _____ _____ Abduction _____ _____ Internal Rotation _____ _____ External Rotation _____	_____ Flexion _____ _____ Abduction _____ _____ Internal Rotation _____ _____ External Rotation _____	<input type="checkbox"/> Normal <input type="checkbox"/> Hypertonia Modified Ashworth Scale: _____ <input type="checkbox"/> Hypotonia	
Elbow	_____ Flexion _____ _____ Extension _____ _____ Pronation _____ _____ Supination _____	_____ Flexion _____ _____ Extension _____ _____ Pronation _____ _____ Supination _____	<input type="checkbox"/> Normal <input type="checkbox"/> Hypertonia Modified Ashworth Scale: _____ <input type="checkbox"/> Hypotonia	
Wrist	_____ Flexion _____ _____ Extension _____	_____ Flexion _____ _____ Extension _____	<input type="checkbox"/> Normal <input type="checkbox"/> Hypertonia Modified Ashworth Scale: _____ <input type="checkbox"/> Hypotonia	
Hand	_____ Grip Strength _____ _____ Pinch Strength _____			
Knee	_____ Flexion _____ _____ Extension _____	_____ Flexion _____ _____ Extension _____	<input type="checkbox"/> Normal <input type="checkbox"/> Hypertonia Modified Ashworth Scale: _____ <input type="checkbox"/> Hypotonia	
Ankle & Foot	_____ Dorsiflexion _____ _____ Plantarflexion _____ _____ Inversion _____ _____ Eversion _____	_____ Dorsiflexion _____ _____ Plantarflexion _____ _____ Inversion _____ _____ Eversion _____	<input type="checkbox"/> Normal <input type="checkbox"/> Hypertonia Modified Ashworth Scale: _____ <input type="checkbox"/> Hypotonia <input type="checkbox"/> Clonus: <input type="checkbox"/> Left <input type="checkbox"/> Right	

SECTION 8: GOALS

Check all that apply.

- Independence with mobility in the home and mobility related activities of daily living (MRADLs) in the community (independence is - no help or oversight provided, and has physically demonstrated independence in operating requested equipment)
- Assisted mobility/occasional assistance with wheelchair propulsion (e.g., verbal cueing, pushing up a ramp or onto a bus, over curbs, etc.)
- Dependent mobility
- Optimize pressure relief
- Proper positioning and/or correction of a physiological condition. Explain: _____
- Other: (Explain) _____

SECTION 9: LIST TYPE OF EQUIPMENT PRESENTLY OWNED OR USED BY THE BENEFICIARY

Brand	Model	Serial Number	Description	Date of Purchase

Beneficiary Name: _____ mihealth Number: _____

SECTION 10: MOBILITY ASSESSMENT - FOR BENEFICIARIES IN A NURSING FACILITY ONLY

This section is to be completed by the Nursing Facility Director of Nursing, Nursing Facility Administrator or ordering/referring physician.

Nursing Facility Name:	NPI:	Date of Admission:
Mobility History: <input type="checkbox"/> Uses nursing facility per diem chair	<input type="checkbox"/> Uses own personal chair	
Wheelchair Description: (Currently used or owned)	Brand:	Model No:
Components:	Serial No:	

Customized Wheelchair Documentation (Required documentation to accompany this form)

- Most Recent MDS Past Two Months of Nursing Notes Current Plan of Care that relates to the equipment ordered

Director of Nursing Signature Date

Print Name

Ordering Physician Signature Date

Print Name

SECTION 11: EVALUATOR (PT, OT, PHYSIATRIST OR REHAB RN) ATTESTATION AND SIGNATURE/DATE

I certify that I conducted the evaluation and have completed the information presented in Sections 1 - 9, and that there is no financial arrangement with the selected durable medical equipment provider and/or the evaluating clinician. I certify that the equipment requested is the most economical alternative that meets the beneficiary's basic medical and functional needs. I certify that the information contained in this form is true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Enter Date Here
Evaluation Date

Enter Text Here

Evaluator Name/Title (Print)

Enter Text Here

Place of Employment and Address

NPI Phone Number

Evaluator Signature Date

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable.

The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.

**Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices
Addendum A: Mobility/Seating**

This form must be completed by a physical therapist, occupational therapist, physiatrist, or rehabilitation registered nurse. The evaluator must complete requested and/or current equipment, warranty information and economic alternative information.

NOTE: Only complete sections that apply to the requested equipment/accessories.

Incomplete information will result in the form being returned to the evaluator for completion.

Beneficiary Name: _____ Mihealth Number: _____

SECTION(s)	<input type="checkbox"/> Requested	<input type="checkbox"/> Current <input type="checkbox"/> None
Manual wheelchair with accessory add-ons.	<input type="checkbox"/> Propels a wheelchair 60 feet, turns around, maneuvers the chair to a table, bed, toilet, negotiates at least a 3% grade, maneuvers on rugs and over door sills <input type="checkbox"/> Cannot propel manual wheelchair without caregiver assist. <input type="checkbox"/> Cannot propel manual wheelchair, used for transport only. <input type="checkbox"/> Medical reason for power assisted wheels: Chair width _____ inches. Chair depth _____ inches. <input type="checkbox"/> Tilt <input type="checkbox"/> Tilt & Recline Medical reasons for function indicated: Hours of continuous wheelchair use per day: <input type="checkbox"/> > 4 hours <input type="checkbox"/> < 4hours; if < 4 hours, how many? _____	Specify brand, model and serial numbers, age of current base: Chair width _____ inches. Chair depth _____ inches. Length of warranty: _____ Warranty begin date: _____ Where will requested device be used? (i.e., home, school, community)
Power wheelchair with standard joystick	<input type="checkbox"/> Able to propel manual wheelchair _____ feet. <input type="checkbox"/> YES <input type="checkbox"/> NO Beneficiary is able to drive a power wheelchair independently _____ feet, turns around, maneuvers the chair to a table, bed, toilet, negotiates at least a minimum of a 3% grade, maneuvers on rugs and over door sills. If NO, explain: Chair width _____ inches. Chair depth _____ inches. Power functions requested: (Check all that apply.) <input type="checkbox"/> Recline <input type="checkbox"/> Elevating seat <input type="checkbox"/> Center mount elevating leg rests <input type="checkbox"/> Tilt <input type="checkbox"/> Tilt & Recline <input type="checkbox"/> Elevating leg rests <input type="checkbox"/> YES <input type="checkbox"/> NO Able to perform, manipulate or work all seat functions without assistance? <input type="checkbox"/> YES <input type="checkbox"/> NO Requires verbal and/or physical assistance to manipulate seat functions? <input type="checkbox"/> YES <input type="checkbox"/> NO Has pressure relief plan of care with equipment? If YES, (explain) _____ Hours of continuous wheelchair use per day: <input type="checkbox"/> > 4 hours <input type="checkbox"/> < 4hours; if < 4 hours, how many? _____	Specify brand, model and serial numbers, age of current base: Chair width _____ inches. Chair depth _____ inches. Length of warranty: _____ Warranty begin date: _____ Where will requested device be used? (i.e., home, school, community) Manual functions requested: <input type="checkbox"/> Tilt <input type="checkbox"/> Tilt & Recline

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	<input type="checkbox"/> Requested	<input type="checkbox"/> Current <input type="checkbox"/> None
Equipment	Beneficiary's ability to use	
Power wheelchair with alternate controls	<p><input type="checkbox"/> Able to propel manual wheelchair _____ feet.</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO Beneficiary is able to drive a power wheelchair independently _____ feet, turns around, maneuvers the chair to a table, bed, toilet, negotiates at least a minimum of a 3% grade, maneuvers on rugs and over door sills.</p> <p style="margin-left: 20px;">If NO, please explain:</p> <p>Chair width _____ inches. Chair depth _____ inches.</p> <p>Power functions requested: <i>(Check all that apply.)</i></p> <p><input type="checkbox"/> Recline <input type="checkbox"/> Elevating seat <input type="checkbox"/> Center mount elevating leg rests</p> <p><input type="checkbox"/> Tilt <input type="checkbox"/> Tilt & Recline <input type="checkbox"/> Elevating leg rests</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO Able to perform, manipulate or work all seat functions without assistance?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO Requires verbal and/or physical assistance to manipulate seat functions?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO Has pressure relief plan of care with equipment?</p> <p>Explain:</p> <p>Specify control needed:</p> <p>Medical need for control indicated:</p> <p>Indicate the beneficiary's ability to use in their environment:</p> <p>Hours of continuous wheelchair use per day: <input type="checkbox"/> > 4 hours <input type="checkbox"/> < 4hours; if < 4 hours, how many? _____</p>	<p>Specify brand, model and serial numbers, age of current base:</p> <p>Chair width _____ inches. Chair depth _____ inches.</p> <p>Length of warranty: _____</p> <p>Warranty begin date: _____</p> <p>Where will requested device be used? <i>(i.e., home, school, community)</i></p> <p>Manual functions requested:</p> <p><input type="checkbox"/> Tilt <input type="checkbox"/> Tilt & Recline</p>
	<input type="checkbox"/> Requested	<input type="checkbox"/> Current <input type="checkbox"/> None
Power wheelchair standing feature	<p><input type="checkbox"/> Beneficiary has a history of pressure ulcers on pelvis, buttocks, hips or back</p> <p><input type="checkbox"/> Will be used for pressure relief in lieu of tilt, recline, tilt/recline, and custom seating</p> <p><input type="checkbox"/> Pressure relief is done by the beneficiary without assistance</p> <p style="margin-left: 20px;">If assistance with pressure relief is required, indicate amount and frequency needed:</p> <p>_____</p> <p>Chair width _____ inches. Chair depth _____ inches.</p> <p>Indicate current pressure relief plan of care (including frequency and duration):</p> <p>Is beneficiary/caregiver compliant with current pressure relief plan of care? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If NO, explain:</p>	<p>Specify brand, model and serial numbers, age of current base:</p> <p>Chair width _____ inches. Chair depth _____ inches.</p> <p>Length of warranty: _____</p> <p>Warranty begin date: _____</p> <p>Where will requested device be used? <i>(i.e., home, school, community)</i></p>

Beneficiary Name: _____ Mihealth Number _____

Equipment	<input type="checkbox"/> Requested	<input type="checkbox"/> Current <input type="checkbox"/> None
Scooter	<input type="checkbox"/> Able to propel manual wheelchair _____ feet. <input type="checkbox"/> Independent trunk balance, <input type="checkbox"/> Adequate bilateral hand functions to work tiller. Chair width _____ inches. Chair depth _____ inches.	Specify brand, model and serial numbers, age of current base: Chair width _____ inches. Chair depth _____ inches. Length of warranty: _____ Warranty begin date: _____ Where will requested device be used? (<i>i.e., home, school, community</i>)




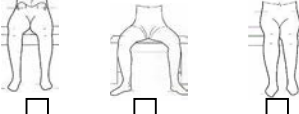




	Device Type (<i>attach additional page(s) if necessary</i>)	
All Accessories / Add Ons	<input type="checkbox"/> Head & Neck	<input type="checkbox"/> Feet <input type="checkbox"/> Footbox
Medical Reason	<input type="checkbox"/> Arms	<input type="checkbox"/> Other - Describe
	List and specify Medical Reason for brand(s) and model(s) requested for this beneficiary:	

Growth adaptability of device	Requested	Current
REQUIRED	Seat width: (inches) _____	Seat width: (inches) _____
	Back height: (inches) _____	Back height: (inches) _____
	Seat depth: (inches) _____	Seat depth: (inches) _____
	Maximum frame growth: (inches) _____	Maximum frame growth: (inches) _____

SEATING SYSTEM

Medical/functional Reason

- New growth > 3 inches depth and/or > 2 inches width
- Change in width and depth; width inches _____ depth in inches _____
- Orthopedic change; explain: _____
- Needs corrective forces to assist with maintaining or improving posture. _____
- Accommodate beneficiary's posture (e.g., current seating postures are not flexible, etc.). _____
- Other medical changes that affect the need for new positioning; specify: _____

