SCHOOL BASED SERVICES

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SECTION 1 – GENERAL INFORMATION

This chapter applies to enrolled Intermediate School Districts, Detroit Public Schools, and Michigan School for the Deaf.

This chapter describes the coverage and reimbursement policy for direct medical services, targeted case management, and personal care services. Coverage applies to individuals up to the age of 21 who are eligible under the provisions of the Individuals with Disabilities Education Act (IDEA) of 1990 as amended in 2004 and to those enrolled in programs that require an Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP). The Centers for Medicare & Medicaid Services (CMS) has determined that services provided in the "school" setting include services provided by qualified school staff in the "home" setting when necessary.

These services assist students with a disability to benefit from special education and related services. Medicaid reimbursement, through the Michigan Department of Health and Human Services (MDHHS), addresses the medical service needs of beneficiaries receiving special education and related services and provides funding for those services. The Social Security Act, as amended in 1988 by the Medicare Catastrophic Coverage Act, specifically provides for medical assistance (Medicaid) to cover "related services" which are specified in Federal Medicaid statute as medically necessary and "included in the child's IEP established pursuant to Part B of the IDEA or furnished to a handicapped infant or toddler because such services are included in the child's IFSP adopted pursuant to Part C (formerly called Part H) of such Act."

Section 504 of the Rehabilitation Act of 1973 requires local school districts to provide or pay for certain services to make education accessible to handicapped children. These services are described in an individualized service plan and provided free of charge to eligible individuals. Medicaid reimbursement is not allowed for these services.

Medicaid school based services are not covered for beneficiaries involuntarily residing in a detention setting with a Benefit Plan ID of INCAR-ESO, INCAR-MA, INCAR-MA-E, or MA-HMP-INC.

Coverage is based on medically necessary, Medicaid-covered services already being provided in the school setting and enables these services provided to Medicaid-eligible beneficiaries to be billed to Medicaid. This ensures federal participation in the funding of these Medicaid covered services. Enrollment as a Michigan Medicaid provider for services delivered in the school setting is limited to the Intermediate School Districts (ISDs), Detroit Public Schools, and Michigan School for the Deaf. For the purpose of this document, the ISDs, Detroit Public Schools, and Michigan School for the Deaf will be referred to as "ISDs" for simplicity.

Enrolled providers are required to establish an interagency agreement to facilitate coordination and cooperation with other human service agencies operating within the same service area. Medicaid services provided by the ISDs are to be provided as outlined in the IEP/IFSP treatment plan and are not expected to replace or substitute for services already provided by other agencies. If services are being provided by another program, ISDs are expected to coordinate the services to prevent service overlap and to assure continuity of care to the Medicaid beneficiary. Enrollment as a SBS provider is not expected to result in any change in the education agency's set of existing services or service utilization. MDHHS periodically evaluates the impact of Medicaid enrollment on special education programs through review of service utilization and other program data and information.

Covered services do not require prior authorization but must be documented and provided by qualified personnel as specified in the Covered Services Section of this chapter.

The following terms have specific meanings in the school setting:

Assistive Technology Device (ATD)	Per IDEA, Section 602, the term "assistive technology device" means any item, piece of equipment or product system, whether acquired commercially off the shelf or modified or customized, that is used to increase, maintain, or improve functional capabilities of a child with a disability.
Assistive Technology Service	The term "assistive technology service" means any service that directly assists a child with a disability in the selection, acquisition or use of an assistive technology device.
Certified Public Expenditure	A certified public expenditure is an expenditure of a governmental unit whose state share is supported by tax dollars, or a mix of tax dollars and appropriated dollars, and is certified as eligible for federal match.
Claims Development Software	The claims development software is a custom-developed software that automates the school district claiming process. The claims development process is comprised of three components: sampling, training, and costs/claim generation.
Direct Medical Services Program	Direct medical services, specialized transportation, targeted case management and personal care services provided in the school setting and reimbursed by Medicaid.

Durable Medical Equipment, Supplies, Prosthetics and Orthotics (DMEPOS)	▪ DME items are those that can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of an illness or injury, and can be used in the beneficiary's home. DME is a covered benefit when: ➢ It is medically and functionally necessary to meet the needs of the beneficiary. ➢ It may prevent frequent hospitalization or institutionalization. ➢ It is life sustaining. ▪ Medical Supplies are those items that are required for medical management of the beneficiary, are disposable or have a limited life expectancy, and can be used in the beneficiary's home. Medical supplies are items that: ➢ Treat a medical condition. ➢ Prevent unnecessary hospitalization or institutionalization. ➢ Support DME used by the beneficiary. ▪ Prosthetics artificially replace a portion of the body to prevent or correct a physical anomaly or malfunctioning portion of the body. Prosthetics are a benefit to: ➢ Improve and/or restore the beneficiary's functional level. ➢ Enable a beneficiary to ambulate or transfer. ▪ Orthotics assist in correcting or strengthening a congenital or acquired physical anomaly or malfunctioning portion of the body. Orthotics are a benefit to: ➢ Improve and/or restore the beneficiary's functional level. ➢ Prevent or reduce contractures. ➢ Facilitate healing or prevent further injury.
Enrolled Medicaid Provider	The 56 Michigan Intermediate School Districts, Detroit Public Schools, and Michigan School for the Deaf that have enrolled and revalidated with the MDHHS CHAMPS Provider Enrollment subsystem.
HT Modifier (Multi-disciplinary team)	The HT modifier is used when billing for an assessment, evaluation or test performed for the IDEA Assessment. Each qualified staff bills using the appropriate procedure code followed by the modifier HT (multi-disciplinary team).
IEP (Individualized Education Program)	A written plan for services for eligible students between the ages of 4 and 26 in Michigan as determined by the federal IDEA statute. Medicaid funds are available to reimburse for health and medical services that are a part of a student's IEP for beneficiaries up to the age of 21.
IFSP (Individualized Family Service Plan)	A written plan for a child with a disability who is between the ages of zero and three years that is developed jointly by the family and appropriate qualified personnel, and is based on multi-disciplinary evaluation and assessment of the child's unique strengths and needs, as well as a family-directed assessment of the priorities, resources and concerns. Medicaid funds are available to reimburse for health and medical services that are a part of a child's IFSP.

IDEA (Individuals with Disabilities Education Act)	The federal statute, IDEA of 1990 as amended in 2004, which requires public schools to determine whether a child has a disability, develop a plan that details the education and support services that the student will receive, provide the services, and evaluate the plan at least annually. There may be federal funding available for some of these responsibilities.
IDEA Assessment	An IDEA assessment is a formal evaluation that includes assessments, evaluations, tests and all related activities performed to determine if an individual is eligible under provisions of the IDEA of 1990, as amended in 2004, and are related to the evaluation and functioning of the individual.
ISD (District)	A corporate body established by statute in the Michigan Revised School Code (PA 451 of 1976) that is regulated by an intermediate school board. Michigan has 56 intermediate school districts.
MDE (Michigan Department of Education)	A department within the State of Michigan.
Random Moment Time Study	A random moment sampling to determine the extent to which Medicaid-reimbursable activities are being performed by capturing what is done during a specific moment in time.
School-Based Services	A program which provides medically necessary Medicaid covered services in the school setting. All Michigan ISDs, Detroit Public Schools, and Michigan School for the Deaf participate in the Direct Medical Services Program.
School Clinical Record	All the written or electronic information that has been created and is necessary to fully disclose and document the services requested for reimbursement.
Special Education Transportation	Transport to and from the student's pick-up and drop-off site where school based services are provided.
TL Modifier (Re-evaluation of Existing Data (REED))	The TL modifier is used with the appropriate procedure codes to identify when a re-evaluation of existing data (REED) was used in the determination of the child's eligibility for special education services.
TM Modifier (Individualized Education Program [IEP])	The TM modifier is used when billing for the multi-disciplinary team assessment for the development, review and revision of an IEP/IFSP treatment plan. Each qualified staff bills for this assessment using the appropriate procedure code with the modifier TM (Individualized Education Program [IEP]).
Treatment Plan	If an evaluation indicates that Medicaid-covered services are required, the qualified staff must develop and maintain a treatment plan for the student. The student's IEP/IFSP form may suffice as the treatment plan as long as the IEP/IFSP contains the required components described under the Treatment Plan subsection of this section.

1.1 Children's Special Health Care Services

The Medicaid School Based Services program covers services provided to children who are determined either dually eligible for Children's Special Health Care Services (CSHCS) and Medicaid (Title V/XIX), or those eligible for only Medicaid (Title XIX). SBS providers are not reimbursed for beneficiaries enrolled only in the CSHCS program (Title V only), and must not submit claims for these beneficiaries.

1.2 Third Party Liability

Federal regulations require that all identifiable financial resources available for payment be billed prior to billing Medicaid. If a Medicaid-eligible child is presently covered by another resource and the school district does not bill the other resource, Medicaid cannot be billed for the services. (Refer to the Coordination of Benefits chapter for additional information.)

1.3 Medical Necessity

A Medicaid service provided by an ISD is determined medically necessary when all of the following criteria are met:

- Addresses a medical or mental disability;
- Needed to attain or retain the capability for normal activity, independence or self care;
- Is included in the student's IEP/IFSP treatment plan; and
- Is ordered, in writing, by a physician or other licensed practitioner acting within the scope of his/her practice under State law. Students who require speech, language and hearing services must be referred. The written order/referral must be updated at least annually. A stamped signature is not acceptable.

1.4 Under the Direction of and Supervision

Certain specified services may be provided under the direction of or under the supervision of another clinician. For the supervising clinician, "under the direction of" means that the clinician is supervising the individual's care which, at a minimum, includes seeing the individual initially, prescribing the type of care to be provided, reviewing the need for continued services throughout treatment, assuring professional responsibility for services provided, and ensuring that all services are medically necessary. "Under the direction of" requires face-to-face contact by the clinician at least at the beginning of treatment and periodically thereafter.

"Supervision of" limited-licensed mental health professionals consists of the practitioner meeting regularly with another professional, at an interval described within the professional administrative rules, to discuss casework and other professional issues in a structured way. This is often known as clinical or counseling supervision or consultation. The purpose is to assist the practitioner to learn from his or her experience and expertise, as well as to ensure good service to the client or patient.

1.5 Covered Services

Medicaid covered services billed by ISDs include:

- Evaluations and tests performed for assessments
- Occupational Therapy Services
- Orientation and Mobility Services
- Assistive Technology Device Services
- Physical Therapy Services

- Speech, Language and Hearing Therapy Services
- Psychological, Counseling and Social Work Services
- Developmental Testing Services
- Nursing Services
- Physician and Psychiatrist Services
- Personal Care Services
- Targeted Case Management (TCM) Services
- Specialized Transportation Services

1.6 Service Expectations

The IEP/IFSP treatment plan must include the appropriate annual goals and short-term objectives, criteria, evaluation procedures, and schedules for determining whether the objectives are being achieved within an appropriate period of time (at least annually). All therapy services must be skilled (i.e., require the skills, knowledge, and education of a licensed occupational therapist, licensed physical therapist, or fully licensed speech-language pathologist or licensed audiologist). Interventions expected to be provided by another practitioner (e.g., teacher, registered nurse), family member or caregiver are not reimbursable as occupational, physical, or speech, language and hearing therapy by this program.

To be covered by Medicaid, occupational, physical, and speech, language and hearing therapy must address a beneficiary's medical need that affects his/her ability to learn in the classroom environment. MDHHS does not reimburse for therapies that do not have medically related goals (i.e., handwriting, increasing attention span, identifying colors and numbers, enhancing vocabulary, improving sentence structure, and reading).

Group therapy or treatment must be provided in groups of two to eight. Services provided as part of a regular classroom activity are not reimbursable. When regularly scheduled attention is provided to one beneficiary who is part of the class currently in session, the service is not reimbursable.

Supplies or equipment utilized in service delivery are included as part of the service and are not reimbursed separately. Art, music and recreation therapies are not covered services.

Medicaid is required to follow the procedure code definition from the Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) manuals. Procedure codes referencing office or outpatient facility include the medical services provided in the school setting. Procedure codes that do not specify a unit of time are to be billed per session. Group therapy is billed per beneficiary.

Certain CPT/HCPCS code descriptions include a specified unit of service time. Service times are based on the time it generally takes to provide the service. If the procedure code specifies "up to 15 minutes of service", the service may be billed in a unit of time from 1-15 minutes. If the procedure code specifies a unit of time "each 15 minutes", the code may be billed when the service time equals the specified unit of time. Any additional time cannot be billed unless the full time specified is reached.

Consultation or consultative services are an integral part or an extension of a direct medical service and are not separately reimbursable.

1.7 TREATMENT PLAN

Requirements	If an evaluation indicates that Medicaid-covered services are required, the qualified staff must develop and maintain a treatment plan for the beneficiary. The beneficiary's IEP/IFSP form may suffice as the treatment plan as long as the IEP/IFSP contains the required components described below. Only qualified staff may initiate, develop or change the beneficiary's treatment plan. The treatment plan must be signed, titled and dated by the qualified staff prior to billing Medicaid for services and must be retained in the beneficiary's school clinical record. (Refer to the Covered Services Section of this chapter for definitions of qualified staff.)
Components	The treatment plan, which is an immediate result of the evaluation, must consist of the following components: ▪ Beneficiary's name; ▪ Description of the beneficiary's qualifying diagnosis and medical condition; ▪ Time-related goals that are measurable and significant to the beneficiary's function and/or mobility; ▪ Long-term goals that identify specific functional achievement to serve as indicators that the service is no longer needed; ▪ Anticipated frequency and duration of treatment required to meet the time-related goals; ▪ Plan for reaching the functional goals and outcomes in the IEP/IFSP; ▪ A statement detailing coordination of services with other providers (e.g., medical and educational); and ▪ All services are provided with the expectation that the beneficiary's primary care provider and, if applicable, the beneficiary's case manager are informed on a regular basis.
Review	The treatment plan must be reviewed and updated at least annually as part of the IEP/IFSP multi-disciplinary team assessment process, or more frequently if the beneficiary's condition changes or alternative treatments are recommended.

1.8 EVALUATIONS

Evaluations for medical services are covered when:

- Performed as part of the IDEA Assessment.
- The beneficiary left and is re-entering special education.
- An initial development, review or revision of the student's IEP/IFSP treatment plan will occur.
- A change or decrease in function occurs.

1.8.A. Evaluations Performed for DMEPOS Medical Suppliers

If an ISD physical therapist, occupational therapist, speech pathologist or audiologist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.

SECTION 2 – COVERED SERVICES

2.1 INDIVIDUALS WITH DISABILITIES EDUCATION ACT ASSESSMENT AND IEP/IFSP DEVELOPMENT, REVIEW AND REVISION

Definition	The Individuals with Disabilities Education Act (IDEA) Assessment is a formal evaluation that includes assessments, evaluations, tests and all related activities performed to determine if a beneficiary is eligible under provisions of the IDEA of 1990, as amended in 2004, and are related to the evaluation and functioning of the beneficiary. These services are reimbursable only after they result in the implementation of an IEP/IFSP treatment plan. If an IEP/IFSP treatment plan is not implemented within one year of the date of service, then none of the services provided are covered.
Provider Qualifications	Qualified staff can bill for assessments, tests, and evaluations performed for the IDEA Assessment. To be covered by Medicaid, the staff must have the following Michigan current credentials: ▪ A licensed occupational therapist (OT) ▪ A certified orientation and mobility specialist (O&M) ▪ A licensed physical therapist (PT) ▪ A fully licensed speech-language pathologist (SLP) ▪ A licensed audiologist ▪ A fully licensed psychologist ▪ A limited-licensed psychologist (under the supervision of a licensed psychologist) ▪ A licensed professional counselor ▪ A limited-licensed counselor (under the supervision of a licensed professional counselor) ▪ A licensed master's social worker ▪ A limited-licensed master's social worker (under the supervision of a licensed master's social worker) ▪ A licensed physician or psychiatrist (MD or DO) ▪ A registered nurse (RN)

Procedure Codes	Qualified staff can bill for three distinct types of assessments/evaluations/tests. All activities, such as meetings and written reports related to the assessment/evaluation/test, are an integral part or extension of the service and are not separately reimbursable. For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) ▪ The **HT modifier** is used with the procedure code when billing for an assessment/evaluation/test performed for the IDEA Assessment. Each qualified staff bills using the appropriate procedure code below followed by the modifier HT (multi-disciplinary team). The date of service is the date of determination of eligibility for special education or early-on services. The determination date must be included in the assessment/evaluation/test. ▪ The **TL modifier** is used with the appropriate procedure codes to identify when a re-evaluation of existing data (REED) was used in the determination of the child's eligibility for special education services. ▪ The **TM modifier** is used with the procedure code when billing for the multi-disciplinary team assessment to develop, review and revise an IEP/IFSP treatment plan. Each qualified staff bills using the appropriate procedure code below with the modifier TM (Individualized Education Program [IEP]). The date of service is the date of the multi-disciplinary team assessment. ▪ **52 Modifier (Reduced Services)** - The 52 modifier is used to describe circumstances in which services provided were reduced in comparison to the full description of the service. ▪ No modifier is used when assessments/evaluations/tests are provided not related to the IDEA Assessment or the IEP/IFSP treatment plan development, review and revision. Each qualified staff bills for these activities using the appropriate procedure code below with no modifier. The date of service is the date the assessment/evaluation/test is completed.

2.2 Occupational Therapy (Includes Orientation and Mobility Services and Assistive Technology Device Services)

2.2.A. Occupational Therapy Services

Definition	**Occupational Therapy:** Occupational therapy (OT) must be rehabilitative, active or restorative and designed to correct or compensate for a medical problem interfering with age-appropriate functional performance. Occupational therapy services must require the skills, knowledge, and education of a licensed occupational therapist, licensed occupational therapy assistant, or Orientation and Mobility specialist.
Prescription	Occupational therapy services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable. Services supported by an Individualized Education Program can precede the signed prescription by up to 90 days; however, the active period of the prescription cannot be longer than one year.

Provider Qualifications	OT services may be reimbursed when provided by: ▪ A licensed occupational therapist (OT); or ▪ A licensed occupational therapy assistant (OTA) under the direction of a licensed occupational therapist (OT). NOTE: The OTA's services must follow the evaluation and treatment plan developed by the OT. The OT must supervise and monitor the OTA's performance with continuous assessment of the beneficiary's progress. All documentation must be reviewed and signed by the supervising OT.
Evaluations for Occupational Therapies	Evaluations are formalized testing and reports for the development of the beneficiary's treatment plan. They may be completed by a licensed occupational therapist. An evaluation includes: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function; ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary.
Assessments for Durable Medical Equipment	If an ISD occupational therapist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.

Services	Occupational therapy services include: ▪ Group therapy provided in a group of two to eight beneficiaries; ▪ Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions; ▪ Wheelchair management/propulsion training; ▪ Independent living skills training; ▪ Coordinating and using other therapies, interventions, or services with the ATD; ▪ Training or technical assistance for the beneficiary or, if appropriate, the beneficiary's parent/guardian; ▪ Training or technical assistance for professionals providing other education or rehabilitation services to the beneficiary receiving ATD services; ▪ Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities; ▪ Evaluating the needs of the beneficiary, including a functional evaluation of the beneficiary. ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD; or ▪ Selecting, providing for the acquisition of the device, designing, fitting, customizing, adapting, applying, retaining, or replacing the ATD, including orthotics.
Procedure Codes	For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.2.B. Orientation and Mobility Services

Definition	**Orientation and Mobility Services:** Orientation and mobility services are services provided to blind or visually impaired students by qualified personnel to enable those students to attain systematic orientation to and safe movement within their environment in the school, home and community. Services are based on the individual student's needs for assistance in compensatory skill development, visual efficiency, utilization of low vision aids/devices and technology, etc. Spatial and environmental concepts and use of information received by the senses (such as sound, temperature and vibration) to establish, maintain, or regain orientation and line of travel (for example, using sound at a traffic light to cross the street); to use the long cane, as appropriate, to supplement visual travel skills or as a tool for safely negotiating the environment for students with no available travel vision; and to understand and use remaining vision and distance low vision aids/devices, as appropriate.
Prescription	Orientation and mobility services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable. Services supported by an Individualized Education Program can precede the signed prescription by up to 90 days; however, the active period of the prescription cannot be longer than one year.
Provider Qualifications	Orientation and mobility services may be reimbursed when provided by: ▪ A certified orientation and mobility specialist with current certification from the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP); or ▪ A licensed occupational therapist.

Evaluations	Evaluations are formalized testing and reports for the development of the beneficiary's treatment plan. They may be completed by an Orientation and Mobility Specialist (O&M) or a licensed occupational therapist. An evaluation for Orientation and Mobility services includes: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (status of sensory skills, proficiency of use of travel tools, current age-appropriate independence, complexity or introduction of new environment, caregiver input, assessment in the home/living environment, assessment in the school environment, assessment in the residential/neighborhood environment, assessment in the commercial environment, and assessment in the public transportation environment; ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary.
Services	Orientation and mobility services include: ▪ Providing assistance in the development of skills and knowledge that enable the child to travel independently to the highest degree possible, based on assessed needs and the IEP; ▪ Training the child to travel with proficiency, safety and confidence in familiar and unfamiliar environments; ▪ Preparing and using equipment and material, such as tactile maps, models, distance low vision aids/devices, and long canes, for the development of orientation and mobility skills; ▪ Evaluation and training performed to correct or alleviate movement deficiencies created by a loss or lack of vision; ▪ Communication skills training (teaching Braille is not a covered benefit); ▪ Systematic orientation training to allow safe movement within their environments in school, home and community; ▪ Spatial and environmental concept training and training in the use of information received by the senses (such as sound, temperature and vibration) to establish, maintain, or regain orientation; ▪ Visual training to understand and use the remaining vision for those with low vision; ▪ Training necessary to activate visual motor abilities; ▪ Training to use distance low vision aids/devices; and ▪ Independent living skills training.

Procedure Codes	For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.2.C. ASSISTIVE TECHNOLOGY DEVICE SERVICES

Definition	Assistive Technology Device Services General Description: Utilizing the description in Section 602(2) of the Individuals with Disabilities Education Act (IDEA), the term 'assistive technology device' means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of a child with a disability. Therapists should restrict their evaluations and services to those within the scope of their practice and consistent with their education and training.
Prescription	Assistive technology device services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable.
Provider Qualifications	Assistive technology device services may be reimbursed when provided by: ▪ A licensed occupational therapist (OT); or ▪ A licensed occupational therapy assistant (OTA).
Evaluations for Assistive Technology Devices	Evaluations are formalized testing and reports for the development of the beneficiary's treatment plan. They may be completed by a licensed occupational therapist. An evaluation includes: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function; ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary in the school environment and home.

Assessments for Durable Medical Equipment	If an ISD occupational therapist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.
Services	ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD. The direct acquisition of medical equipment, such as wheelchairs etc., is not a covered benefit of the SBS program; this service must be billed under the Medical Supplier program coverage. The direct acquisition of medical equipment is covered under the Medical Supplier Medicaid benefit. Assistive Technology Device Services include: ▪ Coordinating and using other therapies, interventions, or services with the ATD. ▪ Training or technical assistance for the beneficiary or, if appropriate, the beneficiary's parent/guardian. ▪ Training or technical assistance for professionals providing other education or rehabilitation services to the beneficiary receiving ATD services. ▪ Neuromuscular re-education of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities. ▪ Evaluating the needs of the beneficiary, including a functional evaluation of the beneficiary. ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD. ▪ Selecting, providing for the acquisition of the device, designing, fitting customizing, adapting, applying, retaining or replacing the ATD, including orthotics. ▪ Wheelchair assessment, fitting, training. If the wheelchair assessment is for equipment billed by a Medicaid medical supplier, all prior authorization and coverage policies and procedures in the Medical Supplier Chapter of this manual must be adhered to by school based providers.
Procedure Codes	For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.3 Physical Therapy Services (Includes Assistive Technology Device Services)

2.3.A. Physical Therapy Services

Definition	Physical therapy (PT) must be rehabilitative, active or restorative and designed to correct or compensate for a medical problem. Physical therapy services must require the skills, knowledge and education of a PT or PTA to provide therapy. Treatment is performed through the use of therapeutic exercises and rehabilitative procedures.
Prescription	Physical therapy services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable.
Provider Qualifications	PT services may be reimbursed when provided by: ▪ A licensed physical therapist (PT); or ▪ A licensed physical therapy assistant (PTA) under the direction of a licensed physical therapist (PT) (i.e., the PT supervises and monitors the PTA's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and signed by the supervising PT.
Evaluations for Physical Therapies	Evaluations are formalized testing and reports to determine a beneficiary's need for services and recommend a course of treatment. They may be completed by a PT. Evaluations include: ▪ The treatment diagnosis and the medical diagnosis, if different than the treatment diagnosis; ▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (i.e., functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (e.g., strength, dexterity, range of motion) directly affecting the beneficiary's ability to function; ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary.

Assessments for Durable Medical Equipment	If an ISD physical therapist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.
Services	Physical therapy services include: ▪ Group therapy provided in a group of two to eight beneficiaries; ▪ Gait training; ▪ Training in functional mobility skills (e.g., ambulation, transfers, and wheelchair mobility); ▪ Stretching for improved flexibility; and ▪ Modalities to allow gains of function, strength or mobility.
Procedure Codes	For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.3.B. ASSISTIVE TECHNOLOGY DEVICE SERVICES

Definition	**Assistive Technology Device Services General Description:** Utilizing the description in Section 602(2) of the Individuals with Disabilities Education Act (IDEA), the term 'assistive technology device' means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of a child with a disability. Therapists should restrict their evaluations and services to those within the scope of their practice and consistent with their education and training.
Prescription	Assistive technology device services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable.
Provider Qualifications	Assistive technology device services may be reimbursed when provided by: ▪ a licensed physical therapist (PT); or ▪ a licensed physical therapy assistant (PTA).

Evaluations for Assistive Technology Devices	Evaluations are formalized testing and reports for the development of the beneficiary's treatment plan. They may be completed by a PT. An evaluation includes: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function; ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary in the school environment and home.
Assessments for Durable Medical Equipment	If an ISD physical therapist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.

Services	ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD. The direct acquisition of medical equipment, such as wheelchairs, etc., is not a covered benefit of the SBS program; this service must be billed under the Medical Supplier program coverage. The direct acquisition of medical equipment is covered under the Medical Supplier Medicaid benefit. Assistive Technology Device Services include: ▪ Coordinating and using other therapies, interventions, or services with the ATD. ▪ Training or technical assistance for the beneficiary or, if appropriate, the beneficiary's parent/guardian. ▪ Training or technical assistance for professionals providing other education or rehabilitation services to the beneficiary receiving ATD services. ▪ Evaluating the needs of the beneficiary, including a functional evaluation of the beneficiary. ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD. ▪ Selecting, providing for the acquisition of the device, designing, fitting customizing, adapting, applying, retaining or replacing the ATD, including orthotics. ▪ Wheelchair assessment, fitting, training. If the wheelchair assessment is for equipment billed by a Medical Supplier, all prior authorization and coverage policies and procedures in the Medical Supplier Chapter of this manual must be adhered to by school based providers.
Procedure Codes	For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.4 Speech, Language and Hearing Therapy (Includes Assistive Technology Device Services)

2.4.A. Speech, Language and Hearing Therapy

Definition	Speech, language and hearing therapy must be a diagnostic or corrective service to teach compensatory skills for deficits that directly result from a medical condition. This service is provided to beneficiaries with a diagnosed speech, language or hearing disorder adversely affecting the functioning of the beneficiary. Speech, language and hearing therapy must require the skills, knowledge and education of a fully licensed speech-language pathologist or audiologist to provide the therapy.
Prescription	Speech, language and hearing services require an annual referral from a physician. A stamped physician signature is not acceptable. Services supported by an Individualized Education Program can precede the signed referral by up to 90 days; however, the active period of the referral cannot be longer than one year.

Provider Qualifications	Speech, language and hearing services may be reimbursed when provided by: ▪ A fully licensed speech-language pathologist (SLP); ▪ A licensed audiologist in Michigan; ▪ A speech-language pathologist (SLP) and/or audiology candidate (i.e., in his clinical fellowship year or having completed all requirements but has not obtained a license), under the direction of a qualified SLP or audiologist. All documentation must be reviewed and signed by the appropriately licensed SLP or licensed audiologist; or ▪ A limited licensed speech language pathologist, under the direction of a fully licensed SLP or audiologist. All documentation must be reviewed and signed by the appropriately licensed supervising SLP or licensed audiologist.
Evaluations for Speech Pathology Services	Evaluations are formalized testing and reports conducted to determine the need for services and recommendation for a course of treatment. They may be completed by a licensed SLP or audiologist. Evaluations include: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current communication status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; and ▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary. Evaluations may also include, but are not limited to,: ▪ Articulation - standardized tests that measure receptive and expressive language, mental age, oral motor skills, articulation skills, current diet level (including difficulties with any food consistencies), current means of communication, and a medical diagnosis. ▪ Language - standardized tests that measure receptive and expressive language, mental age, oral motor skills, current and previous means of communication, and medical diagnosis(es). ▪ Rhythm - standardized tests that measure receptive and expressive language, mental age, oral motor skills, and measurable assessment of dysfluency, current means of communication, and a medical diagnosis. ▪ Swallowing - copy of the video fluoroscopy or documentation that objectively addresses the laryngeal and pharyngeal stages, oral motor assessment that measures consistencies that have been attempted and the results, voice quality (i.e., pre- and post-feeding and natural voice), articulation assessment, and a standardized cognitive assessment. ▪ Voice - copy of the physician's medical assessment of the beneficiary's voice mechanism and the medical diagnosis.

Speech Assessments for Durable Medical Equipment	If an ISD speech pathologist or audiologist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.
Services	Speech, language and hearing services include: ▪ Group therapy provided in a group of two to eight beneficiaries ▪ Articulation, language, and rhythm ▪ Swallowing dysfunction and/or oral function for feeding ▪ Voice therapy ▪ Speech, language or hearing therapy ▪ Speech reading/aural rehabilitation ▪ Esophageal speech training therapy ▪ Speech defect corrective therapy ▪ Fitting and testing of hearing aids or other communication devices
Procedure Codes	For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.4.B. ASSISTIVE TECHNOLOGY DEVICE SERVICES

Definition	**Assistive Technology Device Services General Description:** Utilizing the description in Section 602(2) of the Individuals with Disabilities Education Act (IDEA), the term 'assistive technology device' means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of a child with a disability. Therapists should restrict their evaluations and services to those within the scope of their practice and consistent with their education and training.
Prescription	Assistive technology device services must be prescribed by a physician and updated annually. A stamped physician signature is not acceptable.
Provider Qualifications	Assistive Technology services may be reimbursed when provided by: ▪ A licensed audiologist; ▪ A fully licensed speech-language pathologist (SLP)

Evaluations for Assistive Technology Devices	Evaluations are formalized testing and reports for the development of the beneficiary's treatment plan. They may be completed by an audiologist or SLP. An evaluation includes: ▪ The treatment diagnosis and the medical diagnosis, if different from the treatment diagnosis; ▪ Current therapy being provided to the beneficiary in this and other settings; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ The standardized and other evaluation tools used to establish the baseline and to document progress; ▪ Assessment of the beneficiary's performance components (strength, dexterity, range of motion, sensation, perception) directly affecting the beneficiary's ability to function; ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual, comprehension); and ▪ Evaluation of the needs related to assistive technology device services, including a functional evaluation of the beneficiary in the school environment and home.
Assessments for Durable Medical Equipment	If an ISD audiologist or speech-language pathologist performs assessments for DMEPOS that are billed by a Medicaid medical supplier, the clinician must comply with all prior authorization policies and procedures regarding that DMEPOS item. For example, a physician must order the assessment. The clinician must comply with all requirements for the assessments specified in the Medical Supplier Chapter of this manual. For example, the clinician must perform and write his/her own evaluation and may not sign evaluations completed by a medical supplier. Three appropriate economical alternatives must be ruled out for some items. (Refer to the Medical Supplier Chapter of this manual for details.) If the child is also receiving physical therapy, occupational therapy, speech pathology or audiology services in another outpatient setting, it may be more appropriate for the outpatient clinician to perform the assessment. The ISD clinician must coordinate with all clinicians in other settings.
Services	ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD. The direct acquisition of medical equipment, such as wheelchairs, etc., is not a covered benefit of the SBS program; this service must be billed under the Medical Supplier program coverage. The direct acquisition of medical equipment is covered under the Medicaid Medical Supplier benefit. Assistive Technology Device Services include: ▪ Coordinating and using other therapies, interventions, or services with the ATD. ▪ Training or technical assistance for the beneficiary or, if appropriate, the beneficiary's parent/guardian. ▪ Training or technical assistance for professionals providing other education or rehabilitation services to the beneficiary receiving ATD services. ▪ Evaluating the needs of the beneficiary, including a functional evaluation of the beneficiary. ATD services are intended to directly assist a beneficiary with a disability in the selection, coordination of acquisition, or use of an ATD.

	▪ Selecting, providing for the acquisition of the device, designing, fitting customizing, adapting, applying, retaining or replacing the ATD.
Procedure Codes	For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.4.C. TELEPRACTICE FOR SPEECH, LANGUAGE AND HEARING SERVICES

Definition	Telepractice is the use of telecommunications and information technologies for the exchange of encrypted patient data for the provision of speech, language and hearing services. Telepractice must be obtained through real-time interaction between the patient's physical location (patient site) and the provider's physical location (provider site). Services are provided to patients through hardwire or internet connection. It is the expectation that providers, facilitators and staff involved in telepractice are trained in the use of equipment and software prior to servicing patients. Speech, language and hearing services administered by telepractice are subject to the same provisions as services provided to a patient in person.
Prescription	Speech, language and hearing services require an annual referral from a physician. A stamped physician signature is not acceptable.
Provider Qualifications	Speech, language and hearing services may be reimbursed when provided by: ▪ A fully licensed speech-language pathologist (SLP); ▪ A licensed audiologist in Michigan; ▪ A speech-language pathologist (SLP) and/or audiology candidate (i.e., in his clinical fellowship year or having completed all requirements but has not obtained a license) under the direction of a qualified SLP or audiologist. All documentation must be reviewed and signed by the appropriately licensed SLP or licensed audiologist; or ▪ A limited licensed speech language pathologist under the direction of a fully licensed SLP or audiologist. All documentation must be reviewed and signed by the appropriately licensed supervising SLP or licensed audiologist.
Conditions	Providers must ensure the privacy of the beneficiary and the security of any information shared via telemedicine. The technology used must meet the needs for audio and visual compliance in accordance with current regulations and industry standards. Refer to the General Information for Providers Chapter for complete Health Insurance Portability and Accountability Act (HIPAA) compliance requirements. The patient site may be located within the school, at the patient's home, or any other established site deemed appropriate by the provider. It must be a room free from distractions so as not to interfere with the telepractice session. A facilitator must be trained in the use of the telepractice technology and physically present at the patient site during the entire telepractice session to assist the patient at the direction of the SLP or audiologist.
Billing Instructions	Telepractice services are billed using the same procedure codes as services rendered to a patient who is physically present. In addition to the procedure code, billers use the "GT" modifier to identify services provided by telepractice.

2.5 Psychological, Counseling and Social Work Services

Definitions	Psychological, counseling and social work services include planning, managing and providing a program of face-to-face services for beneficiaries with diagnosed psychological conditions. Psychological, counseling and social work services must require the skills, knowledge and education of a psychologist, counselor or licensed social worker to provide treatment. Psychotherapy is the treatment of a mental disorder or behavioral disturbance for which the clinician provides services through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverses or changes maladaptive patterns of behavior, and encourages personality growth and development. The codes for reporting psychotherapy are divided into two broad categories: Interactive Psychotherapy, and Insight-Oriented, Behavior-Modifying and/or Supportive Psychotherapy. ▪ Interactive psychotherapy refers to the use of physical aids and nonverbal communication to overcome barriers to therapeutic interaction between the clinician and a beneficiary who has not yet developed, or has lost, either the expressive language communication skills to explain their symptoms and response to treatment, or the receptive communication skills to understand the clinician if they would use ordinary adult language for communication. ▪ Insight-oriented, behavior-modifying and/or supportive psychotherapy refers to the development of insight or affective understanding, the use of behavior modification techniques, the use of supportive interactions, and the use of cognitive discussion of reality or any combination of the above to provide therapeutic change.
Provider Qualifications	Psychological, counseling and social work services may be reimbursed when provided by: ▪ A licensed physician or psychiatrist in Michigan; ▪ A fully licensed psychologist in Michigan; ▪ A limited-licensed psychologist under the supervision of a licensed psychologist; ▪ A temporary limited-licensed psychologist under the supervision of a licensed psychologist; ▪ A licensed master's social worker in Michigan; ▪ A limited licensed master's social worker under the supervision of a licensed master's social worker; ▪ A licensed professional counselor in Michigan; or ▪ A limited licensed counselor under the supervision of a licensed professional counselor.
Evaluations	Evaluations or assessments include tests, interviews and behavioral evaluations that appraise cognitive, emotional, social functioning and self-concept. These may also include interpretations of information about a beneficiary's behavior and conditions relating to functioning. A qualified psychologist, counselor or licensed social worker must complete them.

