Michigan Medicaid Policy | MMP

BULLETIN

BEHAVIORAL AND PHYSICAL HEALTH AND AGING SERVICES ADMINISTRATION

MDHHS

Bulletin Number: MMP 23-14

Distribution: All Providers

Issued: March 2, 2023

Subject: Updates to the MDHHS Medicaid Provider Manual; Medicaid Eligibility Requirements; Federal Public Health Emergency

Effective: April 1, 2023

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

Updates to the MDHHS Medicaid Provider Manual

The Michigan Department of Health and Human Services (MDHHS) has completed the April 2023 update of the online version of the MDHHS Medicaid Provider Manual. The manual will be available April 1, 2023 at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Medicaid Provider Manual.

If changes were made in a chapter, a note will appear in the affected section/subsection title of that chapter's table of contents. If both technical and bulletin incorporation changes apply to the section/subsection, color coding will be limited to reflect a bulletin-related change.

Please refer to the online version of this bulletin at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms to view the attachments that describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change.

Medicaid Eligibility Requirements Restart Following Recent Federal Legislation

Medicaid beneficiaries will have to renew their coverage this year, starting in June, as Michigan resumes Medicaid eligibility redeterminations to comply with federal legislation.

During the federal COVID-19 Public Health Emergency (PHE), Congress enacted the Families First Coronavirus Response Act that required state Medicaid agencies continue health care coverage for all medical assistance programs, even if someone's eligibility changed. Michigan’s Medicaid caseload grew by more than 700,000 people during the public health emergency. This requirement was ended by the federal Consolidated Appropriations Act of 2023 signed December 29, 2022.

Renewals for traditional Medicaid and the Healthy Michigan Plan will take place monthly starting in June 2023. Monthly renewal notices will be sent three months prior to a beneficiary's renewal date starting with June renewal dates.

To ensure beneficiaries are aware of upcoming federal redetermination requirements and help them keep their coverage if eligible, MDHHS is launching a multi-media advertising campaign. This will include radio, audio streaming, outdoor, mobile and social media ads, including minority media outlets and stakeholder communications.

More information about how benefits connected to the COVID-19 Public Health Emergency are changing can be found at www.Michigan.gov/2023BenefitChanges.

Federal Public Health Emergency Expected to End on May 11, 2023

The U.S. Department of Health and Human Services is planning for the federal Public Health Emergency (PHE) for COVID-19, declared under Section 319 of the Public Health Service Act, to expire at the end of the day on May 11, 2023.

During the federal COVID-19 PHE, many changes were made to Michigan Medicaid program eligibility, administration, and policies to ease rules for providers and prevent Medicaid beneficiaries from losing health care coverage. Michigan has begun the process of unwinding certain policies that were enacted during the PHE and will continue the unwind process as the authority for these policies expire. A crosswalk that provides information about the policy unwind activities can be found at www.michigan.gov/2023BenefitChanges >> Learn more about Medicaid benefit changes >> I am a Medicaid provider. This crosswalk will be continually updated with the latest information as the department releases updated policies.

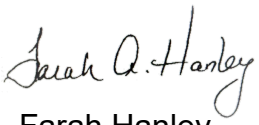
Manual Maintenance

If utilizing the online version of the manual at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms, this bulletin and those referenced in this bulletin may be discarded. If using a CD version of the MDHHS Medicaid Provider Manual, providers should retain all bulletins issued since the version date of the CD. Providers are encouraged to use the MDHHS Medicaid Provider Manual on the MDHHS website; the online version of the manual is updated on a quarterly basis.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit questions, be sure to include your name, affiliation, NPI number, and phone number so you may be contacted if necessary. Typical Providers may phone toll-free 1-800-292-2550. Atypical Providers may phone toll-free 1-800-979-4662.

Approved



Farah Hanley
Chief Deputy Director for Health

Medicaid Provider Manual
April 2023 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans	For the Benefit Plan ID of AUT (Autism Related Services), the following text was added: NOTE: This benefit plan is obsolete as of 3/31/2023.	Update.
Billing & Reimbursement for Dental Providers	3.3 Reporting Provider NPI	The 1st paragraph was revised to read: 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)~~ (Organization) 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. The 3rd paragraph was revised to read: A Type 2 ~~(Group)~~ (Organization) 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~~ Organization 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)~~ (Organization) NPI as the rendering provider.	Updating references to "Group NPI" to read "Organization NPI" for consistency with terminology used throughout the Manual.
Billing & Reimbursement for Institutional Providers	2.3 Reporting Provider NPI	The 3rd paragraph was revised to read: A Type 2 ~~(Group)~~ (Organization) 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~~ Organization 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)~~ (Organization) NPI as the rendering provider.	Updating references to "Group NPI" to read "Organization NPI" for consistency with terminology used throughout the Manual.

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

Medicaid Provider Manual
April 2023 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	8.20 State Veterans' Homes	The following text was added at the end of the subsection: 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.	This sentence is already stated in the Nursing Facility Cost Reporting and Reimbursement Appendix. It was requested to have it added to the Billing & Reimbursement for Institutional Providers chapter in response to a policy clarification.
Billing & Reimbursement for Professionals	2.3 Reporting Provider NPI	The 1st paragraph was revised to read: 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)~~ (Organization) 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. The 3rd paragraph was revised to read: A Type 2 ~~(Group)~~ (Organization) 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~~ Organization 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)~~ (Organization) NPI as the rendering provider.	Updating references to "Group NPI" to read "Organization NPI" for consistency with terminology used throughout the Manual.

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TECHNICAL CHANGES*

<table>
<tr><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th><th>COMMENT</th></tr>
<tr><td>Billing & Reimbursement for Professionals</td><td>7.6.B. New/Used DME</td><td>Modifier information was revised as follows:

<table><tr><th>Modifier</th><th>Description</th><th>Special Instructions</th></tr><tr><td>KH</td><td>DMEPOS item, initial claim, purchase or first month rental</td><td>Use with HCPCS code E0604 for first month of rental only.
Use with HCPCS code A9274 for initial claim only.</td></tr></table></td><td>Update to Special Instructions.</td></tr>
<tr><td>Behavioral Health and Intellectual and Developmental Disability Supports and Services</td><td>Section 3 – Covered Services</td><td>The 2nd sentence was revised to read:

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 the Serious Emotional Disturbance Waiver Services described in this chapter~~.</td><td>Removal of obsolete text.</td></tr>
<tr><td>Behavioral Health and Intellectual and Developmental Disability Supports and Services</td><td>3.21 Peer-Delivered or -Operated Support Services

(new subsection; following subsections were re-numbered)</td><td>Text was relocated from previous placement in the Additional Mental Health Services (B3s) section.