POSTURE:				COMMENTS:
TRUNK	<p style="text-align: center;">Lateral View</p> <p style="text-align: center;">Anterior / Posterior</p>  <p style="text-align: center;"> <input type="checkbox"/> WFL <input type="checkbox"/> ↑ Thoracic <input type="checkbox"/> ↑ Lumbar Kyphosis Lordosis </p> <p> <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other </p>	<p style="text-align: center;">AP View</p> <p style="text-align: center;">Left Right</p>  <p style="text-align: center;"> <input type="checkbox"/> WFL <input type="checkbox"/> Convex Left <input type="checkbox"/> Convex Right </p> <p> <input type="checkbox"/> c-curve <input type="checkbox"/> s-curve <input type="checkbox"/> multiple <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other </p>	<p style="text-align: center;">Superior View</p> <p style="text-align: center;">Rotation-shoulders and upper trunk</p>  <p> <input type="checkbox"/> Neutral <input type="checkbox"/> Left anterior <input type="checkbox"/> Right anterior </p> <p> <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other </p>	<input type="checkbox"/> Hypertonia <input type="checkbox"/> Hypotonia
HIPS	<p style="text-align: center;">Anterior View</p> <p style="text-align: center;">Position</p>  <p style="text-align: center;"> <input type="checkbox"/> Neutral <input type="checkbox"/> Abduct <input type="checkbox"/> Adduct </p> <p> <input type="checkbox"/> Fixed <input type="checkbox"/> Subluxed <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Dislocated <input type="checkbox"/> Flexible </p>	<p style="text-align: center;">Superior View</p> <p style="text-align: center;">Windswept</p>  <p style="text-align: center;"> <input type="checkbox"/> Neutral <input type="checkbox"/> Right <input type="checkbox"/> Left </p> <p> <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other </p>	<p style="text-align: center;">ROM</p> <p>Hip Flexion/Extension Limitations: (PROM in Degrees)</p> <p>Hip Internal/External Range of Motion Limitations:</p>	MMT/O
PELVIS	<p style="text-align: center;">Lateral View</p> <p style="text-align: center;">Anterior / Posterior</p>  <p style="text-align: center;"> <input type="checkbox"/> Neutral <input type="checkbox"/> Posterior <input type="checkbox"/> Anterior </p> <p> <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other </p>	<p style="text-align: center;">AP View</p> <p style="text-align: center;">Obliquity</p>  <p style="text-align: center;"> <input type="checkbox"/> WFL <input type="checkbox"/> R elev <input type="checkbox"/> L elev </p> <p> <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other </p>	<p style="text-align: center;">Superior View</p> <p style="text-align: center;">Rotation-Pelvis</p>  <p style="text-align: center;"> <input type="checkbox"/> WFL <input type="checkbox"/> Right <input type="checkbox"/> Left Anterior Anterior </p> <p> <input type="checkbox"/> Fixed <input type="checkbox"/> Flexible <input type="checkbox"/> Partly Flexible <input type="checkbox"/> Other </p>	If spinal curvature present, indicate degree.

Beneficiary Name: _____ Mihealth Number _____

Requested Seating System		Current Seating System <input type="checkbox"/> None	
Length of warranty? _____ Mobility device to be used with:		Length of warranty: _____ Warranty begin date: _____ Mobility device is used with:	
<input type="checkbox"/> Planar/Non-custom contour	<input type="checkbox"/> Custom *	<input type="checkbox"/> Planar/Non-custom contour	<input type="checkbox"/> Custom *
Manufacturer:	Type:	Manufacturer:	Type:
Components include: <input type="checkbox"/> Seat only <input type="checkbox"/> Back only <input type="checkbox"/> Back and Seat	Components include: <input type="checkbox"/> Seat only <input type="checkbox"/> Back only <input type="checkbox"/> Back and Seat	Date provided: Components include: <input type="checkbox"/> Seat only <input type="checkbox"/> Back only <input type="checkbox"/> Back and Seat	Date provided: Components include: <input type="checkbox"/> Seat only <input type="checkbox"/> Back only <input type="checkbox"/> Back and Seat
Lateral Components Include:	Lateral Components Include:	Lateral Components Include:	Lateral Components Include:
<input type="checkbox"/> Trunk <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Abductor <input type="checkbox"/> Anti-thrust	<input type="checkbox"/> Trunk <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Abductor <input type="checkbox"/> Anti-thrust	<input type="checkbox"/> Trunk <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Abductor <input type="checkbox"/> Anti-thrust	<input type="checkbox"/> Trunk <input type="checkbox"/> Hip <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Abductor <input type="checkbox"/> Anti-thrust
Other Components - List:	Other Components - List:	Additional Components: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, describe:	Additional Components: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, describe:
If requesting custom seating, specify why planar/non-custom contour does not meet beneficiary's medical needs.			
* For definition of custom refer to MDHHS Medicaid Provider Manual, Medical Supplier Chapter, sections Standard Equipment and Custom-Fabricated Seating, and section Standards of Coverage			

EVALUATOR (PT, OT, PHYSIATRIST OR REHAB RN) ATTESTATION AND SIGNATURE/DATE

I certify that I conducted the evaluation and have completed the information in the appropriate Sections of the MSA-1656-Addendum A and that there is no financial arrangement with the selected durable medical equipment provider and/or the evaluating clinician. I certify that the equipment requested is the most economical alternative that meets the beneficiary's basic medical and functional needs. I certify that the information contained in this form is true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Evaluation Date

Evaluator Name/Title (Print)

Place of Employment and Address

NPI

Phone Number

Evaluator Signature

Date

Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices Addendum B: Strollers, Gait Trainers, Standers, Car Seats, and Children's Positioning Chairs

This form must be completed by a physical therapist, occupational therapist, physiatrist, or rehabilitation registered nurse. The Evaluator must complete requested and/or current equipment information, warranty information and economic alternative information.

NOTE: Only complete sections that apply to the requested equipment/accessories. If requesting an equipment/accessories complete Current/None area of the section.

Incomplete information will result in the form being returned to the evaluator for completion.

Beneficiary Name: _____ Mihealth Number: _____

SECTION	<input type="checkbox"/> Requested	<input type="checkbox"/> Current <input type="checkbox"/> None
Equipment	Beneficiary's ability to use	
Stroller	<input type="checkbox"/> Transport only <input type="checkbox"/> Primary mobility device Indicate medical special needs for use and adaptations needed: 	Specify brand, model and serial numbers, age of current device: Length of warranty: _____ Warranty begin date: _____ Where is or will this device be used? (<i>i.e., home, school, community</i>)
	<input type="checkbox"/> Requested	<input type="checkbox"/> Current <input type="checkbox"/> None
Gait trainer (if less than age 21)	<input type="checkbox"/> Is independent with gait trainer. <input type="checkbox"/> Requires assistance with mobility using gait trainer. Describe: How many times per day will beneficiary use gait trainer: How far can beneficiary ambulate with gain trainer/device? _____ft. Indicate the expected performance with the requested equipment: Is beneficiary/caregiver compliant with current mobility plan of care? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, explain:	Specify brand, model and serial numbers, age of current device: Length of warranty: _____ Warranty begin date: _____ Where is or will this device be used? (<i>i.e., home, school, community</i>)
	<input type="checkbox"/> Requested	<input type="checkbox"/> Current <input type="checkbox"/> None
Children's positioning chairs (if less than age 21) e.g., feeder seat, high/low seat, activity chair, etc.	<input type="checkbox"/> Home inaccessible to mobility device. <input type="checkbox"/> Beneficiary is > 40 lbs. with limited head and trunk control <input type="checkbox"/> Beneficiary has current active seizures <input type="checkbox"/> Beneficiary is unable to eat or be safely fed in current mobility device <input type="checkbox"/> Crown to hip measurement on Mat evaluation is > 26" If beneficiary is < 40 lbs. or < 26", explain why commercially available products or other mobility devices will not meet the beneficiary's medical/functional needs:	Specify brand, model and serial numbers, age of current device: Length of warranty: _____ Warranty begin date: _____ Where is or will this device be used? (<i>i.e., home, school, community</i>)

Beneficiary Name: _____ Mihealth Number: _____

	<input type="checkbox"/> Requested	<input type="checkbox"/> Current <input type="checkbox"/> None
Equipment	Beneficiary's ability to use	Where device is used
Car seat	Indicate medical special needs for use and adaptations needed:	Specify brand, model and serial numbers, age of current device: Length of warranty: _____ Warranty begin date: _____ Where is or will this device be used? (<i>i.e., home, school, community</i>)
	<input type="checkbox"/> Requested	<input type="checkbox"/> Current <input type="checkbox"/> None
Stander (If less than age 21)	<input type="checkbox"/> Is dependent with standing <input type="checkbox"/> Walks with assistive device <input type="checkbox"/> Walks with gait trainer <input type="checkbox"/> Required for post-op care Specify treatment plan and state any surgical or other interventions that affect standing:	Specify brand, model and serial numbers, age of current device: Length of warranty: _____ Warranty begin date: _____ Where is or will this device be used? (<i>i.e., home, school, community</i>)
	Indicate current standing plan of care (including how many times per day and how long):	
	Is the beneficiary/caregiver compliant with standing plan of care? <input type="checkbox"/> YES <input type="checkbox"/> NO If NO, explain:	
Growth adaptability of device	<input type="checkbox"/> Requested	<input type="checkbox"/> Current <input type="checkbox"/> None
	Seat width: _____	Seat width: _____
	Seating system height: _____	Seating system height: _____
	Seat depth: _____	Seat depth: _____
	Frame adaptability: _____	Frame adaptability: _____
Equipment	Device Type (attach additional page(s) if necessary)	Medical Reason
All Accessories / Add Ons	<input type="checkbox"/> Head & Neck Type: _____	
	<input type="checkbox"/> Arms Type: _____	
	<input type="checkbox"/> Feet Type: _____	
	<input type="checkbox"/> Other - Describe _____	
Medical Reason	Specify Medical Reason for brand(s) and model(s) requested for this beneficiary:	

Beneficiary Name: _____ Mihealth Number: _____

EVALUATOR (PT, OT, PHYSIATRIST OR REHAB RN) ATTESTATION AND SIGNATURE/DATE

I certify that I conducted the evaluation and have completed the information in the appropriate Sections of the MSA-1656-Addendum B and that there is no financial arrangement with the selected durable medical equipment provider and/or the evaluating clinician. I certify that the equipment requested is the most economical alternative that meets the beneficiary's basic medical and functional needs. I certify that the information contained in this form is true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Evaluation Date

Evaluator Name/Title (Print)

Place of Employment and Address

NPI

Phone Number

Evaluator Signature

Date

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable.

The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.

Michigan Department of Health and Human Services
NURSE AIDE TRAINING AND TESTING PROGRAM INTERIM REIMBURSEMENT REQUEST

Interim reimbursement request data is used to establish the amount of per diem add-on reimbursement to be included in the Medicaid Program per diem payment rate. The total amount of add-on reimbursement for the nurse aide training and testing program during the fiscal year will be adjusted through the annual settlement determination of the training and testing costs apportioned to Medicaid inpatient days.

Information included in this request may reflect estimated costs and projections for the time period indicated.

Send completed request to: MDHHS/LTC REIMBURSEMENT & RATE SETTING SECTION
 PO BOX 30815
 LANSING MI 48909-7979

NOTE: Review detailed "Instructions" on page 3.

1. Provider Cost Period From: _____ To: _____	3. Name of Training Contractor (if used) _____		
2. Training Conducted By <input type="checkbox"/> In-House Staff <input type="checkbox"/> Centralized Training <input type="checkbox"/> Outside Contractor (complete items 3, 4 & 5) From: _____ To: _____	4. Contractor Address _____		
	5. City _____	State _____	Zip Code _____
6. Was the facility designated a "LOCKOUT FACILITY" by the Department of Licensing And Regulatory Affairs at any time during the cost reporting period? <input type="checkbox"/> NO <input type="checkbox"/> YES From: _____ To: _____			
7. Estimated Nurse Aide Training Program Costs for the Period (from Page 2, Line 11) _____			
8. Estimated Total Inpatient Days for the Period _____			
9. Estimated Nurse Aide Training Program Cost Per Day (line 7 divided by line 8) _____			

CERTIFICATION STATEMENT: To be Signed by Provider and/or Authorized Representative

I certify that this claim for adjustment is true, accurate, and prepared with my knowledge and consent, and does not contain untrue, misleading or deceptive information. In the event the actual allowable costs do not support the increased rate, the provider will reimburse the State for excess amounts received. I further agree that retrospective cost settlements will be made in accordance with the State Plan, as applicable.			
10. Signature of Provider and/or Authorized Representative _____	13. Name of Facility _____		
11. Typed Name _____	14. Street Address _____	15. County No. _____	
12. Phone Number _____	16. City _____	State MI	Zip Code _____
17. NPI No. _____	18. Provider License No. _____		

Authority: Title XIX of the Social Security Act.
 Completion: Is Voluntary, but is required if Medical Assistance Program payment is desired.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability

**ESTIMATED NURSE AIDE TRAINING AND TESTING COSTS
Worksheet**

NOTE: Review detailed "Instructions" on page 4.