Psychological Testing	Psychological testing includes tests, interviews, evaluations and recommendations for treatment. This may also include interpretations of information about a beneficiary's behavior and conditions relating to functioning. A fully licensed psychologist or a limited-licensed psychologist may perform psychological testing. Medicaid covers psychological testing that is reasonable and necessary for diagnosing the beneficiary's condition. Medicaid does not cover the time that a beneficiary spends alone in testing. The beneficiary's clinical record must be signed and dated by the staff that administered the tests, and include the actual tests administered and completed reports. The protocols for testing must be available for review. Psychological testing may be billed per hour with a five-hour maximum per year, and a report must be generated from the results of the tests. In accordance with CPT guidelines, the service includes testing time only; it does not include writing a report. Writing the report is considered a part of the testing process and is a requirement for billing. The psychological testing report must include all of the following: ▪ Beneficiary name and birth date; ▪ Psychological tests administered; ▪ Summary of testing results; ▪ Treatment recommendations; and ▪ Psychologist name and dated signature.
Procedure Codes	For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)
Crisis Intervention	Crisis intervention services are unscheduled activities performed for the purpose of resolving an immediate crisis situation. Activities include crisis response, assessment, referral and direct therapy. Since these services are unscheduled activities, they are not listed in the beneficiary's IEP/IFSP treatment plan. Crisis intervention must be billed using the following procedure code: ▪ **S9484** – Crisis intervention mental health services, per hour.

2.6 DEVELOPMENTAL TESTING

Definition	Developmental testing is medically related testing (not performed for educational purposes) provided to determine if motor, speech, language and psychological problems exist or to detect the presence of any developmental delays. Testing is accomplished by the combination of several testing procedures and includes the evaluation of the beneficiary's history and observation. Whenever possible and when age-appropriate, standardized objective measurements are to be used (e.g., Denver II) for children under the age of six. Administering the tests must generate material that is formulated into a report. Developmental testing done for educational purposes cannot be billed to Medicaid.

Documentation	The developmental testing report must include all of the following: ▪ Beneficiary name and birth date; ▪ Tests administered; ▪ A completed quarterly claim breakdown, produced by the claims development software; ▪ Treatment recommendations; and ▪ The dated signature, address and phone number of the person administering the tests.
Provider Qualifications	Developmental testing services may be reimbursed when provided by the following qualified staff in accordance with their professional credentials: ▪ A fully-licensed psychologist in the State of Michigan; ▪ A limited-licensed psychologist under the supervision of a licensed psychologist; ▪ A licensed master's social worker in Michigan; ▪ A limited licensed master's social worker under the supervision of a licensed master's social worker; or ▪ A licensed physician or psychiatrist in Michigan.
Procedure Codes	For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.7 NURSING SERVICES

Definition	Nursing services are professional services relevant to the medical needs of the beneficiary provided through direct intervention. Direct service interventions must be medically based services that are within the scope of the professional practice of the Registered Nurse (RN) and Licensed Practical Nurse (LPN), provided during a face-to-face encounter, and provided on a one-to-one basis. Medicaid policy will follow current Michigan Public Health Code scope of practice guidelines for nursing practices. Services include: ▪ Catheterizations or Catheter care ▪ Maintenance of tracheotomies ▪ Medication administration ▪ Oxygen administration ▪ Tube feeding ▪ Suctioning ▪ Ventilator care Services considered observation or stand-by in nature are not covered. LPN services can only be billed if performed under the supervision of an RN or physician.
Prescription	Direct service interventions require a physician's written order when the initial need for services is determined. Direct service interventions must be reviewed and revised annually or as medically necessary by the beneficiary's attending physician. The nurse is responsible for notifying the attending physician of any change in the beneficiary's condition which may result in a change or modification to the care plan.
Provider Qualifications	Nursing services may be reimbursed when provided by: ▪ A licensed Registered Nurse (RN) in Michigan; or ▪ A Licensed Practical Nurse (LPN) in Michigan.
Evaluations	A RN must complete the evaluations/assessments and prepare a nursing care plan. An evaluation/assessment may be performed when a change in the beneficiary's medical condition occurs. LPNs cannot bill for evaluations/assessments.
Procedure Codes	For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.8 Physician and Psychiatrist Services

Definition	Physician and psychiatrist services are services provided with the intent to diagnose, identify or determine the nature and extent of a beneficiary's medical or other health-related condition. Physician/psychiatrist services include: ▪ Evaluation and consultation with providers of covered services for diagnostic and prescriptive services; includes participation in multi-disciplinary team assessment. ▪ Record review for diagnostic and prescriptive services. Only the services provided by a physician or psychiatrist (MD or DO) through SBS may be billed and reimbursed through the enrolled ISD. Other physician or psychiatrist services, including those which may be delivered through other Medicaid-enrolled providers, are to be billed separately and may not be billed through the enrolled ISD.
Provider Qualifications	A licensed physician or psychiatrist (MD or DO) in Michigan.
Procedure Codes	For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.) Procedure codes that replicate the services of other billed codes, either in part or in total, will not be reimbursed for the same date of service. If a physician order/referral is written as a result of a physician medical conference, the order/referral is considered to be a part of that service and is not separately reimbursable.

2.9 Personal Care Services

Definition	Personal Care Services are a range of human assistance services provided to persons with disabilities and chronic conditions which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance or cueing so that the person performs the task by him/herself. Personal Care Services may be provided when: ▪ The service is medically necessary. Personal Care Services are not covered if they are: ▪ Provided by a family member. A family member is described by the Centers for Medicare & Medicaid Services (CMS) to be "legally responsible relatives"; thus, spouses of beneficiaries and parents of minor beneficiaries (including stepparents who are legally responsible for minor children). ▪ Not documented in the IEP/IFSP. ▪ Educational in focus, such as tutoring, preparation of educational materials or Braille interpretation. ▪ Performed as a group service; however, one or more students may be served one-at-a-time sequentially. Personal Care Services may include, but are not limited to, assisting with the following: ▪ Eating/feeding ▪ Respiratory assistance ▪ Toileting ▪ Grooming ▪ Dressing ▪ Transferring ▪ Ambulation ▪ Personal hygiene ▪ Mobility/Positioning ▪ Meal preparation ▪ Skin care ▪ Bathing ▪ Maintaining continence ▪ Assistance with self-administered medications ▪ Redirection and intervention for behavior ▪ Health related functions through hands-on assistance, supervision and cueing

Personal Care Paraprofessional Provider Qualifications	The personal care paraprofessional personnel are employed in the Special Education Program and shall be qualified under the requirements established by their respective ISD plan. Providers must be trained in the skills needed to perform covered services, and must be under the direction of a qualified professional as designated in the IEP/IFSP. Paraprofessional personnel include: ▪ Teacher Aides ▪ Health Care Aides ▪ Instructional Aides ▪ Bilingual Aides ▪ Program Assistants ▪ Trainable Aides
Prescription	In accordance with 42 CFR 440.167, authorization for Personal Care Services (PCS) may be done by a physician or "other licensed practitioner" operating within the scope of their practice. The State definition of "other licensed practitioner" consists of Registered Nurse (RN), Licensed Occupational Therapist, Licensed Physical Therapist (PT), Master of Social Work (MSW), or fully licensed Speech Language Pathologist (SLP). It is expected that personal care services will be authorized by the appropriate practitioner.
Documentation	Personal care services must be medically necessary and the need for the service must be documented in the student's IEP/IFSP. Each child's school clinical record must contain a completed, signed and dated monthly activity checklist. Service categories (i.e., toileting, feeding, transferring, etc.), times and frequencies must be documented either in the IEP/IFSP, in an attached document, or in the child's treatment authorization.
Procedure Codes	For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.10 TARGETED CASE MANAGEMENT SERVICES

Definition	Targeted case management (TCM) services are services furnished to assist individuals in gaining access to needed medical, social, educational or other services. Targeted case management services include the following assistance: ▪ A comprehensive assessment and periodic reassessment of an individual to determine the need for medical, social, educational or other services. These assessment activities include: ➢ Taking client history; ➢ Identifying the individual's needs and completing related documentation; and

	➢ Gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual. ▪ Development (and periodic revision) of a specific care plan that: ➢ Is based on the information collected through the assessment; ➢ Specifies the goals and actions to address the medical, social, educational or other services needed by the individual; ➢ Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and ➢ Identifies a course of action to respond to the assessed needs of the eligible individual. ▪ Referral and related activities: ➢ To help an eligible individual obtain needed services, including activities that help link an individual with medical, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual; ➢ Monitoring and follow-up activities; ➢ Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals, and conducted as frequently as necessary, including at least one annual monitoring, to determine whether the following conditions are met: ♦ Services are being furnished in accordance with the individual's care plan; ♦ Services in the care plan are adequate. If there are changes in the needs or status of the individual, necessary adjustments are made to the care plan and service arrangements. TCM services may be reimbursed when provided by a Designated Case Manager. Providers must maintain case records that document, for all individuals receiving case management, the following: the name of the individual, the dates of the case management services, the person providing the case management services, and the nature, content, and units of case management services received. The case record must also reflect whether the goals specified in the care plan have been achieved, whether the individual has declined services in the care plan, the need for and occurrences of coordination with other case managers, the timeline for obtaining needed services, and a timeline for re-evaluation of the plan.

Provider Qualifications	The Designated Case Manager is the person responsible for the implementation of the plan of care/treatment plan. The Designated Case Manager must be an individual who meets one of the following criteria: ▪ A licensed RN in Michigan; ▪ A bachelor's degree with a major in a specific special education area; ▪ Has earned credit in coursework equivalent to that required for a major in a specific special education area; or ▪ Has a minimum of three years' personal experience in the direct care of an individual with special needs. In addition to meeting at least one of the above, the Designated Case Manager must also demonstrate knowledge and understanding of all of the following: ▪ Services for infants and toddlers who are eligible under the IDEA law as appropriate; ▪ Part C of the IDEA law and the associated regulations; ▪ The nature and scope of services covered under IDEA, as well as systems of payments for services and other pertinent information; ▪ Provisions of direct care services to individuals with special needs; and ▪ Provisions of culturally competent services within the community being served.
Designated Case Manager Services	Targeted Case Management services include: ▪ Assuring that standard re-examination and follow-up of the beneficiary are conducted on a periodic basis to ensure that the beneficiary receives needed diagnosis and treatment; ▪ Assisting families in identifying and choosing the most appropriate providers of care and services, scheduling appointments, and helping families to maintain contact with providers; ▪ Follow-up to ensure that the beneficiary receives needed diagnostic and treatment services; ▪ Assuring that case records are maintained and indicate all contacts with, or on behalf of, a beneficiary in the same manner as other covered services; ▪ Coordinating school based services and treatment with parents and the child; ▪ Monitoring and recommending a plan of action; ▪ Coordinating performance of evaluations, assessments and other services that the beneficiary needs; ▪ Facilitating and participating in the development, review, modification and evaluation of the multi-disciplinary team treatment plan; ▪ Activities that support linking and coordinating needed health services for the beneficiary; ▪ Providing a summary of provider, parent and student health and behavioral consultation; and ▪ Coordinating with staff/health professionals to establish continuum of health and behavioral services in the school setting.

Procedure Code	For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

2.11 SPECIAL EDUCATION TRANSPORTATION

Definition	Special education specialized transportation services include transport to and from the beneficiary's pick-up and drop-off site where Medicaid services are provided. It includes no more than two one-way trips on a date of service. The need for special education transportation must be specified in the beneficiary's IEP/IFSP treatment plan. Medicaid may reimburse for special education transportation when a beneficiary receives a Medicaid-covered service on the same day. Medicaid does not reimburse for transportation provided in a regular or general education school bus. There is no additional payment for an attendant.
Documentation	Federal requirements include documentation for transportation service claims that must be maintained for purposes of an audit trail, such as an ongoing trip log maintained by the provider of the special education transportation. Ridership must be documented for each one-way trip.
Procedure Codes	For a complete listing of procedure codes, refer to the School Based Services CPT code database on the MDHHS website. (Refer to the Directory Appendix for website information.)

Taxi and Private Vehicle Transportation	For a taxi or family vehicle transportation expense to be reimbursed, the following documentation must be on file at the local education agency (LEA) or intermediate school district (ISD): ▪ Specialized transportation must be included in the Individualized Education Program (IEP). ▪ A Medicaid covered medical service must be provided on the same day as the transportation. ▪ Dates and times of each trip must be listed on the LEA's or ISD's trip log. ▪ Documentation from the beneficiary's physician or a school provider treating the student, stating the reason taxi or family transportation is required must be retained in the student's file. ▪ For transportation by taxi, an additional statement justifying the need for a taxi and the reason other less costly means of transportation cannot be used must be retained in the student's file. ▪ For ongoing transportation needs, documentation is only required once per student per school year. ▪ For one-time or occasional use transportation, documentation is required for each trip, or trip period per beneficiary. ▪ The total number of trips claimed for taxi and family transportation must be included in the Special Education trip count on the Medicaid Allowable Expenditure Report (MAER). Taxi and family vehicle cost reimbursement will be retroactive to July 1, 2012 if the proper documentation has been retained, and a claim for the trip has been approved through the Community Health Automated Medicaid Processing System (CHAMPS). Claims must be filed within one year from the date of service according to Medicaid timely filing requirements. Transportation by stretcher car is not covered. The term "stretcher car" is defined as a vehicle capable of transporting a patient (student) in a prone or supine position (e.g., Ambucab).

SECTION 3 – QUALITY ASSURANCE AND COORDINATION OF SERVICES

3.1 QUALITY ASSURANCE

SBS providers must have a written quality assurance plan on file. SBS costs will be reviewed/audited by MDHHS for determination of medical necessity and to verify that all services were billed and paid appropriately. The purpose of the quality assurance plan is to establish and maintain a process for monitoring and evaluating the quality and documentation of covered services, and the impact of Medicaid enrollment on the school environment.

An acceptable quality assurance plan must address each of the following quality assurance standards:

- Covered services are medically necessary, as determined and documented through appropriate and objective testing, evaluation and diagnosis.
- The IEP/IFSP treatment plan identifies which covered services are to be provided and the service frequency, duration, goals and objectives.
- A monitoring program exists to ensure that services are appropriate, effective and delivered in a cost effective manner consistent with the reduction of physical or mental disabilities and assisting the beneficiary to benefit from special education.
- Billings are reviewed for accuracy.
- Staff qualifications meet current license, certification and program requirements.
- Established coordination and collaboration exists to develop plans of care with all other providers, (i.e., Public Health, MDHHS, Community Mental Health Services Programs (CMHSPs), Medicaid Health Plans (MHPs), Hearing Centers, Outpatient Hospitals, etc.).
- Parent/guardian and beneficiary participation exists outside of the IEP/IFSP team process in evaluating the impact of the SBS program on the educational setting, service quality and outcomes.

3.2 SERVICE COORDINATION AND COLLABORATION

Children with special needs have access to services available in both outpatient and school-based treatment settings. If treatment is provided in both settings, the goals and purpose for the two must be distinct. School based services are provided to assist a child with a disability to benefit from special education. Outpatient services are provided to optimize the child's functional performance in relation to needs in the home or community setting and must not duplicate those provided in the school setting. Collaboration between the school and the community providers is mandated to coordinate treatment and to prevent duplication of services. This collaboration may take the form of phone calls, written communication logs, or participation in team meetings such as the IEP/IFSP meeting.

3.3 ISD RESPONSIBILITIES

Each ISD must establish an implementation plan that includes explicit quality control review mechanisms to ensure full staff training and compliance, accuracy and completeness of the RMTS sample frame (designated employees), adherence to MDHHS-published methodology, editing of all moments for completeness and consistency, and accurate financial and staffing reports. Claiming entities must also fully cooperate with any review requested by the U.S. Department of Health & Human Services (HHS),

maintaining all necessary records for a minimum of seven (7) years after submission of each quarterly claim.

3.3.A. SANCTIONS

It is the intent of the State to pursue, when necessary, remedial action or implement a Corrective Plan if the ISDs or their vendors are not in compliance with Medicaid policy and procedures. If these actions are not successful, a payment freeze will be implemented and sanctions put in place until the matter is resolved. ISDs are responsible for the actions of their vendors.

The following are examples of causes for sanctions. The list is not all-inclusive.

- Repeated errors in completing the RMTS forms or filing of the claims.
- Providing insufficient data or incomplete reports to the State Contractor.
- Failure to use the claims development software.
- Failure to submit requested information, reports, or data to the State Contractor, CMS, MDHHS, MDE, or failure to cooperate with representatives of these agencies during site visits, reviews or audits.
- Failure to comply with the federal mandate to submit procedure-specific claims through the Community Health Automated Medicaid Processing System (CHAMPS).

SECTION 4 – PROVIDER ENROLLMENT

4.1 ENROLLMENT

The 56 Michigan Intermediate School Districts (ISDs), Detroit Public Schools, and Michigan School for the Deaf are the only providers eligible to bill Medicaid for School Based Services. Providers must be enrolled and/or revalidated via the CHAMPS Provider Enrollment subsystem. Any applications or updates must be made through the CHAMPS system.

4.2 CERTIFICATION OF QUALIFIED STAFF

The Michigan Department of Education (MDE) must provide MDHHS with documentation that enrolled ISDs meet the regulatory requirements set forth for all staff providing services in the school setting.

Enrollment as a provider is predicated on certification to MDE that the educational and experiential requirements and credentials of all staff (i.e., licensure, certification, registration, etc.) who may be performing claimable activities have been met and are current. The MDE will assist any school district in this certification process and verify the status of its certification in writing, along with recommendations, with a copy sent to MDHHS.

4.3 MEDICAID ELIGIBILITY RATE

Michigan's RMTS activity codes are designed to reflect the actual direct medical services activities that occur in a school on any given day. Because these activities and services are provided for students who are both Medicaid and non-Medicaid eligible, it is necessary to develop and apply a formula that properly allocates which students are being supported and what activities and services are being provided. This is referred to as the "IEP Medicaid Eligibility Rate (MER)" for the direct medical services program.

IEP MER is determined by calculating the ratio of Medicaid eligible recipients with health-related services indicated on their IEP/IFSPs to the total number of special education population with health-related services indicated on their IEP/IFSPs.

SECTION 5 – FINANCIAL DATA REQUIREMENTS AND UNALLOWABLE COSTS

5.1 FINANCIAL DATA

The financial data reported for the Direct Medical Services (salaries, benefits, supplies, etc.) must be based on actual detailed expenditure reports obtained directly from the participating ISD's financial accounting system. The financial accounting system data is applied using generally accepted governmental accounting standards and principles or applicable administrative rules. The expenditures accumulated for calculating the Direct Medical Services allowable costs are to include actual non-federal expenditures incurred during the claiming period, except for the summer quarter. These allowable expenditures include such things as salaries, wages, fringe benefits and medically related supplies, purchased services and materials.

5.2 UNALLOWABLE COSTS

Providers are not allowed to report any costs that are federal funds, State flow-through funds, or non-federal funds that have been committed as local match for other federal or State funds or programs.

Claims for approved Medicaid School Based Service functions may not include expenditures of:

- Federal funds received by the ISD/LEA directly
- Federal funds that have been passed through a State or local agency
- Non-Federal funds that have been committed as local match for other Federal or State funds or programs

Funds received by an ISD for school based direct medical services are not Federal funds. They are reimbursement for prior expenditures and become, upon receipt, local funds.

SECTION 6 – SCHOOL BASED SERVICES REIMBURSEMENT

6.1 METHOD OF REIMBURSEMENT FOR DIRECT MEDICAL SERVICES, PERSONAL CARE SERVICES AND TARGETED CASE MANAGEMENT

Payment for Michigan's school based services program is a cost-based, provider specific, annually reconciled and cost settled reimbursement methodology.

The Centers for Medicare & Medicaid Services (CMS) also requires Michigan SBS providers to submit procedure specific direct medical services claims for all Medicaid allowable services. These claims do not generate a payment but are required by CMS in order to monitor the services provided, the eligibility of the recipient, and provide an audit trail. Interim monthly payments are tied to the submission of the direct medical services claims. If claim volume decreases significantly or drops to zero in any two consecutive months, all interim payments will be held until the provider is contacted and the issue resolved. MDHHS will monitor provider claim volume to make sure that this mandate is followed.

Claims are submitted and processed through the Community Health Automated Medicaid Processing System (CHAMPS); however, the procedure code fee screens are set to pay zero. SBS providers receive their cash flow from the interim monthly payment process described below.

The interim monthly payments are based on prior year actual costs and reconciled on an annual basis to the current year costs. Cost reporting and reconciliation are based on the school fiscal year which is July 1 through June 30 of each year.

The reimbursement process for the direct medical services is comprised of the following parts:

- The SBS direct medical services procedure code specific billing process;
- The random moment time study (RMTS) component;
- The interim payment process; and,
- The cost reconciliation and cost settlement process.

6.1.A. DIRECT MEDICAL SERVICES PROCEDURE CODE SPECIFIC BILLING

Providers must continue to submit procedure specific claims in addition to the expenditure reports. The procedure specific process is described in the Covered Services Section of this chapter.

Claim documentation must be sufficient to identify the patient clearly, justify the diagnosis and treatment, and document the results accurately. Documentation must be adequate enough to demonstrate that the service was provided and that the service followed the "approved plan of treatment" (for school-based services, the service must be identified in the child's IEP/IFSP).

The ISD may either purchase software for the claims submission function or it may utilize the services of a billing agent. The cost of this process is the responsibility of the ISD.

6.1.B. Random Moment Time Study

For the Random Moment Time Study, all ISDs will be required to utilize the services of the State Contractor who will conduct the statewide time studies.

The quarterly RMTS sampling results are produced by the State Contractor who converts them to percentages. This percentage is applied to program costs to determine reimbursement. Once complete, the time study results are provided to MDHHS where they are uploaded into the cost settlement program.

Costs are reported for direct medical services and specialized transportation services on the Medicaid Allowable Expenditure Report (MAER) and collected via financial worksheets for Personal Care Services and Targeted Case Management.

Electronic Data Systems (EDS) combines all cost information and the RMTS results, the indirect cost rate, and the Medicaid eligibility rate to calculate the total allowable costs. The MDHHS Hospital and Health Plan Reimbursement section performs the reconciliation and cost settlement process.

The ISD and/or State Contractor must comply with all conditions set forth by MDHHS as SBS policy.

The cost for the State Contractor is charged back to providers based on the State Contractor's projected cost per ISD (after federal match).

For detailed description and instructions regarding the Random Moment Time Study, refer to the School Based Services Random Moment Time Study chapter of this manual.

Summer Quarter Process

The summer quarter months are July, August and September. There is a break period between the end of one regular school year and the beginning of the next regular school year during which only a few staff are working. The majority of school staff work during the school year and do not work for part of the summer quarter (9-month staff). However, there are some 9-month staff that opt to receive their pay over a 12-month period. Therefore, different factors must be applied to the summer formula in order to accurately reflect the activities that are performed by the staff.

The summer quarter will be divided into two parts. The first part of the quarter will extend from July 1 to the date the students return to school. The second part of the quarter will be from the date the students return to school through September 30.

The RMTS will still be performed in the summer quarter, but will take place only after the staff start back to work and will only be applied to the costs for the second part of the summer quarter. To accurately reflect the work efforts being performed when all staff have returned to work, the RMTS will be performed during a shorter time period.

6.1.C. Interim Payment Process

Interim payments are calculated based on an estimated monthly cost formula. The monthly cost formula utilizes prior year costs plus any inflation or program changes to calculate a monthly interim reimbursement amount. After the final cost reports have been reviewed and reported to MDHHS, reconciliation will be performed and settlements will be made to make the providers whole.

Interim payments are issued on the first pay cycle of each month based on prior year costs.

To justify an increase in the interim payment, providers must submit written documentation of significant changes in coverage, service utilization or staff costs.

Providers may request an increase or decrease in their interim payment amount at any time throughout the year. Instructions and contact information will be included with the MAER. Any written inquiries should be addressed to the MDHHS Hospital and Clinic Reimbursement Division (HCRD). (Refer to the Directory Appendix for contact information.)

All payments and adjustments are issued by the MDHHS Hospital and Clinic Reimbursement Division. Once the payments are issued to the SBS providers (ISDs), how the interim payment revenue is distributed to the respective LEAs and how the initial and final settlements are handled is up to the discretion of the ISD.

6.1.D. Cost Reconciliation and Settlement

Allowable cost will be based on the following components:

- Costs from the MAER
- Targeted Case Management and Personal Care Services Financial Worksheets
- MDE Indirect Cost Rate
- Random Moment Time Study Percentage
- Health Related IEP Medicaid Eligibility Rate (IEP MER)
- Federal Medical Assistance Percentage (FMAP)

Allowable costs (MAER & financial worksheets for TCM and PCS)	X	Indirect Cost Rate	X	Annual average % time claimable to Medicaid from the time studies	X	Discounted by the Medicaid eligibility percentage	X	% Federal Medical Assistance Percentage (FMAP) rate	=	Medicaid reimbursement amount

The Medicaid Allowable Expenditure Report (MAER) (modeled after the MDE SE-4096 cost report) is utilized to collect allowable costs for the medical professional staff. Costs for the staff providing targeted case management services and personal care services

that are not included in the direct medical costs are obtained from the participating ISD's financial accounting system via financial worksheets sent out by the State Contractor.

To report direct service-related costs, providers will utilize the Medicaid Allowable Expenditure Report. This cost report template may be obtained from the School Based Services Provider Specific webpage. (Refer to the Directory Appendix for website information.) An Excel printable version of the cost report is also available on the website for those providers in need of a paper version. Cost reports from the Local Educational Agencies will be submitted to their Intermediate School District for summation utilizing the Michigan Medicaid Forms (MMF) summary software (available to providers via the File Transfer Service). Providers must register and have access to the secure MILogin in order to utilize the MMF summary software. MILogin registration instructions are also available on the School Based Services Provider Specific webpage.

The filed cost data is used to calculate an initial settlement within 90 days after the receipt of the initial cost report data. The initial settlement may result in either an over or under adjustment to the provider interim payment.

Within six months after the close of the school fiscal year, the School Based Services providers will review, certify, and finalize the MAER and transmit the report to the MDHHS Medical Services Administration for reconciliation. The cost certification form (CMS-10231; Certification of Public Expenditures) must be signed and on file with MDHHS before a final settlement will be processed. The final settlement process will begin within 12-18 months after the close of the school fiscal year. Settlements may take several months for completion. (Refer to the Forms Appendix for a copy of the CMS-10231.)

ISDs/LEAs may submit revisions to the MAER until the final settlements are processed. Instructions for completing revisions are attached to the MAER.

6.2 Method of Reimbursement for Specialized Transportation

6.2.A. Reimbursement

Specialized transportation costs reported on the Michigan Department of Education Transportation Expenditure Report (form SE-4094) are only the costs associated with the special education buses, taxis or private vehicles used for the specific purpose of transporting only special education children. This report does not include any federal dollars.

Medicaid-allowable specialized transportation costs include the following costs from the SE-4094:

- Salaries [Sec. 52 & Sec. 53a]
  - Bus Drivers
  - Aides
  - Employee Benefits (Bus Drivers and Aides only)
- Purchased Services – Staff (Bus Drivers and Aides only)

- Purchased Services – Vehicle Related Costs [Sec. 52 & Sec. 53a]
  - Pupil Transportation by Carrier
  - Pupil Transportation by Carrier (b/y)
  - Family Vehicle K Cost
  - Contracted Taxis
  - Pupil Transportation Fleet Insurance
  - Contracted/Leased Buses
- Supplies [Sec. 52 & Sec. 53a]
  - Gasoline/Fuel
  - Oil/Grease
  - Tires/Batteries
  - Other Expense/Adjustments, only the costs associated with adjustments to allowable costs
  - Bus Amortization

For reimbursement purposes, Bus Aides are defined as aides who ride on the bus providing care to those students being transported, assisting with the specific health concerns documented in the student's Individualized Education Program (IEP).

6.2.B. Specialized Transportation Reconciliation and Settlement

On an annual basis, the cost per trip is calculated by dividing the total Medicaid allowable costs (including indirect cost) by the total ISD-reported special education (specialized) one-way transportation trips. The cost per trip is multiplied by the quantity of Medicaid "allowable" one-way trips gleaned from CHAMPS to arrive at the Medicaid allowable cost.

An "allowable" one-way trip is one that is provided to a Medicaid beneficiary and fulfills all of the following requirements:

- Documentation of ridership is on file;
- The need for the specialized transportation service is identified in the Individualized Education Program (IEP)/Individualized Family Service Plan (IFSP); and
- A Medicaid-covered service (other than transportation) is provided on the same date of service. The Medicaid covered service must also be documented in the IEP/IFSP.

The cost settlement is accomplished by comparing the interim monthly payment totals to the annual Medicaid allowable specialized transportation cost. The cost settlement amount for the specialized transportation is combined with the cost settlement amounts for the Direct Medical Services, Targeted Case Management, and Personal Care Services; any over/under adjustments are processed as one transaction.

SECTION 7 – INDIRECT COST RATE (ICR)

7.1 INDIRECT COSTS

The ISD/LEA unrestricted indirect cost rate is calculated using the Federal Office of Management and Budget (OMB) Title 2 CFR Part 200. The methodology used to determine the indirect cost rate specific to each district is approved by the Federal cognizant agency. The indirect cost rates are updated annually by the Michigan Department of Education.

SECTION 8 – COST CERTIFICATION

8.1 COST CERTIFICATION

Once all cost reports and financial worksheets have been received by MDHHS, the summary worksheet of the Medicaid Allowable Expenditure Report (MAER) will be completed. The summary report will combine the allowable cost data submitted by the ISDs for each LEA for all four cost pools (Direct Medical, Specialized Transportation, Personal Care and Targeted Case Management). The total will be entered into the cost certification form as the "Total Computable Expenditure". The ISD is responsible for annually certifying that the total amount of expenditures for covered services has been expended and that none of the expenditures have been used as match for other programs or services. MDHHS will be utilizing the CMS-10231, "Certification of Public Expenditures (CPE)" form, for this purpose. (Refer to the Forms Appendix.)

SECTION 9 – COST ALLOCATION FACTORS

9.1 FEDERAL MEDICAL ASSISTANCE PERCENTAGE RATE

Federal regulations allow for payments to States on the basis of a Federal medical assistance percentage for part of their expenditures for services under an approved State plan. The formula for calculating this annual percentage is described in section 1905(b) of the Social Security Act. Under the formula, if a State's per capita income is equal to the national average per capita income, the Federal share is 55%. If a State's per capita income exceeds the national average, the Federal share is lower, with a statutory minimum of 50%. If a State's per capita income is lower than the national average, the Federal share is increased, with a statutory maximum of 83%.

9.2 DISCOUNTED HEALTH-RELATED MEDICAID ELIGIBILITY RATE (MER)

The discounted health-related Medicaid Eligibility Rate (MER) percentage is determined by the percentage of the special education student population that is Medicaid eligible in each ISD with a health-related support service code indicated on their December 1 Student Count Report. Support service codes are gleaned from Fields 43 and 57 of the December 1 Student Count Report. Only those codes that relate to covered school based health services are to be utilized.

Field 43	290, 310, 320, 360, 370, 400, 450, 460, 470
Field 57	801, 804, 805, 807, 808, 809, 812, 814, 816, 818

MDHHS receives the file of special education children with health-related support services indicated on their IEPs and matches the names and birthdates of those with health-related support services against the Medicaid eligibility file to identify the percentage that are Medicaid eligible. The eligibility rate is determined once each year utilizing the December 1 Student Count Report. The calculation for the eligibility rate is as follows:

$$\frac{\text{Medicaid special education students with a health-related support service in their IEP}}{\text{Total special education students with a health-related support service in their IEP}}$$

9.3 ALLOCATION OF SALARIES AND BENEFITS OF PERSONNEL PROVIDING DIRECT CARE SERVICES

Actual expenditures for salaries and benefits of all personnel are to be obtained from each participating ISD's financial accounting system. Expenditures related to the performance of approved Medicaid contracted service providers (e.g., occupational therapists, physical therapists) who also provide direct care services must also be obtained from each participating ISD's financial accounting system.

SECTION 10 – DOCUMENTATION

10.1 DIRECT MEDICAL SERVICES DOCUMENTATION

For covered services, the school clinical record must include all of the following:

- Beneficiary name and birth date;
- Date of service/treatment;
- Type (modality) of service/treatment;
- The response to the service/treatment; and
- The name and title of the person providing the service/treatment and a dated signature.

For services that have time-specific procedure codes, the provider must indicate the actual begin and end times of the service in the school clinical record. The record must indicate the specific findings or results of the diagnostic or therapeutic procedures. The student's school clinical record should include documentation of the implementation and coordination of services for the special education student.

Progress notes must be written monthly, or more frequently as appropriate, and must include:

- Evaluation of progress;
- Changes in medical or mental status; and
- Changes in treatment with rationale for change.

(Refer to the General Information for Providers Chapter of this manual for additional information regarding clinical record requirements.)

10.2 RMTS DOCUMENTATION

Each participating LEA must maintain a separate audit file for each quarter billed. The following minimum documentation is required:

- Financial data used to establish cost pools and factors.
- A copy of the quarterly sample results produced by the State Contractor.
- A copy of the warrant, remittance advice or Electronic Funds Transfer (EFT) documentation verifying that payment from MDHHS was received.

ISDs/LEAs must cooperate fully with any review requested by MDHHS and CMS, and maintain all necessary records for a minimum of seven (7) years.

Any changes in Federal regulations related to claims for administrative expenditures are incorporated by reference into this document.

SECTION 11 – AUDIT AND RECOVERY PROCEDURES

11.1 DIRECT SERVICE/TRANSPORTATION PROGRAM AUDIT ACTIVITIES TO BE PERFORMED BY MDHHS OFFICE OF AUDIT STAFF

MDHHS audit review of selected ISD/DPS and MSD cost reports for the Direct Service/Transportation Program may include the following activities:

- Verification that the Medicaid Allowable Expenditure Report (MAER) accurately reports the allowable costs incurred for the appropriate period.
- Verification that the salaries listed for employees/positions included in the RMTS staff pool match the payroll records for the same period as the time study.
- A review of the salaries of employees who changed positions during the time study period.
- If a replacement was hired/transferred, the auditor will verify that only the salary earned while working in a position on the MAER staff pool list was reported, and that salaries for both the original and replacement employees were not duplicated on the report for the same time period.
- Confirmation that none of the direct costs reported were also claimed as an indirect cost, that the proper indirect cost rate was used, and the rate was applied only to costs in the base. The employees in non-standard job categories are the most likely to be considered indirect type employees; therefore, documentation will be reviewed for these individuals.
- Verification that no federal funds were claimed on MAER cost reports and that MAER costs were not accepted for cost-sharing.
- A standard review of other areas, such as confirmation that reported costs were actually paid, support documentation was maintained as required, and costs were properly charged to the correct accounts should also be expected.
- Any other area deemed necessary.

The ISD/DPS/MSD should be prepared to direct the auditor to any document used to support and identify the reported MAER costs.

11.2 STUDENT CLAIMS AUDIT ACTIVITIES TO BE PERFORMED BY MDHHS OFFICE OF AUDIT STAFF

MDHHS audit review of selected ISD/DPS and MSD for approved SBS student claims may include the following activities:

- Verification that appropriate prescriptions/referrals/authorizations are updated annually and ordered by the appropriate individual.
- Verification that occupational, physical, and speech, language and hearing therapy address a beneficiary's medical need that affects his/her ability to learn in the classroom environment.
- Confirmation that services requiring the student to be in attendance have support documentation (i.e., attendance records) on file.
- Confirmation that the providers performing the service have the required licensure/certification.
- Verification that the providers requiring supervision both "under the direction of" and "under the supervision of" have the necessary support documentation on file.