Includes the following subsections:
3.21.A. Drop-In Centers
3.21.B. Peer Specialist Services
3.21.C. Peer Recovery Coach Services
3.21.D. Youth Peer Support Services
3.21.E. Peer Mentoring Services</td><td>Policy text was relocated due to revisions made to the State Plan.</td></tr>
</table>

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.24 Prevention-Direct Service Models (new subsection; following subsections were re-numbered)	Text was relocated from previous placement in the Additional Mental Health Services (B3s) section.	Policy text was relocated due to revisions made to the State Plan.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.31.B.1. Qualified Staff – 1915 (c) Children's Serious Emotional Disturbance Home and Community-Based Services Waiver (SEDW) (new subsection)	New subsection text reads: 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 children/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. • Participation in any additional model fidelity or quality assurance evaluation tools as requested by MDHHS.	Policy text was relocated due to revisions made to the State Plan.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	4.3 Essential Elements; Team Composition and Size	Under "Team Composition and Size", 2nd paragraph, the 8th bullet point was revised to read: • 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. PSSs are individuals with a strong personal knowledge of what it is like to have first-hand lived experience with a mental health condition that has caused a substantial life disruption. The Centers for Medicare & Medicaid Services (CMS) requires that PSSs must be supervised by a Qualified Mental Health Professional (QMHP) as defined by the MDHHS Behavioral and Physical Health and Aging Services Administration (BPHASA). The amount, duration and scope of supervision can vary depending on the demonstrated competency and experience of the PSS and may range from direct oversight to periodic care consultation in accordance with their position description and provider qualifications.	Added for clarification.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	Section 13 – Targeted Case Management	The section title was revised to read: Targeted Case Management/Support and Service Coordination Re-naming of the section reflects the incorporation of text previously located in the Additional Mental Health Services (B3s) section. In addition to Section 13 – Targeted Case Management, revisions were made to the following subsections: • 13.2 Determination of Need • 13.3 Core Requirements • 13.4 Staff Qualifications	Policy text was relocated due to revisions made to the State Plan.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Early and Periodic Screening, Diagnosis and Treatment	Section 6 – Developmental/ Behavioral Assessment	The section title was revised to read: Developmental/Social/Behavioral/Mental Health ~~Assessment~~ Text was revised to read: ~~A~~ Developmental/social/behavioral/mental health screenings, surveillance, and/or assessments are ~~is~~ required at each scheduled EPSDT well child visit from birth through adolescence as recommended by the AAP periodicity schedule and as indicated in the following subsections. 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.	AAP Periodicity Schedule component language change. Relocating language to Developmental Screening subsection.
Early and Periodic Screening, Diagnosis and Treatment	Section 6 – Developmental/Behavioral Assessment	Subsections were re-numbered: 6.~~7~~ 1 Maternal Depression Screening 6.~~1~~ 2 Developmental Screening 6.~~2~~ 3 Autism Spectrum Disorder Screening 6.~~3~~ 4 Developmental Surveillance 6.~~4~~ 5 ~~Psychosocial/Behavioral Assessment~~ Behavioral/Social/Emotional Screening 6.~~5~~ 6 Tobacco, Alcohol or Drug Use Assessment 6.~~6~~ 7 Depression and Suicide Risk Screening	Order reflects alignment with the AAP Periodicity Schedule. Title revisions reflect changes made per incorporation of bulletin MMP 22-50.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Early and Periodic Screening, Diagnosis and Treatment	6.2 Developmental Screening	Text was revised to read: 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. A maximum of three objective standardized developmental 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.)	Language was relocated from the Developmental/Behavioral Assessment section.
Early and Periodic Screening, Diagnosis and Treatment	Section 12 – Children in Foster Care	The 7th paragraph was revised to read: 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~~ behavioral/social/emotional screening; 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~~ behavioral/social/emotional screening 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).	Change per discussions with Child Welfare Medical and Behavioral Health.

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CHAPTER	SECTION	CHANGE	COMMENT
Early and Periodic Screening, Diagnosis and Treatment	12.2 Enrollment and Billing	The 2nd paragraph was revised to read: All children placed into foster care must receive an EPSDT comprehensive examination within 30 days of entering foster care regardless of when their most recent exam was provided. 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.~~ The PCP should screen all children for developmental and behavioral concerns using a validated and standardized screening tool as indicated by the AAP periodicity schedule. (Refer to the Developmental/Social/Behavioral/Mental Health section of this chapter for additional information.)	Language clarifies requirement for all children placed into foster care. Developmental screening language defers to Section 6 vs. duplicating language.
Federally Qualified Health Centers	1.1 Enrollment	The 2nd paragraph was revised to read: 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.	Updating references to "Group NPI" to read "Organization NPI" for consistency with terminology used throughout the Manual.

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CHAPTER	SECTION	CHANGE	COMMENT
Federally Qualified Health Centers	Section 4 – Billing	The 3rd paragraph was revised to read: 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 5th paragraph was revised to read: 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 (Organization) NPI number as the attending or rendering provider.	Updating references to "Group NPI" to read "Organization NPI" for consistency with terminology used throughout the Manual.
Federally Qualified Health Centers	7.8.A. General Provisions for MI Care Team Payment	The 1st paragraph was revised to read: 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.	Updating references to "Group NPI" to read "Organization NPI" for consistency with terminology used throughout the Manual.

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CHAPTER	SECTION	CHANGE	COMMENT
Hearing Services and Devices	1.1.D. Hearing Aid Dealer	Text was revised to read: 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 (Organization) Billing National Provider Identifier (NPI).	Updating references to "Group NPI" to read "Organization NPI" for consistency with terminology used throughout the Manual.
Local Health Departments	1.2 Provider Enrollment	The 1st paragraph was revised to read: 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.	Updating references to "Group NPI" to read "Organization NPI" for consistency with terminology used throughout the Manual.
Nursing Facility Cost Reporting & Reimbursement Appendix	10.7.C. Annual Reconciliation	The 1st paragraph was revised to read: 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. For State Fiscal Year 2022, this reconciliation will take place at least 365 days after the end of the fiscal year.	This will allow the Department flexibility in the timing of QAS payments for FY22.
Pharmacy		Items 14.4 through 14.6 were re-numbered to alphabetize titles in the subsection.	

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CHAPTER	SECTION	CHANGE	COMMENT
Pharmacy	14.11 Opioid Withdrawal Agents, Opioid Type (new subsection; following subsections were re-numbered)	New subsection text reads: Opioid withdrawal agents may be billed in weekly cycles. Professional dispensing fee limits are extended for this category only.	The Point of Sale system was updated to bypass the rule limiting a GSN to 13 dispensing fees per 365 days due to this category of drugs being more often prescribed in smaller quantities to reduce fraud, waste, and abuse.
Practitioner Reimbursement Appendix	1.2 Emergency Department Services	The following text was added at the end of the subsection: The two-tiered fee screen applies only to the attending ED physician E/M service. The standard Medicaid fee screens continue to be applied to other separately billable attending ED physician services and the services of other physicians (e.g. specialists) who provide E/M or other services in the ED. When billing for these additional services, CPT/HCPCS coding conventions and Medicaid program guidelines must be followed.	Adding clarification.
Rural Health Clinics	2.1 Provider Enrollment	The 1st paragraph was revised to read: 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.	Updating references to "Group NPI" to read "Organization NPI" for consistency with terminology used throughout the Manual.

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CHAPTER	SECTION	CHANGE	COMMENT
Rural Health Clinics	6.1 Billing Rural Health Clinic Services	The 3rd paragraph was revised to read: 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 5th paragraph was revised to read: 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 (Organization) NPI number as the attending or rendering provider.	Updating references to "Group NPI" to read "Organization NPI" for consistency with terminology used throughout the Manual.
Tribal Health Centers	2.1 Provider Enrollment	The 1st paragraph was revised to read: MDHHS requires all THCs to have a ~~Group (~~Type 2 – (Organization) National Provider Identification (NPI) number in order to receive the enhanced THC reimbursement. For THCs 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.	Updating references to "Group NPI" to read "Organization NPI" for consistency with terminology used throughout the Manual.