1. Facility Training Staff:			
a. Salaries and Wages			
b. Fringe Benefits			
c. Payroll Taxes			
d. Total Training Staff (1a + 1b + 1c)		1	<u>0</u>
2. Nurse Aide Training Consultants		2	
3. Nurse Aide Student Staff:			
a. Wages			
b. Fringe Benefits			
c. Payroll Taxes			
d. Total Student Staff (3a + 3b + 3c)		3	<u>0</u>
4. Training Program Supplies		4	
5. Training Program Transportation:			
a. Training Staff			
b. Student Staff			
c. Total Transportation (5a + 5b)		5	<u>0</u>
6. Outside Contracted Approved Nurse Aide Training:			
a. Paid Directly by Facility			
b. Reimbursed to Employee Staff			
c. Total Outside Training (6a + 6b)		6	<u>0</u>
7. Nurse Aide Testing Fees:			
a. Paid Directly by Facility			
b. Reimbursed to Employee Staff			
c. Total Testing Fees Paid (7a + 7b)		7	<u>0</u>
8. Other Training Program Costs (Specify):			
a. _____		8a	
b. _____		8b	
9. Total Training Program Cost Before Equipment Allowance (Sum of Lines 1 thru 8b)		9	<u>0</u>
10. Training Program Equipment Use Allowance: (equipment specific to training program)			
a. Number of months in reporting period			
b. Reporting period training program use allowance.			
Line 10.a. <u>0</u> divided by 12 , times 15% =			0.00%
c. Equipment purchased in Current Year (CY) and Prior 6 years:			
CY minus 6 years	\$ _____ times Line 10.b.% =		<u>0</u>
CY minus 5 years	\$ _____ times Line 10.b.% =		<u>0</u>
CY minus 4 years	\$ _____ times Line 10.b.% =		<u>0</u>
CY minus 3 years	\$ _____ times Line 10.b.% =		<u>0</u>
CY minus 2 years	\$ _____ times Line 10.b.% =		<u>0</u>
CY minus 1 year	\$ _____ times Line 10.b.% =		<u>0</u>
Current Year	\$ _____ times Line 10.b.% =		<u>0</u>
d. Total equipment use allowance (Sum of 10.c. line amounts)		10d	<u>0</u>
11. Estimated Total Nurse Aide Training Program Costs (Sum of Line 9 and Line 10d.)		11	<u>0</u>

MSA-1324 INSTRUCTIONS (REQUEST)

PURPOSE

This form is for the provider to obtain Medicaid Program reimbursement outside the routine nursing care rate per diem for OBRA nurse aide training and testing programs. The form must be completed in order to receive interim reimbursement for those providers that have been determined to be a lockout facility, or for those facilities incurring costs in excess of interim reimbursement. Costs will be retrospectively settled to reflect the Medicaid Program's appropriate share of actual allowable training and testing costs.

Training and testing program costs claimed for services and supplies furnished to or purchased by the facility from organizations related to the provider by common ownership or control must adhere to the related party allowable cost principles. Expenses for such transactions should not exceed expenses for like items or services in an arms-length transaction with other non-related organizations, or the cost to the related organization.

Administrative overhead costs and space costs in nursing facilities conducting in-house training are not considered training and testing program costs. The costs reported must be specifically incurred in conducting the approved nurse aide training and testing program.

Supporting accounting records such as class attendance rosters or training participation logs, purchase orders, vendor invoices, contracts, documentation verifying amounts reimbursed to employees for approved training program expenses incurred by the employee prior to employment at the facility (e.g., canceled check, training program receipt) must be maintained for audit purposes. Supporting materials should be readily identifiable as training related cost documentation and must indicate the type of training involved.

Training Program Approval Requirement - Only costs incurred relative to a Department of Licensing And Regulatory Affairs (LARA) Bureau of Community and Health Systems approved Nurse Aide Training Program may be claimed on this schedule. An approved program may be conducted by the provider's facility or by a separate entity from the provider. The provider **must not report and make a claim** for Medicaid Program reimbursement on this schedule for any costs incurred and associated with providing training **by the lockout facility** during the lockout time period. Allowable nurse aide training program costs lockout time period are limited to the costs incurred in obtaining training and testing outside the facility from an approved nurse aide training program.

Note: If the facility maintains separate cost center reporting for the training program, enter the appropriate costs as identified.

ITEM EXPLANATION

1. Provider's Cost Reporting Period
Enter the fiscal period coinciding with the provider's cost reporting period.
2. Mode of Training
It is possible that providers may utilize both in-house staff and outside contractors. If a chain organization or group home ownership uses an approved central training program, indicate the training as "in-house" and check "centralized training." If multiple outside contractors are used, indicate each contractor and the time periods utilized.
6. Lockout Facility
A facility identified by the LARA Bureau of Community and Health Systems as a "lockout facility" cannot conduct a training and testing program, cannot be a training/clinical practice site for another approved program, and cannot conduct clinical skills testing. The facility is notified of the lockout determination action by the LARA Bureau of Community and Health Systems.
8. Estimated Total Inpatient Days for the Period
Indicate the appropriate number of LTC total inpatient days of care estimated to be rendered during the time period reported on this form.
13. Name of Facility
Enter the provider name under which Medicaid payments are issued to the provider.
15. County Number
Enter the two-digit county number.
- 14-16. Provider Location
Enter street address, city (village and/or township) and zip code of the facility's physical location.
17. Provider NPI Number
Enter the Nursing Facility's ten-digit provider NPI number.
18. Provider's License Number
Enter the three-digit license number.

MSA-1324 INSTRUCTIONS (WORKSHEET)

1. Facility Training Staff

Payroll-related costs for facility employees incurred by the approved program's direct training time or the nurse aide training program's preparation time.

2. Nurse Aide Training Consultants

Costs incurred for non-facility staff engaged to provide instruction or consultation for the facility's approved nurse aide training program.

3. Nurse Aide Student Staff

Payroll costs for facility employees incurred while the student is engaged in the approved training program or traveling to and from the off-site approved training location, or is engaged in off-site testing or traveling to and from the off-site testing location.

4. Training Program Supplies

Cost incurred for supplies and materials used in conducting an approved training program.

5. Training Program Transportation

Travel or transportation costs incurred by facility staff conducting the approved training program activity and testing, or for off-site nurse aide training and testing. Identify costs separately for training staff and student staff.

6. Outside Contracted Approved Nurse Aide Training Program

Paid Directly By Facility - Costs incurred to obtain nurse aide training through an outside entity approved training program. Payment for subject training is made directly from the nursing facility to the training entity and the nurse aide trainees are employed by the nursing facility

Reimbursed To Employee Staff - Costs incurred to reimburse a facility employee who had personally paid for an approved nurse aide training program prior to becoming an employee at the facility. Reasonable and necessary expenses incurred by the employee through participation and completion of a Bureau of Community and Health Systems approved training program for which the aide has made payment are eligible for remuneration. Only The cost of tuition and books are reimbursed. The aide must be hired by a facility within 12 months after incurring this expense. The facility must obtain receipts and retain documentation from the employee to verify the expense.

7. Nurse Aide Testing Fees

Paid Directly By Facility - Costs incurred for State-run testing. Payment for testing fees is made directly from the nursing facility to the testing authority for aides employed at the facility.

Reimbursed To Employee Staff - Costs incurred to reimburse a facility employee who had personally paid for State-run testing prior to becoming an employee at the facility. The aide must be hired by a facility within 12 months after paying the testing fee. The facility must obtain receipts and retain documentation from the employee to verify the expense.

8. Other Training Program Costs

Costs incurred that are not classified in the identified cost categories 1-7.

Rental costs for space located off-site of the facility are reimbursable under training and testing only if the space is used solely for the training and testing program. Space costs not meeting this requirement are reimbursable within the plant cost component of Michigan's prospective reimbursement system. Reasonable rental expense for training equipment necessary to the approved training program is an eligible cost.

Enter the detail and cost of these individual expenses in the yellow shaded cells. The total of these items will be automatically calculated by use of the F9 key.

9. Total Training Program Cost Before Equipment Allowance

Subtotal of Lines 1 through 8b costs. This total will be automatically calculated by use of the F9 key.

10. Training Program Equipment Use Allowance

An annual cost allowance is made for equipment purchased specifically for the Bureau of Community and Health Systems approved nurse aide training program. Such equipment purchases are not included in the plant asset costs of the facility for routine nursing care. An annual allowance of 15 percent of the equipment purchase price is reported as a cost of the training program for as long as the equipment is used in the program, but cannot exceed seven years.

The use allowance is an annual percentage adjustment made to the 15 percent amount if the cost report period differs from 12 months. Line 10.a. and Line 10.b. will automatically be calculated.

Enter Line 10.c. the cost of the equipment purchased as required in the yellow shaded cells.

**Michigan Department of Health and Human Services
Completion Instructions for MSA-115
Occupational Therapy - Physical Therapy - Speech Therapy
Prior Approval Request/Authorization**

General Instructions

The MSA-115 must be used by Medicaid-enrolled outpatient hospitals, outpatient therapy providers, nursing facilities and home health agencies to request prior authorization (PA) for therapy services. MDHHS requires that the MSA-115 be typewritten, handwritten forms will not be accepted. Fill-in enabled copies of this form can be downloaded from the Michigan Department of Health and Human Services (MDHHS) website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms. The PA request must be complete and of adequate clarity to permit a determination of the appropriateness of the service without examination of the beneficiary.

PA may be authorized for a period not to exceed six months for outpatient therapy providers and outpatient hospitals, or two months for home health agencies and nursing facilities. If continued treatment is necessary, a subsequent request for PA must be submitted. The provider should retain a copy of the PA form until the approval or denial is determination is received.

For complete information on covered services, PA, and documentation requirements, refer to the Therapy Services Chapter of the Michigan Medicaid Provider Manual located at the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Medicaid Provider Manual.

Attachments/Additional Documentation

All additional attachments/documentation submitted with the request must contain the beneficiary name and **mihealth** card number, provider name and address, and the provider's National Provider Identifier (NPI) number.

When requesting the initial PA, the provider must attach a copy of the initial evaluation and treatment plan to the PA request.

Form Completion

The following fields must be completed unless stated otherwise:

Box Number(s)	Instructions
Box 1	MDHHS use only.
Box 2 - 3	The Medicaid enrolled provider's name and NPI.
Box 4 - 6	The provider's telephone number (including area code), address and fax number (including area code).
Box 7- 10	The beneficiary's name (last, first, and middle initial), sex, mihealth card number, and birth date (in the eight-digit format: MM/DD/YYYY). The information should be taken directly from the mihealth card and should be verified through the Community Health Automated Medicaid Processing System (CHAMPS) (Eligibility Inquiry and/or 270/271 transaction).
Box 11	The date the beneficiary was most recently admitted to the hospital or facility.
Box 12	Enter the beneficiary's diagnosis(es) code(s) and description(s) that relate to the service being requested.
Box 13	The date of onset must be entered. The approximate date of exacerbation must be cited if the beneficiary has a chronic disease (e.g., arthritis) and recently suffered such exacerbation.
Box 14 -16	The therapist's name, office telephone number (including area code), and applicable license/certification number.
Box 17	Initial: The treatment authorization request is the initial prior authorization request for the beneficiary under this treatment plan. Continuing: The treatment authorization request is to continue treatment for additional calendar month(s) of service under the treatment plan.
Box 18	The date MDHHS approved the last approved prior authorization request for the given diagnosis.
Box 19	The requested date range for which treatment is to be rendered, in a eight-digit format (e.g mm/dd/yyyy to mm/dd/yyyy).

Box Number(s)	Instructions
Box 20	The date treatment was started for the given diagnosis (if treatment was initiated previously).
Box 21	The total number of sessions rendered since the development of the treatment plan.
Box 22	Goals must be measurable. In functional terms, the provider's expectation for the beneficiary's ultimate achievement and the length of time it will take (e.g., ambulation unassisted for 20 feet; able to dress self within 15 minutes; oral expression using 4-5 word phrases to express daily needs). See Medicaid Provider Manual for additional documentation requirements.
Box 23	Documentation of the beneficiary's progress from the prior period to the current time in reference to the measurable and functional goals stated in the treatment plan. Documentation of the beneficiary's nursing and family education may be included. The final month of anticipated treatment should include the discharge plan for the carry-over of achieved goals to supportive personnel. See Medicaid Provider Manual for additional documentation requirements.
Box 24	Indicate if the beneficiary is receiving therapy services through school-based services program.
Box 25	Indicate the treatment plan frequency (e.g., 1x/week, 3x/week, 1x/month, etc.) and duration per visit in 15-minute increments, i.e., units (e.g. 2 units/visit, 4 units/visit, etc.).
Box 26	Complete a separate line for each unique HCPCS code/modifiers combination.
Box 27	The Therapies Database on the MDHHS website lists the HCPCS codes that describe covered services. The database is located at the MDHHS website www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.
Box 28	The Billing & Reimbursement Chapter in the Medicaid Provider Manual list the required modifiers used to describe covered services for therapy providers. The Medicaid Provider Manual is located at the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters, & Forms >> Medicaid Provider Manual.
Box 29	The total number of units the service is to be provided during the requested treatment period.
Box 30	The authorized prescribing practitioner must indicate if this is an initial certification or a re-certification and sign and date. Signature is required each time a request is made.
Box 31	The therapist certification is the signature of an authorized representative. The business office of a hospital may designate the director of the department providing the service as its representative. All unsigned requests will be returned for signature.
Box 32-35	MDHHS use only.