- Verification that the beneficiary receiving special education transportation also received a Medicaid-covered service on the same day. In addition, the support documentation for specialized transportation includes an ongoing trip log maintained by the provider of the special education transportation.
- Confirmation that support documentation for personal care services includes a completed, signed and dated monthly activity checklist.
- Verification that group therapy or treatment was provided in groups of two to eight.
- A standard review of the Individualized Education Program (IEP)/Individualized Family Service Plan (IFSP) treatment plan areas, such as the inclusion of a description of the beneficiary's qualifying diagnosis and medical condition, time-related goals that are measurable and significant to the beneficiary's function and/or mobility, and anticipated frequency and duration of treatment required to meet the time-related goals.
- Any other area deemed necessary.

The ISD/DPS/MSD should be prepared to direct the auditor to any document used to support and identify the reported student claims.

11.3 Audit Activities to be Performed by MDHHS Office of Audit Staff

MDHHS audit review of selected ISD/DPS cost reports for the Administrative Outreach Program may include the following activities:

- Verification that the salaries listed for employees/positions included in the Random Moment Time Study (RMTS) staff pool match the payroll records for the same period as the time study.
- A review of the salaries of employees who changed positions during the time study period.
- If a replacement was hired/transferred, the auditor will verify that only the salary earned while working in a position on the AOP staff pool list was reported, and that salaries for both the original and replacement employees were not duplicated on the report for the same time period.
- Verification that any other salaries and costs for supplies, etc., are of direct benefit to the employees on the staff pool list, and therefore, allocable to the AOP in the same percentage as the AOP-eligible employees.
- Confirmation that none of the direct costs reported were also claimed as an indirect cost, that the proper indirect cost rate was used, and the rate was applied only to costs in the base. The employees in non-standard job categories are the most likely to be considered indirect type employees; therefore, documentation will be reviewed for these individuals.
- Verification that no federal funds were claimed on AOP cost reports and that AOP costs were not accepted for cost sharing.
- A standard review of other areas, such as confirmation that reported costs were actually paid, support documentation was maintained as required, and costs were properly charged to the correct accounts should also be expected.
- Any other area deemed necessary.

The ISD/DPS should be prepared to direct the auditor to any document used to support and identify the reported AOP costs.

11.4 Audit Findings and Resolution

Audit findings and resolution will include the following:

- Identified overstatement of expenditures on the MAER will require the revision of the MAER and a revised final settlement for all specifically identified overstatements.
- For claim error rates in excess of the materiality threshold percentage, as established by MDHHS, the recovery will be any excess percentage greater than materiality threshold multiplied by total Medicaid paid to the ISD during the period covered by the audit.

Recoveries and re-filings are limited to fiscal years considered within three years from the last date of payment for that period.

SCHOOL BASED SERVICES ADMINISTRATIVE OUTREACH PROGRAM CLAIMS DEVELOPMENT

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SECTION 1 - CLAIMS DEVELOPMENT OVERVIEW

Using the State of Michigan's competitive bid process, MDHHS will select one Contractor to implement and administer the random moment time study. The Contractor will also provide the ISDs/DPS the option of performing certain time study responsibilities and claims development activities on behalf of those ISDs/DPS that choose to participate in this portion of the State contract and pay for these services.

1.1 CLAIMS DEVELOPMENT ENROLLED PROVIDERS

All ISDs/DPS will be required to utilize the services of the State's RMTS and Claims Development Contractor, who will conduct the statewide time studies and develop and submit claims on their behalf each quarter.

The State Claims Development Contractor will develop an implementation plan on behalf of its ISDs/DPS to conduct the statewide time studies each quarter, utilizing the claims development software, as well as complete all other key functions required for valid claim development.

The cost for the Contractor will be charged back to providers who participate in this option based on the Contractor's projected cost per ISD/DPS (after federal match).

1.2 OVERVIEW OF CLAIMS DEVELOPMENT PROCESS

Based on federal and state statutes and regulations, below is a partial list of specific functions and tasks that must be accomplished for reimbursement of Medicaid Administrative Outreach Program services. Additional details appear in subsequent sections of this chapter.

Claims will be developed by the State's Claims Development Contractor utilizing the claims development software following these basic steps:

- The quarterly RMTS sampling results are produced by the State's RMTS and Claims Development Contractor, who converts them to percentages. The percentages are applied to program costs to determine reimbursement.
- The cost/claim generation component of the claims development software uses ISD/DPS costs and other claim factors to calculate and produce the claim.
- The claim is submitted to MDHHS with verification of claim validity from each ISD/DPS.
- The ISD/DPS and/or Contractor must comply with all conditions set forth by MDHHS as SBS policy.

1.3 IMPLEMENTATION PLAN

Each ISD/DPS must submit an Implementation Plan that reflects the details of their SBS Administrative Outreach Program operation for review and approval by MDHHS and by CMS. Any subsequent changes must also be reported and receive approval.

Claims may not be submitted to MDHHS for reimbursement until MDHHS has approved the Implementation Plan that will be utilized based on this published policy.

SECTION 2 - CLAIM CALCULATIONS

2.1 IMPLEMENTATION PLAN

Each ISD/DPS must submit an implementation plan that reflects the details of their SBS Administrative Outreach Program for review and approval by MDHHS and CMS. Any subsequent changes must also receive approval.

Each implementation plan must include explicit quality control review mechanisms to ensure full staff training and compliance, accuracy and completeness of the sample frame (designated employees), adherence to the MDHHS-published methodology, editing of all moments for completeness and consistency, and accurate financial and staffing reports. Claiming entities must also fully cooperate with any review requested by the U.S. Department of Health & Human Services (HHS), maintaining all necessary records for a minimum of seven (7) years after submission of each quarterly claim.

2.2 SANCTIONS

It is the intent of the State to pursue, when necessary, remedial action or implement a Corrective Plan if the State-selected contractors, the ISD/DPS, or their vendors are not in compliance with the new SBS Administrative Outreach published policy. If this is not successful, a contract payment freeze will be implemented and sanctions put in place until the matter is resolved. Those independent ISDs/DPS not participating in the State's claims development contract will be held accountable for their vendor's actions.

The following are examples of causes for implementation of sanctions for all districts. The list is not all-inclusive.

- Repeated errors in completing the RMTS forms or filing of the claims.
- Providing insufficient data or incomplete reports to the Contractors.
- Failure to use the CLAIMS DEVELOPMENT software.
- Failure to cooperate with, or submit requested information, reports, or data to the Special Monitoring Contractor, CMS, MDHHS, MDE, and other staff involved during site visits, reviews or audits.

2.3 FACTORS FOR CLAIMS DEVELOPMENT

MDHHS will submit quarterly claims on behalf of all participating school districts to the CMS. Each claim will be based on the following factors: The cost pool, percentage of time claimable to Medicaid Outreach Program administration, the Federal Financial Participation (FFP) rate, and the discounted Medicaid eligibility percentage rate for that district. The factors for the summer quarter are described above.

2.3.A. COST POOL

This consists of the actual costs incurred for the quarter being claimed, such as salaries, overhead, etc. Each participating ISD/DPS must certify that the claim they submit to MDHHS contains sufficient non-Federal (State, county, or local) funds to match requirements and that the claim only includes actual costs.

2.3.B. Federal Financial Participation Rate

Federal regulations allow for a reimbursement rate of 50% for Medicaid administrative activities.

2.3.C. Discounted Medicaid Eligibility Percentage

The discounted Medicaid eligibility percentage is determined by the percentage of the student population in each ISD/DPS who are actually Medicaid beneficiaries. The discounted Medicaid eligibility rates will be determined twice each year and applied to certain activities in the claim calculation formula. To calculate the discounted Medicaid eligibility rates, the claiming entity will obtain the September and February fourth Wednesday pupil count report list from the Center for Educational Performance and Information (CEPI). The pupil count list will include the student name and date of birth. MDHHS will provide a method for using the list to verify the number of Medicaid-eligible students. This number will be used in a calculation with the total pupil count to determine the discounted percentage of Medicaid-eligible students in the ISD/DPS. The September pupil count list will be used to determine discounted Medicaid eligibility rates for time studies conducted in the Fall and Winter quarters, and the February pupil count will be used for time studies conducted in the Spring and Summer quarters.

Based on the above factors, the claim that is sent to Medicaid is calculated as follows:

Fall, Winter and Spring Quarter Formulas for Calculating Administrative Outreach Claims

Cost pools (salaries, overhead, etc.)	**X**	% time claimable to Medicaid Outreach Administration from time studies	**X**	Discounted by the Medicaid eligibility percentage	**X**	% Federal Financial Participation (FFP) rate	**=**	The amount of the claim submitted for Medicaid reimbursement

Summer Quarter Formulas

The summer quarter will be divided into two parts. The sum of both parts will be submitted to Medicaid for reimbursement. There will be two workbooks created for the summer quarter, one for each part.

Part I - Summer Quarter Formulas from July 1 to the Date Students Return to School

Cost pool (only the 9-month salaries and related costs that are paid during this time period)	**X**	Average % of time claimable to Medicaid Outreach Administration from the previous three quarters	**X**	Discounted by the Medicaid eligibility percentage	**X**	Percent of FFP rate	**=**	The amount of the partial claim for Part I of the Summer Quarter

- Salary and related costs for 9-month staff that were earned during the school year, but are paid during the summer break, will be collected in a separate cost pool. Salaries paid during this period for 12-month staff are not included in the cost pool.
- The cost pool containing the salaries and related costs of 9-month staff who are paid over 12 months will be claimed based on the average time study results and Medicaid Eligibility (MAE) rate from the previous three quarters.

Part II - Remainder of the Summer Quarter – Begins on the Date Students Return to School through September 30

Cost pools (include all allowable salaries, overhead, etc.)	X	% of time claimable to Medicaid Outreach from the Summer Quarter time study	X	Discounted by the Medicaid eligibility percentage	X	Percent of FFP rate	=	The amount of the claim for Part II of Summer Quarter

- Salary and related costs of all staff eligible for the time study are included in the cost pool, along with other allowable overhead.
- An RMTS is performed and applied to determine the percent of time claimable for Outreach during Part II of the summer quarter.

The claims development software will add the Summer Quarter Part I and Part II claim amounts together to reach the dollar amount of the total Summer Quarter claim submitted to MDHHS for reimbursement.

2.4 Financial Data

The financial data reported (salaries, benefits, supplies, etc.) must be based on actual detailed expenditure reports obtained directly from the participating ISDs'/DPS' financial accounting system. The financial accounting system data is applied using generally accepted governmental accounting standards and principles or applicable administrative rules. The expenditures accumulated for calculating the Administrative Outreach claim are to include only actual expenditures incurred during the claiming period, except for the summer quarter.

2.5 Allocation of Salaries and Benefits of Personnel Providing Direct Care Services

Actual expenditures for salaries and benefits of all personnel included in an Administrative Outreach claim are to be obtained from each participating ISD/DPS financial accounting system. Expenditures related to the performance of approved Medicaid Administrative Outreach functions by contracted service providers (e.g., occupational therapists, physical therapists) who also provide direct care services must also be obtained from each participating ISD/DPS financial accounting system.

2.6 RMTS Documentation and Recordkeeping/Audit File Requirements

Each participating school district will maintain a separate audit file for each quarter billed. The following minimum documentation will be required:

- Financial data used to establish cost pools and factors.
- A copy of the quarterly sample results, produced by the State's RMTS and Claims Development Contractor.
- A completed quarterly claim, produced by the claims development software and signed by the Chief Financial Officer of the ISD/DPS.
- A copy of the warrant, remittance advice or Electronic Funds Transfer (EFT) documentation, verifying that payment from MDHHS was received.

Districts must cooperate fully with any review requested by MDHHS and CMS, and maintain all necessary records for a minimum of seven (7) years after submission of each quarterly claim.

Any changes in Federal regulations related to claims for administrative expenditures are incorporated by reference into this document.

2.7 Non-Student Specific/Pre-Medicaid Eligibility Determination

There are some Administrative Outreach activities and expenditures that are approved by Medicaid that have not been addressed thus far. They are:

- Provided to the entire "at-risk" population,
- Not identifiable to individual students, and
- Provided before Medicaid eligibility is determined.

These activities are to be allocated to the approved Medicaid administrative outreach claim based on the results of the time study conducted during the claiming period.

2.8 Student-Specific Administrative Functions Expenditures

There are some Administrative Outreach functions that are identifiable to individual students after Medicaid eligibility has been determined. These functions are to be allocated in the administrative claim based on both the time study results conducted during the claiming period and the applicable discounted Medicaid eligibility rate.

2.9 Non-Salary Expenditures

Expenditures for materials and supplies related to the approved Medicaid administrative outreach activities may be included in the claim if they can be attributed directly to individuals who are claimed. The principles for claiming expenditures and cost allocation, including correct depreciation of assets as published in the Federal Office of Management and Budget (OMB) Title 2 CFR Part 200, must be followed. Examples include conference fees, registration fees, mileage, pagers, printing fees (i.e., for business cards), furniture, equipment, copy machine expenses, etc. Such expenditures are to be based on actual detailed departmental expenditure reports obtained directly from the participating ISD/DPS

financial accounting system. These expenditures may not include items identified as indirect costs, such as central business office operations, general building maintenance and repair costs, or any other costs classified as an indirect cost.

2.10 Indirect Costs

Allocable indirect costs are the product of the school district aggregate, calculated, approved Medicaid administrative outreach claim amount, multiplied by the ISD/LEA unrestricted indirect cost rate, as approved annually by the Michigan State Board of Education (MSBE). The ISD/LEA unrestricted indirect cost rate is calculated using the Federal Office of Management and Budget (OMB) Title 2 CFR Part 200. The methodology used to determine the indirect cost rate specific to each district has been approved by the Federal cognizant agency. The indirect cost rates are updated annually by the Michigan Department of Education.

2.11 Claim Certification

The accuracy of the submitted claims must be certified by the chief financial officer, the superintendent of the district, or the consortium's lead ISD/DPS designee. Such certification is to be documented on an MDHHS-approved certification form, and conform to the certification requirements of 42 CFR 433.51. Detailed claim analyses and supporting documentation will be maintained by the ISD/DPS for audit or future reference purposes according to the terms identified in the interagency agreement between the district and MDHHS.

The Electronic Signature Verification Statement (DCH-3890) form must be completed by each provider and submitted to MDHHS to certify costs electronically. A copy of the completed DCH-3890 must be kept on file by the provider until the individual signing the certification changes. (Refer to the Forms Appendix for a copy of the form.)

Reimbursement will be paid after the claim has been submitted to, reviewed by, and determined to be acceptable and accurate by MDHHS and CMS.

2.12 Annual Reconciliation

At the end of the district's fiscal year, and after its annual financial audit is completed, a reconciliation of the filed administrative outreach claims, with the financial accounting records and supporting documentation, must be performed. Adjustments to future administrative claims must be made based on the results of the reconciliation analyses to consider any year-end adjustments to accounting entries of any items which might have impacted the claim amounts.

2.13 Fiscal Provisions

School districts must use an appropriate Revenue Code to identify the Medicaid SBS Administrative Outreach Program funds within their accounting records.

2.14 Submission of Claims

All claims must be developed and submitted using the reporting format (structured spreadsheet template) and approved certification forms.

The claim package consists of completed Excel workbooks for each individual ISD/DPS and are combined and consolidated into one claim that is submitted to MDHHS.

All claims are to be submitted in accordance with the reporting requirements established by MDHHS. It is imperative that districts work closely with the Claims Development Contractor to provide pertinent financial, enrollment and personnel data and meet their deadlines and any other technical specifications. Claims not submitted on time must be submitted the following quarter as an adjustment to the prior missed quarter and will be processed for that following quarter. Claims not conforming to reporting requirements will not be accepted or processed.

2.15 Periodicity of Reporting

Districts must submit claims for expenditures related to approved Medicaid administrative outreach activities to MDHHS on a quarterly basis. The claim is due to MDHHS on or before 120 calendar days after the end of the reporting quarter.

Timeframes to Submit Administrative Outreach Claims to MDHHS

	REPORTING PERIOD		CLAIM DUE TO MDHHS	CLAIM SUBMITTED TO CMS BY MDHHS
	BEGIN DATE	ENDING DATE		
Summer	July 1	September 30	January 31	March 31
Fall	October 1	December 31	April 30	June 30
Winter	January 1	March 31	July 31	September 30
Spring	April 1	June 30	October 31	December 31

SCHOOL BASED SERVICES RANDOM MOMENT TIME STUDY

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SECTION 1 – GENERAL TIME STUDY INFORMATION

This chapter describes the random moment time study process for the School Based Services (SBS) direct medical services program.

In accordance with the Centers for Medicare & Medicaid Services (CMS) reimbursement policy, some activities performed by medical professionals and Intermediate School District (ISD) staff in a school-based setting are eligible for federal matching funds. These activities may be performed by staff with multiple responsibilities. CMS reimbursement requirements include the use of a random moment time study (RMTS) as a component of the Medicaid reimbursement methodology. The time study results are used to determine the amount of staff time spent on Medicaid-allowable activities. One statewide time study per staff pool is performed each quarter.

1.1 ADMINISTRATIVE OUTREACH PROGRAM ACTIVITIES

The School Based Services Administrative Outreach Program (AOP) offers reimbursement for the cost of administrative activities that support efforts to identify and enroll potentially eligible persons into Medicaid and that are in support of the state Medicaid plan.

The activities fall into several categories:

- Medicaid Outreach
- Facilitating Medicaid Eligibility Determinations
- Health-related Referral Activities
- Medical Service Program Planning, Policy Development, and Interagency Coordination
- Programmatic Monitoring and Coordination of Medical Services
- Transportation and Translation Services

1.2 DIRECT MEDICAL SERVICES

Medicaid covered services that are medically necessary and specified in the beneficiary's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) include:

- Occupational Therapy Services
- Orientation and Mobility Services
- Physical Therapy Services
- Assistive Technology Device Services
- Speech, Language and Hearing Services
- Psychological, Counseling and Social Work Services
- Developmental Testing Services
- Nursing Services
- Physician and Psychiatric Services

- Personal Care Services
- Targeted Case Management Services

1.3 Staff Pools and Confidence Levels

The RMTS is carried out utilizing customized claims development software that automates aspects of the school district time study process. The claims development software is comprised of three components: sampling/staff pool lists, training, and cost/claim generation. All ISDs are required to utilize the services of the State's RMTS and Claims Development Contractor (hereafter referred to as the Contractor). The Contractor conducts the statewide time studies, produces the implementation plans and reports, and develops and submits the claims on behalf of the 56 ISDs, Detroit Public Schools and Michigan School for the Deaf (hereafter referred to as the ISDs).

Time studies will be carried out over the following staff pools:

- AOP Only Staff – This staff pool consists of individuals who perform only administrative outreach activities. They do not perform any direct medical activities.
- AOP & Direct Medical Staff – This staff pool consists of individuals who perform both Direct Medical activities and AOP activities.
- Personal Care Services Staff – This direct medical only staff pool consists of individuals who perform direct care Personal Care Services.
- Targeted Case Management Services Staff – This direct medical only staff pool consists of individuals who perform Targeted Case Management (TCM) Services.

The RMTS results identifying the percentage of claimable time are applied to the allowable correlating cost pool. All staff pools are mutually exclusive.

The sample size of each cost pool ensures a quarterly level of precision of +/- 2% (two percent) with at least a 95% (ninety-five percent) confidence level and an annual level of precision of +/- 2% (two percent) with at least a 95% (ninety-five percent) confidence level.

Valid moments are completed moments that have been received by the Contractor and determined to be complete and accurate. Invalid moments are moments that are assigned to staff who are no longer in the position as selected, moments that are outside of paid work hours, and moments not returned for any other reason (including Activity Code 18).

As long as the completed observation rate meets or exceeds 85%, missing observations will be dropped from all calculations. Should the completion rate fall below 85%, missing observations will be included as non-matchable.

SECTION 2 – CENTRALIZED CODING

The Contractor is responsible for coding the time study moments. MDHHS oversees the Contractor and ISDs participating to assure their compliance with all aspects of program policy and federal regulations.

SECTION 3 – TIME STUDY METHODOLOGY

3.1 RANDOM MOMENT TIME STUDY OVERVIEW

The time study design logs only what the participant is doing at one moment in time. A random moment consists of one minute of work done by one employee, both chosen at random, from among all such minutes of work that have been scheduled for all designated staff statewide.

The RMTS measures the work effort of each group of approved staff involved in the time study process by sampling and analyzing the work efforts of a randomly-selected cross-section of each staff pool. The RMTS methodology employs a technique of polling employees at random moments over a given time period and tallying the results of the polling over that period. The method provides a statistically valid means of determining the work effort being accomplished in each program of services. The sampling period is defined as the three-month period comprising each federal quarter of the year, except for the abbreviated sample period used in the summer quarter (July through September).

The Contractor will use the claims development software to conduct the statewide time studies each quarter. This software produces random moments concurrent with the entire reporting period which are then paired with randomly selected members of the designated staff pool population. The sampling is constructed to provide each staff person in the pool with an equal opportunity or chance to be included in each sample moment. Sampling occurs with replacement so that after a staff person and a moment are selected, the staff person is returned to the potential sampling universe. Therefore, each staff person has the same chance as any other person to be selected for each moment, which ensures true independence of sample moments.

Once the random sample of staff moments has been generated, the sample is printed in the form of master and location control lists for sample administration purposes, and as time study forms for collecting the moment data. Each sampled moment is identified on its respective control list in chronological order by the name of the staff person to be sampled and the date and time at which the recording should take place.

3.1.A. LONG-TERM SUBSTITUTES

Long-term substitute staff replacing permanent staff on leave may be added to the staff pool lists. The following criteria apply when long-term substitutes are utilized:

- A long-term substitute staff must be employed by the ISD/Local Educational Agency (LEA) for at least 30 calendar days within the quarter.
- The ISD/LEA may report the name of the long-term substitute staff any time after the sampling moments are distributed.
- The long-term substitute staff must meet all of the program requirements and provider qualifications necessary to participate in the Medicaid school based services program staff pool.
- If listed on the staff pool list, the substitute staff must complete the time study moment.
- The cost reflected should be the sum of the cost of the regular staff on leave and the long-term substitute staff.

- All audit liability for the financial data reported and the tracking of the moments is the responsibility of the ISD/LEA reporting entity.
- All staff whose costs are included in the cost pool, including long-term substitutes, must be included in the sample universe for the time study.

3.2 Random Moment Time Study Form Completion

There are two steps to completing a time study form:

- In the first step, for the designated moment, the time study participant provides the answers to three questions (What are you doing? Who are you with? Why are you doing it?). These questions relate to their activities at the time of their randomly selected moment.
- In the second step, the time study forms are collected from the participants, and the Contractor assigns the appropriate activity code for that moment based on the answers to the three time study questions.

The Contractor conducts the statewide time studies each quarter for all ISDs and produces a report detailing the results. This involves importing clinician information from the ISDs to compile the statewide pool of all eligible time study participants for each staff pool list. There are four separate staff pools sampled for the RMTS each quarter: 1) the AOP only staff pool, 2) the AOP and Direct Medical Services staff pool, 3) the Personal Care Services staff pool, and 4) the Targeted Case Management Services staff pool. All staff pools have 800 moments randomly selected for the summer quarter (July-September). For the remaining three quarters, the Direct Medical Services and the Targeted Case Management Services staff pools have 3,000 moments randomly selected per quarter, and the Personal Care Services staff pool has 3,200 moments randomly selected per quarter. The person's name that is associated with each moment is placed on a time study form. The Contractor distributes the control lists of their selected staff and the time study forms to the ISDs prior to the beginning of the reporting period. The Contractor is also responsible for the collection of all time study forms for the ISDs.

The Contractor monitors the status of each time study form so that appropriate follow-up calls are made for delinquent moments or missing data. The ISD is responsible for ensuring that a copy of the time study form and instructions are distributed to staff just prior to the assigned moment. The completed time study forms are returned to the Contractor, generally on a weekly basis, for data entry and tabulation.

At the end of the sampling period after all data has been collected and tabulated, program precision tables will be produced by the Contractor. These tables will verify that a sufficient number of personnel were sampled to ensure time study results that have a confidence level of at least 95% quarterly with a precision level of +/- 2% annually.

3.3 Time Study Staff Pools

To preserve the integrity of the RMTS process and to allow for timely process flow, school staff are given four weeks to review and return the staff pool lists and financials to the Contractor for those staff eligible to participate in each time study group. The staff pool lists must be returned as a complete file with all updates reflected. No partial staff pool list files will be accepted by the Contractor.

If staff pool lists and/or financials for the Personal Care Services, the Targeted Case Management, or the Administrative Outreach Program (AOP) time studies are not returned to the Contractor on or before the published deadline, the LEA staff pool lists and correlating financials will be removed from the time study and claim calculation for the affected quarter. ISD coordinators and LEA financial contact staff will be notified.

When providing the staff pool list of those eligible to participate in the time studies, school districts must certify the list of participants and activities to be claimed to ensure that all appropriate personnel are submitted and that appropriate credentials are in place for billing Medicaid.

3.3.A. AOP Only Staff Pool

AOP Only Staff Pool:

- Administrators
- Counselors
- Early Identification/Intervention Personnel
- Physician Assistants
- Teacher Consultants
- School Psychologists (certified by the Michigan Department of Education but without Michigan licensure)
- Limited Licensed Speech Language Pathologists (without their American Speech-Language-Hearing Association Certificate of Clinical Competence)
- School Social Workers (certified by the Michigan Department of Education but without Michigan licensure)

3.3.B. AOP & Direct Medical Services Staff Pool

AOP & Direct Medical Services Staff Pool:

- Fully Licensed Speech Language Pathologists
- Audiologists
- Counselors
- Licensed Practical Nurses
- Occupational Therapists
- Occupational Therapist Assistants
- Orientation and Mobility Specialists
- Physical Therapists
- Physical Therapist Assistants
- Physician and Psychiatrists
- Psychologists (not School Psychologists)
- Registered Nurses
- Social Workers

3.3.C. Personal Care Services Staff Pool

The following staff may be appropriate for inclusion in time studies if they are involved in Personal Care activities in the school setting:

- Bilingual Aides
- Health Aides
- Instructional Aides
- Paraprofessionals
- Program Assistants
- Teacher Aides
- Trainable Aides

3.3.D. Targeted Case Management Services Staff Pool

Staff with the following credentials may be appropriate for inclusion in time studies if they are involved in Targeted Case Management activities in the school setting:

- A bachelor's degree with a major in a specific special education area.
- Coursework credit equivalent to a major in a specific special education area.
- Minimum of three years' personal experience in the direct care of an individual with special needs.
- A licensed Registered Nurse (RN) in Michigan.

Targeted case managers must also demonstrate knowledge and understanding of all of the following:

- Services for infants and toddlers who are eligible under the IDEA law as appropriate;
- Part C of the IDEA law and the associated regulations;
- The nature and scope of services covered under IDEA, as well as systems of payments for services and other pertinent information;
- Provision of direct care services to individuals with special needs; and
- Provision of culturally competent services within the community being served.

SECTION 4 – ADMINISTRATIVE OUTREACH AND DIRECT MEDICAL ACTIVITY CODE SUMMARY

This section summarizes the code categories utilized for the random moment time study and indicates whether they are claimable for reimbursement under the AOP only, the AOP & Direct Medical program (including Personal Care Services and Targeted Case Management Services), allocated across all programs, or "unallowable" (not claimable). The "unallowable" activities are those that are purely educational in nature.

Activities can fall into one of the following categories for Medicaid reimbursement purposes:

- "A" - Allowable means the expense is allowable for Medicaid reimbursement
  - AOP services have a federal financial participation (FFP) rate of 50%
  - Direct medical IEP/IFSP services have a federal medical assistance percentage (FMAP) rate that varies from year to year
- "U" - Unallowable means the expense is not allowable for Medicaid reimbursement
- "R" - Reallocated means reimbursement across multiple activities that is allocated to isolate the amount applicable to the Medicaid allowable category
- "AOP Medicaid Eligibility Rate (MER)" - The AOP MER is determined by calculating the percentage of the county student population that is Medicaid eligible
- "IEP MER" - The direct medical IEP MER is determined by calculating the percentage of special education students under the age of 21 with health related support services documented in their IEP/IFSPs that are Medicaid eligible

These codes represent activities that may be performed by any time study participants during a typical workday. Some of these activities may be claimed under Medicaid and some may not. In the following section, examples and clarifications of each code are provided to assist with the appropriate coding of the activities.

Activity Code		Federal Matching Rate	Reimburse		IEP MER
			DMS	AOP	
1	Medicaid Outreach and Public Awareness	50%	U	A	AOP MER
2	Non-Medicaid Outreach		U	U	U
3	Facilitating Medicaid Eligibility Determination	50%	U	A	AOP MER
4	Facilitating Application for Non-Medicaid Programs		U	U	U
5	Program Planning, Policy Development and Interagency Coordination Related to Medical Services	50%	U	A	AOP MER
6	Program Planning, Policy Development and Interagency Coordination Related to Non-Medical Services		U	U	U
7	Referral, Coordination, Monitoring of Medical Services (services that are not part of a direct service – AOP only)	50%	U	A	AOP MER

Activity Code		Federal Matching Rate	Reimburse		IEP MER
			DMS	AOP	
9	Referral, Coordination, and Monitoring of Non-Medical Services		U	U	U
10	Medicaid-Specific Training on Outreach, Eligibility and Services	50%	U	A	AOP MER
12	Non-Medicaid Training		U	U	U
13	IEP/IFSP Direct Medical Services	Annual FMAP Rate	A	U	IEP MER
13(A)	IEP/IFSP Personal Care Services	Annual FMAP Rate	A	U	IEP MER
13(B)	IEP/IFSP Targeted Case Management Services	Annual FMAP Rate	A	U	IEP MER
13(C)	Other and Non IEP/IFSP Direct Medical Services		U	U	U
14	Transportation and Translation Services in Support of Medicaid-Covered Services (not specialized direct medical services transportation services)	50%	U	A	AOP MER
15	Transportation and Translation Services in Support of Non-Medicaid-Covered Services		U	U	U
16	General Administration		R	R	N/A
17	School-Related and Educational Activities		U	U	U
17(D)	Non-Returned Moments		U	U	U
18	Not Scheduled to Work and Not Paid		U	U	U

4.1 Activity Coding

4.1.A. Code 1 - Medicaid Outreach and Public Awareness

U – Direct Medical Services

A – Administrative Outreach

This code is used when school staff are performing activities that inform eligible or potentially eligible individuals about Medicaid and how to access Medicaid programs. This code is also used for describing the services covered under the Medicaid program and how to obtain Medicaid preventive services. Activities related to Child Find are not recorded here, but instead under Code 2.

It includes related paperwork, clerical activities, or staff travel required to perform the following activities:

- Informing families and distributing literature about the services and availability of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program and the many different Michigan Medicaid programs such as Healthy Kids, MIChild and Children's Special Health Care Services.
- Informing and encouraging families to access Medicaid managed care systems, i.e., Medicaid Health Plans.
- Informing families about the EPSDT and Medicaid health-related programs and the value of preventive health services and periodic exams.
- Assisting the Medicaid agency to fulfill outreach objectives of the Medicaid program by informing individuals, students, and their families about health resources available through the Federal Medicaid Program.
- Conducting Medicaid outreach campaigns and activities not related to Child Find (e.g., health fairs) that provide information about services provided by such entities as the Community Mental Health Service providers, Local Health Departments, etc.
- Conducting a family planning health education outreach program or campaign, if it is targeted specifically to Medicaid-covered family planning services.
- Contacting pregnant and parenting teenagers about the availability of Medicaid services, including referral to family planning and well baby care programs and services.
- Providing referral assistance to families with information about the Medicaid program.
- Providing information about Medicaid screenings that will help improve the identification of medical conditions that can be corrected or ameliorated through Medicaid services.
- Notifying families of EPSDT program initiatives such as Medicaid screenings conducted at a school site. These screenings are distinct from other general health screenings that are covered by Code 2.
- Coordinating with the local media (newspaper, TV, radio, video) to inform the public about EPSDT screenings, health fairs and other health related services, programs and activities organized by the school.
- Coordinating or attending child health fairs that emphasize preventive health care and promote Medicaid services by presenting Medicaid material in areas with the likelihood of high Medicaid eligibility.
- Informing families about the availability of Medicaid providers of specific covered services, and how to effectively utilize services and maintain participation in the Medicaid program.
- Providing parents, on report card pick-up day or at parent conferences, information about the Medicaid program and health care services available to eligible children, including EPSDT screening services and medically necessary treatment.

4.1.B. Code 2 - Non-Medicaid Outreach

U – Direct Medical Services

U – Administrative Outreach

This code is used for performing activities that inform eligible or potentially eligible individuals about social, vocational and educational programs, including special education, that are not covered by Medicaid and how to access them. Activities include describing the eligible or potentially eligible individuals, the range of benefits covered under these non-Medicaid social, vocational, and educational programs, and how to obtain them (e.g., WIC, SSI, LIF, Child Find).

It includes related paperwork, clerical activities, or staff travel required to perform the following activities:

- Informing families about wellness programs and how to access these programs.
- Scheduling and promoting activities that educate individuals about the benefits of healthy lifestyles and practices.
- Conducting general health education programs or campaigns addressed to the general population.
- Conducting outreach campaigns directed toward encouraging persons to access social, educational, legal or other services not covered by Medicaid.
- Assisting in early identification of children with special medical/mental health needs through various Child Find activities.
- Developing the school district's student/parent handbook.
- Coordinating with the local media (newspaper, TV, radio, video) to inform the public about upcoming events such as health fairs or screenings that focus on non-Medicaid social, vocational and educational programs, and activities such as scholarships, remedial classes, Child Find, DARE, anti-smoking campaigns, etc.
- Providing parents, on report card pick-up day or at parent conferences, information about non-Medicaid programs, social, vocational and educational, and general health care services available in the community or the school for their children.

4.1.C. Code 3 - Facilitating Medicaid Eligibility Determination

U – Direct Medical Services

A – Administrative Outreach

This code is used for assisting an individual to become eligible for Medicaid. This activity does not include the actual determination of Medicaid eligibility.

It includes paperwork, clerical activities, or staff travel required to perform the following activities:

- Verifying an individual's current Medicaid eligibility status.
- Facilitating eligibility determination for Medicaid by planning and implementing a Medicaid information program.
- Participating as a provider of Medicaid eligibility outreach information.
- Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective applicants.
- Referring an individual or family to the local MDHHS office or other local office to make application for Medicaid benefits.
- Assisting individuals or families to complete the Michigan Medicaid eligibility application.
- Assisting the individual or family in collecting/gathering information related to the application and eligibility determination for an individual, including resource information and third party liability (TPL) information, as a prelude to submitting a formal Medicaid application.
- Providing necessary forms and packaging all forms in preparation for the Medicaid eligibility determination.
- Referring families to appropriate sources to obtain Medicaid applications.

4.1.D. Code 4 - Facilitating Application for Non-Medicaid Programs

U – Direct Medical Services

U – Administrative Outreach

This code is used for informing an individual or family about programs such as Child Find, Food Stamps, SSI, WIC, Daycare, Legal Aid, Free and Reduced Lunch, and other social or educational programs and referring them to the appropriate agency to make application.

It includes related paperwork, clerical activities, or staff travel required to perform the following activities:

- Explaining the eligibility process for non-Medicaid programs.
- Assisting the individual or family to collect/gather information and documents for the non-Medicaid program applications.
- Assisting the individual or family in completing the non-Medicaid programs application(s).
- Developing and verifying initial and continuing eligibility for the Free and Reduced Lunch Program.
- Providing necessary forms and packaging all forms in preparation for the non-Medicaid eligibility determination.

4.1.E. Code 5 - Program Planning, Policy Development and Interagency Coordination Related to Medical Services

U – Direct Medical Services

A – Administrative Outreach

This code is used for performing activities associated with the collaborative development of programs with other agencies that assure the delivery of Medicaid-covered medical/mental health services to school-age children. It applies only to employees whose position descriptions include program planning, policy development and interagency coordination, and/or those staff specifically appointed to appropriate committees/programs performing required activities.