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CHAPTER	SECTION	CHANGE	COMMENT
Tribal Health Centers	Section 7 – Billing	The 1st paragraph was revised to read: 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 3rd paragraph was revised to read: 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 (Organization) NPI number as the attending or rendering provider.	Updating references to "Group NPI" to read "Organization NPI" for consistency with terminology used throughout the Manual.
Urgent Care Centers	Section 3 – Provider Enrollment	Text was revised to read: Providers must be enrolled with Medicaid and have a valid Type 2 ~~(Group)~~ (Organization) 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)~~ (Organization) NPI as the rendering provider. The ~~Group~~ Organization NPI must be reported as the billing provider.	Updating references to "Group NPI" to read "Organization NPI" for consistency with terminology used throughout the Manual.
Forms Appendix	MSA-1302; Benefits Monitoring Program Referral	Field titles in Section 3 and Section 4 were revised.	Updating references to "Group NPI" to read "Organization NPI" for consistency with terminology used throughout the Manual.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MMP 21-37	8/1/2022	Non-Emergency Medical Transportation	Section 4 – Transportation Provider Qualifications	The following text was added as the first paragraph: All individual and agency transportation providers must adhere to specific qualifications in order to receive Medicaid reimbursement for providing NEMT services. In accordance with the Consolidated Appropriations Act of 2021, a transportation provider who is a beneficiary's family member, or foster parent, or a taxicab driver must meet the following qualifications: • Provider must not be excluded from participating in any federal health care program. • Provider must not be listed on the MDHHS sanctioned provider list or U.S. Department of Health and Human Services (HHS) exclusion list. • Provider must not have been convicted under a federal or state law after August 21, 1996 for a felony criminal offense relating to unlawful manufacture, distribution, prescription, or dispensing of a controlled substance. The provider will report any felony conviction relating to a controlled substance or traffic violations. A transportation network company (also known as a rideshare company) and its individual drivers must meet these qualifications in order to provide NEMT services and receive reimbursement by the Medicaid NEMT Contractor, health plan or waiver agency. The 4th paragraph was revised to read: 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.

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

Medicaid Provider Manual
April 2023 Updates

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MMP 22-27	8/31/2022	Behavioral Health and Intellectual and Developmental Disability Supports and Services	19.5.A. Geographic Area	The following counties were added to the list: Arenac, Barry, Bay, Berrien, Branch, Cass, Clare, Clinton, Eaton, Gladwin, Gratiot, Hillsdale, Huron, Ingham, Ionia, Isabella, Jackson, Mecosta, Midland, Montcalm, Newaygo, Oakland, Osceola, Saginaw, Shiawassee, St. Joseph, Tuscola, VanBuren
		Directory Appendix	Mental Health/Substance Abuse Resources	Under "Opioid Health Home", text for "Information Available/Purpose" was revised to read: Provider Resources: State Plan Amendment Approval Letter; Opioid Health Home Handbook; Policy Bulletin ~~MSA 20-31~~ MMP 22-27; Health Home Provider Application; Opioid Health Home Directory; Opioid Health Home Brochure and Poster; Opioid Health Home Encounter Codes and Rates.
MMP 22-33	10/5/2022	Practitioner Reimbursement Appendix	3.1 Provider Eligibility	In the 3rd paragraph, the 4th bullet point was revised to read: • Non-physician Practitioners: Nurse practitioners (NPs) and physician assistants (PAs) who provide primary care services ~~under the personal supervision of~~ while working in collaboration with 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~~ collaborating 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.
			3.2 Eligible Primary Care Services	The following bullet points were added: • 99421 through 99423 for online digital E/M services • 99441 through 99443 for non-face-to-face telephone E/M services

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MMP 22-34	10/3/2022	Practitioner Reimbursement Appendix	1.3 Neonatal and Pediatric Critical Care Services	Text was revised to read: Effective for dates of service on and after ~~February 1, 2020~~ October 1, 2022, practitioner rates for inpatient neonatal and pediatric critical and intensive care services will be reimbursed at ~~95%~~ 100% of the Medicare annual rate.
MMP 22-35	11/1/2022	Early and Periodic Screening, Diagnosis and Treatment	9.4 Immunizations	The 1st paragraph was revised to read: 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.) Vaccine counseling services, including stand-alone vaccine counseling services, are covered for all Medicaid beneficiaries when they are counseled regarding the importance of vaccines. Stand-alone vaccine counseling refers to when a beneficiary and/or caregiver receives counseling about a vaccine from a health care practitioner, but the beneficiary does not actually receive the vaccine on the same date of service as the counseling.

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		Practitioner	4.8 Preventive Services	The 1st and 2nd paragraphs were revised to read: 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.) Vaccine counseling ~~visits~~ services, including stand-alone vaccine counseling services, are covered for all adult Medicaid beneficiaries when ~~individuals~~ they are counseled regarding the importance of vaccines ~~but the vaccine is not administered~~. Stand-alone vaccine counseling refers to when a beneficiary and/or caregiver receives counseling about a vaccine from a health care practitioner, but the beneficiary does not actually receive the vaccine on the same date of service as the counseling Preventive services, including vaccine counseling 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.)
MMP 22-36	11/1/2022	Behavioral Health and Intellectual and Developmental Disability Supports and Services	2.1 Mental Health and Developmental Disabilities Services	The 1st sentence was revised to read: Mental health and developmental disabilities services (state plan, HSW, and additional/~~B3~~ 1915(i) SPA) must be:
			2.4 Staff Provider Qualifications	The 1st sentence was revised to read: Providers of specialty services and supports (including state plan, HSW, and additional/~~B3~~ 1915(i) SPA) 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.

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			Section 3 – Covered Services	Text was revised to read: 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~~ 1915(i) SPA services described in the ~~Additional Mental Health Services (B3s)~~ Behavioral Health §1915(i) Home and Community-Based Services (HCBS) State Plan Amendment 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). 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.
			3.29 Transportation (re-numbered)	The 1st sentence was revised to read: 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~~ 1915(i) SPA service at an approved day program site or in a clubhouse psychosocial rehabilitation program.

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			3.31 Wraparound Services for Children and Adolescents (re-numbered)	The 3rd paragraph was revised to read: 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~~ 1915(i) SPA services and other community services and supports.
			15.1 Waiver Supports and Services	Under "Fiscal Intermediary", text was revised to read: Refer to the ~~Additional Mental Health Services (B3s)~~ Behavioral Health §1915(i) Home and Community-Based Services (HCBS) State Plan Amendment section, Fiscal Intermediary Services subsection, of this chapter for information.

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			Section 17 – Additional Mental Health Services	The section title was revised to read:
				
				Behavioral Health §1915(i) Home and Community-Based Services (HCBS) State Plan Amendment
				
				Revisions were made throughout the section. Subsections include:
				• 17.1 Eligibility
				  • 17.1.A. Needs-Based Criteria
				  • 17.1.B. Independent Evaluations and Re-evaluations
				• 17.2 Definitions of Goals That Meet the Intents and Purpose of Behavioral Health 1915(i) State Plan Amendment (SPA) Supports and Services
				• 17.3 Criteria for Authorizing BH 1915(i) SPA Supports and Services
				• 17.4 BH 1915(i) SPA Supports and Services
				  • 17.4.A. Community Living Supports (CLS)
				  • 17.4.B. Enhanced Pharmacy
				  • 17.4.C. Environmental Modifications
				  • 17.4.D. Family Support and Training
				  • 17.4.E. Fiscal Intermediary Services
				  • 17.4.F. Housing Assistance
				  • 17.4.G. Respite Care Services
				  • 17.4.H. Skill-Building Assistance
				  • 17.4.I. Specialized Medical Equipment and Supplies
				  • 17.4.J. Supported/Integrated Employment Services
				  • 17.4.K. Vehicle Modification

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		Behavioral Health and Intellectual and Developmental Disability Supports and Services Children's Waiver Community Living Support Services Appendix	3.3 Decision Guide Table Definitions	In the table, under "IV - Additional Children With Special Needs" the 2nd paragraph for "Definitions" was revised to read: 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)~~ Behavioral Health 1915(i) Home and Community-Based Services State Plan Amendment section of this chapter), whether or not those children are developmentally disabled.
		Behavioral Health and Intellectual and Developmental Disability Supports and Services Children's Serious Emotional Disturbance Home and Community-Based Services Waiver Appendix	Section 3 – Medicaid State Plan Services	In the 3rd paragraph, the 1st sentence was revised to read: 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~~1915(i) SPA service at an approved day program site or in a clubhouse psychosocial rehabilitation program.