Form Submission:

PA request forms for all eligible Medicaid beneficiaries must be submitted electronically*, mailed or faxed to:

MDHHS – Program Review Division
P.O. Box 30170
Lansing, Michigan 48909
Fax Number: **(517) 335-0075**

If submitting electronically, the completed MSA-115 must be uploaded along with the supporting clinical documentation required.

To check the status of a PA request, contact the Program Review Division via telephone at **1-800-622-0276** or electronically via the **CHAMPS Provider Portal** located at <https://milogintp.michigan.gov>.

Authority: Title XIX of the Social Security Act.	Completion: Is voluntary but is required if payment from applicable programs is sought.
The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.	

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
**OCCUPATIONAL THERAPY - PHYSICAL THERAPY –
 SPEECH THERAPY**
PRIOR APPROVAL REQUEST/AUTHORIZATION

1. PRIOR AUTHORIZATION NUMBER (MDHHS USE ONLY)
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The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment. All fields must be completed and typewritten.

2. TREATMENT SITE (Medicaid enrolled provider's name)		3. PROVIDER NPI NUMBER		4. PHONE NUMBER	
5. ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)				6. FAX NUMBER	
7. BENEFICIARY NAME (LAST, FIRST, MIDDLE INITIAL)		8. SEX <input type="checkbox"/> M <input type="checkbox"/> F	9. MIHEALTH CARD NUMBER		10. BIRTH DATE
11. ADM. DATE					11. ADM. DATE
12. ICD DIAGNOSIS(ES) CODE(S) AND DESCRIPTION(S) TO BE TREATED/EVALUATED					13. ONSET DATE
14. THERAPIST NAME (LAST, FIRST, MIDDLE INITIAL)		15. OFFICE PHONE NUMBER		16. LICENSE/CERTIFICATION NUMBER	
17. TREATMENT AUTHORIZATION REQUEST <input type="checkbox"/> INITIAL <input type="checkbox"/> CONTINUING		18. LAST AUTHORIZATION	19. TREATMENT MONTHS / / to / /		20. DATE STARTED
				21. # PREV. SESSIONS	
22. GOALS (NOTE: SEE MEDICAID PROVIDER MANUAL FOR ADDITIONAL DOCUMENTATION REQUIREMENTS.)					
SHORT TERM GOALS			LONG TERM GOALS		
23. PROGRESS SUMMARY (NOTE: SEE MEDICAID PROVIDER MANUAL)					
24. SCHOOL THERAPY PROGRAMS <input type="checkbox"/> YES <input type="checkbox"/> NO		25. TREATMENT REQUESTED FREQUENCY: DURATION VISIT: (UNITS)		30. PHYSICIAN CERTIFICATION I certify <input type="checkbox"/> re-certify <input type="checkbox"/> that I have examined the patient named above and have determined that skilled therapy is necessary; that services will be furnished on an in-patient and/or out-patient basis while the patient is under my care; that I approve the above treatment goals and will review every 60 days or more frequently if the patient's condition requires.	
26. LINE NO.	27. PROCEDURE CODE	28. MODIFIER	29. TOTAL UNITS PER PA	PRESCRIBING PRACTITIONER'S NAME (TYPE OR PRINT) PRESCRIBING PRACTITIONER'S SIGNATURE _____ DATE _____	
01					
02					
03					
04					
05					
MDHHS USE ONLY					
32. REVIEW ACTION: APPROVED <input type="checkbox"/> RETURNED <input type="checkbox"/> DENIED <input type="checkbox"/> NO ACTION <input type="checkbox"/> APPROVED AS AMENDED <input type="checkbox"/>		33. AUTHORIZATION PERIOD APPROVED			
34. CONSULTANT REMARKS <input type="checkbox"/> See CHAMPS					
				31. THERAPIST CERTIFICATION The patient named above (parent or guardian if applicable) understands the necessity to request prior approval for the services indicated. I understand that services requested herein require prior approval and, if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of a material fact may lead to prosecution under applicable Federal or State law.	
				THERAPIST'S SIGNATURE _____ DATE _____	
				35. CONSULTANT SIGNATURE _____ DATE _____	

Michigan Department of Health and Human Services
Practitioner Special Services Prior Approval - Request/Authorization
Completion Instructions

The MSA-6544-B must be used by Medicaid enrolled providers to request provider services that require prior authorization (PA) (e.g. out-of-state care and genetic testing).

MDHHS requests that the MSA-6544-B be typewritten to facilitate processing. A Word fill-in enabled version of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms. For information on required modifiers, documentation, and appropriate quantity amounts, refer to the following documents:

- Standards of Coverage portion of the provider-specific chapters of the Medicaid Provider Manual.
- Billing & Reimbursement for Professionals Chapter of the Medicaid Provider Manual.
- Provider-specific databases on the MDHHS website. www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.
- For more detailed information on procedure codes refer to CHAMPS – External Links – Medicaid Code and Rate Reference.

Completion of this form is as follows:

Box 1	MDHHS Use Only
Box 22	Indicate whether this is the first request for services or if this is a renewal request for ongoing services
Box 24	Enter a complete description of the services, procedures, lab test, etc. requested
Box 25	Enter the HCPCS Procedure Code.
Box 26	Enter the applicable HCPCS Modifier.
Box 27	Enter the quantity of the services requested. If an injectable drug is requested, indicate the number of billing units requested.
Box 28	Enter the dates for which the requested procedure or service will take place.
Box 29	Enter the beneficiary's primary and secondary diagnoses or the CSHCS qualifying diagnosis (list both the code and description)
Box 30	Any additional remarks regarding the request should be listed in this box such as verbal authorization date, retroactive date of service if being requested. Provide other insurance coverage for services requested.
Box 31	Check each box that corresponds to documentation included in the request. No request should leave all boxes unchecked.
Box 32	Must be completed for all requests.

Form Submission

PA request forms and required documentation for all eligible Medicaid beneficiaries must be mailed or faxed to:

**MDHHS - Medical Services Administration
Program Review Division
P.O. Box 30170
Lansing, Michigan 48909**

Fax Number: (517) 335-0075

The status of a PA request may be reviewed in CHAMPS. For additional questions, contact the MDHHS - Medical Services Administration, Program Review Division via telephone at **1-800-622-0276**.

Michigan Department of Health and Human Services
PRACTITIONER SPECIAL SERVICES
PRIOR APPROVAL – REQUEST/AUTHORIZATION

1. PRIOR AUTHORIZATION NUMBER (MDHHS USE ONLY)

The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.

2. Reason for PA Request:

OUT OF STATE CARE CLINICAL PROCEDURE OFFICE ADMINISTERED DRUG OR BIOLOGICAL SURGERY

OTHER _____

3. PROVIDER'S NAME (LAST, FIRST, MIDDLE INITIAL) 4. NPI NUMBER 5. PHONE NUMBER

6. PROVIDER'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP) 7. FAX NUMBER

8. BENEFICIARY'S NAME (LAST, FIRST, MIDDLE INITIAL) 9. SEX M F 10. BIRTH DATE 11. MIHEALTH CARD NUMBER

12. BENEFICIARY'S ADDRESS (NUMBER, STREET, APT./LOT NUMBER, CITY, STATE, ZIP)

13. HOSPITAL/ FACILITY NAME 14. HOSPITAL/ FACILITY NPI

15. REFERRING/ORDERING PHYSICIAN'S NAME (LAST, FIRST, MIDDLE INITIAL) 16. NPI NUMBER 17. PHONE NUMBER

18. REFERRING/ORDERING PHYSICIAN'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP) 19. FAX NUMBER

20. CONTACT NAME 21. CONTACT PHONE NUMBER

22. INITIAL REQUEST RENEWAL REQUEST

23. LINE NO.	24. DESCRIPTION OF SERVICE	25. PROCEDURE CODE	26. MODIFIER	27. QUANTITY	28. ANTICIPATED DATE(S) OF SERVICE
01					
02					
03					
04					

29. DIAGNOSES (CODES AND DESCRIPTIONS) REQUIRING THE ABOVE SERVICES.

30. ADDITIONAL REMARKS, INCLUDING OTHER INSURANCE COVERAGE ON THE DATE OF SERVICE.

31. Identify all relevant clinical documentation that has been submitted to support medical necessity: *If this is an out-of-state request, in addition to clinical documentation, include a letter of medical necessity that explains A) why services cannot be provided in state, B) what in-state services have already been exhausted, and C) the plan to transition care back to the state of Michigan.*

H&P PROGRESS NOTES CONSULTATIONS LABS

PATHOLOGY REPORT OPERATIVE REPORT RADIOLOGY REPORTS PHOTOS ****INCLUDE PHOTOS FOR ALL COSMETIC AND RECONSTRUCTIVE SURGERIES**

DISCHARGE SUMMARY LETTER OF MEDICAL NECESSITY OTHER DIAGNOSTICS: _____

32. **PROVIDER CERTIFICATION:** THE PATIENT NAMED ABOVE (PARENT OR GUARDIAN IF APPLICABLE) UNDERSTANDS THE NECESSITY TO REQUEST PRIOR APPROVAL FOR THE SERVICES INDICATED. I UNDERSTAND THAT SERVICES REQUESTED HEREIN REQUIRE PRIOR APPROVAL AND, IF APPROVED AND SUBMITTED ON THE APPROPRIATE INVOICE, PAYMENT AND SATISFACTION OF APPROVED SERVICES WILL BE FROM FEDERAL AND/OR STATE FUNDS. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY LEAD TO PROSECUTION UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

PROVIDER'S SIGNATURE: _____ DATE: _____

MDHHS USE ONLY

33. REVIEW ACTION: APPROVED DENIED RETURN NO ACTION APPROVED AS AMENDED

34. CONSULTANT REMARKS

CONSULTANT SIGNATURE AND DATE: _____

**PREADMISSION SCREENING (PAS)/ANNUAL
RESIDENT REVIEW (ARR)**

(Mental Illness/Intellectual Developmental
Disability/Related Conditions Identification)

Michigan Department of Health and Human Services
Level I Screening

<input type="checkbox"/> PAS
<input type="checkbox"/> ARR
<input type="checkbox"/> Change in Condition
<input type="checkbox"/> Hospital Exempted Discharge

SECTION I – Patient, Legal Representative and Agency Information

Patient Name (First, MI, Last)			Date of Birth (MM/DD/YY)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address (number, street, apt. or lot #)			County of Residence		Social Security Number	
City	State	Zip Code	Medicaid Beneficiary ID Number		Medicare ID Number	
Does this patient have a court-appointed guardian or other legal representative? <input type="checkbox"/> No <input type="checkbox"/> Yes →			If Yes, give Name of Legal Representative			
County in which the legal representative was appointed			Address (number, street, apt. number or suite number)			
Legal Representative Telephone Number			City	State	Zip Code	
Referring Agency Name			Telephone Number		Admission Date (actual or proposed)	
Nursing Facility Name (proposed or actual)			County Name			
Nursing Facility Address (number and street)			City	State	Zip Code	

Sections II and III of this form must be completed by a registered nurse, licensed bachelor or master social worker, licensed professional counselor, psychologist, physician’s assistant, nurse practitioner or a physician.

Patient Name

SECTION II – Screening Criteria (All 6 items must be completed.)

- 1. The person has a current diagnosis of **Mental Illness** or **Dementia** (Circle one or both) No Yes
- 2. The person has received treatment for **Mental Illness** or **Dementia** (within the past 24 months) (Circle one or both) No Yes
- 3. The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days. No Yes
- 4. There is presenting evidence of mental illness or dementia, including significant disturbances in thought, conduct, emotions, or judgment. Presenting evidence may include, but is not limited to, suicidal ideations, hallucinations, delusions, serious difficulty completing tasks, or serious difficulty interacting with others. No Yes
- 5. The person has a diagnosis of an intellectual/developmental disability or a related condition including, but not limited to, epilepsy, autism, or cerebral palsy and this diagnosis manifested before the age of 22. No Yes
- 6. There is presenting evidence of deficits in intellectual functioning or adaptive behavior which suggests that the person may have an intellectual/developmental disability or a related condition. These deficits appear to have manifested before the age of 22. No Yes

Note: If you check "Yes" to items 1 and/or 2, circle the word "**Mental Illness**" and/or "**Dementia**."