It includes related paperwork, clerical activities or staff travel required to perform the following activities:

- Defining the scope of each agency's Medicaid service in relation to the other, and identifying gaps or duplication of medical/mental health programs.
- Analyzing Medicaid data related to a specific program, population, or geographic area and working with Medicaid resources, such as Medicaid Health Plans, to locate and develop EPSDT health services referral relationships and expanding school medical/mental health programs to school populations of need.
- Creating a collaboration of health professionals to provide consultation and advice on the delivery of health care services to the school populations, and developing methods to improve the referral and service delivery process by Medicaid health providers.
- Containing Medicaid costs for individuals with multiple challenging disabilities by reducing overlap and duplication of Medicaid services through collaborative efforts with Medicaid Health Plans, local Community Mental Health Service providers and Local Health Departments.
- Monitoring and evaluating policies and criteria for performance standards of medical/mental health delivery systems in schools and designing strategies for improvements.
- As a part of the school health policy quality assurance system, maintain and ensure the continuity of all Medicaid health-related services, including developing and monitoring contracts with private providers, agencies and/or provider groups.
- Overseeing the organization and outcomes of the coordinated medical/mental health service provision with Medicaid Health Plans.
- Developing internal referral policies and procedures for use by staff so that appropriate coordination of health services occurs between the various Medicaid providers and entities, such as Community Mental Health Service providers, Local Health Departments, Medicaid Health Plans, and those in the educational setting.

- Designing and implementing strategies to:
  - identify students who may be at high risk for poor outcomes because of poverty, dysfunctional families, and/or inappropriate referrals, and need medical/mental health interventions.
  - identify pregnant students who may be at high risk of poor health outcomes because of drug usage, lack of appropriate prenatal care, and/or abuse or neglect.
  - assure that students with any significant health problems are diagnosed and treated early.
- Presenting specific provider information about Medicaid EPSDT screening in the schools that will help identify medical conditions that can be corrected or ameliorated by services covered through Medicaid.
- Developing procedures for tracking and resolving families' requests for assistance with Medicaid services and providers. This does not include the actual tracking of requests for Medicaid services.
- Developing new health programs with local community health providers for the Medicaid population, as determined by a needs assessment and geographic mapping.
- Working with requests and inquiries from local school board members, county commissioners, or State legislators to resolve unique or unusual requests or boundary issues regarding appropriate care for certain Medicaid-eligible groups or populations.
- Coordinating with interagency committees to identify, promote and develop medical services in the school system.

4.1.F. Code 6 - Program Planning, Policy Development and Interagency Coordination Related to Non-Medical Services

U – Direct Medical Services

U – Administrative Outreach

This code is used when performing activities associated with the development of strategies to improve the coordination and delivery of community services to school-age children, and when performing collaborative activities with other agencies. Non-medical services may include social, educational, and vocational services.

It includes related paperwork, clerical activities or staff travel necessary to perform the following activities:

- Identifying gaps or duplication of other non-medical services (e.g., social, vocational and educational programs) to school-age children and developing strategies to improve the delivery and coordination of these services.
- Developing strategies to assess or increase the capacity of non-medical school programs.
- Developing procedures for tracking and resolving families' requests for assistance with non-medical services and the providers of such services.

- Developing and coordinating advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services to the school populations.
- Developing non-medical referral sources.
- Analyzing non-medical data related to a specific program, population, or geographic area.
- Working with other agencies providing non-medical services to improve the coordination and delivery of services and to improve collaboration around the early identification of non-medical problems.
- Defining the scope of each agency's non-medical service in relation to the other.
- Evaluating the need for non-medical services in relation to specific populations or geographic areas.
- Monitoring the non-medical delivery system in schools.
- Coordinating with interagency committees to identify, promote and develop non-medical services in the school system.

4.1.G. Code 7 - Referral, Coordination, and Monitoring of Medical Services

U – Direct Medical Services

A – Administrative Outreach

This code is issued for developing appropriate referral sources for program-specific services for the school district, coordinating programs and services at the school or district level, and monitoring the delivery of Medicaid services within the school system.

This code is not to be used for providing IEP/IFSP targeted case management referral, coordination and monitoring of Medicaid eligible services. IEP/IFSP targeted case management is reported under code 13(C).

It includes related paperwork, clerical activities or staff travel necessary to perform the following activities:

- Making referrals for, and coordinating access to, medical services.
- Identifying and referring adolescents who may be in need of Medicaid family planning services.
- Making referrals for and/or scheduling appropriate Medicaid-covered immunizations, vision, and hearing testing, but not to include the child health screenings (vision, hearing and scoliosis) and immunizations that are required for all students.
- Providing information about Medicaid EPSDT screening (e.g., dental, vision) in the schools that will help identify medical conditions that can be corrected or improved by services through Medicaid.

- Contacting Medicaid providers of pediatric services in lower income areas to determine the scope of EPSDT screening and treatment services available to meet the needs of the at-risk child.
- Reviewing clinical notes of staff by a designated clinician to identify medical referral and follow-up practices, and making recommendations to supervisors for improvements as needed.
- Conducting quality assurance reviews of specific health-related programs objectives.
- Providing both oral and written instructions about the referral policies and procedures between the various agencies to parents for appropriate coordination of health services in the educational setting and for follow-up at home.

4.1.H. Code 9 - Referral, Coordination, and Monitoring of Non-Medical Services

U – Direct Medical Services

U – Administrative Outreach

This code is used for making referrals for, coordinating, and/or monitoring the delivery of non-medical, such as educational, services.

It includes related paperwork, clerical activities or staff travel necessary to perform the following activities:

- Making referrals for, and coordinating access to, social and educational services, such as childcare, employment, job training, and housing.
- Making referrals for, coordinating, and/or monitoring the delivery of immunizations and child health screenings (vision, hearing, and scoliosis) that are required for all students.
- Making referrals for, coordinating, and monitoring the delivery of educational, scholastic, vocational, and other non-health-related examinations/assessments.
- Gathering any information that may be required in advance of these non-Medicaid-related referrals.
- Participating in a meeting/discussion to coordinate or review a student's need for instructional, scholastic, vocational, and non-health-related services not covered by Medicaid.
- Monitoring and evaluating the non-medical components of the individualized plan, such as parent-teacher conferences regarding a student's educational progress, or compiling attendance reports.
- Linking or referring a family to a non-medical service delivery system.
- Evaluating curriculum and instructional services, policies and procedures.
- Developing procedures for tracking families' requests for assistance with non-medical services and the providers of those services, such as tutors or remedial education courses.

- Health networking beyond the scope of Medicaid that is necessary to coordinate or monitor health fairs or screenings that focus on non-Medicaid social, vocational or educational programs and activities, i.e., scholarships, remedial classes, Child Find, DARE, anti-smoking campaigns, etc.

4.1.I. CODE 10 - MEDICAID-SPECIFIC TRAINING ON OUTREACH, ELIGIBILITY AND SERVICES

U – Direct Medical Services

A – Administrative Outreach

This code is used for coordinating, conducting, or participating in training events and seminars for outreach staff regarding the benefits of the Medicaid program, how to assist families to access Medicaid services, and how to more effectively refer students for services. Training for Child Find activities is NOT recorded here, but under Code 12.

It includes related paperwork, clerical activities or staff travel required to perform the following activities:

- Participating in or coordinating training that improves the delivery of Medicaid services.
- Participating in or coordinating training which enhances early identification, intervention, screening and referral of students with special health needs to EPSDT services.
- Coordinating training to assist families to access Medicaid services.
- Participating in or presenting training that improves the quality of identification, referral, treatment and care of children, e.g., talking to new staff about the EPSDT referral process or available EPSDT and health-related services.
- Conducting Medicaid outreach training of non-medical professional staff for the purpose of targeting and identifying children with special or severe health or mental health needs for appropriate referral to EPSDT screening services.
- Disseminating information on training sessions and conducting all related administrative tasks.
- Conducting seminars and presentations to teachers, parents, and community members on:
  - appropriately identifying students concerning indications of mental health behavioral conditions (i.e., bi-polar disorders, drug/substance abuse, autism, attention deficit, mood disorders, pervasive disability disorder, suicidal tendencies, and clinical depression);
  - identifying physical disabilities and other medical conditions that can be corrected or ameliorated by services covered through Medicaid; and
  - providing information on where and how to seek assistance through the Medicaid system.

4.1.J. Code 12 - Non-Medicaid Training

U – Direct Medical Services

U – Administrative Outreach

This code is used for coordinating, conducting, or participating in training events and seminars for outreach staff regarding the benefits of the programs other than the Medicaid program. Programs may include educational programs such as how to assist families to access the services of the relevant programs, and how to more effectively refer students for those services.

It includes related paperwork, clerical activities, or staff travel required to perform these activities:

- Participating in or coordinating training that improves the delivery of services for programs other than Medicaid.
- Participating in or coordinating training that enhances IDEA Child Find Programs.
- Participating in or coordinating training that improves relationships between and among local agencies.
- Participating in training to improve computer skills to collect data.
- Training regarding educational issues.
- Training regarding other non-medical social service issues.
- Participating in or coordinating training that improves the medical knowledge and skills of skilled professional medical personnel.
- Training on general health awareness and prevention programs, such as DARE, sex education, the Michigan Model, vocational or scholarship programs, MEAP tests, etc.

4.1.K. Code 13 - IEP/IFSP Direct Medical Services

A – Direct Medical Services

U – Administrative Outreach

This code is used for providing medically necessary direct medical services which are part of an IEP/IFSP treatment plan. These services are provided to an individual in order to correct or ameliorate a specific condition. Medical evaluations or assessments that are conducted to determine a child's health-related needs for purposes of the special education eligibility and for the development of the IEP/IFSP are covered under this code.

Direct Medical Services includes related paperwork, clerical activities, or staff travel required to perform the following activities:

- Occupational therapy services
- Physical therapy services

- Speech, language and hearing services
- Orientation and mobility services
- Psychological, counseling and social work services
- Developmental testing and assessments
- Nursing services
- Physician and psychiatrist services
- Assistive technology device services
- Providing health/mental health services contained in an IEP/IFSP
- Medical/health assessment and evaluation as part of the development of an IEP/IFSP
- Conducting medical/health assessments/evaluations and diagnostic testing, and preparing reports
- Providing or participating in face-to-face interventions with either an individual student or a group (2-8 students)
- Administering/monitoring medication included as part of an IEP/IFSP and documented in the IEP/IFSP

4.1.L. CODE 13(A) - IEP/IFSP PERSONAL CARE SERVICES

A – Direct Medical Services

U – Administrative Outreach

This code is used for providing a range of human assistance services to persons with disabilities and chronic conditions which enable them to accomplish tasks that they would normally do for themselves if they did not have a disability or chronic condition. Assistance may be in the form of hands-on assistance or cueing so that the person performs the task by him/herself. The need for services must be documented in the child's IEP/IFSP. Services are not covered when provided by a family member or if they are educational in nature.

Personal care services include related paperwork, clerical activities, or staff travel required to perform the following activities:

- Eating/feeding
- Respiratory assistance
- Toileting
- Grooming
- Dressing
- Transferring
- Ambulation

- Intervention for seizure disorder
- Personal hygiene
- Mobility/Positioning
- Meal preparation
- Skin care
- Muscle strengthening
- Bathing
- Maintaining continence
- Medical equipment maintenance
- Assistance with self-administered medications
- Redirection and intervention for behavior
- Health related functions through hands-on assistance, supervision and cueing

4.1.M. CODE 13(B) - IEP/IFSP TARGETED CASE MANAGEMENT SERVICES

A – Direct Medical Services

U – Administrative Outreach

This code is used for providing services which are a part of the IEP/IFSP treatment plan. These services identify and address special health problems and needs that affect the student's ability to learn, and assist the student to gain and coordinate access to a broad range of medically-necessary services covered under the Medicaid program.

Targeted Case Management Services include related paperwork, clerical activities, or staff travel required to perform the following activities:

- Assure that standard re-examination/follow-up of the student is periodically conducted to ensure the student receives needed diagnosis and treatment
- Assist families in identifying/choosing appropriate care providers and services
- Maintain case records and indicate all contact for student in the same manner as other covered services
- Coordinate performance evaluations/assessments and other service needs for the student
- Prevention of duplicate services
- Facilitation/participation in development, review and evaluation of the multi-disciplinary assessment
- Supporting activities that link or coordinate needed health services for the student
- Meeting with teachers and other professional staff to discuss testing, planning, treatment, coordinating effective interventions, and student progress

- Coordinating school based services and treatment with parents and student
- Monitoring and recommending a plan of action
- Providing modifications to the multi-disciplinary, patient-centered treatment plan
- Coordinating with staff/health professionals to establish continuum of health and behavioral services in the school setting
- Provide summary of provider, parent and student consultation

4.1.N. Code 13(C) - Other and Non IEP/IFSP Direct Medical Services

U – Direct Medical Services

U – Administrative Outreach

This code is used when providing direct medical services that are not documented in an IEP/IFSP or for services that are not allowable for Medicaid federal matching purposes.

- Administering first aid
- Performing routine or mandated child health screens including, but not limited to, vision, hearing, dental, scoliosis, and EPSDT screens
- Administering immunizations
- Discussing health care needs and the importance of well-baby care with adolescents
- Routine medication administration (such as over-the-counter medications or maintenance medications)

4.1.O. Code 14 - Transportation and Translation Services in Support of Medicaid-Covered Services

U – Direct Medical Services

A – Administrative Outreach

This code is used for assisting an individual to obtain transportation to Medicaid-covered services. This does not include the provision of the actual transportation service, but rather the administrative activities involved providing transportation. This code also does not include activities that contribute to the actual billing of transportation as a medical service, nor does it include accompanying the Medicaid-eligible individual to Medicaid services as an administrative activity.

This code is used for school employees who provide translation services related to Medicaid-covered services as an activity. Translation may be allowable as an administrative activity if it is not included and paid for as part of a medical assistance service.

It includes related paperwork, clerical activities or staff travel required to perform the following activities:

- Scheduling or arranging transportation to Medicaid-covered services.
- Assisting or arranging for transportation for the family in support of the referral and evaluation activities.
- Arranging for or providing translation services that assist the individual to access transportation and medical services.
- Arranging for or providing translation services that assist the individual to "communicate" with service providers about medical services being provided.
- Arranging for or providing translation services that assist the individual to understand necessary care or treatment.
- Assisting the student to define/explain their symptoms to the physician.
- Arranging for or providing signing services that assist family members to understand how to provide necessary medical support and care to the student.

4.1.P. Code 15 - Transportation and Translation Services in Support of Non-Medicaid Covered Services

U – Direct Medical Services

U – Administrative Outreach

This code is used for assisting an individual to obtain transportation to services not covered by Medicaid, or accompanying the individual to services not covered by Medicaid.

This code is used for school employees who provide translation services related to social, vocational, or educational programs and activities as an activity separate from the activities referenced in other codes.

It includes related paperwork, clerical activities, or staff travel required to perform the following activities:

- Scheduling or arranging transportation for social, vocational, and/or educational programs and activities.
- Scheduling or arranging transportation to and from school when no Medicaid service has been provided.
- Arranging for or providing translation services that assist the individual to access and understand non-medical services, programs, and activities.
- Arranging for or providing signing services that assist the individual's or family's access to and understanding of non-medical programs and activities.

4.1.Q. Code 16 - General Administration

R – Direct Medical Services

R – Administrative Outreach

This code is used for time study participants performing activities that are not directly assignable to program activities.

It includes related paperwork, clerical activities, or staff travel required to perform these activities. Typical examples (not all inclusive) of general administrative activities may include:

- Establishing goals and objectives of health-related programs as part of the school's annual or multi-year plan
- Reviewing school or district procedures and rules
- Attending or facilitating school or unit staff meetings, training, or board meetings
- Performing administrative or clerical activities related to general building or district functions or operations
- Providing general supervision of staff, including supervision of student teachers or classroom volunteers, and evaluation of employee performance
- Reviewing technical literature and research articles
- Taking lunch, breaks, or time not at work when staff are paid for these activities
- Paid leave day
- Paid leave of absence
- Processing payroll/personnel-related documents
- Maintaining inventories and ordering supplies
- Developing budgets and maintaining records
- Training (not related to curriculum or instruction), such as how to use the district's new computer system
- Other general administrative activities of a similar nature, as listed above, which cannot be specifically identified under other activity codes

4.1.R. Code 17 - School-Related and Educational Activities

U – Direct Medical Services

U – Administrative Outreach

This code is used for any other school-related activities that are not health-related, such as social services, educational services and teaching services, and employment and job training. These activities include the development, coordination, and monitoring of a student's education plan.

It includes related paperwork, clerical activities, or staff travel required to perform these activities. Examples of activities may include:

- Providing classroom instruction (including lesson planning)
- Testing and correcting papers
- Compiling attendance reports
- Performing activities that are specific to instructional, curriculum, and student-focused areas
- Reviewing the education records for students who are new to the school district
- Providing general supervision of students (e.g., playground, lunchroom)
- Monitoring student academic achievement
- Providing individualized instruction (e.g., math concepts) to a special education student
- Conducting external communications related to school educational issues/matters
- Compiling report cards
- Applying discipline activities
- Activities related to the immunization requirements for school attendance
- Compiling, preparing, and reviewing reports on textbooks or attendance
- Enrolling new students or obtaining registration information
- Conferring with students or parents about discipline, academic matters, or other school-related issues
- Evaluating curriculum and instructional services, policies, and procedures
- Participating in or presenting training related to curriculum or instruction (e.g., language arts workshop, computer instruction)
- Translating an academic test for a student
- Transportation, if covered as a medical service under Medicaid

4.1.S. CODE 17(D) – NON-RETURNED MOMENTS

U – Direct Medical Services

U – Administrative Outreach

This code is used for moments that are not returned by the published deadline. As long as the compliance rate remains above 85%, these moments will not be used as a negative factor in the RMTS calculation.

4.1.T. Code 18 - Not Scheduled to Work and Not Paid

U – Direct Medical Services

U – Administrative Outreach

This code is used for time study participants who are not scheduled to work and not paid on the randomly selected moment pre-printed on the time study form.

Examples of this may include:

- Participant is a part-time employee who is not scheduled to work at the selected sample time
- The selected sample time falls before or after the participant's scheduled work day
- School is closed due to an unpaid holiday or an unpaid school district day off (i.e., winter break, spring break, or a built-in "bad weather day")
- Unpaid leave of absence

SECTION 5 – CONFIDENTIALITY

Aggregate time study data may occasionally be useful for other administrative tasks (i.e., planning) and may be used in that way. However, any individually identifiable information must be protected as required by all applicable state and federal statutes and regulations to ensure confidentiality and protection of privacy.

SECTION 6 – TIME STUDY TRAINING

6.1 TRAINING

The approved training methods, materials, information, and instructions are tailored to each group involved in the time studies.

The Contractor, along with MDHHS, is responsible for developing training programs and materials and, along with the ISD coordinator, providing follow-up assistance as needed. For training, there are some services the Contractor will provide statewide and other services that will be provided to the individual ISDs.

6.1.A. LOCAL ISD COORDINATOR TRAINING

All ISDs have an ISD Coordinator/representative who receives training that ensures a thorough understanding of their coordinator responsibilities, the approved time study and cost reporting activities. These individuals must understand their role as the liaison between the Medicaid Program, the Contractor, and other staff. They must understand and be able to convey to others the basic purpose of the program, assist the Contractor with follow-up as needed, and serve as a facilitator for the Contractor to "navigate" the district as necessary.

6.1.B. TIME STUDY PARTICIPANT TRAINING

For time study participants, it is essential that these individuals understand the purpose of the time studies, that time is of the essence related to completion of the form, and that their role is crucial to the success of the time study. The Contractor develops and provides detailed written information and instructions for completing the time study forms as a coversheet attached to each time study form. The coversheet provides a "tutorial" with the aforementioned basics of the program as well as information about the Medicaid covered services provided in the school setting.

SECTION 7 – SUMMARY OF TIME STUDY STEPS

The Contractor duties are to:

- Import eligible school district staff information to create the RMTS staff pools.
- Randomly select staff/moments to be sampled.
- Generate printed or electronic RMTS forms for each moment.
- Generate and distribute a master list of selected moments to the ISD Coordinators as a local control list.
- Generate mailing labels addressed to randomly selected staff.
- Code the time study responses.
- Calculate activity percentages for each of the activity codes.
- Scan completed and coded time study forms.
- Transfer raw data from scanned forms to the claims development software to calculate activity percentages for each of the activity codes.
- Produce quarterly reports summarizing the results of the random moment time studies (RMTS) and RMTS compliance reporting. (Both reports are forwarded to the MDHHS Program Policy Division for posting on the MDHHS website. Refer to the Directory Appendix for website information.)
- Produce periodic and special RMTS reports that provide data and information sorted by LEA and ISD that are provided to the CMS, MDHHS, MDE, ISDs and their auditors.
- Create and verify the eligible staff pools for time studies from the quarterly information provided by the ISDs.
- Distribute time study forms and collect completed time study forms.
- Code the activity forms received from the ISDs.
- Initiate and complete the ISD claim workbooks by obtaining the financial data from each LEA and compiling data to complete the workbook.

SECTION 8 – SUMMER QUARTER TIME STUDY METHODOLOGY

8.1 AOP QUARTERLY CLAIM (OTHER THAN SUMMER QUARTER)

The claim consists of the results of the quarterly RMTS of the approved staff pool for the quarter and the correlating allowable costs applied to the reimbursement methodology.

8.2 AOP SUMMER QUARTER FORMULA AND RANDOM MOMENT TIME STUDY

The summer quarter months are July, August and September. There is a break period between the end of one regular school year and the beginning of the next regular school year during which only a few staff are working. The majority of school staff work during the school year and do not work for part of the summer quarter (9-month staff). However, there are some 9-month staff that opt to receive their pay over a 12-month period. Therefore, different factors must be applied to the summer formula in order to accurately reflect the activities that are performed by the staff.

The summer quarter is divided into two parts producing two partial claims. For the AOP process, the sum of both claims is submitted to Medicaid for reimbursement for the summer quarter. The first part of the quarter is from July 1 to the date students return to school. The second part of the quarter is from the date students return to school through September 30.

The summer time study of 800 moments is performed after students return to school and is only applied to the staff pool costs for the second part of the summer quarter (Fall staff pool costs). The RMTS is performed during a shorter time period to accurately reflect the work efforts being performed when all staff have returned to work.

The sums of Part I and Part II are utilized to calculate the claim submitted to Medicaid for reimbursement.

8.2.A. PART I - JULY 1 TO THE INDIVIDUAL ISD DATE THAT STUDENTS RETURN TO SCHOOL

Part I of the summer quarter is comprised of the following elements:

- Staff Pool – those eligible staff in the April through June staff pool
- Costs – April through June allowable staff pool costs
- A weighted average of the October-December, January-March, April-June, and the summer time study results.

8.2.B. PART II – DATE STUDENTS RETURN TO SCHOOL THROUGH SEPTEMBER 30

Part II of the summer quarter is comprised of the following elements:

- Staff Pool – the eligible new Fall staff returning to work
- Costs – the allowable cost associated with the new Fall staff pool
- RMTS – the time study for Part II is performed for a shortened period of time from the day students return to school through September 30. The start date will vary by ISD depending on the date the students return to school.

8.3 Direct Medical Summer Quarter Formula and Random Moment Time Study

A weighted average of the four time study results for the staff pool periods listed below is applied to the Medicaid Allowable Expenditure Report (MAER) total costs. The MAER costs include the annual costs associated with the direct medical services, personal care services and targeted case management services.

The direct medical services time study application is comprised of the following elements:

- Staff Pools – Those individuals eligible to participate in the following four staff pool periods:
  - October through December
  - January through March
  - April through June
  - Date students return to school through September 30 (summer time study)
- Cost Pool – The costs from the annual Medicaid Allowable Expenditure Report (direct medical services, targeted case management and personal care services).
- RMTS – A weighted average of the October–December, January–March, April–June and the summer time study results as described above.

8.4 Financial Reporting Compliance Requirements

The financial data reported (salaries, benefits, supplies, purchased services, and other expenditures) must be based on actual detailed expenditures from LEA payroll and financial systems. Payroll and financial system data must be applied using generally accepted governmental accounting standards and principles or applicable administrative rules. The expenditures accumulated must correlate to the claiming period.

SECTION 9 – AUDIT AND QUALITY ASSURANCE

9.1 AUDIT

9.1 A. ACTIVITIES TO BE PERFORMED BY MDHHS OFFICE OF AUDIT STAFF

MDHHS audit staff review of selected ISD cost reports includes the following activities:

- Verification that the salaries listed for employees/positions included in the Random Moment Time Study (RMTS) staff pool match the payroll records for the same period as the time study.
- A review of the salaries of employees who changed positions during the time study period.
- If a replacement was hired/transferred, the auditor will verify that only the salary earned while working in a position on the staff pool list was reported, and that salaries for both the original and replacement employees were not duplicated on the report for the same time period.
- Verification that any other salaries and costs for supplies, etc., are of direct benefit to the employees on the relevant staff pool list and, therefore, allocable to that staff pool cost. For the Direct Medical program, all supplies and materials must be medically related.
- Confirmation that none of the direct costs reported were also claimed as an indirect cost, that the proper indirect cost rate was used, and the rate was applied only to costs in the base. The employees in non-standard job categories are the most likely to be considered indirect type employees; therefore, documentation will be reviewed for these individuals.
- Verification that no federal funds were claimed on the cost reports and that costs were not accepted for cost sharing.
- A standard review of other areas, such as confirmation that reported costs were actually paid, support documentation was maintained as required, and costs were properly charged to the correct accounts.
- Verification of recipient eligibility, documentation of services in the IEP/IFSP, and provider credentials.

The ISD must be prepared to direct the auditor to any document used to support and identify the reported RMTS costs.

9.1.B. SSAE 16 AUDIT REQUIREMENTS

The Contractor is required to have a Type II Statement on Standards for Attestation Engagements (SSAE) 16 audit to provide the necessary assurances that the claiming process (e.g., methodology, time studies, cost allocations, etc.) have been properly applied.

In a SSAE 16 Type II engagement, the service auditor expresses an opinion on whether the description of the service organization's system is fairly presented, whether the controls included in the description are suitably designed, whether the controls were

operating effectively, and provides a description of the service auditor's tests of operating effectiveness and the results of those tests.

The Contractor must undergo a SSAE 16 audit annually. The SSAE 16 audit must be submitted within 90 days after the end of the examination period.

Three (3) copies of the audit should be forwarded to the MDHHS Program Policy Section. (Refer to the Directory Appendix for contact information.)

9.2 Quality Assurance, Oversight and Monitoring

Quality assurance, oversight and monitoring activities include:

9.2.A. MDHHS Program Policy – Oversight of Administration and Operations

MDHHS policy staff responsibilities are:

- Review quarterly time study results against historical benchmarks according to:
  - Overall results and matchable percentages
  - Benchmarks by activity code and by staff category
- Detailed investigation of anomalies in results.
- Determination of policy or procedure changes based on results of anomaly review.
- Overall statistical requirements in terms of confidence and precision levels on a quarterly basis and an annual basis.
- Sampling to review coding activities performed by the Contractor.
- Disseminate CMS guidance.
- Monitor ISDs processing of claims for compliance with State and Federal regulations and program guidelines.
- Assure that billing entities have the processes in place to correct any claims paid in error.
- Provide information and training to billing entities as needed for program compliance.
- Provide operational oversight and technical assistance.
- Assist the ISDs with quality assurance and compliance monitoring.
- Provide oversight of the ISDs quality assurance and compliance plans to insure that they provide oversight and monitoring of such things as documentation, provider credentials, record retention, parental consent, and confidentiality.

9.2.B. MDHHS Office of Inspector General – Post Payment Review and Compliance

MDHHS Office of Inspector General staff responsibilities are:

- Post payment review for the purpose of adherence to provider policy, provider credentials and appropriate billing practices.
- Post payment review for the purpose of reported fraud or abuse.

For more detailed information regarding the Fraud and Abuse and Post Payment Review, refer to the Post Payment Review and Fraud/Abuse Section of the General Information for Providers Chapter.

9.2.C. MDHHS Rate Review Section – Cost Settlement Review

MDHHS Rate Review Section staff responsibilities are:

- Import and create a database of the cost report data submitted by the ISDs.
- Perform reviews of the data for accuracy and completeness.
- Summarize the data and forward to the ISDs for final approval.
- Compile cost settlement summaries and prepare over/under adjustments.

9.2.D. Contractor Oversight and Quality Assurance

There are several levels of quality assurance and validation built into the RMTS process.

- In terms of coding, the Contractor has a coding process in place in which centralized coders code all moments, and then a second coder reviews all moments coded as matchable for verification of accurate and consistent application of activity codes. The second coder also reviews a random sample of 10% of all non-matchable moments for quality assurance purposes.
- Quality assurance and validation includes the quarterly review which includes the Contractor meeting with MDHHS staff specifically to review time study results and other procedural issues. Each quarter, the team reviews detailed reports which outline the current quarter time study results benchmarked against past quarter results. The results are reviewed by activity code as well as by matchable/non-matchable categories. Comparisons are made of the variances in the overall quarterly results from the same quarter in the previous year, as well as variances of the current quarter against the average of the past four quarters. Results are reviewed and discussed in terms of results by staff category. Any anomalies identified are pursued through a detailed investigation of the moments which produced the anomaly. The Contractor, in conjunction with MDHHS, then determines how to handle any issues in terms of additional communication or training for RMTS participants, policy or procedural changes, etc.
- ISDs utilizing the web-based input process may view compliance reporting online.
- ISDs utilizing the paper methodology are sent compliance reporting on a weekly basis.

9.2.E. ISD Oversight

ISD responsibilities are to:

- have systems in place to monitor service delivery, claim documentation, claim billing, and payments received.
- verify that the credentials of all clinicians are current and appropriate for Medicaid billing and that services rendered are within the scope of the clinician's practice.

SPECIAL PROGRAMS

TABLE OF CONTENTS

SECTION 1 – GENERAL INFORMATION

This chapter applies to all providers.

The Michigan Department of Health and Human Services (MDHHS) administers the Medicaid Program, Children's Special Health Care Services (CSHCS), Maternity Outpatient Medical Services (MOMS) and other special programs described elsewhere in this manual. In addition to these traditional programs, MDHHS administers many other programs/coverages to meet the healthcare needs of Michigan's medically indigent population. Programs vary in scope and eligibility requirements and are funded through various sources, including federal, state, and/or private. Some of the programs offer comprehensive or reduced Medicaid benefits as indicated. Additional information regarding these programs may be available on the MDHHS website.

Contact information for the various programs is listed in the Directory Appendix.

SECTION 2 – PROGRAMS THAT TARGET SPECIFIC MEDICAL CONDITIONS

2.1 BREAST AND CERVICAL CANCER CONTROL PROGRAM

2.1.A. ELIGIBLE BENEFICIARIES

The Breast and Cervical Cancer Control Program (BCCCP) covers uninsured low-income women of all ages especially, but not limited to, women aged 40-64. Certain income restrictions do apply. Enrollees in the Breast and Cervical Cancer Control Program (BCCCP) are exempt from co-pays.

- Insured women may apply if certain insurance, age, and income requirements are met.
- Women who are enrolled in a managed care program, health maintenance organization (HMO) or have Medicare Part B are not eligible.

2.1.B. COVERED SERVICES

Covered services include:

- Clinical breast exams
- Pap smears
- Pelvic exams
- Screening mammogram, and
- Appropriate referral to community providers for follow-up of abnormalities.

Breast biopsy, colposcopy-directed services, colposcopy service, diagnostic mammograms, and loop electrosurgical excision procedure (LEEP) may be provided based upon medical needs, financial and insurance status, and availability of federal grant funds or Michigan tobacco tax dollars.

2.2 TRAUMATIC BRAIN INJURY REHABILITATION PROGRAM

2.2.A. ELIGIBLE BENEFICIARIES

The Traumatic Brain Injury (TBI) Rehabilitation Program covers adults age 18 or older who are U.S. citizens and have incurred a traumatic brain injury in the past 15 months, or have experienced a significant change within the last three months but are medically stable. Individuals must be a RANCHO 5-6 and currently Medicaid eligible. There must be a documented need for comprehensive, specialized rehabilitative services.

Individuals must be bowel and bladder trained and able to actively participate in 21 hours of therapy a week. Services must be provided under a physician approved plan of care and rendered in a residential or outpatient program that is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and has an agreement with a Medicaid approved nursing facility.

2.2.B. Covered Services

In addition to regular Medicaid coverage, the TBI Rehabilitation Program provides:

- Hearing & speech/language services
- Occupational therapy
- Physical therapy
- Physician services
- Psychological services
- Social work.

Vocational and educational services are not reimbursable by Medicaid.

SECTION 3 – GENERAL COVERAGE PROGRAMS

3.1 MEDICARE SAVINGS PROGRAM

3.1.A. ELIGIBLE BENEFICIARIES

Low income Medicare beneficiaries and those individuals who are eligible for Medicare but do not enroll due to the cost may participate in the Medicare Savings Program (MSP). Financial and nonfinancial requirements and restrictions do apply.

3.1.B. COVERED SERVICES

The MSP pays Medicare coinsurance, deductible, and premiums.

3.2 SPECIAL N SUPPORT

3.2.A. ELIGIBLE BENEFICIARIES

Families that received the low-income families (LIF) Medicaid but are no longer eligible due to an increase in child support may qualify for Special N Support. Most of the health coverage is provided by Medicaid Health Plans (MHPs), and the majority of the beneficiaries are already enrolled in a MHP.

3.2.B. COVERED SERVICES

Special N Support beneficiaries receive regular Medicaid coverage for four months.

3.3 FREEDOM TO WORK

3.3.A. ELIGIBLE BENEFICIARIES

Medicaid-eligible disabled adults aged 16 through 64 years old with earned income may be eligible. A beneficiary must move into this Medicaid category from another Medicaid category. SSI beneficiaries whose SSI eligibility may end due to financial factors are among those eligible to be considered for this program.

To be eligible, the beneficiary must be employed on a regular and continuing basis. There may be temporary breaks in employment up to 24 months if they are the result of involuntary layoff or are determined to be medically necessary.

For a married beneficiary, the spouse's income and assets are not considered when determining eligibility for this Medicaid category. The beneficiary's total countable unearned income cannot exceed 100 percent of the Federal Poverty Level (FPL). The beneficiary's countable assets are limited to $75,000. In addition, the beneficiary is allowed to have IRS-recognized retirement accounts (including IRAs and 401Ks) of unlimited value.

3.3.B. Covered Services

Freedom To Work beneficiaries receive regular Medicaid coverage.

3.3.C. Premiums

If the beneficiary's earned income is below 250 percent of the FPL, there is no premium required for coverage. If the beneficiary's earned income is between 250 percent of the FPL and $75,000 per year, the premium is based on the sliding fee scale. If the total countable earned income exceeds $75,000 per year, the beneficiary must pay a premium equal to 100 percent of the cost of Medicaid coverage.

3.4 Medicaid for Supplemental Security Income Beneficiaries

3.4.A. Eligible Beneficiaries

Supplemental Security Income (SSI) covers disabled children whose families have low income, and low-income adults who are aged, disabled or blind. The Social Security Administration determines eligibility and awards monthly SSI payments based on income and assets requirements. Beneficiaries awarded SSI are automatically eligible for regular Medicaid coverage.

3.4.B. Covered Services

SSI beneficiaries are eligible for regular Medicaid. In some cases, Medicare premiums are paid by Medicaid based upon certain individual situations and previous work histories.

3.5 Transitional Medical Assistance

3.5.A. Eligible Beneficiaries

Transitional Medical Assistance (TMA) covers families who are U.S. citizens that are no longer eligible for the low-income family (LIF) Medicaid because the parent(s) has too much income from employment. The family must have received low-income family Medicaid for at least three months of the previous six months to be eligible for TMA. Most of the health coverage is provided by HMOs contracted by MDHHS. The majority of the beneficiaries are already enrolled in a MHP. A renewal of the application to TMA is not necessary.

3.5.B. Covered Services

TMA provides regular Medicaid coverage, or a comprehensive health care package that includes vision, dental and mental health services, if the beneficiary has been enrolled in a MHP for 12 months.

SECTION 4 – COMMUNITY-BASED LONG TERM CARE

4.1 MI CHOICE WAIVER (HOME AND COMMUNITY-BASED WAIVER FOR THE ELDERLY AND DISABLED)

The MI Choice Waiver provides services to aged and physically disabled individuals 18 years old and over who are eligible for full Medicaid and want to stay in their homes or another residential setting but, without the provision of waiver services, would require the level of care only available in a nursing facility. Income and assets requirements and restrictions apply. Applicants must also meet the Michigan Medicaid Nursing Facility Level of Care Determination criteria. Individuals must be currently Medicaid approved or be Medicaid eligible if they were to enter a nursing facility. MDHHS contracts with local agencies to administer this program. (Refer to the MI Choice Waiver Chapter for additional information.)