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		Healthy Michigan Plan	5.6.B.4. Crisis Services	Under "Crisis Residential Services", 1st paragraph, 3rd bullet point ("Provider Criteria"), the last sentence was revised to read: 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~~ 1915(i) SPA services do not require re-approval. Under "Intensive Crisis Residential Services", 3rd paragraph, 4th bullet point ("Approval"), the last sentence was revised to read: 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~~ 1915(i) SPA services do not require re-approval.
			5.6.B.7. Peer-Delivered or Peer-Operated Support Services	In the table in the 3rd paragraph, under "Drop-In Centers", the 2nd paragraph was revised to read: 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~~ 1915(i) SPA services do not require re-approval.
			5.6.B.9. Targeted Case Management	In the 3rd paragraph, under "Provider Qualifications", the last sentence was revised to read: 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~~ 1915(i) SPA services do not require re-approval.

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		Acronym Appendix		Addition of: EFL - Essential for Living LOCUS - Level of Care Utilization System SIS - Supports Intensity Scale SIS-A - Supports Intensity Scale – Adult Version SIS-C - Supports Intensity Scale – Children's Version
MMP 22-39	12/29/2022	Program of All-Inclusive Care for the Elderly	4.1 Initial Applications	Text was revised to read: Initial applications are for applicants seeking to become a PACE organization for the first time. 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~~,~~ to enroll as a Michigan Medicaid provider~~,~~ and complete a feasibility study. Prospective entities will not be considered if the prospective entity has active sanctions in other states, as defined in the Federal regulations (42 CFR Part 460 Subpart D). ~~MDHHS will evaluate potential PACE organizations using the following criteria:~~

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			4.1.A. Letter of Intent (new subsection)	New subsection text reads: A prospective PACE entity must submit a letter of intent to MDHHS that includes: • Name of organization • Location of potential PACE center • Service area that is being requested by county and/or zip code • Capacity For budget consideration, a letter of intent must be received by MDHHS prior to August 1 (14 months) in advance of the fiscal year in which the program plans to open. If MDHHS receives multiple letters of intent for the same service area, the feasibility studies will be reviewed in the order in which the letters of intent are received. If MDHHS receives a letter of intent for a service area that is already being serviced by a PACE provider, MDHHS will begin the unmet need process. (Refer to the Unmet Need subsection in this chapter for additional information.) Within 14 business days of receiving the letter of intent, MDHHS will send a letter to the prospective PACE entity to confirm the receipt of their letter of intent and notify the prospective PACE entity that a feasibility study must be submitted to MDHHS within 90 calendar days from the date of the letter.

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			4.1.B. Feasibility Study (new subsection)	New subsection text reads: 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, at minimum, 125 participants); ➢ documents the organization's timeline for development and anticipated costs; ➢ identifies the anticipated source of referrals for potential beneficiaries and assesses the availability of long-term care services already in existence in the community; ➢ demonstrates organizational commitment to principles consistent with the PACE model; ➢ shows evidence of experience in providing primary, acute and/or long-term care services to the target population and evidence of positive community support; ➢ shows evidence that the organization has the depth in leadership and experience required to develop and implement PACE successfully; ➢ shows 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);

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				➢ includes assurance of adequate financial capacity to fund program development and start-up costs, including identification of participant capacity and break-even consideration; ➢ shows evidence of the proposed provider network and assurance that the organization will have staff and professionals experienced in providing care to the target population; ➢ shows evidence that the Executive (Program) Director position will be staffed with a full-time employee; ➢ shows evidence that the key positions of Executive Director, 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; ➢ shows evidence that the key positions will be staffed on-site; and ➢ demonstrates ability to meet state and federal PACE requirements. Other evaluation criteria may be considered and will be available to organizations that file a letter of intent with MDHHS to become a PACE organization. Once MDHHS has approved the prospective PACE entity's feasibility study, MDHHS will send an approval letter and the entity will have one year from the date of the letter to submit a PACE application to MDHHS and the Centers for Medicare & Medicaid Services (CMS). Prior to the submission, MDHHS will provide a State Assurance document in support of the application.

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			4.2 Expansion Applications	Text was revised to read: An expansion application is for existing PACE organizations who are seeking to expand. Types of expansions include: • A PACE organization requests to expand its geographic service area without building additional sites. • A PACE organization requests to open another physical site in the existing geographic service area. • A PACE organization requests to expand its geographic service area and open another physical site in the expanded area. • A PACE organization requests to expand its current building. 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. A PACE organization will not be considered if the PACE organization has active sanctions, as defined in the Federal regulations (42 CFR Part 460 Subpart D).

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			4.2.A. Letter of Intent (new subsection)	New subsection text reads: An existing PACE provider must submit a letter of intent to MDHHS that includes: • Name of organization • Location of potential PACE center (if applicable) • Service area that is being requested by county and/or zip code (if applicable) • Capacity increase For budget consideration, a letter of intent must be received by MDHHS prior to August 1 (14 months) in advance of the fiscal year in which the program plans to open. If MDHHS receives multiple letters of intent for the same service area, the feasibility studies will be reviewed in the order in which the letters of intent are received. Within 14 business days of receiving the letter of intent, MDHHS will send a letter to the PACE program to confirm the receipt of their letter of intent and notify the PACE program that a feasibility study must be submitted to MDHHS within 90 calendar days from the date of the letter.

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			4.2.B. Feasibility Study (new subsection)	New subsection text reads: MDHHS will evaluate 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, at minimum, 125 participants); ➢ documents the organization's timeline for development and anticipated costs; ➢ identifies the anticipated source of referrals for potential beneficiaries; ➢ assesses the availability of long-term care services already in existence in the community; ➢ demonstrates organizational commitment to principles consistent with the PACE model; ➢ shows evidence of experience in providing primary, acute and/or long-term care services to the target population and evidence of positive community support; ➢ shows evidence that the organization has the depth in leadership and experience required to develop and implement PACE successfully; ➢ shows 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);

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				➢ includes assurance of adequate financial capacity to fund program development and start-up costs, including identification of participant capacity and break-even consideration; ➢ shows evidence of the proposed provider network and assurance that the organization will have staff and professionals experienced in providing care to the target population; ➢ shows evidence that the Executive (Program) Director position will be staffed with a full-time employee; ➢ shows evidence that the key positions of Executive Director, 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; ➢ shows evidence that the key positions will be staffed on-site; and ➢ demonstrates the ability to meet state and federal PACE requirements. Other evaluation criteria may be considered and will be available to organizations that file a letter of intent with MDHHS to become a PACE organization. Once MDHHS has approved the PACE program's feasibility study, MDHHS will send an approval letter and the PACE program will have one year from date of the letter to submit a PACE application to MDHHS and CMS. Prior to the submission, MDHHS will provide a State Assurance document in support of the application.