Explain any "Yes"

Note: The person screened shall be determined to require a comprehensive Level II OBRA evaluation if any of the above items are "Yes" UNLESS a physician, nurse practitioner or physician's assistant certifies on form DCH-3878 that the person meets at least one of the exemption criteria.

SECTION III – CLINICIAN'S STATEMENT: I certify to the best of my knowledge that the above information is accurate.

Clinician Signature		Date	Name (type or print)
Address (number, street, apt. number or suite number)			Degree/License
City	State	Zip Code	Telephone Number

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

AUTHORITY: Title XIX of the Social Security Act

COMPLETION: Is voluntary, however, if NOT completed, Medicaid will not reimburse the nursing facility.

DISTRIBUTION: If any answer to items 1 – 6 in SECTION II is "Yes", send ONE copy to the local Community Mental Health Services Program (CMHSP), **with a copy of form DCH-3878** if an exemption is requested. The nursing facility must retain the original in the patient record and provide a copy to the patient or legal representative.

PREADMISSION SCREENING (PAS)/ANNUAL RESIDENT REVIEW (ARR)

Mental Illness/Intellectual Developmental Disability/Related Conditions Identification

Instructions for Completing Level I Screening

This form is used to identify prospective and current nursing facility residents who meet the criteria for possible mental illness or intellectual/developmental disability, or a related condition and who may be in need of mental health services.

Sections II and III must be completed by a registered nurse, licensed bachelor or master social worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or physician.

Preadmission Screening or Hospital Exempted Discharge: The referral source completing the Level I Screening (DCH-3877), must complete and provide a copy to the proposed nursing facility **prior to admission. Check the appropriate box in the upper right-hand corner.**

Annual Resident Review or Change in Condition: This form must be completed by the nursing facility. **Check the appropriate box in the upper right-hand corner.**

Section II – Screening Criteria – All 6 items in this section must be completed. The following provides additional explanation of the items.

1. **Mental Illness:** A current primary diagnosis of a mental disorder as defined in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

Current Diagnosis means that a clinician has established a diagnosis of a mental disorder within the past 24 months. Do NOT mark "Yes" for an individual cited as having a diagnosis "by history" only.

2. **Receipt of treatment for mental illness or dementia within the past 24 months** means any of the following: inpatient psychiatric hospitalization; outpatient services such as psychotherapy, day program, or mental health case management; or referral for psychiatric consultation, evaluation, or prescription of psychopharmacological medications.
3. **Antidepressant and antipsychotic medications** mean any currently prescribed medication classified as an antidepressant or antipsychotic, plus Lithium Carbonate and Lithium Citrate.
4. **Presenting evidence** means the individual currently manifests symptoms of mental illness or dementia, which suggests the need for further evaluation to establish causal factors, diagnosis and treatment recommendations. Further evaluation may need to be completed if evidence of suicidal ideation, hallucinations, delusion, serious difficulty completing tasks or serious difficulty interacting with others.
5. **Intellectual/Developmental Disability/Related Condition:** An individual is considered to have a severe, chronic disability that meets ALL 4 of the following conditions:
 - a. It is manifested before the person reaches **age 22**.
 - b. It is likely to continue indefinitely.
 - c. It results in substantial functional limitations in **3 or more** of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.

d. It is attributable to:

- Intellectual/Developmental Disability such that the person has significant subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period;
- cerebral palsy, epilepsy, autism; or
- any condition other than mental illness found to be closely related to Intellectual/Developmental Disability because this condition results in impairment in general intellectual functioning OR adaptive behavior similar to that of persons with Intellectual/Developmental Disability and requires treatment or services similar to those required for these persons.

6. **Presenting evidence** means the individual manifests deficits in intellectual functioning or adaptive behavior, which suggests the need for further evaluation to determine the presence of a developmental disability, causal factors, and treatment recommendations. These deficits appear to have manifested before the age of 22.

Note: When there are one or more "Yes" answers to items 1 – 6 under SECTION II, complete form DCH-3878, Mental Illness/Intellectual/Developmental Disability/Related Condition Exemption Criteria Certification only if the referring agency is seeking to establish exemption criteria for a dementia, state of coma, or hospital exempted discharge.

Michigan Department of Health and Human Services
Completion Instructions for MSA-0732
Private Duty Nursing Prior Authorization – Request for Services

The MSA-0732 form (page 2) must be submitted every time services are requested, i.e., before services can begin and for each specified authorization period thereafter, no less than 15 days prior to the end of the current authorization period.

MDHHS requests that the MSA-0732 be typewritten to facilitate processing. A Word fill-in enabled version of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Forms.

This form must be used to request Prior Authorization (PA) for Private Duty Nursing (PDN) services for beneficiaries with Medicaid coverage under 21 years of age. Private Duty Nursing is not a benefit under Children’s Special Health Care Services (CSHCS). Beneficiaries with CSHCS coverage may be eligible for PDN under Medicaid. A request to begin services may be submitted by a person other than the PDN such as the hospital Discharge Planner, CSHCS case manager, physician, or physician’s staff person. When this is the case, the person submitting the request must do so in consultation with the PDN who will be assuming responsibility for the care of the beneficiary. If services are being requested for more than one beneficiary in the home, a separate form must be completed for each beneficiary.

Refer to the Medicaid Provider Manual, Private Duty Nursing Chapter, Prior Authorization Subsection, for the listing of required documentation to accompany each request.

Completion of this form is as follows:

Item#	Instructions
1	Prior Authorization Number. MDHHS use only.
2	Check specific box as to whether this is an initial or renewal request. If a renewal, check the INCREASE UNITS or DECREASE UNITS box only if this request demonstrates an increase or decrease in time from the previous authorization period. Time is authorized and billed in 15-minute incremental units (1 unit = 15 minutes).
3 - 7	PDN provider information. Provide complete agency name, or name of individual (last, first, and middle initial). Designate whether RN or LPN. Include NPI number, phone number, address, and fax number.
8 - 14	Beneficiary information. Provide complete name and birth date (month, day, and year); sex, mihealth card number, complete address, county, and primary diagnosis using the appropriate ICD code only.
15 - 18	Other insurance information if applicable, including name of company and beneficiary’s group/policy and certificate/contract numbers.
19 - 25	Hospital information including complete address and phone number, anticipated discharge date, and name and contact information of Discharge Planner, if beneficiary is currently hospitalized.
26 - 30	Ordering physician information. Provide complete name (including MD or DO); NPI number, phone number, address, and fax number.
31 - 35	Description of the service(s) to be provided utilizing HCPCS code T1000 and modifier TD for RN or TE for LPN. Use modifier TT if caring for more than one beneficiary. Include the number of total units per month required to provide the service(s) with the start date and end date, if known.
36 - 40 43 - 49	Home environment information, including number of siblings residing in the home (include step and foster child(ren) if applicable) and if they receive PDN. Provide child’s name and mihealth card number if receiving PDN. Also provide the number of other individuals in the home requiring care (e.g., elderly parent, grandparent, disabled spouse, sibling), name(s) and number of caregivers for the beneficiary for whom services are being requested, and whether the caregiver(s) either work and/or attend school outside of the home. If so, how many hours are spent working and/or attending school. (Additional pages may be required.)
41 - 42	Current school information if child is or will be attending school during the authorization period when PDN services are being provided. Include number of hours per day and per week, including travel time.
50 - 56	If more than one PDN or PDN agency is involved, their name(s), phone number(s), fax number(s), and which PDN will be managing the care plan (i.e., the provider named in items 2 – 6, or the provider named in this space).
57	List all other services in the home. Failure to disclose all services in the home may result in recoupment of Medicaid dollars for PDN reimbursement.
58	The Provider’s signature certifies that (1) the individual PDN or agency requesting the services understands the necessity for obtaining prior authorization for PDN and; (2) The information provided on this form is accurate and complete.
59	Signature certifies that Parent/Guardian of beneficiary attests that information provided on this form is accurate and complete to the best of their ability.
60	MDHHS use only

Form Submission

The completed MSA-0732 (page 2) and required documentation must be mailed or faxed to:

Michigan Department of Health and Human Services **Fax:** (517) 241-7813
Program Review Division
P.O. Box 30170
Lansing, MI 48909

Questions should be directed to MDHHS - Medical Services Administration, Program Review Division via telephone at **1-800-622-0276**.

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable programs is sought.

The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.

Michigan Department of Health and Human Services
PRIVATE DUTY NURSING
PRIOR AUTHORIZATION – REQUEST FOR SERVICES

1. PRIOR AUTHORIZATION NUMBER (MDHHS USE ONLY)

The provider is responsible for eligibility verification. Authorization does not guarantee beneficiary eligibility or payment.

2. INDICATE IF THIS REQUEST IS: <input type="checkbox"/> INITIAL <input type="checkbox"/> RENEWAL <input type="checkbox"/> INCREASE UNITS <input type="checkbox"/> DECREASE UNITS					
3. PROVIDER'S NAME (AGENCY NAME, OR INDIVIDUAL'S NAME (IF INDEPENDENT RN/LPN))		4. NPI NUMBER		5. PHONE NUMBER	
6. PROVIDER'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)				7. FAX NUMBER	
8. BENEFICIARY'S NAME (LAST, FIRST, MIDDLE INITIAL)		9. SEX <input type="checkbox"/> M <input type="checkbox"/> F	10. BIRTH DATE	11. MIHEALTH CARD NUMBER	
12. BENEFICIARY'S ADDRESS (NUMBER, STREET, APT./LOT NUMBER, CITY, STATE, ZIP)		13. COUNTY		14. PRIMARY DIAGNOSIS (ICD CODE)	
15. OTHER INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO	16. HEALTH INSURANCE COMPANY NAME		17. GROUP / POLICY NUMBER	18. CERTIFICATE / CONTRACT NUMBER	
19. IS BENEFICIARY CURRENTLY HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PROVIDE FACILITY NAME, ADDRESS, PHONE NUMBER, DISCHARGE PLANNER BELOW.			ANTICIPATED DISCHARGE DATE:		
20. HOSPITAL NAME		21. HOSPITAL ADDRESS (NUMBER, STREET, CITY, STATE, ZIP)		22. PHONE NUMBER	
23. NAME OF DISCHARGE PLANNER		24. DISCHARGE PLANNER'S PHONE NUMBER		25. DISCHARGE PLANNER'S FAX NUMBER	
26. ORDERING PHYSICIAN'S NAME (LAST, FIRST, MIDDLE INITIAL, MD OR DO)		27. NPI NUMBER		28. PHONE NUMBER	
29. PHYSICIAN'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)			30. FAX NUMBER		
31. DESCRIPTION OF SERVICE		32. HCPCS/MODIFIER CODE(S)	33. UNITS PER MONTH	34. START DATE	
				35. END DATE	
36. NUMBER OF SIBLINGS	37. DOES ANYONE ELSE RECEIVE PDN SERVICES? <input type="checkbox"/> YES <input type="checkbox"/> NO	38. IF YES, PROVIDE CHILD'S NAME RECEIVING PDN SERVICES		39. CHILD'S MIHEALTH CARD NUMBER	
40. NUMBER OF OTHER INDIVIDUALS IN HOME REQUIRING CARE		41. IS THE BENEFICIARY CURRENTLY IN SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	42. IF YES, HOW MANY HOURS? _____ PER DAY _____ PER WEEK (INCLUDE TRAVEL TIME)		
43. NUMBER OF CAREGIVERS	44. CAREGIVERS NAME AND RELATIONSHIP TO BENEFICIARY		45. WORK OR ATTEND SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	46. NUMBER OF HRS/DAYS AT WORK AND/OR SCHOOL	
	47. CAREGIVERS NAME AND RELATIONSHIP TO BENEFICIARY		48. WORK OR ATTEND SCHOOL? <input type="checkbox"/> YES <input type="checkbox"/> NO	49. NUMBER OF HRS/DAYS AT WORK AND/OR SCHOOL	
50. IS MORE THAN ONE PDN/PDN AGENCY INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO	51. NAME OF OTHER PERSON/AGENCY		52. NPI NUMBER		53. PHONE NUMBER
					54. FAX NUMBER
55. WHO WILL BE MANAGING THE PDN CARE PLAN?			56. PHONE NUMBER (IF DIFFERENT THAN #5 ABOVE)		
57. OTHER THAN PDN, DOES THE BENEFICIARY RECEIVE OTHER SERVICES IN THE HOME? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, LIST OTHER SERVICES IN THE HOME					
PROVIDER'S SIGNATURE			DATE		
58. CERTIFICATION: THE PATIENT NAMED ABOVE (PARENT OR GUARDIAN IF APPLICABLE) UNDERSTANDS THE NECESSITY TO REQUEST PRIOR AUTHORIZATION FOR THE SERVICES INDICATED. I UNDERSTAND THAT SERVICES REQUESTED HEREIN REQUIRE PRIOR AUTHORIZATION AND, IF APPROVED AND SUBMITTED ON THE APPROPRIATE INVOICE, PAYMENT AND SATISFACTION OF AUTHORIZED SERVICES WILL BE FROM FEDERAL AND/OR STATE FUNDS. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY LEAD TO PROSECUTION UNDER APPLICABLE FEDERAL AND/OR STATE LAW. PROVIDER CERTIFIES THAT INFORMATION PROVIDED ON THIS FORM IS ACCURATE AND COMPLETE TO THE BEST OF THEIR ABILITY.					
59. PARENT GUARDIAN OF BENEFICIARY CERTIFIES THAT INFORMATION PROVIDED ON THIS FORM IS ACCURATE AND COMPLETE TO THE BEST OF THEIR ABILITY.					
PARENT/GUARDIAN SIGNATURE			DATE		
MDHHS USE ONLY					
60. REVIEW ACTION: APPROVED <input type="checkbox"/> INSUFFICIENT DATA <input type="checkbox"/> DENIED <input type="checkbox"/> NO ACTION <input type="checkbox"/> APPROVED AS AMENDED <input type="checkbox"/>					
CONSULTANT SIGNATURE			DATE		

PROVIDER ELECTRONIC SIGNATURE AGREEMENT COVER SHEET
Michigan Department of Health and Human Services

Instructions:

- Provider should retain a COPY in the office
- MUST be submitted with DCH-1401, Electronic Signature Agreement.