4.2 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

PACE is a comprehensive service delivery system for frail, elderly individuals who meet the Michigan Medicaid Nursing Facility Level of Care criteria. Refer to the PACE Chapter of this manual for additional information.

SECTION 5 – MICHILD

5.1 ELIGIBLE BENEFICIARIES

Effective January 1, 2016, the Michigan Department of Health and Human Services (MDHHS) converted the MIChild program to a Medicaid expansion program. Although individuals are enrolled in a Medicaid expansion program, the program will continue to be referred to as the MIChild program. All Medicaid coverages and conditions will apply in accordance with current Medicaid policy.

The MIChild Medicaid program provides health care coverage for children who:

- Are age 0 through 18
- Have income at or below 212% of the Federal Poverty Level under the Modified Adjusted Gross Income (MAGI) methodology
- Do not have other comprehensive medical insurance (this includes insurance that covers inpatient and outpatient hospital services, laboratory, x-ray, pharmacy and physician services)
- Do not qualify for other MAGI related Medicaid programs
- Are residents of the State of Michigan

The child's eligibility for MIChild is determined through the MAGI methodology. All criteria for MAGI eligibility must be met to be eligible for MIChild.

Families enrolled in the MIChild program are required to pay a premium of $10 per month per family to maintain coverage for their children. Children enrolled in MIChild are exempt from copay for services.

5.2 COVERED SERVICES

Children enrolled in MIChild are considered Medicaid beneficiaries and are entitled to all Medicaid covered services.

SECTION 6 – CHILD AND ADOLESCENT HEALTH CENTERS AND PROGRAMS

Under an agreement with MDHHS, Child and Adolescent Health Centers and Programs (CAHCPs) provide medical services and outreach on behalf of the Medicaid Health Plans (MHPs) to school-aged children. (Refer to the Medicaid Health Plan Chapter of this manual for additional information.)

SECTION 7 - FLINT FAMILY SUPPORTS COORDINATION SERVICES

Family Supports Coordination services are part of a comprehensive health benefit available to pregnant women and children who were served by the Flint water system who meet the Medicaid eligibility requirements.

Family Supports Coordination services assist individuals in gaining access to appropriate medical, educational, social, and/or other services. Family Supports Coordination services include assessments, planning, linkage, advocacy, care coordination, referral, monitoring, and follow-up activities.

In addition to Family Supports Coordination services, eligible beneficiaries will receive the full array of Medicaid-covered benefits. This includes the provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children up to age 21, Non-Emergency Medical Transportation (NEMT), and Maternal Infant Health Program (MIHP) services.

7.1 ELIGIBILITY

Providers may verify beneficiary eligibility for Family Supports Coordination services through a Community Health Automated Medicaid Processing System (CHAMPS) online eligibility inquiry or via a Health Insurance Portability and Accountability Act (HIPAA) 270 transaction. The CHAMPS or 271 eligibility response for beneficiaries eligible for Family Supports Coordination services will show:

- a current MAGI category beginning with "F"; and
- a current benefit plan of "TCMF" in addition to their assigned Medicaid or Children's Health Insurance Program (CHIP)-related benefit plans.

7.2 CORE ELEMENTS OF FAMILY SUPPORTS COORDINATION

The purpose of Family Supports Coordination services is to provide a comprehensive array of services that are appropriate to the conditions of the individual. At a minimum, Family Supports Coordination services must include:

- a face-to-face comprehensive assessment, history, re-assessments, and identification of a course of action to determine the specific needs of the beneficiary and to develop an individual Plan of Care;
- planning, linking, coordinating, follow-up, and monitoring to assist the beneficiary in gaining access to services;
- coordination with the beneficiary's primary care provider (PCP), other providers, and Medicaid Health Plan (MHP), as applicable; and
- any other service approved by MDHHS.

7.2.A. INITIAL/ ANNUAL COMPREHENSIVE ASSESSMENT VISIT

All comprehensive assessment visits, including the initial face-to-face comprehensive assessment visit, must be conducted by a qualified licensed nurse or social worker with the beneficiary in the beneficiary's home or primary place of residence. The purpose of the comprehensive assessment visit is to gather sufficient information to develop an

individualized Plan of Care for the beneficiary and to ensure that all other eligible individuals in the household are identified for further screening.

It is expected that face-to-face assessments are performed annually; however, the frequency should be based on the needs and circumstances of the beneficiary and/or family. Active participation by the beneficiary and/or parent(s)/legal guardian(s) is necessary. Comprehensive assessment activities include:

- obtaining client history;
- identifying the beneficiary's needs and completing related documentation; and
- gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the beneficiary.

At a minimum, the comprehensive assessment visit shall assess:

- the growth and development of beneficiaries up to age 21;
- the behavioral profile of beneficiaries up to the age of 21, including the notation of aggressive or hyperactive behavior;
- the beneficiary's access to a PCP and other health care providers;
- whether the beneficiary's PCP has conducted a developmental and social-emotional screen(s) utilizing a standardized and validated tool, such as the Ages & Stages Questionnaire: Social-Emotional (ASQ:SE) or the Pediatric Symptom Checklist (PSC) as indicated by the American Academy of Pediatrics (AAP) Periodicity Schedule, and documenting the results of any screenings performed;
- whether the beneficiary's PCP has assessed the beneficiary for sources of toxic stress and for sources of strength using nationally recognized tools, such as the Adverse Childhood Experiences (ACEs) and Resiliency questionnaires, and documenting the results of any screenings performed;
- the beneficiary's access to prenatal care, potential for pregnancy complications, pica activities, and intent to breastfeed (pregnant beneficiaries);
- the beneficiary's educational and nutritional needs, including participation in the Women, Infants and Children (WIC) program and/or the Food Assistance Program (FAP);
- the beneficiary's environment and typical family practices that may pose a lead risk;
- lead hazards within the family's dwelling; and
- access to NEMT.

7.2.B. Development of the Plan of Care and Documentation

During or immediately following the face-to-face initial comprehensive assessment visit, a Plan of Care must be developed for beneficiaries who agree to participate in Family Supports Coordination services, with the active participation of the parent(s)/legal guardian(s) when applicable. The development (and periodic revision) of a specific Plan of Care that is based on the information collected through the comprehensive

assessment must specify the goals and actions to address the medical, educational, social, and/or other services needed by the beneficiary. The supports coordinator must ensure the active participation of the beneficiary, and work with the beneficiary (or the beneficiary's parent[s]/legal guardian[s]) and others to develop those goals, and to identify a course of action to respond to the assessed needs of the beneficiary. The Plan of Care is to be shared with the beneficiary's MHP and PCP, if applicable. Beneficiaries must consent to share the Plan of Care with the MHP and other providers identified in the Plan of Care. At a minimum, the Plan of Care must:

- identify a course of action to respond to the assessed needs of the beneficiary (e.g., plan for the testing of family members at risk for lead hazard exposure);
- provide education and information regarding lead hazards, including the impact of lead exposure on the developing fetus of pregnant beneficiaries; and
- facilitate blood lead testing and follow-up testing and treatment as recommended by the PCP.

Family Supports Coordination providers are required to document the following information for all beneficiaries receiving Family Supports Coordination services:

- the name of the beneficiary;
- the dates of the supports coordination services;
- the name of the Family Supports Coordination provider and the qualified professional (i.e., licensed nurse or social worker) providing the supports coordination services;
- the nature and content of the supports coordination visits received, and whether goals specified in the Plan of Care have been achieved;
- whether the beneficiary has declined services within the Plan of Care;
- the need for, and occurrences of, coordination with other providers;
- a timeline for obtaining needed services;
- a timeline for re-evaluation of the Plan of Care; and
- the beneficiary's consent to share information.

7.2.C. Referrals and Related Activities

In collaboration with the PCP and the MHP, it is expected that the supports coordinator will facilitate and coordinate referral and related activities to assist the beneficiary in obtaining needed services. Activities such as scheduling appointments or linking the beneficiary with medical, educational, social, and/or other programs and services to address identified needs and achieve goals specified in the Plan of Care are primary components of Family Supports Coordination services. Referral activities include, but are not limited to, the coordination of age-appropriate services such as:

- health care related services, including physical and specialty behavioral health services;
- nutritional services, such as coordinating referrals to the Special Supplemental Nutrition Program, WIC program, or FAP;

- educational services, such as age-appropriate referrals to Early On, Great Start Readiness Programs, Head Start, and school-based services;
- additional social supports (including home visiting programs) to assist the beneficiary in obtaining other assistance, such as financial, housing, and transportation assistance, and lead assessment and abatement resources; and
- blood lead testing and re-testing for family members at risk for lead exposure, and education regarding lead hazards including the impact of lead exposure on young children and the developing fetus.

7.2.D. Monitoring and Follow-Up Activities

Monitoring and follow-up activities include activities and contacts that are necessary to ensure the Plan of Care is implemented and adequately addresses the eligible beneficiary's needs, and which may be conducted with the beneficiary, family members, service providers, or other entities or individuals. Monitoring and follow-up activities are conducted as frequently as necessary by the supports coordinator.

A maximum of five (5) face-to-face monitoring visits are billable per year for each eligible beneficiary. To be reimbursed, the visit must be face-to-face. Additional monitoring and follow-up activities are likely between face-to-face visits but are not reimbursable. At least one annual face-to-face monitoring visit should be conducted to determine whether the following conditions are met:

- services are being furnished in accordance with the beneficiary's Plan of Care;
- services in the Plan of Care are adequate; and
- changes in the needs or status of the beneficiary are reflected in the Plan of Care.

Monitoring and follow-up activities include making necessary adjustments in the Plan of Care and service arrangements with providers.

7.3 Accessing Services

Accessing Family Supports Coordination services may occur a number of ways. If the beneficiary is an MHP member, the MHP may initiate the initial contact with the beneficiary and identify those beneficiaries that may benefit from Family Supports Coordination services. Fee-for-Service (FFS) and MHP beneficiaries may also access Family Supports Coordination services either through a referral from their PCP or through a self-referral.

7.4 Covered Supports and Services

A maximum of six (6) face-to-face visits per year will be reimbursed for each eligible beneficiary as follows:

- one (1) visit for the initial/annual comprehensive assessment.
- a maximum of five (5) visits for monitoring and follow-up.

For additional visits, MDHHS requires the provider to obtain prior authorization before the service is rendered. (Refer to the Directory Appendix for contact information regarding prior authorizations.)

Reimbursement for assessment and monitoring visits is inclusive of all related care coordination and monitoring activities. MDHHS does not reimburse for missed appointments/visits. A beneficiary may not be billed for a missed appointment/visit.

Medicaid reimbursement for Family Supports Coordination services may not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

Supports coordination includes contacts with non-eligible beneficiaries when the contact is:

- directly related to identifying the eligible beneficiary's needs and care for the purpose of assisting the beneficiary in accessing services;
- identifying needs and supports to assist the beneficiary in obtaining services;
- providing supports coordinators with useful feedback; and
- alerting supports coordinators to changes in the beneficiary's needs.

Family supports coordination does not include activities that constitute the direct delivery of underlying medical, educational, social, and/or other services to which an eligible beneficiary has been referred, including foster care programs and services such as, but not limited to, the following:

- research gathering and completion of documentation required by the foster care program;
- assessing adoption placements;
- recruiting or interviewing potential foster care parents;
- serving legal papers;
- home investigations;
- providing transportation;
- administering foster care subsidies; and
- making placement arrangements.

7.5 Transfer of Care/ Records

During the course of care, the beneficiary may require services from a different supports coordinator due to relocation of the beneficiary's primary residence or due to a request of the beneficiary to change supports coordinators. When there is a planned change of the supports coordinator, information about the new supports coordinator (e.g., contact information) should be provided to the beneficiary. The referring supports coordinator must consult with the new supports coordinator about the case and transfer all applicable information and records, including all completed assessment visits and the updated Plan of Care, to the new supports coordinator in compliance with the privacy and security requirements of federal and state laws and regulations including, but not limited to, the HIPAA and the Michigan Mental Health Code.

7.6 Family Supports Coordination Closure

Family Supports Coordination services are available to all eligible beneficiaries up to age 21, or for pregnant women up to and through 60 days post-delivery. Family Supports Coordination services will be discontinued:

- if the beneficiary is no longer eligible;
- when the beneficiary parent(s) or guardian(s) refuses the service; or
- if CMS does not extend the Flint, Michigan Section 1115 Demonstration Waiver.

When services are refused, Family Supports Coordination services may be resumed at any point during the defined period of eligibility. A discharge summary, including the services provided, outcomes, current status, and ongoing needs of the beneficiary, must be completed and provided to the PCP when the Family Supports Coordination case is closed.

7.7 Provider Qualifications

Genesee Health System, the local community mental health (CMH) serving Genesee County, serves as the Designated Provider Organization (DPO) for Family Supports Coordination services. The DPO:

- has a sufficient number of qualified staff to meet the service needs of the target population and has the administrative capacity to ensure the provision of quality services in accordance with state and federal requirements;
- has experience in the coordination and linkage of community services;
- has the willingness and capabilities to coordinate with the beneficiary's PCP and MHP as applicable; and
- must seek approval by MDHHS of all subcontractors for the provision of Family Supports Coordination services.

The DPO will provide Family Supports Coordination services primarily through the use of a supports coordinator. The supports coordinator must meet one of the following professional qualifications:

- licensure as a registered nurse by the Michigan Department of Licensing and Regulatory Affairs (LARA), and at least one year of experience providing community health, pediatric or maternal infant health nursing services; or
- licensure as a social worker by LARA, and at least one year of experience providing social work services to families.

7.8 Claims Submission and Payment

All claims submitted and accepted are processed through CHAMPS. Claims must be submitted on the ASC X12N 837 5010 professional format when submitting electronic claims or on the CMS 1500 claim form for paper claims. (Refer to the Billing & Reimbursement for Professionals Chapter for additional billing information.)

7.8.A. Initial/Annual Assessments

Face-to-face assessment visits are to be billed using HCPCS code T2024 for an individual or family. This includes reimbursement for the development of a Plan of Care for one individual. HCPCS code T2024 with modifier TT (additional patient) should be billed for each additional individual Plan of Care that is developed from the assessment visit. For informational/reporting purposes, use modifier UN (two patients served), UP (three patients served), UQ (four patients served), UR (five patients served), or US (six or more patients served).

Assessment visits must be in the home or "home-like" environment. One face-to face initial/annual assessment visit per year per family/household is allowed. Additional assessment visits beyond one per year per family/household require prior authorization.

7.8.B. Follow-up/Monitoring

Face-to-face follow-up/monitoring visits are to be billed using HCPCS code T1017 for an individual or family. For informational/reporting purposes, use modifier UN (two patients served), UP (three patients served), UQ (four patients served), UR (five patients served), or US (six or more patients served), and enter the Medicaid beneficiary ID numbers of the family members served during the follow-up visit in the claim notes.

Follow-up visits must last at least 30 minutes and ideally take place in the home or "home-like" environment but may be performed in the office. A maximum of five face-to face follow-up/monitoring visits per year per family/household is allowed. Additional follow-up visits beyond five per year per beneficiary require prior authorization.

SECTION 8 – PEDIATRIC OUTPATIENT INTENSIVE FEEDING PROGRAM SERVICES

Pediatric Outpatient Intensive Feeding Program services are for beneficiaries with significant feeding and swallowing difficulties and are part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. (Refer to the Early and Periodic Screening, Diagnosis and Treatment Chapter for additional information.)

Pediatric Outpatient Intensive Feeding Program services may be reimbursed through Medicaid Fee-for-Service (FFS). Covered services that are carved out of the Medicaid Health Plan (MHP) delivery system will be reimbursed through FFS consistent with applicable Medicaid policy.

8.1 GENERAL INFORMATION

Pediatric feeding disorders are a complex set of feeding and swallowing problems that disrupt the acquisition of functional age-appropriate feeding habits. To resolve complex pediatric feeding issues, clinical evidence indicates that both medical and behavioral interventions are needed. Failure to address feeding issues in young children can be severe and include growth failure, susceptibility to chronic illness, and/or death.

A Pediatric Outpatient Intensive Feeding Program is an onsite day program that is delivered by a team of medical, behavioral health and other professionals who address complex feeding issues through integrated, individualized care

8.2 PROGRAM SERVICES

Medicaid covers medically necessary Pediatric Outpatient Intensive Feeding Program services for eligible beneficiaries. Pediatric Outpatient Intensive Feeding Program services primarily focus on children who have been diagnosed by a medical professional to have significant feeding difficulties that have not been resolved or treated adequately through less intensive therapies. Pediatric Outpatient Intensive Feeding Program services utilize a multi-disciplinary team to assist the beneficiary and his/her parents/guardians in improving the beneficiary's ability to eat and swallow and improve nutritional outcomes. Pediatric Outpatient Intensive Feeding Program services include an initial comprehensive assessment, individualized plan of care (POC), on-going monitoring, and incorporate appropriate behavioral modification techniques and parent/guardian education/training. Pediatric Outpatient Intensive Feeding Program services offer an intensive focus on oral-motor skill development with attention to nutritional markers for the most therapeutic outcome.

Medicaid covers medically necessary Pediatric Outpatient Intensive Feeding Program services for eligible beneficiaries. Pediatric Outpatient Intensive Feeding Program services:

- Primarily focus on children who have been diagnosed by a medical professional to have significant feeding difficulties that have not been resolved or treated adequately through less intensive therapies;
- Utilize a multi-disciplinary team to assist the beneficiary and his/her parents/guardians in improving the beneficiary's ability to eat and swallow and improve nutritional outcomes;
- Include an initial comprehensive assessment, individualized POC, ongoing monitoring, and incorporate appropriate behavioral modification techniques and parent/guardian education/training; and

- Offer an intensive focus on oral-motor skill development with attention to nutritional markers for the most therapeutic outcome.

Pediatric Outpatient Intensive Feeding Program services are designed to evaluate, diagnose and treat beneficiaries with significant feeding and swallowing difficulties. The initial comprehensive evaluation is performed by a multi-disciplinary team who meets with the beneficiary and his/her parents/guardians to assess the beneficiary's current status and potential for improvement. The initial comprehensive evaluation should include:

- Assessment of medical history and physical exam;
- Nutritional history and evaluation of growth and nutritional parameters;
- Psychological assessment of developmental, cognitive, emotional and behavioral function;
- Psychosocial evaluation;
- Evaluation of oral-motor function (may include videofluoroscopy swallow study, Fiberoptic Endoscopic Evaluation of Swallowing (FEES), clinical swallowing evaluation, and sensory evaluation);
- Standardized tests and/or objective functional baseline measures to assist with planning short- and long-term goals and to document progress;
- Observation of a simulated meal/snack time; and
- Development of an individualized POC.

Following the initial comprehensive evaluation, the beneficiary and his/her parents/guardians commit to an outpatient program which may typically be held five days per week, six to eight hours per day, for a period up to six weeks. The goals of Pediatric Outpatient Intensive Feeding Program services are to:

- Promote consistent mealtime acceptance;
- Promote good nutrition;
- Increase the variety of foods the beneficiary will eat;
- Promote development of oral-motor skills for feeding;
- Promote developmental feeding skills, such as cup drinking and self-feeding;
- Transition from tube to oral feeding; and
- Assist the beneficiary and/or parents/guardians in acquiring feeding skills through education/training.

Beneficiaries should be routinely monitored, and one-on-one consultations and/or conferences with team members should be routinely scheduled to discuss progress. Supportive services provided during this time may include speech therapy, occupational therapy, physical therapy and/or social work. Progress is assessed regularly and the POC is updated, if continuation is necessary.

8.3 Indications for Services

Pediatric Outpatient Intensive Feeding Program services may be considered medically necessary for individuals with anatomical, physiological, congenital, or cognitive conditions and/or complications of

severe illness who experience significant feeding difficulties. Eligible beneficiaries must meet all the following criteria:

- Significant oral-motor problems and/or chronic medical condition exist;
- Normal feeding milestones have not been met through previous therapies and treatment;
- Suboptimal nutritional status has been determined; and
- Inadequate responsiveness to less intensive treatment has been clinically documented.

Examples of feeding disorders treated in these programs include, but are not limited to:

- Oral-motor dysfunction (including swallowing, oral and/or pharyngeal dysphagia);
- Severe pathology in the perception of, or response to, sensory input to the extent that it significantly limits the ability to function;
- Gastrointestinal disorders; and
- Feeding tube dependency.

Pediatric Outpatient Intensive Feeding Program services are not covered for individuals with specific eating disorders (e.g., binge eating, bulimia, anorexia or obesity-related disorders).

8.4 Provider Qualifications

Pediatric Outpatient Intensive Feeding Programs are provided under the delegation and supervision of a Medical Director and delivered by a multi-disciplinary team of medical, behavioral health and other professionals who are licensed, certified and/or registered to provide health-related services within the scope of practice for their discipline. The multi-disciplinary team should integrate and coordinate an individualized, comprehensive POC to address complex feeding issues. Each Pediatric Outpatient Intensive Feeding Program must have the following staff actively involved in the assessment process and/or development/implementation of the POC.

Provider Type	Required Qualifications
Pediatrician	A Medicaid-enrolled and CSHCS-approved physician who possesses or is eligible for Pediatric Specialty Board Certification. Physicians are expected to remain familiar with current developments and standards of treatment in their respective fields. May serve in the required role as Medical Director.
Subspecialist	A Medicaid-enrolled and CSHCS-approved physician who possesses or is eligible for Pediatric Subspecialty Board Certification, including physicians with special training and demonstrated clinical experience related to pediatric feeding clinic issues. Physicians are expected to remain familiar with current developments and standards of treatment in their respective fields. May serve in the required role as Medical Director.
Licensed Behavioral Health Professional	A Licensed Behavioral Health Professional, such as a licensed psychologist or licensed Master's Social Worker, with at least two years of professional experience in providing services to children/youth and their families.
Occupational Therapist	A Licensed Occupational Therapist with at least one year of professional pediatric experience.
Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN)	An RD or RDN in possession of a Master's degree in human nutrition, public health, or a health-related field with an emphasis on nutrition, and one year of pediatric nutrition experience in providing nutrition assessment, education and counseling.

Provider Type	Required Qualifications
Speech-Language Pathologist	A Licensed Speech-Language Pathologist in possession of a Master's degree, and at least one year of professional pediatric experience.
Other staff	Other staff may include registered nurses, physical therapists, etc.
Parent/Guardian and/or Beneficiary	The parent/guardian and/or the beneficiary must be an active, participating team member in the development of the beneficiary's comprehensive POC.

8.5 Service Provider Enrollment

CSHCS-approved, Medicaid-enrolled program sites must be certified by the Michigan Department of Health and Human Services (MDHHS). MDHHS certification will be based upon adherence to the following requirements:

- Existence of a program schedule of services and supports.
- Assessment and POC services must be delivered by professional staff, as identified.
- If an aide under professional supervision delivers direct services, that supervision must be documented in the beneficiary's medical record.

Certification of new program sites will be contingent upon submission of acceptable enrollment information to MDHHS or upon a site visit by MDHHS.

8.6 Prior Authorization

Pediatric Outpatient Intensive Feeding Program services require prior authorization. Requests for prior authorization must be submitted utilizing form MSA-6544-B (Practitioner Special Services Prior Approval – Request/Authorization) and include documentation to support medical necessity such as height/weight measurements and previously attempted therapeutic interventions. (Refer to the Prior Authorization subsection of the Practitioner Chapter for additional information.) Medicaid forms can be accessed on the MDHHS website. (Refer to the Directory Appendix for website information.)

A copy of the prior authorization must be retained in the beneficiary's medical record.

Pediatric Outpatient Intensive Feeding Program services must request prior authorization to continue intensive treatment services beyond the current authorization period, even if a beneficiary changes providers. A copy of the latest re-evaluation must be submitted with the prior authorization request.

Requests for continued treatment must be supported by all of the following:

- Summary of previous treatment period (not to exceed 90 days prior to that time period for which prior authorization is being requested), including measurable progress on each short- and long-term goal, rate of progress, statement of the beneficiary's response to treatment, and any factors that have affected progress during the therapy period. Do not send daily treatment notes.
- Revised goals and justification for any change in the treatment plan for the requested period of treatment.
- Statement detailing any parent/guardian education and training.

8.7 Billing and Reimbursement

Reimbursement for Pediatric Outpatient Intensive Feeding Program services is a bundled payment rate based on the covered services provided by a multi-disciplinary team. This service is reimbursed as a daily rate comprised of all costs associated with the services provided within the day program, including: facility-related costs; medical care services provided by the physician and other licensed practitioners; services provided by clinical staff working under the delegation and supervision of a licensed medical practitioner; and diagnostic, screening and rehabilitative services. Services are billed as FFS claims through the Community Health Automated Medicaid Processing System (CHAMPS) regardless of beneficiary health plan status. Providers are to bill using Healthcare Common Procedure Coding System (HCPCS) code S0317 (disease management; per diem).

THERAPY SERVICES

TABLE OF CONTENTS

SECTION 1 – GENERAL INFORMATION

This chapter applies to enrolled Private Practice, Outpatient, Nursing Facility, and Home Health Agency therapy providers.

The term Medicaid throughout this chapter refers to all programs administered by MDHHS unless specifically stated otherwise. The primary objective of Medicaid is to ensure that essential health care services are made available to those individuals who would not otherwise have the financial resources to purchase them. Policies are aimed at maximizing medically necessary health care services available to eligible Medicaid beneficiaries.

The primary objective of the Children's Special Health Care Services (CSHCS) Program is to ensure that CSHCS beneficiaries receive medically necessary services related to a CSHCS qualifying diagnosis as recommended by a CSHCS authorized subspecialist. Providers should refer to the Children's Special Health Care Services chapter of this manual for information specific to CSHCS only beneficiaries.

1.1 SERVICE PROVISION

Therapy may be provided by Medicaid-enrolled providers when performed by properly credentialed/licensed or appropriately supervised professionals in the following settings:

- Occupational Therapy (OT) and Physical Therapy (PT)
  - Outpatient Hospital
  - Comprehensive Outpatient Rehabilitation Facility (CORF)
  - Outpatient Rehabilitation Agency (Rehab Agencies)
  - Commission on Accreditation of Rehabilitation Facilities (CARF)-Accredited Outpatient Medical Rehabilitation Program
  - Physical Therapist or Occupational Therapist in Private Practice
  - Physician's Office/Clinic
  - Optometrist's Office
  - Nursing Facility
  - Home Health Agency
- Speech-Language Therapy (ST)
  - Outpatient Hospital
  - Comprehensive Outpatient Rehabilitation Facility (CORF)
  - Outpatient Rehabilitation Agency (Rehab Agencies)
  - CARF-Accredited Outpatient Medical Rehabilitation Program
  - Council on Academic Accreditation (CAA)-Accredited University Graduate Education Program
  - Speech-Language Pathologist in Private Practice

- Physician's Office/Clinic
- Nursing Facility
- Home Health Agency

Medicaid covers medically necessary rehabilitative therapy services for beneficiaries of all ages. Rehabilitative services include teaching or training someone to perform or develop a level of reasonable functional proficiency of tasks or skills that were previously learned, with or without compensatory strategies. Examples may include, but are not limited to:

- PT to regain functional ambulation using a cane following a stroke, or to advance from ambulation with an assistive device/physical assistance to ambulation without an assistive device or physical assistance;
- OT to achieve independent dressing following a spinal cord injury, or to develop dressing independence without an assistive device or physical assistance;
- Speech-Language Pathology (SLP) to improve articulation and fluency following a traumatic brain injury or develop communication skills utilizing an augmentative communication strategy.

Medicaid beneficiaries under 21 years of age and Healthy Michigan Plan beneficiaries may be eligible for medically necessary habilitative therapy services. Habilitation therapy includes teaching/training someone to perform/develop a level of reasonable functional proficiency of a task that was not previously learned/achieved at a typically expected age or without compensatory techniques or processes. Examples may include, but are not limited to:

- PT for a child who is not walking at a typically expected age.
- OT teaching normal dressing skills beyond the typically expected age of learning.
- SLP for communication skills including articulation errors beyond the typically expected age of learning or syntax and semantics for a person with significant hearing impairment.

Documentation must objectively support the request for rehabilitative and/or habilitative therapy.

1.2 Therapy Database

For specifics regarding Medicaid coverage of the Healthcare Common Procedure Coding System (HCPCS), refer to the MDHHS Therapies Database on the MDHHS website or the Medicaid Code and Rate Reference tool in the Community Health Automated Medicaid Processing System (CHAMPS). (Refer to the Directory Appendix for website information.) The database includes covered private practice, outpatient, nursing facility, and home health therapy codes, applicable limits, and prior authorization requirements.

1.3 Documentation in Beneficiary Medical Record

Therapy providers must retain all applicable documentation in the beneficiary's medical record for seven years. For audit purposes, the beneficiary's medical record must substantiate the medical necessity of the service performed.

1.4 Practitioner Signatures

In all documentation requiring a signature, the signature must be hand written by the practitioner or submitted electronically. A stamped signature, second party signature, or statement of "signature on file" will not be accepted. NOTE: An electronic signature must specifically identify and authenticate the individual practitioner. This applies to signatures for ordering, referring, and treating practitioners.

1.5 Modifiers

Therapy claims must be submitted using the appropriate procedure code and therapy modifier to distinguish the discipline under which the service is delivered. To differentiate between habilitative and rehabilitative therapy, services should also be reported with the appropriate modifier that represents the nature of the therapy being performed. Only Medicaid beneficiaries under 21 years of age and Healthy Michigan Plan beneficiaries may be eligible for medically necessary habilitative therapy services. In addition to these modifiers, maintenance therapy services should be billed with the MDHHS identified modifier to categorize the service as maintenance related.

Therapy services submitted without these modifiers may be denied. Refer to the Billing and Reimbursement chapters in this manual for additional modifier information.

1.6 Reimbursement

Reimbursement structure is based on the provider's enrollment type. Reimbursement methodologies include the MDHHS Outpatient Prospective Payment System or the Medicaid fee screens. (Refer to the Medicaid Code and Rate Reference tool in CHAMPS or the MDHHS Therapies Database on the MDHHS website.) For Not Otherwise Classified codes or covered codes without established fee screens, the authorized reimbursement amount is indicated on the approved prior authorization request.

SECTION 2 – PROVIDER REQUIREMENTS

2.1 OUTPATIENT HOSPITALS

Outpatient OT, PT and ST services may be provided to beneficiaries of all ages in the outpatient hospital.

2.2 COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES AND OUTPATIENT REHABILITATION AGENCIES

Comprehensive Outpatient Rehabilitation Facilities (CORFs) and rehab agencies may enroll with Medicaid for reimbursement of outpatient OT, PT and ST services provided by qualified professionals. All CORFs and rehab agencies must provide proof of Medicare certification when enrolling in Medicaid.

2.3 COMMISSION ON ACCREDITATION OF REHABILITATION FACILITIES-ACCREDITED OUTPATIENT MEDICAL REHABILITATION PROGRAMS

Commission on Accreditation of Rehabilitation Facilities (CARF)-accredited outpatient medical rehabilitation programs may enroll with Medicaid for reimbursement of outpatient OT, PT and ST services provided by qualified professionals. The program must not be part of, or owned by, a hospital, CORF or rehab agency. All CARF-accredited outpatient medical rehabilitation programs must provide proof of their current CARF accreditation when enrolling in Medicaid.

2.4 NURSING FACILITY

A Medicaid-certified nursing facility (NF) is defined as a nursing home, county medical care facility, or hospital long term care unit with Medicaid certification. Nursing facilities must provide or obtain specialized rehabilitative services if required by the beneficiary's plan of care.

In situations where the therapist is not an employee of the facility, the facility must establish a valid contract with a therapist/speech-language pathologist who meets applicable licensure/certification/accreditation requirements. A valid contract allows the facility to retain professional and administrative control over the services provided. Therefore, an agreement that stipulates only the use of facility space does not constitute a valid contract.

2.5 HOME HEALTH AGENCY

A Home Health Agency (HHA) is an organization that provides home care services, such as skilled nursing care, OT, PT, ST and home health aide services. The HHA must be Medicare certified to enroll as a Medicaid provider and must comply with the Medicare/Medicaid conditions of participation.

OT, PT, and ST services may be provided by an HHA if Medicare/Medicaid conditions of participation, including medical necessity, are met. A therapist in the home health setting may be responsible for supervision of the home health aide. Refer to the Home Health chapter for additional information.

2.6 UNIVERSITY AFFILIATED SPEECH-LANGUAGE PATHOLOGY GRADUATE EDUCATION PROGRAMS

University graduate education programs accredited by the American Speech-Language-Hearing Association's (ASHA) Council on Academic Accreditation (CAA) in Audiology and Speech-Language Pathology may enroll with Medicaid for reimbursement of outpatient speech-language therapy provided

by qualified professionals. The university program must be freestanding and not part of, or owned by, a hospital, CORF or rehab agency. All university programs must provide proof of their current ASHA-CAA when enrolling in Medicaid.

2.7 Physical Therapists, Occupational Therapists, and Speech-Language Pathologists' Private Practice

PT, OT, and ST services may be provided to beneficiaries of all ages when provided by a Medicaid enrolled physical therapist, occupational therapist, or speech-language pathologist employed by an individual/sole, partnership, or group practice. These providers are eligible for direct reimbursement.

2.8 Physician's Office or Clinic

PT, OT, and ST services may be provided to beneficiaries of all ages in a physician's office or one of the following clinics: Federally Qualified Health Center, Rural Health Clinic, Tribal Health Center, or Local Health Department.

SECTION 3 – PRIOR AUTHORIZATION REQUESTS

Prior authorization is required for certain therapy services before the services are rendered. To determine which therapy services require prior authorization, refer to the Standards of Coverage and Service Limitations Section of this chapter, the Medicaid Code and Rate Reference tool in CHAMPS, or the MDHHS Therapies Database on the MDHHS website. (Refer to the Directory Appendix for website information.)

Prior authorization is not required for the first 60-days of home health therapy if the beneficiary has not received home therapy within the last year (365 consecutive days from the date of service) and services do not exceed the visit maximum. If a beneficiary has previously received home health therapy and services were provided more than 60 days ago but less than 365 days, authorization is needed.

Prior authorization (PA) is needed when therapy limits are exceeded regardless of diagnosis.

PA may be authorized for a period not to exceed six months for outpatient and private practice therapy providers and outpatient hospitals, or two months for home health agencies and nursing facilities.

Nursing facilities participating in Medicare are not required to obtain prior authorization for the deductible and/or coinsurance amounts when Medicare approves the services.

If a beneficiary is approved for ventilator care and requires therapy, prior authorization for the therapy must be obtained under the Ventilator Dependent Care Unit (VDCU) National Provider Identification (NPI).

Prior authorization requests must be submitted on the Occupational Therapy-Physical Therapy-Speech Therapy Prior Approval Request/Authorization form (MSA-115). (Refer to the Forms Appendix or the MDHHS website for a copy of the form.) Required medical documentation must accompany the form.

The information on the MSA-115 must be:

- Typed – All information must be clearly typed in the designated boxes of the form.
- Thorough – Complete information, including the appropriate HCPCS procedure codes, must be provided on the form. The form and all documentation must include the beneficiary's name and **mihealth** card ID number, provider name and address, and the provider's NPI number.

Whenever a beneficiary is admitted to a nursing facility directly from a general hospital or from another nursing facility where the beneficiary was receiving reimbursable therapy services, the name of that facility and the date of discharge from that facility should be included on the prior authorization request.

Prior authorization requests should be submitted with the appropriate therapy modifier to distinguish the discipline under which the service is being requested and a modifier that represents the nature of the therapy being requested (habilitative vs rehabilitative therapy). Requests for maintenance therapy services should also contain the appropriate maintenance modifier. Refer to the Billing & Reimbursement Chapters for additional modifier information.

For all Medicaid Fee-for-Service (FFS) beneficiaries, the MSA-115 must be mailed or faxed to the MDHHS Program Review Division. Providers can check the status of a prior authorization request in CHAMPS or

by contacting the MDHHS Program Review Division via telephone. (Refer to the Directory Appendix for website and contact information.)