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MMP 22-42	12/29/2022	General Information for Providers	9.4 Clinical Trials	Text was revised to read: PA requirements that apply to services provided outside of a clinical trial apply to routine services within a clinical trial. PA requests, when required, must contain the clinical trial number, be complete, and include a completed and signed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210). (Refer to the Forms Appendix to review the form and to the Directory Appendix for form access on the MDHHS website.) .~~and submitted~~ Submit requests electronically via FFS Direct Data Entry (DDE) in CHAMPS to allow for expedited review. Refer to the Practitioner Chapter for additional information for coverage of routine patient costs for services associated with participation in a qualified clinical trial.
		Billing & Reimbursement for Institutional Providers	6.3 Clinical Trials	Text was revised to read: All claims for routine patient costs associated with participation in a clinical trial must include the National Clinical Trial (NCT) number and an ICD-10 diagnosis code indicating the services are associated with a clinical trial. Claims must also include a completed and signed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210). (Refer to the Forms Appendix to review the form and to the Directory Appendix for form access on the MDHHS website.)
			6.3.B. Reporting Non-Covered Services	The last paragraph was revised to read: Refer to the Billing & Reimbursement for Professionals and the Practitioner chapters for additional information.

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			7.9 Clinical Trials	Text was revised to read: All outpatient hospital facility claims for routine patient costs associated with participation in a qualified clinical trial must adhere to the inpatient hospital claim guidelines for reporting covered services using the CMS UB04/837I institutional claim format. (Refer to the Hospital Claim Completion – Inpatient section, Clinical Trials subsection for additional information.) In addition, outpatient hospital facility claims must include: • A completed and signed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210). • Clinical trial and non-clinical trial services on separate line items when claims are submitted for both types of services on the same claim. • Each line identified with the appropriate Healthcare Common Procedure Coding System (HCPCS) Modifier Q0 or Q1. ➢ HCPCS Modifier Q0 - **investigational clinical service** provided in a clinical research study that is in an approved clinical research study. ➢ HCPCS Modifier Q1 – **routine clinical service** provided in a clinical research study that is in an approved clinical research study. Report non-covered services/charges with the appropriate modifier and a token charge ($1) for a 'no cost' item in the covered charge field. Refer to the Billing & Reimbursement for Professionals and the Practitioner chapters for additional information.
			7.9.A. Reporting Non-Covered Services	Subsection was deleted. Text was relocated to the Clinical Trials subsection.

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		Billing and Reimbursement for Professionals	6.8 Clinical Trials	Text was revised to read: All claims for routine patient costs associated with participation in a clinical trial must include the National Clinical Trial (NCT) number and an ICD-10 diagnosis code indicating the services are associated with a clinical trial. Claims must also include a completed and signed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210). (Refer to the Forms Appendix to review the form and to the Directory Appendix for form access on the MDHHS website.) Generally, services, investigational drugs, or items that are part of the clinical trial and considered experimental or investigational should not be reported on a claim. In instances when claims processing edits require non-covered services be billed with their associated procedures, or when it is necessary for a provider to show the items and services provided free-of-charge to receive payment for the covered routine costs, providers are instructed to report non-covered services/charges on a separate claim line with the appropriate modifier and a charge of $0. Refer to the Billing & Reimbursement for Institutional Providers and the Practitioner chapters for additional information.
			6.8.B. Reporting Non-Covered Services	Subsection was deleted. Text was relocated to the Clinical Trials subsection.
		Federally Qualified Health Centers	4.3 Clinical Trials	In the 2nd paragraph, the following bullet point was added: • A completed and signed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210). (Refer to the Forms Appendix to review the form and to the Directory Appendix for form access on the MDHHS website.)

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		Pharmacy	8.4 Documentation Requirements	The following paragraph was added: If prior authorization is being submitted for an item related to a clinical trial, PA requests must also include a completed and signed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210). Refer to the Forms Appendix for a copy of BPHASA-2210.
			8.5.C. Clinical Trial Attestation Form (new subsection)	New subsection text reads: For items and services that require prior authorization and were provided in connection with a beneficiary's participation in a qualified clinical trial, a completed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210) is required to be submitted with the pharmacy prior authorization request. Refer to the Forms Appendix for a copy of the form. Refer to the Prior Authorization section of the Directory Appendix for Pharmacy Prior Authorization contact information.
		Practitioner	3.6.D. Determination for Coverage	The 3rd bullet point was revised to read: • Based on attestation of the principal investigator or provider regarding the appropriateness of the qualifying clinical trial via the Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210); and

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			3.6.E. Attestation to the Appropriateness of the Qualified Clinical Trial (new subsection; the following subsections were re-numbered)	New subsection text reads: A completed and signed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210) must be submitted with all claims and PA requests for routine patient costs for items and services furnished in connection with a beneficiary's participation in a qualified clinical trial. The form represents the attestation by the principal investigator and health care provider to the appropriateness of the clinical trial. The BPHASA-2210 must be signed by both the principal investigator of the clinical trial and a qualified health care provider. Qualified health care providers include licensed providers who are part of the beneficiary's health care team such as, but not limited to; the beneficiary's primary care, specialty, treating, referring, or ordering provider, pharmacist, or the principal investigator of the clinical trial. The completed form must be submitted with all claims and PA requests for routine patient costs for items and services furnished in connection with a beneficiary's participation in a qualified clinical trial. (Refer to the Forms Appendix for form BPHASA-2210.)
			3.6.F. Prior Authorization (subsection was re-numbered)	Text was revised to read: Not all items and services ~~and costs~~ associated with a clinical trial require prior authorization (PA). All PA requirements that apply to services provided outside of a clinical trial apply to routine services within a clinical trial. PA requests for routine patient costs for items and services furnished in connection with a beneficiary's participation in a qualified clinical trial must include a completed and signed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210). Refer to the General Information for Providers Chapter for additional PA requirements.

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			3.6.G. Claims for Services (subsection was re-numbered)	The 1st paragraph was revised to read: All claims for routine patient costs associated with participation in a clinical trial must include a completed and signed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210), the National Clinical Trial (NCT) number and an ICD-10 diagnosis code indicating the services are associated with a clinical trial, such as Z00.6 (encounter for examination for normal comparison and control in clinical research program). Claims may also include any future ICD-10 diagnosis code(s) that falls within the structure and conventions of the classification and general guidelines applicable to clinical trial services as established by CMS and National Center for Health Statistics (NCHS) services.
		Rural Health Clinics	6.3 Clinical Trials	In the 2nd paragraph, the following bullet point was added: • A completed and signed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210). (Refer to the Forms Appendix to review the form and to the Directory Appendix for form access on the MDHHS website.)
		Tribal Health Centers	7.1 Clinical Trials	In the 2nd paragraph, the following bullet point was added: • A completed and signed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210). (Refer to the Forms Appendix to review the form and to the Directory Appendix for form access on the MDHHS website.)
		Forms Appendix		Addition of: BPHASA-2210; Attestation to the Appropriateness of the Qualified Clinical Trial

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MMP 22-43	11/29/2022	Billing & Reimbursement for Institutional Providers	2.3.B. Attending Provider	The 1st paragraph was revised to read: The attending provider NPI is a requirement for all claims submitted within the institutional claim format with one exception. Hospital-owned ambulance Medicaid-enrolled providers submitting Emergency Ambulance Transport claims may report the attending provider NPI, however, completion of this field is not required. For all institutional claims, the attending ~~physician~~ provider must be Medicaid enrolled. If the attending ~~physician~~ 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.
		Hospital	Section 1 - General Information	The 1st paragraph was revised to read: 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.~~ The attending provider is the individual who has the primary responsibility for the treatment and care of the beneficiary. Depending on the setting and professional licensure regulations, the specific provider type can vary. 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.
			1.1 Inpatient Hospital	In the 1st paragraph, the 2nd bullet point was revised to read: • Furnished under the direction of a physician (MD or DO), podiatrist, oral/maxillofacial surgeon, certified nurse midwife, or a dentist.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			1.2 Outpatient Hospital	In the 1st paragraph, the 1st bullet point was revised to read: • Furnished under the direction of ~~a physician (MD or DO) or a dentist~~ the provider with the primary responsibility for the treatment and care of the beneficiary in the outpatient setting. The provider type varies according to the service provided. A complete list of allowed attending providers for outpatient services can be found on the MDHHS website. Refer to the Directory Appendix for website information.
			1.5.A. Abuse	Text was revised to read: 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~~ provider determines the beneficiary requires further assessment and treatment. Inpatient stays for the sole purpose of custodial or protective care are not a covered benefit.
		Directory Appendix	Provider Resources	Addition of: **Contact/Topic:** Hospital Attending Provider Types Lists **Web Address:** https://www.michigan.gov/mdhhs/assistance-programs/medicaid/portalhome/medicaid-providers/medicaid-provider-alerts/data/pages/institutional
MMP 22-44	12/1/2022	Hospital	Section 2 – Prior Authorization	In the table, under "Organ Transplants", information for "Obtained Via" was revised to read: Contact the ~~OMA~~ Program Review Division (PRD)