Mail to:

Provider Enrollment Section
Michigan Department of Health and Human Services
PO Box 30238
Lansing, MI 48909
Fax: 517-241-8233

Reason for Submission (check all that apply)

<input type="checkbox"/> Revalidation	<input type="checkbox"/> New Tax ID/SSN (List Provider Enrollment staff contact name)
<input type="checkbox"/> Domain Access <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Both	<input type="checkbox"/> Other (List reason)
<input type="checkbox"/> Domain Administrator Contact Information	

Contact Information (REQUIRED)

Name	Email Address	Phone Number
MILogin User ID	Provider's NPI Number	
Provider's Date of Birth	Provider's Home Address	

Provider Enrollment Office Use Only

<input type="checkbox"/> Provided Domain Administrator contact information <input type="checkbox"/> Sent/Gave to team lead for processing <input type="checkbox"/> Sent to processor with W-9 attached <input type="checkbox"/> Opened for revalidation
--

AUTHORITY: 42 CFR 455.104 COMPLETION: Voluntary, but required for access to CHAMPS.	The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.
--	--

Provision of Low Vision Services and Aids Support Documentation

To facilitate processing of your request for low vision services and aids, this form must be completed. Failure to provide complete documentation will result in automatic disapproval of your request. Do not use abbreviations as their use may result in misinterpretation and possible disapproval. A Vision Services Approval/Order form (DCH-0893) must accompany this documentation. (Exception: High add bifocals do not require prior approval; hence, a completed DCH-0893 should be sent directly to the State's vision contractor.)

Beneficiary's Name	Medicaid ID Number
---------------------------	---------------------------

Based on the Low Vision Evaluation provide the following information:

A. HISTORY

1. History of onset of low vision (including, but not limited to, onset, duration, etiology, and any ocular surgery):

2. Present spectacle correction:

R _____	VA _____	ADD _____	VA _____
L _____	VA _____	ADD _____	VA _____

3. Contact Lenses: (If worn)

Power R _____	Type R _____
Power L _____	Type L _____

4. Low vision aids presently in use:

Magnifiers: _____	Electronic Projection Magnifier: _____
Microscopics: _____	Filers/typoscopes/visors: _____
Telescopes: _____	Other: _____
Loupes: _____	

5. Relevant Systemic Conditions:

B. BENEFICIARY'S GOALS

C. SUMMARY FINDINGS

1. Ocular Diagnosis(es):
R _____ **L** _____

2. Vision Impairment Diagnosis:
R _____ **L** _____

3. Nature and Extent of Visual Fields:

4. Specifications of best conventional spectacle correction:

At distance	R _____	VA _____
	L _____	VA _____
At near	R _____	VA _____
	L _____	VA _____

D. RECOMMENDED TREATMENT

1. No treatment at this time. Follow-up for monitoring (check one):
 3 Months 6 Months 9 Months 12 Months

2. Referral for medical and/or surgical treatment:

3. Description of Recommended Low Vision Aids:

A. VA	
R _____	L _____
Description, manufacturer and catalog number _____	
Describe specific use:	
Describe benefit:	
Acquisition Cost	Professional Fee

B. VA	
R _____ Description, manufacturer and catalog number _____	L _____
Describe specific use:	
Describe benefit:	
Acquisition Cost	Professional Fee

C. VA	
R _____ Description, manufacturer and catalog number _____	L _____
Describe specific use:	
Describe benefit:	
Acquisition Cost	Professional Fee

E. OTHER RECOMMENDATIONS - DESCRIBE BENEFITS

F. PROGNOSIS

Signature of Examiner _____

Examiner (Print) _____

Date _____

REQUEST FOR AUTHORIZATION OF PRIVATE ROOM SUPPLEMENTAL PAYMENT FOR NURSING FACILITY

Michigan Department of Health and Human Services

This is my written request for authorization of supplemental payment for a single room for:

Name of Beneficiary/Resident	Medicaid ID Number
Facility Contact	Facility Telephone Number - -
Facility Name	Facility Fax Number - -
Facility Address	

The basis for this request is:

<input type="checkbox"/>	I believe a single room is medically necessary. (If medically necessary, the Medicaid daily rate already pays for a single room.)
<input type="checkbox"/>	I believe a single room is not medically necessary, but is needed for the following reason(s): _____

I understand that I must accept responsibility for paying the difference between the facility's two-person room and single room rates that are listed below. I will pay any difference in the rates that may change over time, as long as a single room is needed.

Two-person room rate: \$ _____ per day

Single room rate: \$ _____ per day

Printed Name of Requestor	Telephone Number - -
Address	Relationship to Beneficiary/Resident

Signature of Requester	Date
------------------------	------

MAIL TO: Long Term Care Services
Michigan Department of Health and Human Services
PO Box 30479
Lansing, MI 48909-7979

FAX TO: 517-241-8995

Note: If no response is received within 10 working days, contact 517-241-4293.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

Completion Instructions for DCH-0078 Request to Add, Terminate or Change Other Insurance

Form DCH-0078 is a formal request for change in other insurance status and must be submitted by the Medicaid provider, Medicaid Health Plan, Local Health Department or the Michigan Department of Health and Human Services caseworker to add, terminate, or change beneficiary insurance information other than Medicaid.

INSTRUCTIONS:

To add, terminate or change other insurance on-line, visit <https://www.Michigan.gov/ReportTPL> to access the form and instructions.

To submit the form via fax or mail:

- ❖ PRINT or TYPE to complete the form
- ❖ Place a check mark in the appropriate "Add," "Terminate," or "Change" field
- ❖ Sections denoted by * are mandatory to be completed
- ❖ Attach clear copy of insurance card (front and back) when adding insurance (if available)
- ❖ Retain a COPY in beneficiary file
- ❖ Submit form and applicable attachments

via: Fax Number: **517-346-9817**

Mail to: Michigan Department of Health and Human Services
Third Party Liability Division
Bureau of Medicaid Operations
PO Box 30479
Lansing MI 48909

Allow 7-10 business days for the request to be completed. To verify the request has been completed, view the beneficiary eligibility information in the Community Health Automated Medicaid Processing System (CHAMPS).

AUTHORITY: Title V and Title XIX of the Social Security Act.
COMPLETION: Is voluntary.

The Michigan Department of Health and Human Services is an equal opportunity employer, services, and programs provider.

Michigan Department of Health and Human Services

REQUEST TO ADD, TERMINATE OR CHANGE OTHER INSURANCE

ADD

TERMINATE

CHANGE

SECTION 1 – Medicaid Provider/Medicaid Health Plan/LHD/MDHHS Caseworker Information *

Requestor Name	Date	County/Local Health Department
Phone Number ()	FAX Number ()	Case Number (if available)

SECTION 2 – List of Beneficiaries/Clients to Add, Terminate or Change Insurance *

Beneficiary/Client Name	Date of Birth	mihealth ID	Beneficiary/Client Name	Date of Birth	mihealth ID
Beneficiary/Client Name	Date of Birth	mihealth ID	Beneficiary/Client Name	Date of Birth	mihealth ID
Beneficiary/Client Name	Date of Birth	mihealth ID	Beneficiary/Client Name	Date of Birth	mihealth ID

SECTION 3 – Policyholder Information *

Policyholder Name (Last, First, Middle)	Date of Birth	Employer Name
Social Security Number	Employer City and State	
Type of Coverage (use an "X") <input type="checkbox"/> Traditional <input type="checkbox"/> Managed Care (Preferred Provider Organization, Health Maintenance Organization, Point of Service)		
Health Insurance Company Name	Group / Policy Number	Certificate / Contract Number
Pharmacy Insurance Name	Dental Insurance Name	Vision Insurance Name

SECTION 4 – Reason For Change

<input type="checkbox"/> Divorce →	Date of Divorce	<input type="checkbox"/> Military Discharge →	Date of Discharge
<input type="checkbox"/> Coverage Termination →	Date of Termination	<input type="checkbox"/> Employment Termination →	Date of Termination
<input type="checkbox"/> OTHER (explain): →	Date of Change	Reason:	

Attachments: Attach documentation to substantiate a request to terminate or change insurance coverage, such as a letter from an insurance company or employer.

COMMENTS:

SUBMIT:

MDHHS - THIRD PARTY LIABILITY DIVISION

FAX (517) 346-9817

AUTHORITY: Title V and Title XIX of the Social Security Act.
COMPLETION: Is voluntary.

The Michigan Department of Health and Human Services is an equal opportunity employer, services, and programs provider.

SAMPLE NOTICE OF NON-COVERAGE

(Hospital Letterhead)

(Name of Patient)
(Address)
(City, State, Zip)

(Date of Notice)

(Medical Record Number)
(Beneficiary Number)
(Attending Physician's Name)
(Admission Date)

Dear (Name of Patient)

SUBJECT: CONTINUED STAY NOTICE OF NON-COVERAGE

As a Medicaid beneficiary, it is important for you to understand that there are circumstances when Medicaid does not pay for hospital care or certain services provided in the hospital. Medicaid pays for hospital care when the services are medically necessary and delivered in the most appropriate setting.

The Utilization Review Committee of (Name of Hospital) has reviewed the medical services you have received for (Specify services or condition) from (Date of Admission) to (Date of Notice). The Review Committee has determined that your continued stay in an acute care hospital is not medically necessary, and the medical services you are receiving for (Specify services or condition) could be safely rendered in another less costly setting. You should discuss with your attending physician the arrangements for the health care you may require.

You will not be responsible for payment of the services which are rendered by this hospital from (Date of Admission) through the date you receive this notice, except for payment of deductible, coinsurance, or any convenience services or items not covered by Medicaid. If you decide to stay in the hospital, you will be responsible for payment of all services provided to you by this hospital beginning the day after you receive this notice.

For example: If you receive this notice on _____ you will be responsible for payment of services provided beginning_____.

The Michigan Peer Review Organization (MPRO) is the review organization authorized by the Medicaid Program to re-review on behalf of the patient or his/her physician any hospital denied to Medicaid patients in the State of Michigan.

If you disagree with this decision and you remain in the hospital, you or your representative may request an immediate review by MPRO. You may request this by calling:

Michigan Peer Review Organization
Attention: Medicaid PACER Program
22670 Haggerty Rd., Ste. 100
Farmington Hills, MI 48335-2611
Telephone: 1-800-727-7223

"SAMPLE"
NOTICE OF NON-COVERAGE

(Hospital Letterhead)

(Name of Patient)
(Address)
(City, State, Zip)

(Date of Notice)

(Medical Record Number)
(Beneficiary Medicaid Number)
(Attending Physician's Name)
(Admission Date – *if applicable*)

Subject: NOTICE OF NON-COVERAGE FOR
INPATIENT HOSPITAL ADMISSION

Dear (Name of Patient):

As a Medicaid beneficiary, it is important for you to understand that there are circumstances when Medicaid does not pay for hospital care or inpatient services provided in the hospital. Medicaid pays for hospital care when the services are medically necessary and delivered in the most appropriate setting.