Prior authorization requests may also be submitted electronically via FFS Direct Data Entry (DDE) in CHAMPS. (Refer to the General Information for Providers chapter of this manual for additional information.) A copy of the MSA-115 must be attached to each electronic prior authorization request.

A copy of the prior authorization determination letter must be retained in the beneficiary's medical record.

3.1 Emergency/Verbal Prior Authorization

A provider may contact MDHHS to obtain a verbal prior authorization when the prescribing practitioner (practicing within their scope of practice as defined by state law) has indicated that it is medically necessary to provide therapy services without delay. If a therapy service is required during MDHHS nonworking hours, providers must contact the Program Review Division the next working day.

To obtain verbal prior authorization, providers may call or fax a request to the Program Review Division. (Refer to the Directory Appendix for contact information. Refer to the Forms Appendix for a copy of form MSA-115 and completion instructions.) If the provider faxes a request, the request must state "verbal prior authorization required."

The following steps must be completed before a prior authorization number is issued for billing purposes:

- The verbal authorization date must be entered on the MSA-115 or electronically in CHAMPS via FFS DDE.
- The MSA-115 or FFS DDE prior authorization request must be submitted to the Program Review Division within 30 days of the verbal authorization.
- Supporting documentation must be submitted with the prior authorization request.

The verbal authorization does not guarantee reimbursement for the services if:

- The beneficiary was not eligible for Medicaid when the therapy service was provided.
- The Program Review Division does not receive the completed MSA-115 and documentation within 30 days of the verbal authorization.
- The prescription is dated after the date the verbal authorization was requested.

3.2 Retroactive Prior Authorization

Therapy services provided before prior authorization is requested will not be covered unless the beneficiary was not eligible on the date of service and a subsequent eligibility determination was made retroactive to the date of service. If the MDHHS eligibility file does not show that retroactive eligibility was approved, then the request for retroactive prior authorization will be denied.

- Exception for nursing facilities: When a beneficiary is admitted to a nursing facility directly from a general hospital or from another nursing facility where the beneficiary was receiving reimbursable therapy services, retroactive authorization may be requested to ensure continuity of a treatment regimen if the request is filed within ten days following admission. Retroactive

authorization may be granted when the service is rendered within Program guidelines for coverage (e.g., is restorative in nature).

3.3 Beneficiary Eligibility

Approval of a therapy service on the prior authorization request confirms that the service is authorized for the beneficiary. Approval of a prior authorization request does not guarantee beneficiary eligibility or payment. It is the provider's responsibility to verify the beneficiary's eligibility prior to rendering the service.

3.4 Billing Authorized Services

After prior authorization is issued, the information (e.g., prior authorization number, HCPCS/ CPT procedure code, modifier, and quantity) that was approved on the prior authorization must match the information on the claim form.

Therapy rendered to a nursing facility beneficiary must be billed by the nursing facility.

Refer to the Billing & Reimbursement Chapters of this manual for complete billing instructions.

SECTION 4 – STANDARDS OF COVERAGE AND SERVICE LIMITATIONS

4.1 OCCUPATIONAL THERAPY

MDHHS uses the terms Occupational Therapy, OT, and therapy interchangeably. OT is covered when furnished by a Medicaid-enrolled therapy provider and the documentation is signed by the treating therapist. Medicaid reimburses for occupational therapy services when provided by any of the following:

- A licensed occupational therapist.
- A licensed occupational therapy assistant under the supervision of an occupational therapist (i.e., the occupational therapy assistant services must follow the evaluation and treatment plan developed by the occupational therapist, and the occupational therapist must supervise and monitor the occupational therapy assistant's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and co-signed by the supervising occupational therapist.
- A student completing their clinical affiliation under the direct supervision of (i.e., in the presence of) an occupational therapist. All documentation must be reviewed and co-signed by the supervising occupational therapist.

OT is considered an all-inclusive charge. Medicaid does not reimburse for a clinic room charge in addition to therapy services unless the room charges are unrelated. MDHHS expects occupational therapists and occupational therapy assistants to utilize the most ethically appropriate therapy within their scope of practice as defined by state law or the appropriate national professional association. OT must be medically necessary, reasonable and required to achieve one or more of the following:

- Return the beneficiary to the functional level prior to illness or disability;
- Return the beneficiary to a functional level that is appropriate to a stable medical status;
- Prevent a reduction in medical or functional status had the therapy not been provided.

Therapies provided to nursing facility beneficiaries outside the nursing facility premises must be provided in the outpatient department of a general hospital or medical care facility.

Therapies provided to county medical care facility, hospital long term care unit, or hospital swing bed beneficiaries outside their respective facilities must be provided in the outpatient department of a general hospital.

Medicaid standard coverage allows the following:

Outpatient/Private Practice Occupational Therapy	Nursing Facility Occupational Therapy	Home Health Occupational Therapy
• Up to 144 units of OT per calendar year period. • Prior authorization is required for treatment that exceeds this unit limitation.	• Prior authorization is required.	• Up to 24 visits of OT in a 60-consecutive day period. • Prior authorization (PA) is required for treatment that exceeds this visit limitation or for continued treatment beyond the initial 60 days.

OT is expected to result in measurable improvement that is significant to the beneficiary's ability to perform daily living tasks appropriate to his/her chronological, developmental, or functional status. Functional improvements must be achieved in a reasonable, and generally predictable, amount of time as specified in the short- and long-term goals identified on the evaluation/re-evaluation and treatment plan. Functional improvements must be maintainable. Medicaid does not cover therapy if the beneficiary's maximum functional potential has been realized, the beneficiary has plateaued, or the therapy has no impact on the beneficiary's ability to perform age-appropriate tasks. However, medically necessary habilitative therapy services may be covered under Early and Periodic Screening, Diagnosis and Treatment (EPSDT) or Healthy Michigan Plan.

Medicaid only covers OT services that require the skills, knowledge, and education of an occupational therapist. Medicaid does not cover interventions provided by another practitioner or caregiver (e.g., registered nurse, physical therapist, family member, teacher, etc.).

Occupational therapy may be covered for one or more of the following:	▪ Therapeutic use of everyday life activities/occupations*. ▪ Adaptation of environments and processes to enhance functional performance in occupations*. ▪ Graded tasks (performance components) in activities as prerequisites to an engagement in occupations*. ▪ Oral function (including swallowing, oral and/or pharyngeal dysphagia, and increasing nutrition/hydration). ▪ Design, fabrication, application, or training in the use of assistive technology or orthotic/prosthetic devices. ▪ Skilled services that are designed to develop, train, monitor, and modify a maintenance program to be carried out by family or caregivers. ▪ Severe pathology in the perception of, or response to, sensory input to the extent that it significantly limits the ability to function. ▪ Federal EPSDT regulations require coverage of medically necessary treatment for beneficiaries under 21 years of age, including medically necessary habilitative therapy services. (Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter for additional information.) *Covered occupations include: ▪ Activities of daily living (self-care activities). ▪ Instrumental activities of daily living (multistep activities to care for self and others, such as household management and childcare).

Occupational therapy is not covered for the following:	▪ If provided solely for educational, vocational, or recreational purposes. ▪ If therapy services are required to be provided by another public agency (e.g., community mental health services provider, school-based services, etc.). ▪ If a therapy service requires prior authorization and the service is rendered before prior authorization is approved. ▪ Habilitative therapy designed to facilitate the normal progression of development without compensatory techniques or processes. (Refer to the Early and Periodic Screening, Diagnosis and Treatment and the Healthy Michigan Plan chapters for coverage exceptions.) ▪ If therapy is rote practice of achieved skills. ▪ Development of perceptual motor skills and sensory integrative functions to follow a normal sequence. (Refer to the Early and Periodic Screening, Diagnosis and Treatment and the Healthy Michigan Plan chapters for coverage exceptions.) ▪ If therapy is designed to facilitate the normal progression of development without compensatory techniques or processes. (Refer to the Early and Periodic Screening, Diagnosis and Treatment and the Healthy Michigan Plan chapters for coverage exceptions.) ▪ Non-diagnostic, non-therapeutic, routine, or repetitive tasks without skilled feedback (e.g., sitting with a beneficiary needing prompting to swallow or take small bites which does not require the skills of a therapist, etc.) ▪ Feeding for a beneficiary whose status is nothing per oral cavity (NPO), with physician orders to continue NPO, and who does not demonstrate the potential to improve oral and/or pharyngeal phases of swallowing (i.e., pleasure eating). ▪ Continuation of therapy that is maintenance in nature, except as described under Maintenance Visits in the Prescription Requirements subsection (below). ▪ If Medicare determines the service is not medically necessary. ▪ Additionally for nursing facility beneficiaries: ➢ Therapy provided by a physician (MD or DO). ➢ Services covered by the facility's per diem rate, including diversional OT, reality orientation, restorative nursing functions, routine maintenance, or the development of the therapy and treatment plan.

4.1.A. Duplication of Services

Medicaid does not cover two disciplines working concurrently on similar goals/areas (e.g., dysphagia, assistive technology, sitting and standing balance/tolerance, etc.). Collaboration between treating therapists is required to coordinate therapy and prevent duplication of services. Documentation of the collaboration must be retained in the beneficiary's medical record for audit purposes.

4.1.B. Access to Services for School-Aged Beneficiaries

School based therapy services are covered by Medicaid when they assist a child/youth with a disability to benefit from special education. This includes beneficiaries up to the age of 21 who are eligible under the provisions of the Individuals with Disabilities Education Act (IDEA) of 1990 as amended, and those enrolled in programs that require an Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP). Therapy provided solely for educational purposes (e.g., pre-academic goals such as improved attention span, catching/throwing/kicking balls, etc.) is not covered by Medicaid.

Beneficiaries receiving school-based therapy may also receive medically-based therapy services in an outpatient setting, nursing facility, or through a home health agency. If therapy is provided in more than one setting, the goals and purpose for each must be distinct.

Outpatient therapy services are provided to optimize the child's/youth's maximum functional performance in relation to needs in the home or community setting and must not directly duplicate those provided in the school setting. Collaboration between the school and community providers is required to coordinate therapy and prevent direct duplication of services. Documentation of the collaboration must be retained in the beneficiary's medical record for audit purposes.

Beneficiaries receiving school-based therapy services with medically-related goals may be eligible for the continuation of services in an outpatient setting during the summer months to maintain function. Prior authorization is required if standard coverage limitations have been exceeded. (Refer to the Requirements of Continued Therapy under the Prescription Requirements subsection below for additional information.)

4.1.C. Aquatic Therapy

Medicaid does not cover aquatic therapy as a separately reimbursable treatment or modality. A covered therapeutic procedure performed in a pool may be reimbursed when billed using the HCPCS code describing the covered procedure if the service meets all Medicaid coverage requirements.

4.1.D. Group Therapy

OT is not covered by Medicaid when provided concurrently to a group of two or more individuals by the same therapist. Covered therapeutic procedures require direct (one-to-one) contact between the beneficiary and the therapist.

4.1.E. Serial Casting

Serial casting is a process in which a joint(s) that lacks full range of motion is immobilized with a rigid or semi-rigid cast. During this procedure, the affected joint(s) is gradually and progressively set in a more anatomically correct alignment to improve joint alignment, increase muscle length, or to achieve a decrease in abnormal tone, resulting in an increase in the range of motion.

Casts are applied and removed in succession, usually every week, until full range of motion, flexibility, or plateau is reached. Upon removal of each cast, the limb is stretched, and a new cast is applied to hold the limb in place.

Serial casting is a covered benefit when performed by, or under the direct supervision of, a qualified therapist and defined in a treatment plan as a medically necessary therapy service for improving range of motion or reducing abnormal tone. The referral for therapy services must specifically indicate that the beneficiary is being referred for serial casting, or the referring provider must provide written concurrence, via signature, of any treatment plan that includes serial casting.

4.1.F. Prescription Requirements

Outpatient and private practice therapy requires a prescription from a physician or other licensed practitioner practicing within their scope of practice as defined in State law for occupational therapy. Home health and nursing facility therapy require a prescription from a physician for occupational therapy.

A treatment plan meeting all the requirements below is considered a prescription. The prescription/treatment plan must contain all the following:

- Beneficiary's name;
- Beneficiary's date of birth;
- Prescribing practitioner's name, address, and telephone number;
- Prescribing practitioner's signature;
- The date the prescription was written;
- The frequency and duration of the therapy services;
- Diagnosis; and
- For swallowing or oral motor evaluation/treatment, the documentation must clearly specify allowance of trial feeds and/or oral intake during therapy). All documentation, including the prescription, current plan of care, and prior authorization, must consistently substantiate this allowance.

A copy of the prescription must be retained in the beneficiary's medical record. A prescription is valid for 90 days from the date that the prescription was written unless the termination date is otherwise stated by the authorized prescribing practitioner on the prescription.

If the beneficiary has another insurance plan (e.g. Medicare or commercial insurance) and the service is a covered benefit, the provider must follow the requirements of the other insurance plan(s), including but not limited to, prescription, prior authorization, and provider qualifications. (Refer to the Coordination of Benefits chapter for more information.)

Evaluations/ Re-evaluations	An evaluation is formalized testing at the initiation of the beneficiary's treatment plan. Evaluations may be provided up to two times in a 365-day period. Evaluations of swallowing function may be provided up to four times in a 365-day period. Objective and periodic re-evaluations and reports are utilized to determine the measurable functional change resulting from the treatment plan. Re-evaluations may be provided up to two times in a 365-day period. Prior authorization is required if an evaluation or re-evaluation is needed more frequently. An evaluation/re-evaluation is required for the initiation of therapy and continued therapy. OT evaluations/re-evaluations must be completed and signed by the occupational therapist and include all the following: ▪ Standardized tests and/or objective functional baseline measures to establish short- and long-term goals and to document progress; ▪ Corresponding baseline measures for all short- and long-term goals; ▪ Treatment diagnosis(es); ▪ Medical diagnosis(es), if different from treatment diagnosis; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ Assessment of the beneficiary's performance components (e.g., strength, dexterity, range of motion, sensation, perception, muscle tone, etc.) directly affecting the beneficiary's ability to function or make progress toward goals; and ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual comprehension). Oral function/swallowing evaluations must also include: ▪ Presence/absence of coughing; ▪ History of recent respiratory illness; ▪ Current diet, documenting difficulties with food consistencies; ▪ Aversion/sensitivity during eating; ▪ Objective oral motor assessment addressing labial, glossal, laryngeal, and pharyngeal stages; ▪ Report or copy of a video fluoroscopy and any other formal testing, if available; and ▪ Voice quality (i.e., pre- and post-feeding and natural voice), if applicable.

Treatment Plan/Plan of Care	The OT treatment plan that results from the evaluation must be medically necessary, signed by the occupational therapist, and include all the following: ▪ Time-related short-term goals that are measurable, functional, and significant to the beneficiary's function or mobility; ▪ Long-term goals that are measurable, functional, and identify specific maximum functional achievement for the requested authorization period; ▪ Functional outcome measures specific to maximum functional achievement for the current course of therapy (up to 12 consecutive months); ▪ Anticipated type, frequency and duration of therapy required to meet short- and long-term goals; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ Plan for discharge from service; and ▪ Signature of the prescribing practitioner confirming agreement with the treatment plan. A treatment plan, including all the criteria established above, must be submitted with the prior authorization request.
Initiation of Services	OT may be initiated upon completion of the evaluation (current within 12 months) and development of a treatment plan that is medically necessary as documented in the beneficiary's medical record. The initiation of therapy services may begin if all the following have been met: ▪ The beneficiary is Medicaid-eligible; ▪ A copy of the signed and dated (no more than 90 days prior to the initiation of services) prescription for occupational therapy is retained in the beneficiary's medical record; ▪ The standard coverage limitations have not been exceeded; ▪ Therapy is provided by the evaluating discipline (e.g., a speech-language pathologist may not provide treatment under an occupational therapist's evaluation); and ▪ There is a change in medical status resulting in decreased activities of daily living skills, oral motor skills, or functional ability.

Requirements of Continued Therapy	The occupational therapist must request prior authorization to continue therapy beyond standard coverage limitations, even if the beneficiary changes providers. A copy of the latest evaluation/re-evaluation (completed no more than 12 months prior to the prior authorization request) must be submitted with the prior authorization request. Requests for continued therapy must be supported by all the following: ▪ Summary of previous treatment period (not to exceed the 90 days prior to that period for which prior authorization is being requested), including measurable progress on each short- and long-term goal, rate of progress, a statement of the beneficiary's response to treatment, and any factors that have affected progress during the therapy period. Do not send daily treatment notes. ▪ Revised goals and justification for any change in the treatment plan for the requested period of therapy. ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable. ▪ Statement detailing any family/caregiver services being provided in a maintenance program, if appropriate. ▪ A copy of the prescription indicating the date range of the requested treatment period must be provided with each prior authorization request. The prescription must meet all the requirements established under this subsection. A treatment plan meeting all the prescription requirements is considered a prescription. ▪ The anticipated plan of discharge for the current course of therapy (up to 12 consecutive months). If more than 12 months of therapy is anticipated, a new course of therapy with a new evaluation/re-evaluation and treatment plan is required.

Maintenance Visits	The skills of an occupational therapist may be required for training, review of previously achieved skills, monitoring of a maintenance program being carried out by family or caregivers, or continued follow-up for the fit and function of orthotic, prosthetic, or assistive technology devices. Maintenance visits in an outpatient or nursing facility setting may be provided up to four times per 90-consecutive day period. If more than four maintenance visits are required in a 90-consecutive day period, the therapist must request prior authorization. Maintenance visits in a home setting may be provided up to four times per 60-consecutive day period. If more than four maintenance visits are required in a 60-consecutive day period, the therapist must request prior authorization. The occupational therapist must complete the MSA-115 or FFS DDE plus MSA-115 prior authorization request, and include all the following: ▪ Summary of previous treatment period, including measurable progress on each short- and long-term goal. This must include the treating occupational therapist's analysis of the therapy, rate of progress, and justification for any change in the treatment plan. Documentation must relate to the 90-day period immediately prior to that period for which prior authorization is being requested. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during the therapy period. ▪ A copy or description of the maintenance program. ▪ A statement detailing the reason(s) additional maintenance visits are medically necessary. ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable. ▪ The anticipated frequency and duration of maintenance visits. ▪ The anticipated plan of discharge for the current course of therapy (up to 12 months). ▪ A treatment plan signed by the prescribing practitioner that includes all the criteria established under Treatment Plan/Plan of Care above.

4.1.G. DISCHARGE SUMMARY

MDHHS requires the occupational therapist to document a discharge summary to identify the completion of OT services and the discharge status. The discharge summary must be retained in the beneficiary's medical record and include all the following:

- Dates of service (i.e., initial and discharge dates);
- Description of therapy services provided;
- Functional status at discharge related to treatment areas/goals/maximum functional achievement over the course of therapy;
- Analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status;
- A copy or description of the maintenance program, if appropriate;
- Identification of assistive technology devices (e.g., walker) and its current utilization, if appropriate; and

- Recommendations/referral to other services, if appropriate.

4.1.H. Supplies and Equipment

MDHHS does not allow separate reimbursement for supplies and equipment used as part of a therapy treatment or for trials/training in the use of complex durable medical equipment when required to establish competency for a prior authorization request. The cost of supplies and equipment used are included in the reimbursement for the therapy.

4.2 Physical Therapy

MDHHS uses the terms Physical Therapy, PT, and therapy interchangeably. PT is covered when furnished by a Medicaid-enrolled therapy provider and the documentation is signed by the treating therapist. Medicaid reimburses for physical therapy services when provided by any of the following:

- A licensed physical therapist.
- A licensed physical therapy assistant under the supervision of a physical therapist (i.e., the physical therapy assistant services must follow the evaluation and treatment plan developed by the physical therapist, and the physical therapist must supervise and monitor the physical therapy assistant's performance with continuous assessment of the beneficiary's progress). All documentation must be reviewed and co-signed by the supervising physical therapist.
- A student completing their clinical affiliation under the direct supervision of (i.e., in the presence of) a physical therapist. All documentation must be reviewed and co-signed by the supervising physical therapist.

PT is considered an all-inclusive charge. Medicaid does not reimburse for a clinic room charge in addition to therapy services unless the room charges are unrelated. MDHHS expects physical therapists and physical therapy assistants to utilize the most ethically appropriate therapy within their scope of practice as defined by state law or the appropriate national professional association. PT must be medically necessary, reasonable and required to achieve one or more of the following:

- Return the beneficiary to the functional level prior to illness or disability;
- Return the beneficiary to a functional level that is appropriate to a stable medical status;
- Prevent a reduction in medical or functional status had the therapy not been provided.

Therapies provided to nursing facility beneficiaries outside the nursing facility premises must be provided in the outpatient department of a general hospital or medical care facility.

Therapies provided to county medical care facility, hospital long term care unit or hospital swing bed beneficiaries outside their respective facilities must be provided in the outpatient department of a general hospital.

Medicaid standard coverage allows the following:

Outpatient/Private Practice Physical Therapy	Nursing Facility Physical Therapy	Home Health Physical Therapy
• Up to 144 units of PT per calendar year period. • Prior authorization is required for treatment that exceeds this unit limitation.	• Prior authorization is required.	• Up to 24 visits of PT in a 60-consecutive day period. • Prior authorization (PA) is required for treatment that exceeds this visit limitation or for continued treatment beyond the initial 60 days.

PT is expected to result in measurable improvement that is significant to the beneficiary's ability to perform mobility skills appropriate to his/her chronological, developmental, or functional status. Functional improvements must be achieved in a reasonable, and generally predictable, amount of time as specified in the short- and long-term goals identified on the evaluation/re-evaluation and treatment plan. Functional improvements must be maintainable. Medicaid does not cover therapy if the beneficiary's maximum functional potential has been realized, the beneficiary has plateaued, or the therapy has no impact on the beneficiary's ability to perform age-appropriate tasks. However, medically necessary habilitative therapy services may be covered under EPSDT or Healthy Michigan Plan.

Medicaid only covers PT services that require the skills, knowledge, and education of a physical therapist. Medicaid does not cover interventions provided by another practitioner or caregiver (e.g., registered nurse, licensed occupational therapist, family member, teacher, etc.).

Physical therapy may be covered for one or more of the following:	▪ If expected to result in the restoration or amelioration of the anatomical or physical basis for the restriction in performing age-appropriate functional mobility skills. ▪ PT service that is diagnostic. ▪ For a temporary condition that creates decreased mobility and/or function. ▪ Training in functional mobility skills (e.g., ambulation, transfers, floor mobility, transitions, wheelchair mobility, etc.). ▪ Stretching for improved flexibility. ▪ Modalities to allow gains of function, strength, or mobility. ▪ Training in the use of orthotic/prosthetic devices and assistive technology devices. ▪ Severe pathology in the perception of, or response to, sensory input to the extent that it significantly limits the ability to function. ▪ Skilled services that are designed to develop, train, monitor, and modify a maintenance program to be carried out by family or caregivers. ▪ Federal EPSDT regulations require coverage of medically necessary treatment for beneficiaries under 21 years of age, including medically necessary habilitative therapy services. (Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter for additional information.)

Physical therapy is not covered for the following:	▪ If provided solely for educational, vocational, or recreational purposes. ▪ If therapy services are required to be provided by another public agency (e.g., community mental health services provider, school-based services, etc.). ▪ If a therapy service requires prior authorization and the service is rendered before prior authorization is approved. ▪ Habilitative therapy designed to facilitate the normal progression of development without compensatory techniques or processes. (Refer to the Early and Periodic Screening, Diagnosis and Treatment and the Healthy Michigan Plan chapters for coverage exceptions.) ▪ If therapy is rote practice of achieved skills. ▪ Development of perceptual motor skills and sensory integrative functions to follow a normal sequence. (Refer to the Early and Periodic Screening, Diagnosis and Treatment and the Healthy Michigan Plan chapters for coverage exceptions.) ▪ Continuation of therapy that is maintenance in nature, except as described under Maintenance Visits in the Prescription Requirements subsection below. ▪ If Medicare determines the service is not medically necessary. ▪ Additionally for nursing facility beneficiaries: ➢ Therapy provided by a physician (MD or DO); ➢ Services covered by the facility's per diem rate, including routine maintenance and the development of the therapy and treatment.

4.2.A. Duplication of Services

Medicaid does not cover two disciplines working concurrently on similar goals/areas (e.g., assistive technology, hand therapy, sitting and standing balance/tolerance, transfers, etc.). Collaboration between treating therapists is required to coordinate therapy and prevent duplication of services. Documentation of the collaboration must be retained in the beneficiary's medical record for audit purposes.

4.2.B. Access to Services for School-Aged Beneficiaries

School-based therapy services are covered by Medicaid when they assist a child/youth with a disability to benefit from special education. This includes beneficiaries up to the age of 21 who are eligible under the provisions of the Individuals with Disabilities Education Act (IDEA) of 1990 as amended, and those enrolled in programs that require an Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP). Therapy provided solely for educational purposes (e.g., pre-academic goals such as improved attention span, catching/throwing/kicking balls, etc.) is not covered by Medicaid.

Beneficiaries receiving school-based therapy may also receive medically-based therapy services in an outpatient setting, nursing facility, or through a home health agency. If therapy is provided in more than one setting, the goals and purpose for each must be distinct.

Outpatient therapy services are provided to optimize the child's/youth's maximum functional performance in relation to needs in the home or community setting and must not directly duplicate those provided in the school setting. Collaboration between the school and community providers is required to coordinate therapy and prevent direct duplication of services. Documentation of the collaboration must be retained in the beneficiary's medical record for audit purposes.

Beneficiaries receiving school-based therapy services with medically-related goals may be eligible for the continuation of services in an outpatient setting during the summer months to maintain function. Prior authorization is required if standard coverage limitations have been exceeded. (Refer to Requirements of Continued Therapy under the Prescription Requirements subsection below for additional information.)

4.2.C. Aquatic Therapy

Medicaid does not cover aquatic therapy as a separately reimbursable treatment or modality. A covered therapeutic procedure performed in a pool may be reimbursed when billed using the HCPCS code describing the covered procedure if the service meets all Medicaid coverage requirements.

4.2.D. Group Therapy

PT is not covered by Medicaid when provided concurrently to a group of two or more individuals by the same therapist. Covered therapeutic procedures require direct (one-to-one) contact between the beneficiary and the therapist.

4.2.E. Serial Casting

Serial casting is a process in which a joint(s) which lacks full range of motion is immobilized with a rigid or semi-rigid cast. During this procedure, the affected joint(s) is gradually and progressively set in a more anatomically correct alignment to improve joint alignment, increase muscle length, or to achieve a decrease in abnormal tone, resulting in an increase in the range of motion.

Casts are applied and removed in succession, usually every week, until full range of motion, flexibility, or plateau is reached. Upon removal of each cast, the limb is stretched, and a new cast is applied to hold the limb in place.

Serial casting is a covered benefit when performed by, or under the direct supervision of, a qualified therapist and defined in a treatment plan as a medically necessary therapy service for improving range of motion or reducing abnormal tone. The referral for therapy services must specifically indicate that the beneficiary is being referred for serial casting, or the prescribing provider must provide written concurrence, via signature, of any treatment plan that includes serial casting.

4.2.F. Prescription Requirements

Outpatient and private practice therapy requires a prescription from a physician or other licensed practitioner practicing within their scope of practice as defined in State law for

physical therapy. Home health and nursing facility therapy require a prescription from a physician for physical therapy.

A treatment plan meeting all of the requirements below is considered a prescription. The prescription/treatment plan must contain all the following:

- Beneficiary's name;
- Beneficiary's date of birth;
- Prescribing practitioner's name, address, and telephone number;
- Prescribing practitioner's signature;
- The date the prescription was written;
- The frequency and duration of the therapy services; and
- Diagnosis.

A copy of the prescription must be retained in the beneficiary's medical record. A prescription is valid for 90 days from the date that the prescription was written unless the termination date is otherwise stated by the authorized prescribing practitioner on the prescription.

If the beneficiary has another insurance plan (e.g. Medicare or commercial insurance) and the service is a covered benefit, the provider must follow the requirements of the other insurance plan(s), including but not limited to, prescription, prior authorization, and provider qualifications. (Refer to the Coordination of Benefits chapter for more information.)

Evaluations/ Re-evaluations	An evaluation is formalized testing at the initiation of the beneficiary's treatment plan. Evaluations may be provided up to two times in a 365-day period. Objective and periodic re-evaluations and reports are utilized to determine the measurable functional change resulting from the treatment plan. Re-evaluations may be provided up to two times in a 365-day period. Prior authorization is required if an evaluation or re-evaluation is needed more frequently. An evaluation/re-evaluation is required for the initiation of therapy and continued therapy. PT evaluations/re-evaluations must be completed and signed by the physical therapist and include all the following: ▪ Standardized tests and/or objective functional baseline measures to establish short- and long-term goals and to document progress; ▪ Corresponding baseline measures for all short-and long-term goals; ▪ Treatment diagnosis(es); ▪ Medical diagnosis(es), if different from treatment diagnosis; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ Medical history as it relates to the current course of therapy; ▪ The beneficiary's current functional status (functional baseline); ▪ Assessment of the beneficiary's performance components (e.g., strength, dexterity, range of motion, sensation, perception, muscle tone, etc.) directly affecting the beneficiary's ability to function or make progress toward goals; and ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual comprehension).
Treatment Plan/Plan of Care	The PT treatment plan that results from the evaluation must be medically necessary, signed by the physical therapist, and include all the following: ▪ Time-related short-term goals that are measurable, functional, and significant to the beneficiary's function or mobility; ▪ Long-term goals that are measurable, functional, and identify specific maximum functional achievement for the requested authorization period; ▪ Functional outcome measures specific to maximum functional achievement for the current course of therapy (up to 12 consecutive months); ▪ Anticipated type, frequency, and duration of therapy required to meet short- and long-term goals; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ Plan for discharge from service; and ▪ Signature of the prescribing practitioner confirming agreement with the treatment plan. A treatment plan, including all the criteria established above, must be submitted with the prior authorization request.

Initiation of Services	PT may be initiated upon completion of the evaluation (current within 12 months) and development of a treatment plan that is medically necessary as documented in the beneficiary's medical record. The initiation of therapy services may begin if all the following have been met: ▪ The beneficiary is Medicaid-eligible; ▪ A copy of the signed and dated (no more than 90 days prior to the initiation of services) prescription for physical therapy is retained in the beneficiary's medical record; ▪ The standard coverage limitations have not been exceeded; ▪ Therapy is provided by the evaluating discipline (e.g., occupational therapist cannot provide treatment under a physical therapist's evaluation); and ▪ There is a change in medical status resulting in decreased mobility skills or functional ability.
Requirements of Continued Therapy	The physical therapist must request prior authorization to continue therapy beyond standard coverage limitations, even if the beneficiary changes providers. A copy of the latest evaluation/re-evaluation (completed no more than 12 months prior to the authorization request) must be submitted with the prior authorization request. Requests for continued therapy must be supported by all the following: ▪ Summary of previous treatment period (not to exceed the 90 days prior to that period for which prior authorization is being requested), including measurable progress on each short- and long-term goal, rate of progress, a statement of the beneficiary's response to treatment, and any factors that have affected progress during the therapy period. Do not send daily treatment notes; ▪ Revised goals and justification for any change in the treatment plan for the requested period of therapy; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ Statement detailing any family/caregiver services being provided in a maintenance program, if appropriate; ▪ A copy of the prescription indicating the date range of the requested treatment period must be provided with each prior authorization request. The prescription must meet all the requirements established in this subsection. A treatment plan meeting all the prescription requirements is considered a prescription; and ▪ The anticipated plan of discharge for the current course of therapy (up to 12 months). If more than 12 months of therapy is anticipated, a new course of therapy with a new evaluation/re-evaluation and treatment plan is required.

Maintenance Visits	The skills of a physical therapist may be required for training, review of previously achieved skills, monitoring of a maintenance program being carried out by family or caregivers, or continued follow-up for the fit and function of orthotic, prosthetic, or assistive technology devices. Maintenance visits in an outpatient or nursing facility setting may be provided up to four times per 90-consecutive day period. If more than four maintenance visits are required in a 90-consecutive day period, the therapist must request prior authorization. Maintenance visits in a home setting may be provided up to four times per 60-consecutive day period. If more than four maintenance visits are required in a 60-consecutive day period, the therapist must request prior authorization. The physical therapist must complete the MSA-115 or FFS DDE plus MSA-115 prior authorization request, and include all the following: ▪ Summary of previous treatment period, including measurable progress on each short- and long-term goal. This must include the treating physical therapist's analysis of the therapy, rate of progress, and justification for any change in the treatment plan. Documentation must relate to the 90-day period immediately prior to that period for which prior authorization is being requested; ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during the therapy period; ▪ A copy or description of the maintenance program; ▪ A statement detailing the reason(s) additional maintenance visits are medically necessary; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ The anticipated frequency and duration of the maintenance visits; ▪ The anticipated plan of discharge for the current course of therapy (up to 12 consecutive months); ▪ A treatment plan signed by the prescribing practitioner that includes all the criteria established under Treatment Plan/Plan of Care (above).

4.2.G. DISCHARGE SUMMARY

MDHHS requires the physical therapist to document a discharge summary to identify the completion of PT services and the discharge status. The discharge summary must be retained in the beneficiary's medical record and include all the following:

- Dates of service (i.e., initial and discharge dates);
- Description of therapy services provided;
- Functional status at discharge related to treatment areas/goals/maximum functional potential over the course of therapy;
- Analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status;
- A copy or description of the maintenance program, if appropriate;
- Identification of assistive technology devices (e.g., walker) and its current utilization, if appropriate; and

- Recommendations/referral to other services, if appropriate.

4.2.H. Supplies and Equipment

MDHHS does not allow separate reimbursement for supplies and equipment used as part of a therapy treatment or for trials/training in the use of complex durable medical equipment when required to establish competency for a prior authorization request. The cost of supplies and equipment used are included in the reimbursement for the therapy.

4.3 Speech-Language Therapy

MDHHS uses the terms speech therapy, SLP, speech-language pathology, speech-language therapy (ST), and therapy to mean speech and language services and speech-language therapy. Speech-language therapy is covered when furnished by a Medicaid-enrolled therapy provider and the documentation is signed by the treating therapist. Medicaid reimburses services for speech-language therapy when provided by any of the following:

- A speech-language pathologist with a current license and who is authorized by ASHA to use Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP) credentials.
- An appropriately supervised speech-language pathologist candidate (i.e., in their clinical fellowship year) or having completed all requirements but has not obtained a license. All documentation must be reviewed and co-signed by the appropriately credentialed supervising speech-language pathologist.
- A student completing their clinical affiliation under the direct supervision of (i.e., in the presence of) a licensed speech-language pathologist. All documentation must be reviewed and co-signed by the appropriately credentialed supervising speech-language pathologist.

ST is considered an all-inclusive charge. Medicaid does not reimburse for a clinic room charge in addition to therapy services unless the room charges are unrelated. MDHHS expects speech-language pathologists to utilize the most ethically appropriate therapy within their scope of practice as defined by state law or the appropriate national professional association. ST must be medically necessary, related to a medical diagnosis, reasonable, and required to achieve one or more of the following:

- Return the beneficiary to the functional level prior to illness or disability;
- Return the beneficiary to a functional level that is appropriate to a stable medical status; and
- Prevent a reduction in medical or functional status had the therapy not been provided.

Speech-Language therapy is limited to services for:

- Articulation
- Language
- Fluency
- Oral function (including swallowing, oral and/or pharyngeal dysphagia, and increasing nutrition/hydration)

- Training in the use of a speech-generating device (SGD)/Augmentative and Alternative Communication (AAC) device/Augmentative Communication Device (ACD)
- Evaluation and instruction in the use of an oral-pharyngeal prosthesis
- Voice
- Rehabilitation of executive skills function status post neurological insult (examples may include reasoning, decision making, judgement, and language)
- Audiologic/Aural Rehabilitation

Speech-Language Therapies (ST) provided to nursing facility beneficiaries outside the nursing facility premises must be provided in the outpatient department of a general hospital or medical care facility.

Therapies provided to county medical care facility, hospital long term care unit, or hospital swing bed beneficiaries outside their respective facilities must be provided in the outpatient department of a general hospital.

Medicaid standard coverage allows the following:

Outpatient/Private Practice Speech-Language Therapy	Nursing Facility Speech-Language Therapy	Home Health Speech-Language Therapy
• Up to 36 visits of ST per calendar year period. • Prior authorization is required for treatment that exceeds this unit limitation.	• Prior authorization is required.	• Home Health ST is covered for CSHCS beneficiaries only. • Prior authorization is required.