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			3.23 Organ Transplants	Revisions were made to text for 3.23 Organ Transplants. Additional revisions include: • Deletion of subsections ➢ 3.23.A. Donor Search ➢ 3.23.B. Transportation and Lodging • Addition of subsections: ➢ 3.23.A. Coverage Criteria ➢ 3.23.B. General Requirements for Transplant Programs ➢ 3.23.C. Organ Specific Criteria ➢ 3.23.D. Prior Authorization ○ 3.23.D.1. Psychosocial Assessment ○ 3.23.D.2. Third Party Liability (or Coordination of Benefits) ➢ 3.23.E. Donor and Donor Search ➢ 3.23.F. Medicaid Organ Donor for Non-Medicaid Recipient ➢ 3.23.G. Transportation and Lodging

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Practitioner	12.6 Organ Transplant	Text was revised to read: 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.~~ Refer to the Hospital Chapter for further information. ~~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**~~	~~If Medicare eligibility is denied, the denial notice must be attached to the PA request.~~ ~~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.~~ ~~The donor must exhaust all possible insurance sources before Medicaid is billed for the services.~~ ~~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.~~
~~**Transportation and Lodging**~~	~~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.~~
~~**Donor Searches**~~	~~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.~~

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MMP 22-46	12/1/2022	Medical Supplier	2.34 Pneumatic Compressors and Appliances (Lymphedema Pumps)	The subsection title was revised to read: Pneumatic/Non-pneumatic Compressors and Appliances (Lymphedema Pumps) Text for "Definition" was revised to read: ~~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.~~ Pneumatic/non-pneumatic compressors (lymphedema pumps) and appliances (sleeve/garment) apply pressure to a limb to remove excess fluid from the limb. The compressor may be pneumatic (uses air to compress) or non-pneumatic (other compression mechanism used such as nickel-titanium shape-memory alloy). The compressor and appliance may be either non-segmented (single chamber) or segmented (multiple chambers) with or without calibrated gradient pressure. An integral part of treatment, along with the pneumatic/non-pneumatic compression device, is leg or arm elevation and the use of custom fabricated gradient pressure stockings or sleeves, compression bandaging, etc. Under "Standards of Coverage", the 1st paragraph was revised to read: A pneumatic/non-pneumatic compression device may be covered only as a treatment of last resort (e.g., other less intensive treatment has not been effective). Under "PA Requirements", text was revised to read: PA is required for all requests. Coverage will only be provided for one type of compressor (pneumatic or non-pneumatic).

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				Under "Payment Rules", the following paragraph was added: For purchased items, the manufacturer's warranty must be exhausted prior to requesting a repair or replacement part.
MMP 22-47	12/1/2022	Medicaid Provider Manual Overview	1.1 Organization	The following text was added to the table: **Chapter Title**: Doula Services **Affected Providers**: MDHHS Registered Doulas **Chapter Content**: Provider enrollment requirements, covered services, and reimbursement considerations.

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<table>
<tr><th>BULLETIN NUMBER</th><th>DATE ISSUED</th><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th></tr>
<tr><td rowspan="3"></td><td rowspan="3"></td><td>Billing & Reimbursement for Professionals</td><td>6.9 Doula Services

(new subsection; the following subsections were re-numbered)</td><td>New subsection text reads:

All claims for doula services must include an ICD-10 diagnosis code and HD modifier to support the services billed. In addition, doulas are encouraged to report the appropriate ICD-10 diagnosis codes within the range of Z55-Z56 to describe any relevant social determinants of health.

<table>
<tr><th>Visit Type</th><th>Procedure Code</th><th>Modifier</th><th>Primary Diagnosis Codes</th><th>Limit per Pregnancy</th></tr>
<tr><td>Prenatal Visits and Postpartum Visits</td><td>S9445</td><td>HD</td><td>Prenatal: Z33.1
Postpartum: Z39.2</td><td>6 total visits</td></tr>
<tr><td>Attendance at Labor and Delivery</td><td>T1033</td><td>HD</td><td>Z33.1</td><td>1 visit</td></tr>
</table>
</td></tr>
<tr><td>7.1 General Billing Guidelines</td><td>Addition of the following text:

<table>
<tr><th>Modifier</th><th>Description</th><th>Special Instructions</th></tr>
<tr><td>HD</td><td>Pregnant/parenting program</td><td>Report to identify doula services.</td></tr>
</table>
</td></tr>
<tr><td>Doula Services</td><td></td><td>Addition of new chapter.</td></tr>
</table>

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Maternity Outpatient Medical Services Program	2.1 Covered Services	The following bullet point was added: • Doula services through 60 days postpartum.
		Medicaid Health Plans	1.1 Services Covered by Medicaid Health Plans (MHPs)	In the 1st paragraph ("The following services must be covered by MHPs:"), the following bullet point was added: • Doula services
		Practitioner	7.11 Doula Services (new subsection)	New subsection text reads: MDHHS certified doulas typically provide non-clinical physical, emotional, and educational support services to pregnant individuals during the prenatal, labor and delivery, and postpartum periods. Evidence indicates doula services are associated with improved birth outcomes. Refer to the Doula Services Chapter for additional information.
		Directory Appendix	Doula Services Resources (new section)	Addition of the following text: **Contact/Topic:** MDHHS Doula Initiative **Email/Web Address:** Email: MDHHS-MIDoula@michigan.gov Website: https://www.michigan.gov/Doula **Information Available/Purpose:** Information regarding the MDHHS Doula Registry and Doula Advisory Council. Resources for doula providers.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MMP 22-49	12/1/2022	Dental	6.2.D. Sealants	The 1st paragraph was revised to read: Coverage is limited to fully erupted permanent first and second molars (2, 3, 14, 15, 18, 19, 30, 31), fully erupted first and second primary molars (A, B, I, J, K, L, S, T) and fully erupted first and second permanent premolars (4, 5, 12, 13, 20, 21, 28, 29) for beneficiaries ~~age 5 through 15~~ under age 21 for the prevention of pit and fissure caries. Sealants are covered once every three years. Medicaid reimbursement includes repair and replacement of the sealant for three years. In the last paragraph, the last bullet point was revised to read: • Previous restoration on identified ~~tooth~~ surface .
MMP 22-50	12/1/2022	Dental	6.2.B. Topical Application of Fluoride	In the table, under "Varnish", text was revised to read: 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: • ~~Under age 3~~ Ages 0 through 5: Four times per 12 months as a therapeutic application for all children. • Ages ~~3~~ 6 through 15: One time per six months and cannot be combined with topical application of non-varnish fluoride within the same six months.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Early and Periodic Screening, Diagnosis and Treatment	6.5 Psychosocial/Behavioral Assessment (re-numbered)	The subsection title was revised to read: ~~Psychosocial/Behavioral Assessment~~ Behavioral/Social/Emotional Screening Text was revised to read: ~~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.~~

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				The behavioral/social/emotional screening should be family-centered and may include asking about caregiver emotional and mental health concerns and social determinants of health, racism, poverty, and relational health. A behavioral/social/emotional screening is to be performed during each well child visit from newborn through 21 years of age in accordance with the AAP periodicity schedule, the American College of Obstetricians and Gynecologists (Women's Preventive Services Initiative) recommendations, and the American Academy of Child & Adolescent Psychiatry guidelines. The behavioral/social/emotional screening may be accomplished by using an evidence-based, 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 screening is positive. Providers should establish office routines for screening and surveillance. Children with significant risk factors should be monitored with heightened surveillance and more frequent screening. 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. A behavioral/social/emotional screening should also 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/caregiver identifies behavioral or social-emotional concerns. If the screening 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 behavioral/social/emotional screening for children in foster care.)