NOTICE OF NON-COVERAGE

(Name of Hospital) Utilization Review (UR) Committee has reviewed your physician's request for your hospital admission. The request has been denied. The hospital's UR Committee has determined that your admission to (Name of Hospital) for treatment of (Specify services or condition) is either: 1) not medically necessary, or 2) that the medical services you may require for the treatment of your condition can be safely rendered in another less costly setting. You should discuss arrangements for any health care treatment you may require with your physician.

APPEAL RIGHTS

The Michigan Peer Review Organization (MPRO) is the review organization authorized by the Medicaid Program to review on behalf of the patient or his/her physician any hospital care denied to Medicaid patients in the State of Michigan.

If you disagree with this decision, you or your representative must request an immediate review by MPRO. You must request this review by calling:

Michigan Peer Review Organization
Attention: Medicaid PACER Program
22670 Haggerty Road, Suite 100
Farmington Hills, MI 48335-2611
Telephone: 1-800-727-7223

If MPRO confirms the hospital's initial decision, you will be notified in writing of its decision. If you decide to proceed with the admission to the hospital, you will be responsible for the payment of all services provided to you by the hospital beginning with the date of admission.

If MPRO overturns the hospital's decision, you will also be notified in writing of MPRO's decision. The hospital will contact your physician and make arrangements for your admission to the hospital. Medicaid will cover the cost of your hospital stay except for the payment of any deductible, coinsurance, or convenience services or items not covered by Medicaid.

Maternal Infant Health Program Provider and Medicaid Health Plan Care Coordination Agreement

This agreement is made and entered into this _____ day of _____, in the year _____ by and between _____ (Medicaid Health Plan) and _____ (Maternal Infant Health Program provider).

A. Legal Basis

Whereas, in order to expand enrollment, the Michigan Department of Health and Human Services (MDHHS) has established a competitive bid process that has resulted in contracts with Medicaid Health Plans (MHPs) that are deemed to be qualified to provide specified health care services to Medicaid beneficiaries; and

Whereas, Medicaid-covered maternal and infant health services will be provided through arrangements between MDHHS, MDHHS contracted MHPs, and selected Maternal Infant Health Program (MIHP) providers.

Now, therefore, the MHP and the MIHP provider agree as follows:

B. Terms of Agreement

This agreement will be effective _____ in the year _____. This agreement will be subject to amendment due to changes in the contract between MDHHS and the MHP or changes to the MIHP Medicaid policy certification requirements.

This agreement is effective upon execution and will continue for the length of MHP and MDHHS contract period. Either party may cancel this agreement for cause upon 30 days written notice. Reasons for cause include: breach of duty or obligation; fraud or abuse; federal or state sanctions; and failure to comply with state law or rules the Medicaid Provider Manual, or the MIHP Operations Guide. The terminating party is required to notify MDHHS at least 30 days prior to termination. This agreement will automatically terminate when an MIHP provider fails to maintain the certification requirements of MDHHS.

Once a signed agreement is obtained from both parties, the provisions of this agreement will be extended for a timeframe consistent with the MHP and MDHHS contract period, and the MIHP provider maintaining certification with MDHHS. Either party may cancel this agreement upon 30 days written notice. MDHHS must be notified of the termination of this agreement.

C. Purpose, Administration and Point of Authority

MIHP services are home-visiting preventive services provided to pregnant women, mothers, and their infants to promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development. These support services are to be provided by a multidisciplinary team of health care professionals consisting of a qualified licensed registered nurse, licensed social worker and, if available, a registered dietitian and/or infant mental health specialist.

MIHP services are intended to supplement regular prenatal/infant care and to assist physicians (MD, DO), certified nurse midwives (CNMs), and nurse practitioners (NPs) contracted with MHPs. In compliance with MIHP and MHP guidelines, MIHP providers are to coordinate care with medical care providers, mental health providers, and the MHPs, as well as assist in the coordination of transportation services as needed for health care, support services and pregnancy-related appointments.

MDHHS/MHP Contracts and MHP/MIHP Care Coordination Agreements will be available for review upon request by MDHHS. The intent of the Care Coordination Agreement is to explicitly describe the services to be coordinated and the essential aspects of collaboration between the MHP and the MIHP provider.

The MHP shall designate in writing to the MIHP provider the person who has authority to administer this agreement. The MIHP provider shall designate in writing to the MHP the person who has authority to administer this agreement.

D. Areas of Responsibility

Mutually Served Consumers

Mutually served consumers refers to MHP beneficiaries who also qualify for MIHP services. All pregnant and infant Medicaid beneficiaries may qualify for MIHP services. The intent of establishing written procedures between the MHP and the MIHP provider is to assure service coordination and continuity of care for persons receiving services from both entities.

Services to be Provided by the MHP

The MHP will provide Medicaid covered services to Medicaid beneficiaries as required by the MHP contract with MDHHS. MIHP services are voluntary. Beneficiaries may refuse MIHP services at any time.

The MHP will notify all Medicaid beneficiaries enrolled in the MHP of the availability of MIHP services at the time of enrollment. The MHP shall provide a referral for MIHP services for those pregnant and infant Medicaid beneficiaries who are not currently receiving MIHP services or receiving equivalent maternal or infant support services from an evidence-based home visiting program. Referrals can be made in person, by letter, email, fax, or telephone.

Services to be Provided by the MIHP Provider

The MIHP provider will provide the following services:

- Psychosocial and nutritional screening and assessment;
- Plan of care development;
- Professional intervention services by a multidisciplinary team consisting of a qualified licensed registered nurse and licensed social worker and, when available, a registered dietitian and/or an infant mental health specialist;
- Coordination with the MHP for transportation services as needed for health care, substance use disorder treatment, support services, oral health services, and/or pregnancy-related appointments.
- Referral to community services (e.g. mental health, substance use disorder);
- Referral to or provision of childbirth or parenting education classes;
- Coordination with medical care providers; and
- Coordination with the MHP.

MIHP providers will bill and receive reimbursement for MIHP services provided to MHP members as noted in the provider contract established with the applicable MHP.

E. Medical Coordination

Both parties agree to establish a process for clinical staff to communicate on a regular basis to review the care coordination plans and status of mutually served beneficiaries in accordance with applicable privacy laws such as HIPAA, the Mental Health Code and 42 CFR Part 2. This may involve the sharing of written documents and verbal reports. Both parties will collaborate on development of referral procedures and effective means of communicating the need for individual referrals. The MIHP provider will provide the MHP with names of MHP beneficiaries receiving MIHP services on a regular basis, utilizing a standardized form. Communication may include assessment/screening results, the plan of care, and discharge summaries upon request.

The MIHP and MHP will accept and use the MDHHS behavioral health consent form (Consent to Share Behavioral Health Information form [MDHHS-5515]) to disclose medical information protected under the Mental Health Code or substance use disorder information under 42 CFR Part 2.

F. Grievance and Appeals

MIHP providers and MHPs are required to establish internal processes for resolution of grievances and appeals from Medicaid beneficiaries. Medicaid beneficiaries may file a grievance or appeal on any aspect of service provided to them by the MIHP or the MHP in accordance with MIHP and MHP grievance and appeal policies.

The MIHP provider is required to direct beneficiaries to the MHP's grievance and appeal process as appropriate. The MHP is required to direct beneficiaries to the MIHP provider's grievance and appeal process as appropriate.

Both parties will participate in grievance and appeal policies and shall cooperate in identifying, processing, and promptly resolving all grievances and appeals. Both parties are responsible for informing the other about their grievance and appeal process.

G. Dispute Resolution

Both parties agree to participate in a dispute resolution process in the event that the MHP or the MIHP provider contests a decision or action by the other party related to the terms of this agreement.

The dispute resolution process should include:

- Request to the other party for reconsideration of the disputed decision or action.
- Appeal to MDHHS regarding a disputed decision by an MHP, or for a disputed decision by an MIHP provider.

H. Transportation

The MHP and the MIHP provider each have specific requirements for coordinating transportation services for Medicaid beneficiaries. These responsibilities are outlined in the MHP contract with MDHHS, the contract between the MIHP and the MHP and in the Maternal Infant Health Program Chapter of the Medicaid Provider Manual.

The MIHP provider may coordinate transportation in accordance with the established MIHP/MHP provider agreement or refer the Medicaid beneficiary to utilize the MHP transportation benefit to access MHP covered services, substance use disorder treatment, oral health services, support services and/or pregnancy-related appointments.

Transportation must be arranged and provided within a reasonable timeframe to meet the needs of the beneficiary. The provision or arrangement of transportation may not be delayed due to disagreements between the MIHP and MHP regarding financial responsibility for transportation. Disputes as to payment of transportation services may be handled through the dispute resolution process.

I. Quality Improvement

Both parties agree to have mechanisms in place to conduct Quality Improvement activities to monitor the coordination of services. The MIHP provider and the MHP shall participate in quality improvement programs and shall cooperate in conducting reviews and audits of care.

J. Governing Laws

Both parties agree that performance under this agreement will be conducted in compliance with all federal, state and local laws, regulations, guidelines, and directives.

K. Signatures

Maternal Infant Health Program Provider

Medicaid Health Plan

Signature

Signature

Title

Title

Date

Date

Business Address

Business Address

Business Telephone

Business Telephone

Billing Provider NPI: 1111111111

Name: Example O. Provider

EIN/TIN: 010101010

Vendor ID: XX0000000

Pay Cycle: XX

RA Number: 78176112

RA Date: 10/12/2017

FINANCIAL ADJUSTMENTS

Adjustment Type	Previous Balance	Adjustment Amount	Remaining Balance
Balance Owed by Tax ID	\$0.00		\$0.00

CLAIM SUMMARY

Category	Count
Paid	64
Credited	0
Denied	29
GA	0

Total Approved	\$261,244.79	Total Adjusted	\$0.00	Total Paid	\$261,244.79
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Warrant/EFT #: 000032295

Warrant/EFT Date: 10/12/2017

RA Sample



164271838000003

Gross Adj ID Beneficiary Name Beneficiary ID Patient Account # Medical Record #	Original TCN TCN Type of Bill	Submitter ID Rendering Provider NPI	Invoice Date Service Date(s)	Revenue Procedure Modifier	PPS DRG APC	Qty	Billed Amount	Approved Amount	Category	Reason	Remark
Patient, One XXXXXXXXXX XXXXXXXXXX XXX XXXXXXXXXX	XXXXXXXXXXXXXXXXXX XX	0059	09/27/2017 07/31/2017-07/31/2017				\$4,605.51	\$0.00	D		MA32
	XXXXXXXXXXXXXXXXXX		-	0022		1	\$0.00	\$0.00	D		N522, N56
	XXXXXXXXXXXXXXXXXX		07/31/2017-07/31/2017	0130		1	\$760.00	\$0.00	D	B7	M53, N522
	XXXXXXXXXXXXXXXXXX		-	0250		7	\$394.06	\$0.00	D	B7	N522
	XXXXXXXXXXXXXXXXXX		-	0270		1	\$103.19	\$0.00	D	B7	N522
	XXXXXXXXXXXXXXXXXX		-	0410		0	\$3,969.00	\$0.00	D	B7	N522
Patient, Two XXXXXXXXXX XXXXXXXXXX XXX XXXXXXXXXX	XXXXXXXXXXXXXXXXXX XX	12901	09/27/2017 08/01/2017-08/31/2017				\$13,129.74	\$0.00	D		
	XXXXXXXXXXXXXXXXXX		-	0022		13	\$0.00	\$0.00	D		N56
	XXXXXXXXXXXXXXXXXX		-	0022		8	\$0.00	\$0.00	D		N56
	XXXXXXXXXXXXXXXXXX		-	0022		10	\$0.00	\$0.00	D		N56
	XXXXXXXXXXXXXXXXXX		-	0130		13	\$9,880.00	\$0.00	D	B7	
	XXXXXXXXXXXXXXXXXX		-	0130		8	\$6,080.00	\$0.00	D	B7	
	XXXXXXXXXXXXXXXXXX		-	0130		10	\$7,600.00	\$0.00	D	B7	N362
	XXXXXXXXXXXXXXXXXX		-	0430		68	\$2,505.67	\$0.00	D	B7	N301, N674
	XXXXXXXXXXXXXXXXXX		-	0434		1	\$99.65	\$0.00	D	B7	N301, N674
Patient, Three XXXXXXXXXX XXXXXXXXXX XXX XXXXXXXXXX	XXXXXXXXXXXXXXXXXX XX	0059	10/03/2017 09/01/2017-09/30/2017				\$7,650.00	\$5,532.10	P		N48
	XXXXXXXXXXXXXXXXXX		09/01/2017-09/30/2017	0120		30	\$7,650.00	\$5,532.10	P	142, 45	
Patient, Four XXXXXXXXXX XXXXXXXXXX XXX XXXXXXXXXX	XXXXXXXXXXXXXXXXXX XX	0059	10/03/2017 09/01/2017-09/30/2017				\$7,650.00	\$4,690.10	P		



164271838000004

Michigan Department of Health and Human Services
Special Services Prior Approval - Request/Authorization
Completion Instructions

The MSA-1653-B must be used by Medicaid enrolled DME, Medical Suppliers, Orthotists, Prosthetists, Hearing Aid Dealers, Audiologists and Cochlear Manufacturers.