ST is expected to result in a measurable improvement that is significant to the beneficiary's ability to demonstrate communication and/or oral motor function appropriate to his/her chronological, developmental, cognitive, or functional status. Functional improvements must be achieved in a reasonable, and generally predictable, amount of time as specified in the short- and long-term goals identified on the evaluation/re-evaluation and treatment plan. Functional improvements must be maintainable. Medicaid does not cover therapy if the beneficiary's maximum functional potential has been realized, the beneficiary has plateaued, or the therapy has no impact on the beneficiary's ability to perform age-appropriate tasks. However, medically necessary habilitative therapy services may be covered under EPSDT or Healthy Michigan Plan.

Medicaid only covers ST services that require the skills, knowledge, and education of a speech-language pathologist. MDHHS does not cover interventions provided by another practitioner or caregiver (e.g., registered nurse, licensed physical therapist, family member, teacher, etc.).

Speech-Language therapy that is related to a medical diagnosis may be covered for one or more of the following:	▪ It is expected to result in the restoration or amelioration of the beneficiary's ability to communicate wants, needs, and desires to their previous level of function following illness or injury. ▪ A temporary condition that results in decreased comprehension and expression, fluency, and/or oral function. ▪ Training to improve articulation. ▪ Training to improve receptive and expressive language. ▪ Training to improve fluency. ▪ Training to improve oral and/or pharyngeal phases of swallowing. ▪ Training in the use of a SGD/AAC/ACD device. ▪ Training in the use of an oral-pharyngeal prosthesis. ▪ Training in voice disorders. ▪ Training in the use of compensatory communication strategies. ▪ Training in restoration of executive skill functions. ▪ Skilled services that are designed to develop, train, monitor, and modify a maintenance program to be carried out by family or caregivers. ▪ Federal EPSDT regulations require coverage of medically necessary treatment for beneficiaries under 21 years of age, including medically necessary habilitative therapy services. (Refer to the Early and Periodic Screening, Diagnosis and Treatment chapter for additional information.)

Speech-Language therapy is not covered for the following:	▪ If provided solely for educational, vocational, social/emotional, or recreational purposes. ▪ If therapy services are required to be provided by another public agency (e.g., community mental health services provider, school-based services, etc.). ▪ If a therapy service requires prior authorization and the service is rendered before prior authorization is approved. ▪ Habilitative therapy designed to facilitate the normal progression of development without compensatory techniques or processes. (Refer to the Early and Periodic Screening, Diagnosis and Treatment and the Healthy Michigan Plan chapters for coverage exceptions.). ▪ If therapy is rote practice of achieved skills. ▪ Feeding for a beneficiary whose status is NPO, with physician orders to continue NPO, and who does not demonstrate the potential to improve oral and/or pharyngeal phases of swallowing (i.e., pleasure eating). ▪ Non-diagnostic, non-therapeutic, routine, or repetitive tasks without skilled feedback (e.g., sitting with a beneficiary needing prompting to swallow or take small bites which does not require the skills of a therapist, etc.). ▪ Continuation of therapy that is maintenance in nature, except as described under Maintenance Visits in the Prescription Requirements subsection (below). ▪ If Medicare determines the service is not medically necessary. ▪ Additionally for nursing facility beneficiaries: ➢ Therapy provided by a physician (MD or DO) is not a covered benefit for beneficiaries in a nursing facility. ➢ Services covered by the facility's per diem rate including routine maintenance and the development of the therapy and treatment.

4.3.A. Duplication of Services

Medicaid does not cover two disciplines working concurrently on similar goals/areas (e.g., dysphagia, assistive technology, etc.). Collaboration between treating therapists is required to coordinate therapy and prevent duplication of services. Documentation of the collaboration must be retained in the beneficiary's medical record for audit purposes.

4.3.B. Access to Services for School-Aged Beneficiaries

School-based therapy services are covered by Medicaid when they assist a child/youth with a disability to benefit from special education. This includes beneficiaries up to the age of 21 who are eligible under the provisions of the Individuals with Disabilities Education Act (IDEA) of 1990 as amended, and those enrolled in programs that require an Individualized Education Program (IEP) or an Individualized Family Service Plan (IFSP). Therapy provided solely for educational purposes (e.g., pre-academic goals such as improved attention span, catching/throwing/kicking balls, etc.) is not covered by Medicaid.

Beneficiaries receiving school-based therapy may also receive medically-based therapy services in an outpatient setting, nursing facility, or through a home health agency. If therapy is provided in more than one setting, the goals and purpose for each must be distinct.

Outpatient therapy services are provided to optimize the child's/youth's functional performance in relation to needs in the home or community setting and must not directly duplicate those provided in the school setting. Collaboration between the school and community providers is required to coordinate therapy and prevent direct duplication of services. Documentation of the collaboration must be retained in the beneficiary's medical record for audit purposes.

Beneficiaries receiving school-based therapy services with medically-related goals may be eligible for the continuation of services in an outpatient setting during the summer months to maintain function. Prior authorization is required if standard coverage limitations have been exceeded. (Refer to Requirements of Continued Therapy under the Prescription Requirements subsection below for additional information.)

4.3.C. Group Therapy

Group therapy requires documentation justifying the benefit of group therapy in addition to, or in place of, individual therapy. No more than one session of individual speech-language therapy and one session of group speech-language therapy may be provided on the same date of service. Group therapy is not covered in the home setting.

4.3.D. Prescription Requirements

Outpatient and private practice therapy requires a prescription from a physician or other licensed practitioner practicing within their scope of practice as defined in State law for speech-language therapy. Home health and nursing facility therapy require a prescription from a physician for speech-language therapy.

A treatment plan meeting all the requirements below is considered a prescription. The prescription/treatment plan must contain all the following:

- Beneficiary's name;
- Beneficiary's date of birth;
- Prescribing practitioner's name, address, and telephone number;
- Prescribing practitioner's signature;
- The date the prescription was written;
- The frequency and duration of the therapy services;
- Diagnosis; and
- For swallowing or oral motor evaluation/treatment, the documentation must clearly specify allowance of trial feeds and/or oral intake during therapy. All documentation, including the prescription, current plan of care, and prior authorization, must consistently substantiate this allowance.

A copy of the prescription must be retained in the beneficiary's medical record. A prescription is valid for 90 days from the date that the prescription was written unless the termination date is otherwise stated by the authorized prescribing practitioner on the prescription.

If the beneficiary has another insurance plan (e.g. Medicare or commercial insurance) and the service is a covered benefit, the provider must follow the requirements of the other insurance plan(s), including but not limited to, prescription, prior authorization, and provider qualifications. (Refer to the Coordination of Benefits chapter for more information.)

Evaluations/ Re-evaluations	An evaluation is formalized testing at the initiation of the beneficiary's treatment plan. Evaluations may be provided up to two times in a 365-day period. Oral function or swallowing evaluations may be provided up to four times in a 365-day period. Objective and periodic re-evaluations and reports are utilized to determine the measurable functional change resulting from the treatment plan. Re-evaluations may be provided up to two times in a 365-day period. Prior authorization is required if an evaluation or re-evaluation is needed more frequently. An evaluation/re-evaluation is required for the initiation of therapy and continued therapy. Speech-Language therapy evaluations/re-evaluations must be completed and signed by the speech-language pathologist and include all the following: ▪ Standardized tests and/or objective functional baseline measures used to establish short- and long-term goals and to document progress; ▪ Corresponding baseline measures for all short-and long-term goals; ▪ Treatment diagnosis(es); ▪ Medical diagnosis(es), if different from treatment diagnosis; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ Medical history as it relates to the current course of therapy; ▪ Assessment of the beneficiary's performance components (e.g., functional communication, receptive, expressive, articulation, fluency, voice, oral function, muscle tone, etc.) directly affecting the beneficiary's ability to function or make progress toward goals; ▪ Assessment of the beneficiary's cognitive skill level (e.g., ability to follow directions, including auditory and visual comprehension). Oral function/swallowing evaluations must also include: ▪ Presence/absence of coughing; ▪ History of recent respiratory illness; ▪ Current diet, documenting difficulties with food consistencies; ▪ Aversion/sensitivity during eating; ▪ Report or copy of a video fluoroscopy and any other formal testing, if available; ▪ Objective oral motor assessment addressing labial, glossal, laryngeal, and pharyngeal stages; ▪ Voice quality (i.e., pre- and post-feeding and natural voice), if applicable.

Treatment Plan/Plan of Care	The ST treatment plan that results from the evaluation must be medically necessary, signed by the speech-language pathologist, and include all the following: ▪ Time-related short-term goals that are measurable, functional, and significant to the beneficiary's communication needs; ▪ Long-term goals that are measurable, functional, and identify specific maximum functional achievement for the requested authorization period; ▪ Functional outcome measures specific to maximum functional achievement for the current course of therapy (up to 12 consecutive months); ▪ Anticipated type, frequency and duration of therapy required to meet short- and long-term goals; ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable; ▪ Plan for discharge from service; and ▪ Signature of the prescribing practitioner confirming agreement with the treatment plan. A treatment plan, including all the criteria established above, must be submitted with the prior authorization request.
Initiation of Services	Speech-Language therapy may be initiated upon completion of the evaluation (current within 12 months) and development of a treatment plan that is medically necessary as documented in the beneficiary's medical record. The initiation of therapy services may begin if all the following have been met: ▪ The beneficiary is Medicaid eligible; ▪ A copy of the signed and dated (no more than 90 days prior to the initiation of services) prescription for speech-language therapy is retained in the beneficiary's medical record; ▪ The standard coverage limitations have not been exceeded; ▪ Therapy is provided by the evaluating discipline (e.g., an occupational therapist cannot provide treatment under a speech-language pathologist's evaluation); and ▪ If there is a change in medical status resulting in decreased communication skills, oral motor skills, or functional ability.

Requirements of Continued Therapy	The speech-language pathologist must request prior authorization to continue therapy beyond standard coverage limitations, even if the beneficiary changes providers. A copy of the latest evaluation/re-evaluation (completed no more than 12 months prior to the prior authorization request) must be submitted with the prior authorization request. Requests for continued therapy must be supported by all the following: ▪ Summary of previous treatment period (not to exceed the 90 days prior to that period for which prior authorization is being requested), including measurable progress on each short- and long-term goal, rate of progress, a statement of the beneficiary's response to treatment, and any factors that have affected progress during the therapy period. Do not send daily treatment notes. ▪ Revised goals and justification for any change in the treatment plan for the requested period of therapy. ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable. ▪ Statement detailing any family/caregiver services being provided in a maintenance program, if appropriate. ▪ A copy of the prescription indicating the date range of the requested treatment period must be submitted with each prior authorization request. The prescription must meet all the requirements established under this subsection. A treatment plan meeting all the prescription requirements is considered a prescription. ▪ The anticipated plan of discharge for the current course of therapy (up to 12 months). If more than 12 months of therapy is anticipated, a new course of therapy with a new evaluation/re-evaluation and treatment plan is required.

Maintenance Visits	The skills of a speech-language pathologist may be required for training, review of previously achieved skills, monitoring of a maintenance program being carried out by family or caregivers, or continued follow-up for the fit and function of orthotic, prosthetic, or assistive technology devices. Maintenance visits in an outpatient or nursing facility setting may be provided up to four times per 90-consecutive day period. If more than four maintenance visits are required in a 90-consecutive day period, the speech-language pathologist must request prior authorization. Maintenance visits in a home setting may be provided up to four times per 60-consecutive day period. If more than four maintenance visits are required in a 60-consecutive day period, the speech-language pathologist must request prior authorization. The speech-language pathologist must complete the MSA-115 or FFS DDE plus MSA-115 prior authorization request, and include all the following: ▪ Summary of previous treatment period, including measurable progress on each short- and long-term goal. The summary must include the treating speech-language pathologist's analysis of the therapy, rate of progress, and justification for any change in the treatment plan. Documentation must relate to the 90-consecutive day period immediately prior to that period for which prior authorization is being requested. ▪ A statement of the beneficiary's response to treatment, including factors that have affected progress during the therapy period. ▪ A copy or description of the maintenance program. ▪ A statement detailing the reason(s) additional maintenance visits are medically necessary. ▪ Documentation of collaboration between all therapy providers actively treating the beneficiary, if applicable. ▪ The anticipated frequency and duration of the maintenance visits. ▪ The anticipated discharge plan for the current course of therapy (up to 12 consecutive months). ▪ A treatment plan signed by the prescribing practitioner that includes all the criteria established under Treatment Plan/Plan of Care (above).

4.3.E. Discharge Summary

MDHHS requires the speech-language pathologist to document a discharge summary to identify the completion of speech-language therapy services and the discharge status. The discharge summary must be retained in the beneficiary's medical record and include all the following:

- Dates of service (i.e., initial and discharge dates);
- Description of therapy services provided;
- Functional status at discharge related to treatment areas/goals/maximum functional achievement over course of therapy;
- Analysis of the effectiveness of the therapy program, including reasons for goals not met or changes in the treatment plan necessitated by changes in medical status;
- A copy or description of the maintenance program, if appropriate;

- Identification of assistive technology devices provided (e.g., SGD/AAC, switches) and its current utilization, if appropriate; and
- Recommendations/referrals to other services, if appropriate.

4.3.F. Supplies and Equipment

MDHHS does not allow separate reimbursement for supplies and equipment used as part of a therapy treatment or for trials/training in the use of complex durable medical equipment when required to establish competency for a prior authorization request. The cost of supplies and equipment used are included in the reimbursement for the therapy. Refer to the Speech Generating Devices subsection of the Medical Supplier Chapter for additional information regarding SGDs, including trial periods.

4.3.G. Evaluations and Follow-Up for Speech-Generating Devices/Voice Prostheses

An evaluation by the speech-language pathologist for recommendation of a SGD may be billed once in three years. Prior authorization is required for evaluations exceeding standard coverage limitations. The results of this evaluation must be shared with the provider submitting the SGD prior authorization request.

SGD set-up, programming, and modification services that require the skills of a speech-language pathologist (beyond those provided by the SGD vendor) may be billed up to two times per year.

Prior authorization is required for all SGDs. The Special Services Prior Approval-Request/Authorization form (MSA-1653-B) must be submitted for all original, replacement, upgrade, or repair of SGDs. (Refer to the Forms Appendix for additional information.)

Refer to the Speech Generating Devices subsection of the Medical Supplier Chapter for additional information regarding SGDs.

An evaluation for the use and/or fitting of a voice prosthetic device to supplement oral speech may be billed only if the evaluation was done to determine the need for an electro-larynx. The evaluation may be provided once in three years.

TRIBAL HEALTH CENTERS

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SECTION 1 – GENERAL INFORMATION

Under the Indian Self-Determination and Education Assistance Act (Public Law 93-638), tribal facilities, including Tribal Health Centers (THCs), are those owned and operated by American Indian/Alaska Native tribes and tribal organizations under contract or compact with the Indian Health Service (IHS).

The Michigan Department of Health and Human Services (MDHHS), which administers the State Medicaid Agency (SMA), has the authority to enter into reimbursement agreements with THCs to establish a payment mechanism for Medicaid beneficiaries receiving outpatient services through a THC.

Under the Michigan Medicaid State Plan, THCs have the option of choosing from one of three reimbursement mechanisms. The THC may elect to be reimbursed under only one of the options listed below, and the selected option applies to all beneficiaries receiving services at the THC. The options are:

- A THC may choose to be certified as an IHS facility and receive the IHS outpatient all-inclusive rate (AIR) for eligible encounters. The AIR applies to encounters for both native and non-native Medicaid beneficiaries. THCs are reimbursed at the AIR unless the THC chooses a different payment option and informs MDHHS of this choice in writing.
- If a THC chooses to be reimbursed as a FQHC, the entity would be required to adhere to the same requirements specified in the Federally Qualified Health Centers Chapter.
- A THC may be reimbursed as a fee-for-service provider. THCs choosing this option receive payment for covered services. No additional reimbursement or settlement is made.

Upon federal approval by the Health Resources and Services Administration, THCs may be reimbursed as a Federally Qualified Health Center (FQHC) by signing the FQHC Memorandum of Understanding (MOU). THCs choosing this option will receive the FQHC encounter rate set by the State in accordance with the Michigan Medicaid State Plan and federal regulations. The FQHC encounter rate applies to encounters for both native and non-native Medicaid beneficiaries. A THC electing to be reimbursed as an FQHC is not required to have a contract with the managed care entity.

SECTION 2 – MEDICAID ENROLLMENT

2.1 PROVIDER ENROLLMENT

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.

Individual providers (doctors, dentists, optometrists, etc.) are required to obtain a Provider (Type 1 - Individual) NPI number and report the number to MDHHS.

2.1.A. NON-PHYSICIAN BEHAVIORAL HEALTH SERVICES

Licensed psychologists (Master's Limited or Doctoral level), social workers (Master's level), professional counselors (Master's or Doctoral level), and marriage and family therapists who serve Medicaid beneficiaries are required to enroll as Medicaid providers. Services must be billed using the appropriate evaluation and management (E/M) codes listed in the American Medical Association's Current Procedural Terminology (CPT) Book or Healthcare Common Procedure Coding System (HCPCS) codes. Providers should refer to the Non-Physician Behavioral Health provider database on the MDHHS website for the current list of covered procedure codes. The list of allowable services is reviewed annually and updated as applicable. Refer to the Additional Code/Coverage Resource Materials Section of the General Information for Providers Chapter for additional information regarding coverage parameters.

2.2 NONENROLLED PROVIDERS

Professional services performed by limited licensed psychologists (except as noted in Section 333.18223 of the Public Health Code), social workers, professional counselors, marriage and family therapists or student interns must be performed under the supervision of an enrolled, fully-licensed provider of the same profession. Since MDHHS does not directly enroll these providers, claims for their services must be billed using the NPI of the supervising provider responsible for ensuring the medical necessity and appropriateness of the services. Claims submitted with the non-enrolled provider's NPI in the rendering provider field will reject.

SECTION 3 – BENEFITS

3.1 COVERED SERVICES

THC services are reimbursed at the current Medicaid fee screens and reconciled annually, if applicable, for services provided to Medicaid fee-for-service (FFS) or managed care beneficiaries. THC Medicaid services include:

- Physician (MD, DO) services
- Podiatrist (DPM) services
- Chiropractor (DC) services
- Optometrist (OD) services
- Dental (DDS) services
- Certified nurse practitioner (CNP) services
- Certified nurse midwife (CNM) services
- Physician assistant (PA) services
- Services and supplies incident to the services rendered by the provider:
  - Pharmacy services administered by the provider and billed under the provider's NPI number
  - Laboratory services billed under the provider's NPI number
  - Diagnostic services billed under the provider's NPI number
- Therapies (i.e., Occupational, Physical, and Speech, Hearing, and Language Evaluation and Therapy) rendered under the physician's NPI number

The services listed may be modified in accordance with benefits covered under the Medicaid State Plan. MDHHS notifies providers of changes (additions/deletions) in Medicaid covered services through the Medicaid bulletin process. Providers should refer to these documents to verify that benefits are covered prior to rendering services.

For clarification of covered services:

Physician Services	Physician services must comply with coverages and limitations published in the Practitioner Chapter of this manual and in MDHHS Bulletins.
Podiatrist Services	Podiatrist services must comply with coverages and limitations published in the Practitioner Chapter of this manual and in MDHHS Bulletins.
Chiropractor Services	Chiropractor services must comply with the coverages and limitations published in the Chiropractor Chapter of this manual and MDHHS Bulletins.
Certified Nurse Midwife (CNM)	CNM services must comply with coverages and limitations published in the Practitioner Chapter of this manual and in MDHHS Bulletins.

Maternal Infant Health Program (MIHP)	THCs providing Maternal Infant Health Program (MIHP) services must be certified through MDHHS. Information specific to the coverages and limitations for MIHP services are detailed in the Maternal Infant Health Program Chapter of this manual. MIHP related services rendered to fee-for-service beneficiaries must be billed on the ASC X12N 837 5010 professional format. Refer to the Billing & Reimbursement for Professionals Chapter of this manual for specific billing guidelines. If the THC subcontracts any MIHP services, no duplicate billing is permitted.
Physician's Assistant	Physician's assistant services must comply with coverages and limitations published in the Practitioner Chapter of this manual and in MDHHS Bulletins.
Pharmacy Services	Pharmacy services billed under the practitioner NPI number are included in the encounter rate but do not constitute a separate encounter as they are considered part of the office visit. Practitioner pharmacy services do not include drugs provided by a pharmacy. THCs with enrolled pharmacy providers may continue to bill prescription claims to the MDHHS Pharmacy Benefits Manager (PBM). Medication Therapy Management (MTM) services are face-to-face consultations provided by pharmacists to optimize drug therapy and improve therapeutic outcomes for beneficiaries. MTM services provided according to Medicaid policy may be eligible to receive the encounter rate. (Refer to the Pharmacy Chapter of this manual for additional information.) MDHHS contracts with a PBM for processing of all fee-for-service (FFS) pharmacy claims for Medicaid. (Refer to the Pharmacy Chapter of this manual for an explanation of coverages and limitations.)
Laboratory Services	The Practitioner Chapter of this manual explains the coverages and limitations of the Medicaid laboratory benefit. Laboratory services billed under the practitioner's NPI number are included in the THC encounter rate but do not constitute a separate encounter for reimbursement purposes as they are considered part of the office visit. THCs cannot bill for any services rendered by an outside laboratory provider or for an outside laboratory's employees performing tests.
Diagnostic Services	Diagnostic testing performed as part of an office visit must be directly related to the presenting condition and substantiated in the medical records. (Refer to the Billing & Reimbursement for Professionals Chapter of this manual for billing information.) Diagnostic testing services do not constitute a separate encounter. These services are regarded as part of the office visit and are included in the encounter reimbursement. Examples of diagnostic tests are allergy testing, audiologic function tests, x-rays, and EKGs.
Telemedicine	A THC can be either an originating or distant site for telemedicine services. Refer to the Billing & Reimbursement for Institutional Providers Chapter for specific billing instructions. Refer to the Telemedicine Section of the Practitioner Chapter for additional information regarding telemedicine services. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

Therapies	Physical therapy, speech therapy, and occupational therapy are covered when performed at the THCs. Refer to the appropriate chapter of this manual and MDHHS Bulletins for an explanation of current coverages and limitations. The Billing & Reimbursement for Professionals Chapter of this manual describes the billing requirements for services provided. Therapies provided on the same date of service as a physician visit are included in the encounter reimbursement.

3.2 Dental Coverages and Limitations

THC dental services are covered if provided in the THC and must comply with coverages and limitations for dental services as specified in the Dental Chapter of this manual. Dental benefits covered for beneficiaries under the age of 21 differ from those covered for beneficiaries age 21 and over.

Information for billing dental services is published in the Billing & Reimbursement for Dental Providers Chapter of this manual.

MDHHS contracts with Dental Health Plans (DHPs) for the administration of dental services for ***Healthy Kids Dental*** (HKD) beneficiaries. Claims for services provided to beneficiaries enrolled in the HKD program should be submitted to the beneficiary's DHP. Payment is made based on the DHP fee schedule. No additional reimbursement is made by MDHHS.

(Refer to the Directory Appendix for DHP contact information.)

3.3 Vision Coverages and Limitations

Vision services are covered if provided at the THC. Vision providers are ophthalmologists and optometrists. The vision services provided by an ophthalmologist or optometrist must comply with coverages and limitations published in the Vision Chapter of this manual.

MDHHS contracts for the volume purchase of frames and lenses from an optical house. Frames and lenses covered by the program must be ordered through the contractor and are listed in the Vision Chapter of this manual.

Some vision services require prior authorization (PA) before they can be rendered. The Vision Services Approval/Order Form (DCH-0893) is used to obtain PA. (Refer to the Vision Chapter for information on services that require PA and to the Forms Appendix for a copy of the form.)

3.4 Services Provided to Medicaid Health Plan Enrollees

For Medicaid-covered services provided to Medicaid beneficiaries enrolled in a Medicaid Health Plan (MHP), THCs receive payment from the MHP based on an agreement or contract with the MHP. In the absence of an agreement or contract, payment is based on the Medicaid fee-for-service (FFS) rates in effect on the date of service (DOS). Approved services provided to MHP enrollees are then recognized as encounters.

3.5 Medicare and Medicaid Beneficiaries

For dually eligible Medicare and Medicaid beneficiaries, Medicaid reimburses coinsurance and deductible amounts on Medicare-approved claims up to Medicare's IHS encounter rate.

SECTION 4 – SUBSTANCE ABUSE

Outpatient substance abuse services provided by physicians, clinical social workers, clinical psychologists, and substance abuse treatment specialists are reimbursed. These services may include:

- Initial complete physical
- Medical history
- Social history
- Psychiatric history
- Individual, family, and group counseling
- Outpatient substance abuse treatment
- Intensive outpatient counseling
- Therapies (i.e., Psychiatric occupational/recreational therapy) in a Tribal-operated substance abuse treatment center are covered services provided they are active, restorative, and designed to prevent, correct, or compensate for a specific medical problem.
- Methadone

4.1 REQUIREMENTS FOR PARTICIPATION

All programs must meet the following criteria to bill Medicaid for services:

- Licensed by the state licensing agency to provide each type of substance abuse service; and
- Accredited as an alcohol and/or drug abuse program by one of the five national accreditation bodies:
  - The Joint Commission
  - Commission on Accreditation of Rehabilitation Facilities (CARF)
  - American Osteopathic Association (AOA)
  - Council on Accreditation of Services for Families and Children (CASFC)
  - National Committee on Quality Assurance (NCQA)

4.2 AUTHORIZATION

Services provided at the THC to American Indian and Alaska Native beneficiaries do not require the authorization of the regional Prepaid Inpatient Health Plan (PIHP).

4.3 AMERICAN INDIAN AND ALASKA NATIVE SERVICES

American Indians and Alaska Natives who are Medicaid beneficiaries can obtain substance abuse services directly from the THC. These services are not included in the MDHHS §1915(b) Managed Specialty Services and Supports Waiver for PIHPs and substance use disorder services. THCs should contact their regional PIHP to determine the appropriate process for accessing other funding sources or other service providers for those individuals requiring substance abuse services not covered by the THC.

4.4 Services Provided to Non-American Indians and Alaska Natives

The MDHHS Prepaid Inpatient Health Plan (PIHP) for Specialty Developmental Disabilities, Mental Health and Substance Abuse services assumes responsibility for certifying admission/continuing stays and reimbursing claims for the specialized substance abuse services of non-American Indians and Alaska Natives. Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of this manual for further information on PIHPs, Mental Health and Substance Abuse Services. Substance abuse services for non-American Indians and Alaska Natives must not be billed under CPT and HCPCS codes.

4.5 Service Limits

THCs may exceed the substance abuse treatment limits for American Indian and Alaska Native beneficiaries as long as the medical record and plan of care documents the medical necessity.

4.6 Noncovered Services

The following substance abuse services are not covered when provided through THCs:

- Emergency and non-emergency transportation
- Initial emergency screening and medical stabilization
- Acute medical detoxification services
- Medications prescribed in the management or treatment of methadone
- Room and Board

SECTION 5 – MENTAL HEALTH

Outpatient mental health services provided by physicians, clinical social workers, and clinical psychologists are covered. These services may include:

- Health assessment
- Psychiatric evaluation
- Psychological testing
- All other assessments and testing
- Case management
- Child therapy
- Crisis interventions
- Crisis residential services
- Intensive crisis stabilization services
- Individual psychotherapy
- Family psychotherapy
- Group psychotherapy
- Interpretation or explanation of data to family
- Medication administration
- Medication review
- Therapies (i.e., psychiatric occupational/recreational therapy) in a mental health treatment center are a covered service provided they are active, restorative, and designed to prevent, correct, or compensate for a specific medical problem.

5.1 NONENROLLED PROVIDERS

Professional services provided by limited licensed psychologists (except as noted in Section 333.18223 of the Public Health Code), social workers, professional counselors, marriage and family therapists or student interns are covered but must be performed under the supervision of an enrolled, fully-licensed provider of the same profession. Individuals who meet Michigan licensure/certification requirements for social workers and psychologists may provide services.

5.2 AUTHORIZATION

Mental health services provided at the THC to American Indian and Alaska Native beneficiaries do not require the authorization of PIHPs/CMHSPs.

5.3 American Indian and Alaska Native Services

American Indians and Alaska Natives who are Medicaid beneficiaries can obtain mental health services directly from the THC. THC services are not included in the MDHHS §1915(b) Managed Specialty Services and Supports Waiver for PIHPs and substance use disorder services. THCs may refer tribal members to the PIHP/CMHSP for mental health services not provided at the THC.

5.4 Non-American Indian Services

PIHPs/CMHSPs assume responsibility for community-based mental health and developmental disability services covered through Medicaid for non-American Indians. Refer to the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter of this manual for policies and procedures. Non-American Indian mental health services must not be billed under CPT or HCPCS codes.

5.5 Noncovered Services

Mental Health services that are **not** the responsibility of the THC are as follows:

- Home-based mental health services
- Nursing facility (NF) mental health monitoring
- Emergency and non-emergency transportation

SECTION 6 – ENCOUNTERS

THCs are eligible to receive an encounter (per visit) rate as reimbursement for Medicaid covered services provided at the THC for native and non-native Medicaid beneficiaries.

The IHS outpatient all-inclusive rate (AIR) is determined by the Centers for Medicare & Medicaid Services (CMS) and is published in the Federal Register. The FQHC encounter rate under the FQHC MOU is an alternative methodology that was based on the prospective payment system (PPS) outlined in section 1902(bb) of the Social Security Act.

6.1 DEFINITION

An encounter is a face-to-face visit between a Medicaid beneficiary and the THC provider of health care services who exercises independent judgment in the provision of Medicaid-covered services. The THC provider may be credited with no more than one face-to-face encounter with a given beneficiary per day, except when the beneficiary, after the first encounter, suffers a separate or different illness or injury requiring additional diagnosis or treatment.

For a service to be defined as an encounter, the Medicaid-covered service must be recorded in the patient's record.

6.2 SERVICES BUNDLED IN THE ENCOUNTER

Ancillary Medicaid services (e.g., labs, x-rays, injections, etc.) are included in the per visit encounter. These ancillary services are described as being provided incident to the office visit. For example, lab services billed under the physician's NPI number would not be considered a separate encounter.

Ancillary services provided at another facility are not bundled under the office visit encounter. For example, services provided by the local hospital are not included in the encounter.

SECTION 7 – BILLING

The Group (Type 2 - Organization) NPI number must be used as the billing provider on all electronic and paper claims submitted to Medicaid. Do not use Provider (Type 1 - Individual) as the billing provider. The billing provider loop or field is mandatory to complete.

The NPI (Type 1 – Individual) number is the individual who has overall responsibility for the patient's medical care and treatment reported in the claim or encounter. The attending provider field is mandatory to complete. Additionally, the NPI (Type 1 – Individual) number of the practitioner who performed the service should be entered as the rendering provider. Do not enter a Group (Type 2) NPI number as the attending or rendering provider.

MDHHS will use the billing provider NPI field (Type 2 - Organization) to determine the number of encounters and calculate the settlement for the year-end reconciliation.

7.1 OTHER INSURANCE

Billing instructions related to coordination of benefits are published in the Coordination of Benefits Chapter of this manual. Other insurance and all other payments received for services rendered to a Medicaid beneficiary must be reported. If payment received from other insurance exceeds the amount Medicaid would have paid, the THC must still submit a claim to Medicaid with the appropriate procedure code in order for the visit to be counted as an encounter.

7.2 MEDICARE AND MEDICAID CLAIMS

Refer to the Billing & Reimbursement Chapters of this manual for specific instructions regarding Medicare and Medicaid claims. If the Medicare payment exceeds the Medicaid fee screen, the appropriate procedure code should still be billed to Medicaid for encounter and reconciliation purposes.

7.3 PAYER OF LAST RESORT

The IHS is the payer of last resort for persons defined as eligible for contract health services under the regulations in 42 CFR, Part 36a, Subpart G, Section 36.61, notwithstanding any State or local law or regulation to the contrary.

7.4 COPAYMENTS

Medicaid copayments for chiropractic, dental, physician, podiatry and vision services are waived under the THC benefit as part of the reconciliation. (Refer to the General Information for Providers chapter for a list of services requiring copayments.)

Refer to the Billing Beneficiaries Section of the General Information for Providers Chapter of this manual for additional information regarding copayment requirements. Beneficiaries may not be denied care or services based on inability to pay a copayment, except as outlined in that section.

7.5 Timely Filing Billing Limitation

The same timely filing billing limitations explained in the General Information for Providers Chapter of this manual pertain to encounters as well as claim submission.

7.6 Place of Service

Place of service codes are not applicable to institutional billing. However, if the THC performs a service that must be billed on the professional claim form within the clinic, THCs must use place of service (POS) code 07. For services provided outside the THC, bill with the appropriate POS code noted in the Billing & Reimbursement for Professionals Chapter of this manual.

THC services provided to beneficiaries at the THC are reconciled annually, if applicable.

The THC may bill for covered services that are not provided at the THC. These services must be billed with the appropriate Place of Service (POS) code in compliance with the coverages and limitations specified in the Practitioner Chapter of this manual. A complete list of POS codes can be found in the Billing & Reimbursement for Professionals Chapter of this manual.

Services billed to Medicaid are subject to audit and verifications.

SECTION 8 – MEDICAID PAYMENTS, ANNUAL RECONCILIATION AND APPEALS

8.1 QUARTERLY PAYMENTS

Quarterly payments are made to the THC at the beginning of each quarter. The payment is based on an estimate of the difference between the amount the THC receives for Medicaid services from FFS claims, managed care encounters, and other third party payments (including Medicare) during the year and the amount due the center based on the THC encounter rate.

8.2 INITIAL RECONCILIATION AND SETTLEMENT

An annual reconciliation, if applicable, ensures that reimbursement is made according to the payment option selected by the THC. The initial reconciliation and settlement is calculated approximately six months after the THC's fiscal year end. The number of encounters is determined from Medicaid fee-for-service (FFS) and managed care approved claims. Any difference between the THC rate and the amount paid to the THC from FFS and managed care payments, other insurance and quarterly payments is paid to or recovered from the THC. Future quarterly payments are adjusted based on the information in the initial reconciliation.

8.3 FINAL RECONCILIATION AND SETTLEMENT

A final reconciliation and settlement is calculated approximately one year after the THC's fiscal year end. This will allow time for all claims to clear the payment system.

8.4 APPEALS

A Medicaid provider has the right to appeal any adverse action taken by MDHHS unless that adverse action resulted from an action over which MDHHS had no control (e.g., Medicare termination, license revocation). The appeals process is outlined in MDHHS Medicaid Provider Reviews and Hearings rules, Michigan Administrative Code R400.3402 through R400.3425, amended, and filed with the Secretary of State on May 19, 2016. Any questions regarding this appeal process should be directed to the Michigan Administrative Hearing System (MAHS). (Refer to the Directory Appendix for contact information.)

URGENT CARE CENTERS

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SECTION 1 – GENERAL INFORMATION

An Urgent Care Center (UCC) is a medical clinic or office, not located in a hospital emergency department, whose purpose is to provide unscheduled diagnosis and treatment of illnesses for ambulatory beneficiaries requiring immediate medical attention for non-life-threatening conditions. It is expected that UCCs will provide access to a place of service (POS) more appropriate than a hospital emergency department for addressing non-emergency medical needs when a beneficiary's primary care provider (PCP) is not available.

1.1 Staff Credentials

The UCC medical director must be a Michigan-licensed physician. The UCC medical director is responsible for the medical management of the UCC. All Medicaid-covered physician services must be performed by the physician, the physician's employee, or an employee of the same legal entity that employs the physician under the physician's delegation and supervision. Only persons currently licensed/certified in an appropriate health occupation/profession (e.g., physician assistant, nurse practitioner), as authorized by Public Act 368 of 1978 as amended, may provide direct patient care under the delegation and supervision of a physician when the physician is not physically present on the premises.

1.2 Hours of Operation

UCCs must be open seven days a week, and include evening hours, weekends and holidays. Hours of operation must be posted in the facility. UCCs must accept walk-in patients of all ages during all hours the facility is open to see patients.

SECTION 2 - COVERED SERVICES

Unscheduled, non-emergency, medically necessary services that are a non-life threatening condition or injury or illness that can be treated appropriately in a UCC are Medicaid covered services.