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			6.7 Depression Screening (re-numbered)	The subsection title was revised to read: Depression and Suicide Risk Screening Text was revised to read: A depression and suicide risk screening is to be performed annually for all ~~children and~~ adolescents who are 12 years of age ~~and older~~ until 21 years of age as indicated by the AAP periodicity schedule and per the Guidelines for Adolescent Depression in Primary Care (GLAD-PC). A depression screening may be accomplished using a standardized screening tool such as the ~~Patient Health Questionnaire-2 (PHQ-2),~~ Patient Health Questionnaire-9 (PHQ-9), PHQ-9 modified for Adolescents (PHQ-A), 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~~. Every effort should be made to preserve the confidentiality of the adolescent. Any information obtained during the visit should only be shared outside of the office with the permission of the parent or caregiver to protect the adolescent's safety. (Refer to the Directory Appendix for website information.)

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			9.11 Hepatitis B Virus Infection (new subsection; the following subsections were re-numbered)	New subsection text reads: A risk assessment for hepatitis B virus (HBV) infection is to be performed for children from newborn to 21 years of age as indicated by the AAP periodicity schedule, according to recommendations per the United States Preventive Services Task Force (USPSTF) and the 2021-2024 edition of the AAP Red Book: Report of the Committee on Infectious Diseases. These screenings, provided for individuals under 21 years of age, are considered an EPSDT service. An HBV infection screening may be provided to any individual requesting the screen, regardless of their disclosure of risk, since there may be reluctance to disclose these risks. Screening for hepatitis B should be performed with Hepatitis B Surface Antigen (HBsAg) tests approved by the U.S. Food and Drug Administration (FDA), followed by a confirmatory test for initially reactive results. Serologic panels performed concurrently with or after HBsAg screening aid in facilitating the diagnosis and to determine further management. Individuals who test positive for an HBV infection generally receive education regarding reducing the risk of transmission to others (e.g., during childbirth or with sex and needle-sharing partners and household contacts). EPSDT services include the coverage of any follow-up services and referrals that are medically necessary to treat an HBV infection. Individuals with HBV infection should be provided information about treatment options, how to prevent transmission of HBV to others, and drug treatment, as appropriate. Every effort should be made to preserve the confidentiality of the patient.

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			9.13 Sudden Cardiac Arrest and Sudden Cardiac Death (new subsection; the following subsections were re-numbered)	New subsection text reads: Assessing for risk of sudden cardiac arrest (SCA) and sudden cardiac death (SCD) is to be performed as appropriate from 11 to 21 years of age and as indicated by the AAP periodicity schedule. The AAP recommends screening children for SCA and SCD by asking four questions whereas a positive response may indicate an increased risk for SCA and SCD. The PCP may find a positive response to be a significant cue to perform a cardiovascular evaluation which may occur at their discretion. It is recommended that SCA and SCD screening should be performed for all children regardless of their athletic participation. The screening should be performed at the same time as the pre-participation examinations, at a minimum of every three years, or on entry into middle or junior high school and into high school. Depending on family and PCP concerns, more frequent screening may be appropriate. The four questions that may be applied directly to a family questionnaire are as follows: • Have you ever fainted, passed out, or had an unexplained seizure suddenly and without warning, especially during exercise or in response to sudden loud noises such as doorbells, alarm clocks, and ringing telephones? • Have you ever had exercise-related chest pain or shortness of breath? • Has anyone in your immediate family (parents, grandparents, siblings) or other more distant relatives (aunts, uncles, cousins) died of heart problems or had an unexpected sudden death before age 50? This would include unexpected drownings, unexplained auto crashes in which the relative was driving, or Sudden Infant Death Syndrome (SIDS).

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				• Are you related to anyone with hypertrophic cardiomyopathy or hypertrophic obstructive cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT) or anyone younger than 50 years with a pacemaker or implantable defibrillator? A positive response from these four questions, or an abnormal electrocardiogram (ECG), should prompt further investigation that may include referral to a pediatric cardiologist or pediatric electrophysiologist.
			10.1 Fluoride Varnish	Text was revised to read: ~~Providers should~~ The PCP is to apply fluoride varnish, with parent or caregiver approval, to the primary teeth of all infants and children starting at the age of primary tooth eruption and until the establishment of a dental home. Once teeth are present, apply fluoride varnish to all children every three to six months in the primary care or dental office based on caries risk until six years of age as ~~recommended~~ indicated 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.~~

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				The AAP recommends that providers receive additional training on oral screenings, fluoride varnish indications and application, and office implementation. Additional training on oral screenings, fluoride varnish indications and application, and office implementation can be found in the Smiles for Life Curriculum Course: Caries Risk Assessment, Fluoride Varnish and Counseling. 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.)
		Acronym Appendix		Addition of: ASQ-SE - Ages and Stages Questionnaire – Social-Emotional GLAD-PC - Guidelines for Adolescent Depression in Primary Care HBsAg - Hepatitis B Surface Antigen tests HBV - hepatitis B virus PHQ-9 - Patient Health Questionnaire-9 PHQ-A - Patient Health Questionnaire-9 modified for Adolescents SCA - sudden cardiac arrest SCD - sudden cardiac death

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MMP 22-52	12/1/2022	General Information for Providers	2.5 Medicare Cost Share Enrollment Type (new subsection)	New subsection text reads: Billing, rendering, attending, ordering, and referring Medicare providers who only intend to submit claims to Medicaid for reimbursement of Medicare cost-sharing for dual eligible beneficiaries may choose the restricted cost-sharing option, Medicare Cost Share, during CHAMPS enrollment. Medicare provider types not recognized by Medicaid must choose the Medicare Cost Share option. These providers must contact Provider Enrollment for enrollment assistance. (Refer to the Directory Appendix for contact information.) This special enrollment type is only available to providers participating in original Medicare. Providers participating in Medicare Part C, also known as a Medicare Advantage Plan, must complete a full Medicaid enrollment.
		Coordination of Benefits	2.6.F. Medicaid Liability	The following text was added after the 4th paragraph: Claims submitted by providers with a Medicare Cost Share enrollment type will only adjudicate if Medicare is reported primary for these providers. Claims submitted for reimbursement of Medicaid primary services will deny for Medicare cost-sharing only providers. Billing, rendering, attending, ordering, and referring provider types reported on these cost-sharing claims must be enrolled either as a Medicare Cost Share or full Medicaid provider.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MMP 23-01	12/29/2022	Hearing Services and Devices	4.7 Measurable Benefits/ Conformity Check	The subsection title was revised to read: Measurable Benefits/ Conformity ~~Check~~ Evaluations The last paragraph was revised to read: A conformity evaluation for verification and validation of a hearing aid's benefit and performance provided on the same date of service as the dispensing fee will not be separately reimbursed. Hearing aid conformity evaluations for beneficiaries with an existing hearing aid may be provided up to a maximum of two times per year ~~if necessary~~ without PA.