MDHHS requests that the MSA-1653-B be typewritten to facilitate processing. A Word fill-in enabled version of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms. The form is generally self-explanatory. For information on required modifiers, documentation, and appropriate quantity amounts, refer to the following documents:

- Standards of Coverage portion of the provider-specific chapters of the Medicaid Provider Manual.
- Billing & Reimbursement for Professionals Chapter of the Medicaid Provider Manual.
- Provider-specific databases on the MDHHS website. www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.

Completion of this form is as follows:

Box 1	MDHHS Use Only
Box 12	Check Yes if beneficiary is in a Nursing Facility or No if the beneficiary is not in a Nursing Care Facility. If Yes, include the Nursing Facility name, address and phone number.
Box 20	Enter a complete description of the item requested, including manufacturer, model, style, etc. DME, orthotics and prosthetics, must provide the brand name, model, and catalog or part number.
Box 21	Enter the HCPCS Procedure Code.
Box 22	Enter the applicable HCPCS Modifier.
Box 25	Enter the beneficiary's primary and secondary diagnoses or the CSHCS qualifying diagnosis (list both the code and description). DME/POS providers must submit the prescription/CMN with this form.
Box 26	Any additional remarks regarding the request should be listed in this box such as verbal authorization date, retroactive date of service if being requested. Provide other insurance coverage for services requested.
Box 28	Must be completed for all requests.

Form Submission

PA request forms and required documentation for all eligible Medicaid beneficiaries must be mailed or faxed to:

MDHHS - Medical Services Administration
Program Review Division
P.O. Box 30170
Lansing, Michigan 48909

Fax Number: (517) 335-0075

To check the status of a PA request, contact the MDHHS - Medical Services Administration, Program Review Division via telephone at **1-800-622-0276**.

Michigan Department of Health and Human Services
SPECIAL SERVICES
PRIOR APPROVAL – REQUEST/AUTHORIZATION

1. PRIOR AUTHORIZATION NUMBER (MDHHS USE ONLY)
--

The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.

2. PROVIDER'S NAME (LAST, FIRST, MIDDLE INITIAL)		3. NPI NUMBER		4. PHONE NUMBER	
5. PROVIDER'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)				6. FAX NUMBER	
7. BENEFICIARY'S NAME (LAST, FIRST, MIDDLE INITIAL)		8. SEX <input type="checkbox"/> M <input type="checkbox"/> F	9. BIRTH DATE	10. MIHEALTH CARD NUMBER	
11. BENEFICIARY'S ADDRESS (NUMBER, STREET, APT./LOT NUMBER, CITY, STATE, ZIP)					
12. DOES BENEFICIARY RESIDE IN A NURSING FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PROVIDE FACILITY NAME, ADDRESS, PHONE NUMBER.					
13. REFERRING/ORDERING PHYSICIAN'S NAME (LAST, FIRST, MIDDLE INITIAL)			14. NPI NUMBER		15. PHONE NUMBER
16. REFERRING/ORDERING PHYSICIAN'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)				17. FAX NUMBER	

18. LINE NO.	19. BRAND NAME, MODEL CATALOG OR PART NUMBER	20. DESCRIPTION OF SERVICE	21. PROCEDURE CODE	22. MODIFIER	23. QUANTITY	24. CHARGE
01						
02						
03						
04						
05						
06						
07						

25. DIAGNOSES (CODES AND DESCRIPTIONS) REQUIRING THE ABOVE SERVICES.	26. ADDITIONAL REMARKS, INCLUDING OTHER INSURANCE COVERAGE, FOR SERVICES REQUESTED.
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27. INDICATE ANY OTHER SERVICES PROVIDED TO THIS BENEFICIARY DURING THE PAST YEAR.

28. PROVIDER CERTIFICATION: THE PATIENT NAMED ABOVE (PARENT OR GUARDIAN IF APPLICABLE) UNDERSTANDS THE NECESSITY TO REQUEST PRIOR APPROVAL FOR THE SERVICES INDICATED. I UNDERSTAND THAT SERVICES REQUESTED HEREIN REQUIRE PRIOR APPROVAL AND, IF APPROVED AND SUBMITTED ON THE APPROPRIATE INVOICE, PAYMENT AND SATISFACTION OF APPROVED SERVICES WILL BE FROM FEDERAL AND/OR STATE FUNDS. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY LEAD TO PROSECUTION UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

PROVIDER'S SIGNATURE _____ DATE _____

MDHHS USE ONLY	
29. REVIEW ACTION: APPROVED <input type="checkbox"/> RETURN <input type="checkbox"/> DENIED <input type="checkbox"/> NO ACTION <input type="checkbox"/> APPROVED AS AMENDED <input type="checkbox"/>	30. CONSULTANT REMARKS

CONSULTANT SIGNATURE _____ DATE _____

**VISION SERVICES APPROVAL/ORDER
COMPLETION INSTRUCTIONS FOR DCH-0893**
Michigan Department of Health and Human Services

GENERAL INSTRUCTIONS

The DCH-0893 must be used by Medicaid enrolled vision providers to request Prior Approval (PA) and/or order optical hardware for vision services. MDHHS requests that the DCH-0893 be typewritten to facilitate processing. A fill-in enabled copy of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms. The request for PA must be complete and of adequate clarity to permit a determination of the appropriateness of the service without examination of the beneficiary. The form is generally self-explanatory. The following instructions are to assist in completing the DCH-0893.

Note:

- If prior authorization is required, attach documentation of medical necessity and the detailed training plan (if applicable) pursuant to the Medicaid Provider Manual.
- If applicable, complete and attach form MSA-0891 (Provision of Low Vision Services and Aids Support Documentation).
- If applicable, complete and attach form MSA-0892 (Documentation of Medical Necessity for the Provision of Contact Lenses).

Item	Instructions
1	MDHHS use only
2 - 3	Related to the ordering provider.
4	Provide the date the service and/or hardware is being ordered.
5 - 7	Related to the ordering provider
8 - 9	Related to the prescribing provider
10	Ordering Provider Signature requires a hand-written signature (i.e., a stamped signature is unacceptable).
11 - 15	Beneficiary information which can be obtained from the mihealth card or, for Children's Special Health Care Services (CSHCS) enrollees, from the Client Eligibility Notice.
16	The diagnosis(es) code(s) reflecting the greatest specificity for the diagnosis(es) from the International Classification of Diseases (ICD). If appropriate, each eye's diagnosis(es) must be included.
17 - 21	Relate to services and materials being requested and applicable charges. <ul style="list-style-type: none"> • Lines 01 through 07 are available for lenses, frames, and/or special characteristics (e.g., prisms, high adds) or other services (e.g., contact lens, orthoptics), if applicable. • Item 18 (Procedure Code) must reflect the appropriate CPT/HCPCS procedure code. • Item 19 (Modifier) must reflect a valid modifier applicable for the listed procedure code. • Item 20 (Quantity) must reflect the appropriate quantity for each procedure code. Each spectacle lens procedure code represents one lens. When requesting approval for, or ordering, a pair of spectacle lenses using the same procedure code, use a quantity of "2." • Item 21 (Charge) is completed only <u>for items without fee screens requiring prior approval</u>. Enter your usual and customary charge.
22 - 24	Relate to the type/style of lens(es) and frame requested.
25	Enter all lens specifications. The width and style must be consistent with the procedure code appearing in Item 18.
26	Additional instructions to the vision contractor necessary for proper fabrication.
27	Specifications from the beneficiary's previous lens(es). This is applicable for diopter changes or replacements, as well as when requesting frames only. NOTE: The only time this item is left blank is for initial spectacles.
28 - 29	MDHHS use only.

Submission Instructions

Prior Approval

PA requests should be received by the MDHHS Vision Contract Manager no more than 30 calendar days from the date of order. If received beyond 30 days, the provider must include a detailed explanation of why the form submission was delayed.

The provider should retain a copy of the completed form for their file and **mail or fax** the DCH-0893 to:

**MDHHS Vision Contract Manager
Program Review Division
PO Box 30170
Lansing, MI 48909

Fax: 517-335-0075**

Upon completion of the PA process, a copy of the DCH-0893 is returned to the provider.

Optical Hardware Order

Orders placed with the vision contractor must be received no more than 30 calendar days after the date of order. If beyond the 30 days, the contractor will return the order to the provider who must explain to the Medicaid Program Review Division why the form submission was delayed and request an exception from the time limit.

When placing an order with the contractor, the provider should retain a copy of the completed form for their file and submit the DCH-0893 to:

**Classic Optical Laboratories
3710 Belmont Avenue
PO Box 1341
Youngstown, OH 44501-1341

Telephone: 888-522-2020
Fax: 888-522-2022
Online Address: <http://www.classicoptical.com>**

Note: Optical hardware orders may also be submitted through an online process with the vision contractor. To utilize on-line submission, contact Classic Optical Laboratories for additional information.

VISION SERVICES APPROVAL / ORDER
Michigan Department of Health and Human Services

1. Prior Authorization Number (MDHHS Use Only)

The provider is responsible for eligibility verification. Approval does NOT guarantee beneficiary eligibility or payment.

2. Ordering Provider Name (Last, First, Middle Initial)				3. Ordering Provider NPI Number		4. Date of Order (MM/DD/YYYY)			
5. Address (No. & Street, Suite, etc.)				10. Ordering Provider Certification The patient named below (parent or guardian if applicable) understands the necessity to request vision services and/or prior approval for the vision services indicated. I understand that services requested herein may require prior approval and, if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of material fact may lead to prosecution under applicable Federal and State law.					
City		State						Zip Code	
6. Provider Fax Number		7. Provider Phone Number							
8. Individual Prescribing Provider Name (Last, First, Middle Initial)									
9. Individual Prescribing Provider NPI Number									
11. Beneficiary Name (Last, First, Middle Initial)				12. Birth Date		13. mihealth Card Number			
14. Beneficiary Address (No. & Street, Apt./Lot #, City, State, Zip Code)				15. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		16. ICD Diagnosis Code			
	17. Description of Service(S)			R	L	18. Proc. Code	19. Mod.	20. Quantity	21. Charge
01				<input type="checkbox"/>	<input type="checkbox"/>				
02				<input type="checkbox"/>	<input type="checkbox"/>				
03				<input type="checkbox"/>	<input type="checkbox"/>				
04				<input type="checkbox"/>	<input type="checkbox"/>				
05				<input type="checkbox"/>	<input type="checkbox"/>				
06				<input type="checkbox"/>	<input type="checkbox"/>				
07				<input type="checkbox"/>	<input type="checkbox"/>				
Note: If prior authorization is required, attach documentation of medical necessity pursuant to Medicaid Provider Manual.									
22. Lens Type: <input type="checkbox"/> Plastic <input type="checkbox"/> Glass <input type="checkbox"/> Polycarbonate <input type="checkbox"/> Lens(es) Only <input type="checkbox"/> Frame Only									
23. Lens Style: <input type="checkbox"/> Single Vision <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Hi Index <input type="checkbox"/> Cataract									
24. Frame Name			C-Size		Manufacturer				
Color			Eye Size		Bridge Size		Temple Style & Length		
25. LENS SPECIFICATIONS									
	SPHERE	CYLINDER	AXIS	PRISM POWER & BASE DIRECTION	MRP				
					HORIZONTAL	HEIGHT			
R									
L									
	ADD	SEGMENT HEIGHT	WIDTH & STYLE	SEGMENT INSET	TOTAL INSET	PD			
R							Far:		
L							Near:		
26. Special Instructions to Laboratory:									
27. PREVIOUS LENS SPECIFICATIONS									
	SPHERE	CYLINDER	AXIS	ADD	PRISM/ DIRECTION	LENS STYLE			
R									
L									
MDHHS USE ONLY									
28. Review Action: <input type="checkbox"/> Approved <input type="checkbox"/> Insufficient Data <input type="checkbox"/> Approved as Amended <input type="checkbox"/> Denied <input type="checkbox"/> No Action									
29. Consultant Comments							Initials and Date		