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			4.8 Dispensing Fee	Subsection text was revised to read: The hearing aid dealer may ~~only~~ bill ~~the~~ a dispensing fee when providing direct patient contact in delivering, fitting and orientating ~~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,~~ This fee applies to both digital or contralateral routing system models purchased through the Medicaid volume purchase contract agreement and noncontracted hearing aids. The dispensing fee covers all services and products listed below for a period of 90 days unless otherwise noted. ~~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)~~

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				• ~~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.~~ • Hearing aid delivery. Packing, shipping, and handling are provided by the hearing aid manufacturer at no cost to the dispensing provider. • Initial and follow-up care for hearing aid set up and management. Services include, but are not limited to, electroacoustic assessments, programming or setting of internal device controls, device inspections, cleanings, physical fit adjustments, and accessory pairing. • Initial and follow-up hearing aid education. Services include, but are not limited to, orientation, education, and instruction on use, care, and maintenance of the device. • One 90-day supply of disposable batteries per aid (non-rechargeable models). • All components necessary for the hearing aid's operation. These are generally provided by the hearing aid manufacturer and include items such as rechargeable batteries, chargers, cords, tubing, connectors, or receivers. • A 90-day trial/adjustment period with exchange/return privilege. This warranty is provided by the hearing aid manufacturer at no cost to the dispensing provider.

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				The dispensing fee should be billed separately from the hearing aid using the appropriate HCPCS code. Components of the dispensing fee are not to be billed separately. Earmolds and hearing aid supplies and accessories not provided by the manufacturer may be billed separately from the dispensing fee. 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 the hearing aid fitting/checking visit ~~services or earmolds provided during the 90-day trial period~~.
			4.10 Hearing Aid Checks and Programming	The subsection title was revised to read: Hearing Aid ~~Checks and Programming~~ Fitting and Checking Services Text was revised to read: Follow-up hearing aid ~~checks~~ fitting and checking services performed by a hearing aid dealer or audiologist are ~~billable~~ covered services ~~only~~ after the hearing aid's 90-day dispensing fee ~~trial~~ period. Hearing aid fitting and checking visits ~~services~~ may include, but are not limited to, all the following services: device inspection, maintenance and cleaning, ~~resetting volume,~~ reprogramming or setting of internal device controls, listening checks, device counseling/training/education, and physical fit adjustments. ~~and other electro acoustic testing.~~ Individual services included in the fitting and checking visit or device handling, pick up, and drop off fees are not to be charged separately. Hearing aid fitting and checking visits ~~checks~~ may be billed up to a maximum of two times per year without PA.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MMP 23-02	1/5/2023	Behavioral Health and Intellectual and Developmental Disability Supports and Services Non-Physician Behavioral Health Appendix	Section 2 – Provider Qualifications	In the 4th paragraph, the following bullet point was added: • Graduate of a board-approved health profession training program for psychology, social work, counseling, or marriage and family therapy (Master's or Doctoral Level) who has completed all requirements but has not obtained a limited or temporary educational license. Medicaid will cover services for a period of no longer than one year from the date the individual successfully completed their graduate coursework. The graduate's supervising provider must monitor and ensure compliance of this requirement The 5th paragraph was revised to read: ~~These~~ Student interns, graduates and 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.
MMP 23-03	12/29/2022	Home Help	4.3.A. Date of Facility Admission	Text was revised to read: Providers are not eligible for payment for Home Help services provided on the day a client is admitted to ~~any of the facilities listed above~~ a nursing facility, institution for mental diseases, AFC, HFA, or correctional institution. Payments for Home Help services provided on these days are subject to denial and recoupment. Providers may be eligible for payment for Home Help services provided on the day a client is admitted to a hospital. Refer to the Provider Payments (Payment for Services Provided on the Client's Hospital Admission Date) subsection in this chapter for more information.

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			8.9.D. Payment for Services Provided on the Client's Hospital Admission Date (new subsection; the following subsections were re-numbered)	New subsection text reads: A provider may be paid for Home Help services provided on the client's date of hospital admission if the client had active Medicaid on the date the services were provided and the provider: • Provided the services on or after February 1, 2023. • Provided the services before the time the client was admitted to the hospital. • Provided the services in the client's home or workplace. NOTE: Laundry and shopping authorized to be done outside the client's home may be eligible for payment if completed before the time the client was admitted to the hospital. • Logs the services provided on the service verification. • Submits a completed, signed and dated BPHASA-2207 Home Help Billing for Hospital Admission Date form to the client's ASW or local MDHHS office as soon as possible after learning the client was admitted to a hospital but no later than 365 days from the date of service. Refer to the Forms Appendix for a copy of the BPHASA-2207. It can also be downloaded from the Home Help webpage. Refer to the Directory Appendix for webpage information. If the BPHASA-2207 is approved, payment will be based on the total amount of authorized time for the tasks documented on the provider's service verification. It will not be based on the time in and time out documented on the BPHASA-2207.

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			8.9.D.1. Submitting the BPHASA-2207 With the Service Verification (new subsection)	New subsection text reads: The provider may send the BPHASA-2207 to the client's ASW or local MDHHS office when they submit the service verification. The provider may submit the BPHASA-2207 any time after the client's hospital admission date but no later than 365 days later. The BPHASA-2207 may be submitted in person or by fax, U.S. mail, or email. (Refer to the Directory Appendix for contact information.) • Agency providers may send the BPHASA-2207 with the MSA-1904. • Individual caregivers who use the ESV will need to send the BPHASA-2207 to the client's ASW or local MDHHS office after they submit the ESV. • Individual caregivers who use the PSV must send the BPHASA-2207 separately from the PSV. The fax number and mailing address on the PSV will not route the BPHASA-2207 to the client's local MDHHS office. NOTE: Hospitalization data is not always available when the client's ASW processes payment. If MDHHS finds that the time span on the BPHASA-2207 overlaps with the time the hospital reports the client was admitted to the hospital, MDHHS may recoup the portion of the Home Help payment for this day of service.
			8.9.D.2. Submitting the BPHASA-2207 After the Service Verification (new subsection)	New subsection text reads: MDHHS will recoup payment for services provided on the client's hospital admission date if the service verification is not supported by a BPHASA-2207. A provider that does not submit the BPHASA-2207 with their service verification should send the BPHASA-2207 to the client's ASW or local MDHHS office as soon as possible. If a provider does not submit the BPHASA-2207 in time to avoid recoupment, they may use the form to request repayment of recouped funds.

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		Forms Appendix		Addition of: BPHASA-2207; Home Help Billing for Hospital Admission Date
MMP 23-04	12/29/2022	Hospital Reimbursement Appendix	Section 1 – Outpatient	The 1st paragraph was revised to read: Reimbursement to outpatient hospitals, including off-campus satellite clinics, hospital-owned ambulance services, freestanding dialysis centers (ESRDs), comprehensive outpatient rehabilitation facilities (CORFs), and rehabilitation agencies for outpatient services is made in accordance with Medicaid's Outpatient Prospective Payment System (OPPS). Covered dental services provided in outpatient hospitals are reimbursed according to the Medicaid fee schedule. 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.
MMP 23-05	12/29/2022	Children's Special Health Care Services	5.3 Payment Agreement	The 3rd paragraph was revised to read: 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.~~

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				The following paragraph was added: If a family experiences a change in income or family size during the year, they are encouraged to work with the LHD to submit an Income Review/Payment Agreement Amendment (MSA-0927). A refund may be available if the fees paid are greater than the amount due indicated on the amendment. Refunds may be prorated up to 12 months to the date of the event, though not further than the beginning of the current MSA-0738 agreement period. Payment agreement adjustments may not be applied to previous agreements. All other payments are non-refundable.