Michigan Department of Health and Human Services (MDHHS) covered services are based on the level of care that can be appropriately rendered in an urgent care place of service.

MDHHS will not cover separate facility charges.

Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

All facilities must provide clinical documentation for services rendered and complete a discharge summary which must be sent to the appropriate PCP. If a beneficiary does not have a PCP, the facility must document assistance with arranging a medical home for follow-up care.

SECTION 3 – PROVIDER ENROLLMENT

Providers must be enrolled with Medicaid and have a valid Type 2 (Group) National Provider Identifier (NPI) for MDHHS claim adjudication.

Claims must also include the appropriate Type 1 (Individual) NPI of the specific provider performing the service(s) as the rendering provider. A valid MDHHS-enrolled rendering provider number is required for claim adjudication. Providers must not enter a Type 2 (Group) NPI as the rendering provider. The Group NPI must be reported as the billing provider.

3.1 NPI Edits

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

SECTION 4 – BILLING & REIMBURSEMENT

UCC providers must follow uniform billing guidelines using the professional CMS-1500 claim format or electronic Health Care Claim Professional (837) ASC X12N Version 5010 information. All providers are encouraged to bill electronically. Refer to the Billing & Reimbursement for Professionals chapter for additional CMS-1500 or 837P Professional claims submission and billing information.

If ancillary services are provided by UCC staff using hospital-owned equipment (i.e., done in the same building where urgent care is located), the hospital may bill that service on the institutional claim format for the technical service.

Reimbursement is based on the practitioner fee schedule. Services performed in a UCC are reimbursed at the non-facility rate based on the non-facility relative value unit (RVU). MDHHS utilizes the Medicaid National Correct Coding Initiative (NCCI) coding policies and edits as developed by the Centers for Medicare & Medicaid Services (CMS) to promote national correct coding methodologies. To avoid duplicate payments, UCC providers must submit only one non-facility service claim per beneficiary per DOS. Separate physician service claims should not be submitted.

4.1 Copay Requirements

A copayment may be required for office evaluation and management (E&M) visits for beneficiaries age 21 years and older.

Refer to the General Information for Providers Chapter for information about copayments. Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)

VISION

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SECTION 1 – GENERAL GUIDELINES AND REQUIREMENTS

The Michigan Department of Health and Human Services (MDHHS) contracts for the volume purchase of frames and lenses from an optical laboratory, referred to in this chapter as the contractor.

Vision providers (e.g., opticians, dispensing ophthalmologists, optometrists) must order frames and lenses from the contractor. A list of lenses is available in the MDHHS Vision Services Fee Schedule located on the MDHHS website. A list of available frames is available from the contractor, currently Classic Optical Laboratories. (Refer to the Directory Appendix for contact information.)

Orders placed with the contractor must be postmarked no later than 30 days after the date of order. If orders are placed beyond the 30 days, the contractor returns the order to the provider, who must explain to Medicaid why submission was delayed and request an exception from the time limit.

Procurement of contact lenses, low vision aids, and prosthetic eyes must be obtained from the vision provider's own source and are subject to prior authorization (PA) requirements as described in this chapter.

1.1 BENEFICIARY ELIGIBILITY AND COPAYMENTS

Providers must verify beneficiary eligibility prior to rendering services or ordering materials. If a beneficiary's eligibility expires prior to the date the material is delivered, reimbursement is made **only** if the beneficiary was eligible on the date the material was ordered by the vision provider and the date of order is used when billing. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.)

A copayment may be required for Medicaid beneficiaries age 21 and older for each separately reimbursable:

- Ophthalmological service performed by an optometrist or ophthalmologist; and
- Dispensing service for glasses or contact lenses billed by dispensing ophthalmologists or optometrists.

Refer to the General Information for Providers Chapter for information about copayments. Current copayment amounts are listed on the MDHHS website. (Refer to the Directory Appendix for website information.)

1.2 PRIOR AUTHORIZATION

Some vision services and materials require PA before they can be rendered. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

The Vision Services Approval/Order Form (DCH-0893) is used to obtain PA. A copy of the DCH-0893 and completion instructions can be found in the Forms Appendix of this manual. Complete and mail or fax the DCH-0893 to the MDHHS Program Review Division. (Refer to the Directory Appendix for contact information.) PA requests must be postmarked no later than 30 calendar days after the date of order. If

beyond the 30 days, the provider must include a detailed explanation of why the submission was delayed.

When requesting prior approval, providers should make a photocopy of the completed form for the beneficiary file. Upon completion of the PA process, MDHHS returns one copy of the DCH-0893 to the provider.

An electronic copy of the DCH-0893 is available on the MDHHS website. (Refer to the Directory Appendix for website information.)

1.3 Coding of Services

The American Medical Association's (AMA) Current Procedural Terminology (CPT) is the national coding standard for health care professional services. Vision providers must use CPT codes in effect on the date of service to describe and identify the services and procedures performed. Optometrists must be Therapeutic Pharmaceutical Agent certified in order to use many of these codes. All prescriptions or prescription orders must comply with state and federal laws. (Refer to the Pharmacy Chapter of this manual for additional information.)

Providers must use the International Classification of Diseases (ICD) for diagnostic coding of diseases, injuries, and conditions. Codes must be used at the highest level of specificity.

Healthcare Common Procedure Coding System (HCPCS) is a system developed by the Centers for Medicare & Medicaid Services (CMS) to report materials, supplies, and certain services not covered by the CPT codes. HCPCS codes are to be used when applicable.

1.4 Medicare

All vision services are subject to editing for Medicare coverage. MDHHS reimburses vision providers for coinsurance and deductible amounts on Medicare-approved claims up to Medicaid's reimbursement limit.

If a service requires PA by Medicaid and is covered by Medicare, vision providers do not have to obtain PA, nor does the vision provider have to obtain lenses or frames through the volume purchase program.

(Refer to the Billing & Reimbursement for Professionals Chapter of this manual for additional information.)

1.5 Contractor Guarantee

Frames and lenses furnished by the contractor are guaranteed for 90 days. If any material is found to be unsatisfactory due to contractor error or defective workmanship or materials, the materials and work order form should be returned to the contractor. The contractor is required to correct, adjust, or replace the materials.

If the vision provider supplies the contractor with incorrect specifications that results in eyeglasses being fabricated which the beneficiary cannot use, the vision provider is responsible for payment to the contractor for the remake. The contractor may not charge the vision provider more than what they would charge MDHHS for the remake. MDHHS does not pay for the remake (e.g., eyeglasses, lenses, or frames) due to vision provider error.

1.6 Complaint Process

To resolve problems (such as an overdue shipment, error in an order, or defective workmanship), vision providers should first contact the contractor.

If the lenses and/or frames are not received from the contractor within 21 days from the date they were ordered, vision providers are responsible for contacting the contractor to determine the cause of the delay.

If difficulties are encountered with the contractor in resolving a problem, vision providers should call the Vision Contract Manager. (Refer to the Directory Appendix for contact information.) Vision providers must be prepared to report the beneficiary's name and Medicaid ID number, and a detailed explanation of the problem(s) they have experienced.

MDHHS reviews the complaint, takes necessary action to correct the problem, and notifies the vision provider of the resolution.

SECTION 2 – DIOPTER CRITERIA

2.1 INITIAL LENSES

Initial lenses are considered to be the first prescription lenses ever worn by a person regardless of how they were obtained (e.g., through Medicaid, other insurance, or private pay). Initial lenses are a Medicaid benefit and do not require PA if the following minimum diopter criteria are met:

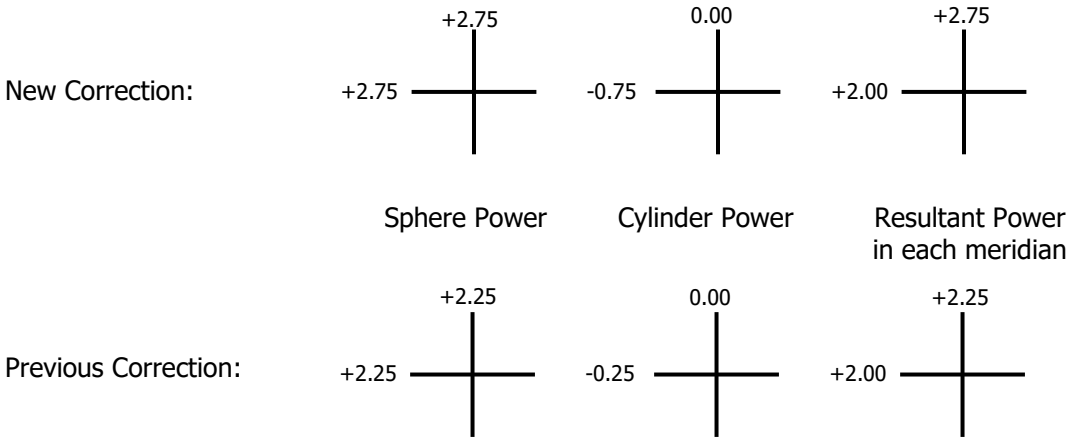
Age Group 42 Years and Younger	
▪ 0.50D myopia ▪ 0.50D astigmatism	▪ 0.75D anisometropia ▪ 0.75D hyperopia

Age Group 43 Years and Older	
▪ 0.50D myopia ▪ 0.50D astigmatism ▪ 0.75D anisometropia	▪ 0.50D hyperopia ▪ 0.50D presbyopia

2.2 SUBSEQUENT LENSES

Regardless of age group, subsequent lenses are medically necessary lenses that are provided after initial lenses. Subsequent lenses are a Medicaid benefit and do not require PA if there is a change in the refractive error of 0.75D or more in the meridian of greatest change, or a change in the cylinder axis of at least 10 degrees for cylinders of 1.00D or more. These lenses must also meet minimum dioptric criteria as specified above. The change need only be present in one eye.

The following example illustrates how this requirement is assessed for a new correction (+2.75-0.75 ax 092) and a previous correction (+2.25-0.25 ax 090). The dioptric power in each meridian can be portrayed in the form of cross diagrams.



This is an example of where the change in dioptric power for subsequent lenses has not been met. Note that the resultant powers in the vertical meridians of the "new" and "previous" correction are +2.75 and +2.25 respectively. There is only a 0.50D change in the vertical meridian and no change in the horizontal.

For periods greater than 24 months from the date of the previous prescription, subsequent lenses may be ordered for diopter changes less than those specified above.

SECTION 3 – SERVICES

This section provides information on both Medicaid covered and noncovered services.

3.1 DIAGNOSTIC SERVICES

In providing services, it is the responsibility of the optometrist or ophthalmologist to determine that the services are medically necessary, appropriate, and within the scope of current medical practice and Medicaid limitations. The prescribing optometrist or ophthalmologist is held responsible if he orders excessive or unnecessary services, regardless of who actually renders the services. The prescribing optometrist or ophthalmologist may be subject to corrective action related to these services, including recovery of funds.

Documentation Guidelines for Evaluation and Management Services, 1995, 1997, or latest version thereof, developed jointly by CMS and the AMA, must be adhered to when using the CPT/HCPCS procedure codes.

Eye Examinations	▪ A routine eye examination once every two years is a Medicaid benefit and does not require PA. Examinations include, but are not limited to, case history, determination of visual acuity (each eye), ophthalmoscopy, biomicroscopy, ocular motility, tonometry, refraction, diagnosis, treatment program and disposition. (Use appropriate CPT/HCPCS procedure codes for routine eye exam and applicable ICD diagnosis codes. ▪ Nonroutine eye examinations are a Medicaid benefit for the purpose of evaluation and treatment of chronic, acute, or sudden onset of abnormal ocular conditions. (Use appropriate CPT/HCPCS procedure codes.)
Glaucoma Screenings	Glaucoma screenings are covered without PA on an annual basis for beneficiaries who: ▪ Have no ocular complaints or prior history of glaucoma and who have diabetes; ▪ Have a family history of glaucoma; or ▪ Are African-American, age 50 or older. This screening entails a dilated eye examination, tonometry, and direct ophthalmoscopy or slit lamp examination. If this screening is provided as part of another billable service, separate reimbursement for this screening is not allowed. Use the appropriate CPT/HCPCS procedure code for glaucoma screening and the applicable ICD diagnosis code. If the beneficiary presents with a visual or ocular complaint, the glaucoma screening code should not be used. The procedure code which best describes the visit should be selected from the CPT Evaluation and Management (E/M) codes or General Ophthalmological procedure codes.

3.2 Dispensing Services

Dispensing services are a Medicaid benefit and do not require PA. Vision providers may bill a dispensing fee for dispensing prescription lenses, prescription lenses with frames, or replacing a complete frame.

Reimbursement for the dispensing service includes the vision provider's services in selecting, ordering, verifying, and aligning/fitting of eyeglasses as described above. Routine follow-up and post-prescription visits (e.g., for minor adjustments) are considered part of the dispensing service and are not separately reimbursable.

3.3 Nursing Facility Beneficiaries

Covered and noncovered vision services, as well as PA requirements, apply to vision services provided to beneficiaries residing in a nursing facility (NF).

Performance of vision services (except replacement of a frame part for eyeglass repair) must be upon the written request of the beneficiary, a member of the beneficiary's family, or other beneficiary representative and upon the written order of the beneficiary's attending physician (MD, DO) prior to the date of the vision provider's visit.

If service is provided in the NF, a copy of the request and written order must be retained by the facility as part of the beneficiary's record.

Vision services are not considered a part of the facility's per diem rate. The vision provider or contractor must bill MDHHS for vision services rendered.

No additional payments are made to vision providers for a visit(s) to the NF. Appropriate procedure codes must be utilized.

3.4 Ophthalmic Frames and Lenses

A complete pair of eyeglasses is a Medicaid benefit and does not require PA when:

- The eyeglasses being prescribed are the beneficiary's first pair of eyeglasses ever worn. These eyeglasses are considered to be initial eyeglasses and must meet minimum diopter criteria for initial lenses.
- The beneficiary's correction meets diopter criteria for subsequent lenses and the frames are unusable.
- A previously used frame requires oversized lenses. (Oversized lenses are not a Medicaid benefit, therefore, a complete pair of eyeglasses must be ordered.)
- Prescription lenses remain usable, but the original frame is broken beyond repair and the original frame is not a Medicaid benefit.
- The beneficiary's correction meets diopter criteria for subsequent lenses and the frames remain usable, but the vision provider or beneficiary elects not to send the frames to the contractor or the contractor feels that the previously used frames will break or otherwise be damaged during lens insertion.

- The beneficiary's eyeglasses have been lost, stolen, or broken beyond repair and the number of replacements have not exceeded Medicaid limits which are:
  - For beneficiaries age 21 and over, one pair of replacement eyeglasses per year.
  - For beneficiaries under age 21, two pair of replacement eyeglasses per year.

  One year is defined as 365 days from the date the first pair of eyeglasses (initial or subsequent) was ordered.

The DCH-0893 must be used when ordering frames and/or lenses. A copy of the form and instructions for completing the form are available in the Forms Appendix of this manual and on the MDHHS website. (Refer to the Directory Appendix for website information.) These orders must be sent directly to the contractor. Orders may be mailed, faxed, or entered directly online at the contractor's website. (Refer to the Directory Appendix for contact information. The contractor must be contacted directly to register for on-line access.) The contractor fills the vision provider's order in accordance with the lens and frame specifications indicated on the DCH-0893. The order form is returned to the provider if the eligibility information is not completed.

Procedures identified as requiring PA must first receive approval from the MDHHS Program Review Division. (Refer to the Prior Authorization subsection in this chapter for instructions on obtaining PA.)

The contractor monitors orders to assure that Medicaid replacement limitations, diopter criteria, and PA requirements are being maintained. The contractor returns an order if the order exceeds the replacement limits, does not meet diopter criteria, or requires PA.

The contractor bills MDHHS for the frames and/or lenses ordered by vision providers. Vision providers subsequently bill for a dispensing service for dispensing the frames and/or lenses.

If the beneficiary has other insurance that covers frames and/or lenses, the material may still be obtained through the contractor. (Refer to the Billing & Reimbursement for Professionals and the Coordination of Benefits Chapters of this manual when billing for the dispensing service if other insurance is involved.)

3.4.A. LENSES

Lenses must conform to the latest edition of the *American National Standard Recommendations for Prescription Ophthalmic Lenses*.

Plastic and glass lenses are a Medicaid benefit. Refer to the Additional Code/Coverage Resource Materials subsection of the General Information for Providers Chapter for additional information regarding coverage parameters.

- Plastic and glass bifocals are available in Round 22, FT-28, FT-35, and Executive style.
- Plastic and glass trifocals are available in FT-7x28 segments.

Photochromic, Tinted and Dyed Lenses	PA is required for these lens features. Appropriate documentation of medical necessity must be attached to the DCH-0893 when submitted to the MDHHS Program Review Division.
Polycarbonate Lenses	For beneficiaries age 21 and over, polycarbonate lenses are a Medicaid benefit when diopter criteria is met and the lenses are inserted into a safety frame marked "Z 87" or "Z 87-2". For beneficiaries under age 21, polycarbonate lenses may be inserted into any covered Medicaid frame and do not require PA.

Oversized lenses, no-line, progressive style multi-focals, or transitions are not Medicaid benefits.

3.4.B. Ophthalmic Frames

Frames must conform to the latest edition of the *American National Standard Requirements for the Dress Ophthalmic Frames*.

Ophthalmic frame styles that are a Medicaid benefit are available from the contractor. Vision providers may order sample frames directly from the contractor. The vision provider is charged for sample frames at the same price stated in the current contract. Neither the provider nor the contractor may charge Medicaid for sample frames.

Vision providers must offer a beneficiary the opportunity to select a frame from at least 80 percent of the total authorized frame styles. A vision provider who fails to comply with this requirement is subject to termination of enrollment in Medicaid.

If a frame manufacturer discontinues production of a frame that is listed as a benefit, vision providers may utilize the discontinued frame from their sample kit. If lenses are required, they must be ordered from the contractor. Submit the DCH-0893 to the MDHHS Program Review Division for approval. (Refer to the Directory Appendix for contact information.)

Safety Frames	Safety frames are a Medicaid benefit. A list of authorized safety frame styles is available from the contractor. These frames conform to ANSI Z87.1-2003 standards, and samples can be purchased from the contractor at contract prices. Only polycarbonate lenses of 2 millimeter minimum thickness shall be used in frames marked "Z 87" or "Z 87-2".
Frame Repairs	Frame repairs (e.g., aligning temples, insertion of screws, adjusting frames) are not a separately reimbursable service and cannot be billed.

3.4.C. Subsequent Lenses Placed in Previously Used Frames

Subsequent lenses that are to be placed in a beneficiary's previously used frame are a Medicaid benefit and do not require PA. Previously used frames are defined as ophthalmic frames in which the beneficiary has had previous corrective lenses incorporated and which were previously worn.

All noncontract previously used frames require PA.

To order subsequent lenses for insertion into a previously used frame, vision providers must complete the DCH-0893, indicating all information necessary for proper fabrication. Vision providers have the option of having the contractor insert the lenses, in which case the provider must supply the previously used frame to the contractor, or inserting the newly fabricated lenses into the frames in their office.

If the previously used frames are sent to the contractor for lens insertion, the contractor is required to fabricate the lenses and mail the frames and lenses to the vision provider within nine working days after receiving the frames. If a special prescription requires more than nine working days to complete, the contractor must notify the vision provider. If the provider does not receive the materials within three weeks from the date the order was sent, he should contact the contractor.

If the vision provider or beneficiary elects not to send the previously used frames as might be requested by the contractor, or if the contractor feels that the previously used frames may break or otherwise be damaged during lens insertion, the vision provider is requested to order a complete pair of eyeglasses.

If frames are sent to the contractor, either at the contractor's request or the vision provider's preference, the vision provider is responsible for paying the postage necessary to ship the frames. Also, vision providers are responsible for paying for frames lost or damaged in transit.

If a previously used frame requires lenses that are not a Medicaid benefit (e.g., oversize lenses), a complete pair of eyeglasses that are a benefit must be ordered.

3.4.D. Replacement or Repair

Eyeglasses	Eyeglass repairs are a separately reimbursed service when the repair is considered major (e.g., reinsertion of a lens, repair of a sheared screw, shortening or replacing temples, etc.) and when the glasses are deemed repairable. Minor repairs (e.g., insertion of screw, adjustments of nose pads or temples, etc.) that occur as a result of the beneficiary's typical wear patterns are not separately reimbursed. The appropriate HCPCS code(s) must be reported for the component part that is being replaced. The reason for the repair must be documented in the beneficiary's file and made available upon request. If a provider determines that eyeglasses are repairable, the provider must guarantee the repair for a minimum of 30 days. Subsequent repair for the same issue within 30 days is the responsibility of the provider. If replacement eyeglasses are needed within the 30 day time frame following a repair, the provider must return the reimbursement received for the repair to MDHHS. Eyeglasses that are broken beyond repair may be eligible for replacement by the contractor. Eyeglass replacement requires prior authorization if replacement limits have been exceeded.

Lenses Only	Replacement of a corrective lens(es), without frames, for one that is damaged or broken is a benefit if that lens(es) is covered by Medicaid and the replacement limits have not been exceeded. A replacement lens(es) must be an identical copy of the damaged or broken lens. It does not require PA. Vision providers must order the lens(es) directly from the contractor. For periods greater than 24 months from the date of the previous prescription when ordering subsequent lenses or complete eyeglasses, see Subsequent Lenses subsection above for appropriate diopter criteria.
Frames Only	Replacement of a complete frame (front and temples) is a Medicaid benefit only when the original frame is broken beyond repair, the prescription lenses remain usable, and the replacement limits have not been exceeded. The replacement frame must be an identical replacement. If an identical frame is not listed as a Medicaid benefit, the beneficiary must select a frame that is a covered benefit. The contractor bills Medicaid for the complete frame. The vision provider inserts the lenses into the frame and bills Medicaid for the dispensing service.

3.4.E. Two Pairs of Eyeglasses

Two pairs of single vision eyeglasses (one for near visual tasks and the other for distance visual tasks) are a Medicaid benefit in either of the following instances:

- When the beneficiary has clearly demonstrated the inability to adjust to bifocals after a reasonable trial period.
- When the beneficiary's physical condition does not allow bifocal usage.

PA is required when requesting two pairs of eyeglasses. Appropriate documentation must be attached to the DCH-0893 and submitted to the MDHHS Program Review Division.

Providing both multi-focal and single vision eyeglasses for interchangeable usage is not a Medicaid benefit.

3.4.F. Nondeliverable Eyeglasses

If a beneficiary fails to return to the vision provider for dispensing of eyeglasses, the vision provider should make every effort to locate the beneficiary, including contacting the local MDHHS office in the beneficiary's area.

If the beneficiary still cannot be located, the eyeglasses should be sent to the local MDHHS office (or local nonprofit agency if the MDHHS office refuses to accept them) in the beneficiary's area within 90 days of placing the order with the contractor. Do not send the nondelivered lenses and/or frames to MDHHS unless requested to do so by MDHHS.

To bill for dispensing, the provider must use the date of order for the lenses and/or frames.

Medicaid does not reimburse vision providers for postage and handling.

3.4.G. Eyeglass Case

One eyeglass case for every complete pair of eyeglasses ordered is a Medicaid benefit and must be provided by the contractor. Vision providers cannot bill for eyeglass cases.

3.5 Low Vision Services

Evaluation	A low vision evaluation is a benefit when the beneficiary presents with moderate visual impairment, severe visual impairment, or profound visual impairment. Under these conditions, a low vision evaluation does not require PA. This evaluation includes, but is not limited to, a detailed case history, effectiveness of any low vision aids in use, visual acuity in each eye with best spectacle correction, steadiness of fixation, assessment of aids required for distance vision and near vision, evaluation of any supplemental aids, evaluation of therapeutic filters, development of treatment, counseling of beneficiary, and advice to family (if appropriate). The CPT E/M or General Ophthalmological procedure code which best describes this service should be utilized.
Aids	High add bifocals do not require PA. For high add bifocals, complete the DCH-0893 and submit to the contractor. The prescription and fitting of low vision optical aids (such as telescopes, microscopes, and certain other low vision aids) require PA. Only basic and essential low vision aids are a Medicaid benefit. The Provision of Low Vision Services and Aids Support Documentation (MSA-0891) form outlines the information required when requesting PA for low vision services and aids. A sample of this form is provided in the Forms Appendix. It can also be obtained through the MDHHS website. (Refer to the Directory Appendix for website information.) This form must be attached to DCH-0893 and submitted as part of the PA process. (Refer to the Prior Authorization subsection above.) Reimbursement for a low vision aid is based on the manufacturer's charge for the aid plus a professional fee. Procurement of the low vision aid is done through the vision provider's own source. The professional fee includes procurement, verification, and fitting of the aid. Only an enrolled optometrist or a dispensing ophthalmologist can bill for a low vision aid.
Rehabilitative Services	Low vision rehabilitative services include instructions, training, and assistance to the beneficiary in the most effective use of the low vision aid. Documentation for these services should be included when requesting the low vision aid.

3.6 Contact Lenses

3.6.A. Evaluation

A comprehensive contact lens evaluation is a Medicaid benefit when the beneficiary presents with one of the following conditions (use appropriate HCPCS comprehensive contact lens evaluation code):

- Aniridia
- Anisometropia or Antimetropia (of two diopters or greater that results in Aniseikonia)
- Aphakia
- Irregular cornea
- Keratoconus (if vision cannot be improved to 20/40 or better with eyeglasses)
- Other conditions which have no alternative treatment (e.g., Aniseikonia with documentation and severe Keratoconjunctivitis sicca)

3.6.B. Prescription and Fitting

The prescription and fitting of contact lenses is a Medicaid benefit and requires PA, except for beneficiaries who are under six years of age with a diagnosis of aphakia.

3.6.B.1. Prescription

The prescription for contact lenses requires the complete description of contact lens specifications. The following must be included on a prescription for contact lenses:

- complete description of the contact lens(es) parameters
- material of the contact lens(es)
- manufacturer of the contact lens(es)
- material discard and replacement schedule
- number of lenses required to provide a one-year supply
- prescription expiration date

3.6.B.2. Fitting

The fitting of the contact lens(es) must include:

- determination of appropriate initial contact lens parameters based on clinical observation, and measurements of the eye with or without a trial (sample) contact lens.

- a trial or adaption period of one to three months, including a fitting warranty that provides for adjustments in the contact lens parameters either by exchange or by modification of existing materials.

  Note: Certain custom contact lens designs may not be warranted by the manufacturer. This type of custom contact lens design will be considered on a case-by-case basis. The provider must provide a detailed explanation of need, initial cost, and potential re-fitting cost.
- instruction of proper insertion, removal, disinfection, and care of the contact lens(es).
- initial supply of contact lenses, storage case, and solutions sufficient to last until the fitting is complete.

3.6.C. Replacement and Supplies

Procurement of contact lenses is to be done through the vision provider's own source.

The Documentation of Medical Necessity for the Provision of Contact Lenses form (MSA-0892) outlines the information required when requesting contact lens PA. A sample of this form is provided in the Forms Appendix and can also be obtained through the MDHHS website. (Refer to the Directory Appendix for website information.)

This form must be attached to the Vision Services Approval/Order form (DCH-0893) and submitted to MDHHS as part of the PA process. (Refer to the Prior Authorization subsection in this chapter for additional information.)

Requests for contact lens replacements due to loss or damage will require PA and will be reviewed on an individual basis.

Except as previously indicated, contact lens supplies (e.g., wetting and cleaning solutions, carrying cases) are not Medicaid benefits.

3.7 Strabismus and Amblyopia Examination

Strabismus and amblyopia examinations (sensorimotor examination) are Medicaid benefits and do not require PA.

3.8 Orthoptics and Pleoptics Training

Orthoptics and Pleoptics Training	Orthoptics and Pleoptics (O & P) training is a Medicaid benefit only when there is a diagnosis of one of the following conditions: ▪ Amblyopia ▪ Esotropia ▪ Exotropia ▪ Heterotropia ▪ Strabismus

	▪ Ocular Motor and Fusion Dysfunction PA is not required for O & P training for beneficiaries under age 21. PA is required for beneficiaries age 21 and older for O & P training. When requesting PA, the following documentation must be attached to the DCH-0893 and submitted to the Program Review Division: ▪ Visual acuity, each eye, with best spectacle correction; ▪ Magnitude and direction of the subjective and objective angle of strabismus at distance and near; ▪ Refractive error of each eye; ▪ Degree of fusion; ▪ History of strabismus, including onset, duration, prior treatment; and ▪ Other relevant information. In addition to the above documentation, a detailed plan indicating the training procedures and equipment to be employed, frequency of office visits, home training aids, and prognosis must be attached to the DCH-0893. This training plan may be authorized for a period of up to three calendar months. O & P training is limited to a maximum of 13 visits within the first three calendar months of therapy without PA. PA will be required for additional necessary visits. If continued training beyond the period that was authorized is necessary, a new request for PA must be submitted with the following information: ▪ Update of the above-listed items; ▪ Report of the results of previous training; and ▪ Indication for further treatment with a detailed plan.
Orthoptic Training Aids	Orthoptic training aids are a Medicaid benefit when incorporated in an orthoptics or pleoptics training plan (as described above) and require PA. The following documentation must be included with the vision provider's detailed plan when requesting the purchase of an aid: ▪ How the aid is to be used; ▪ Complete description of the aid; ▪ Name of the manufacturer; and ▪ Manufacturer's charge. Reimbursement for a training aid is based on the manufacturer's charge to the vision provider plus a professional fee. The professional fee includes procurement, instruction in use, and fitting when applicable. Procurement of the training aid is done through the vision provider's own source. Purchase of orthoptic training aids must be billed only by an enrolled optometrist or dispensing ophthalmologist.

3.9 Prosthetic Eyes

A prosthetic eye (plastic/custom) or shell is a Medicaid benefit and does not require PA.

For an enlargement or reduction of an ocular prosthesis, PA is required. PA is also required when requesting a prosthesis other than a plastic/custom eye. When requesting PA, the DCH-0893 should be completed, with documentation attached, and submitted to the MDHHS Program Review Division. Procurement of the prosthesis should be obtained from the provider's own source.

Reimbursement for a prosthesis is made on a per case basis which includes, but is not limited to:

- Trial fitting
- Supply of prosthesis
- Solutions
- Training in insertion and removal
- Instruction in care
- Subsequent office visits to achieve maximum wearing time and optimal cosmetic fit
- Any necessary modification during the adaptation period of six months

ACRONYM APPENDIX

Acronym	Meaning
AA	Anesthesiologist Assistant
AAAHC	Accreditation Association for Ambulatory Health Care
AADE	American Association of Diabetes Educators
AAP	American Academy of Pediatrics
AAR	Access Assessment and Referral
AASA	Aging and Adult Services Agency**)**
ABA	Applied Behavior Analysis
ABAS-III	Adaptive Behavior Assessment System-III
ABC	American Board for Certification in Orthotics, Prosthetics and Pedorthics, Inc.
ABI	Applied Behavioral Intervention
ABLLS-R	Assessment of Basic Language and Learning Skills - Revised
ABR	Auditory Brainstem Response
ACA	Affordable Care Act
ACEs	Adverse Childhood Experiences
ACHC	Accreditation Commission for Health Care
ACIP	US Public Health Service Advisory Committee on Immunization Practices
ACRC	Admissions and Certification Review Contractor
ACT	Assertive Community Treatment
ADA	American Dental Association; Americans with Disabilities Act; American Diabetes Association
ADI-R	Autism Diagnostic Interview - Revised
ADL	Activities of Daily Living
ADOS-2	Autism Diagnostic Observation Schedule - Second Edition
AER	Administrative Expense Report
AFC	Adult Foster Care
AFC/HFA	Adult Foster Care Facility/Home for the Aged

Acronym	Meaning
AFLS	Assessment of Functional Living Skills
AFO	Ankle-Foot Orthosis
AHI	Apnea-Hypopnea Index
AI	Assessment Indicator
AIMS	Attachment-Interaction-Mastery-Support
AIR	All-Inclusive Rate
ALD	Alternative Listening Device
ALMB	Additional Low Income Medicare Beneficiary
ALS	Advanced Life Support
ALTE	Apparent Life Threatening Event
AMA	American Medical Association; against medical advice
ANSI	American National Standards Institute
AOA	American Osteopathic Association
AOD	alcohol and other drug
APA	American Psychological Association
APC	Ambulatory Payment Classification
APR-DRG	All Patient Refined Diagnosis Related Grouper
APS	Adult Protective Services
APTA	American Physical Therapy Association
AQAR	Administrative Quality Assurance Review
ARD	Assessment Reference Date
ARR	Annual Resident Review
ASAM	American Society of Addiction Medicine
ASC	Ambulatory Surgical Center
ASD	Autism Spectrum Disorder
ASHA	American Speech-Language-Hearing Association
ASM	American Society for Microbiology

Acronym	Meaning
ASQ	Ages and Stages Questionnaire
ATD	Assistive Technology Device
ATP	Assistive Technology Professional
ATR-BC	Registered Art Therapist – Board Certified
AUAM	Ambulatory Uterine Activity Monitor
BACB	Behavioral Analyst Certification Board
BCaBA	Board Certified Assistant Behavior Analyst
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst-Doctoral
BCCCP	Breast and Cervical Cancer Control Program
BHDDA	Behavioral Health Developmental Disabilities Administration (MDHHS)
BHT	Behavioral Health Treatment
BICROS	Bilateral Contralateral Routing of Signals
BIPA	Section 702 of the Medicare, Medicaid, and CHIP Benefits Improvement and Protection Act of 2000. Section 702 of BIPA created a new section 1902(bb) in the Social Security Act.
BLS	Basic Life Support
BMI	Body Mass Index
BMP	Benefits Monitoring Program
BSBP	Bureau of Services for Blind Persons
BSN	Bachelor of Science in Nursing
BSW	Bachelor of Social Work
BY	Base Year
CAA	Council on Academic Accreditation; Care Area Assessment
CADC	Certified Alcohol and Drug Counselor
CAFAS	Child and Adolescent Functional Assessment Scale
CAH	Critical Access Hospitals
CAHCP	Child and Adolescent Health Center and Program

Acronym	Meaning
CALOCUS	Child and Adolescent Level of Care Utilization System
CAMTS	Commission on Accreditation of Medical Transport Systems
CAP	College of American Pathologists
CAPD	Continuous Ambulatory Peritoneal Dialysis (hospital)
CARF	Commission on Accreditation of Rehabilitation Facilities
CBC	Complete Blood Count
CBSA	Core Based Statistical Area
CCA	Care Coordination Agreement
CCI	Child Caring Institution
CDC	Centers for Disease Control and Prevention
CDL	Commercial Driver's License
CDT	Current Dental Terminology
CENA	Competency Evaluated Nurse Aide
CF	Cystic Fibrosis
CFR	Code of Federal Regulations
CFY	Clinical Fellowship Year
CHAMPS	Community Health Automated Medicaid Processing System
CHAP	Community Health Accreditation Program
CHIP	Children's Health Insurance Program
CIP	Capital Interim Payment
CKD	Chronic Kidney Disease
CLIA	Clinical Laboratory Improvement Amendments
CLS	Community Living Supports
CMCF	County Medical Care Facilities
CMCFSP	County Medical Care Facilities Special Payments
CMHC	Community Mental Health Center
CMHSP	Community Mental Health Services Program

Acronym	Meaning
CMN	Certificate of Medical Necessity
CMP	Civil Money Penalty
CMS	Centers for Medicare & Medicaid Services
CNA	Certified Nurse Aide
CNM	Certified Nurse Midwife
CNP	Certified Nurse Practitioner
COA	Council on Accreditation of Services for Families and Children
COB	Coordination of Benefits
CON	Certificate of Need
CORF	Comprehensive Outpatient Rehabilitation Facility
CPAP	Continuous Positive Airway Pressure
CPH	Community Public Health
CPS	Children's Protective Services
CPT	Current Procedural Terminology
CQAR	Clinical Quality Assurance Review
CR	Cardiac Rehabilitation
CRN	Claim Reference Number
CRNA	Certified Registered Nurse Anesthetist
CROS	Contralateral Routing of Signals
CRP	Collaborative Remediation Project
CRTS	Certified Rehabilitation Technology Supplier
CSHCS	Children's Special Health Care Services
CSW	Certified Social Worker
CT	Computerized Axial Tomography
CTLSO	Cervical-Thoracic-Lumbar-Sacral Orthosis
CTS	Community Transition Services
CWP	Children’s Home and Community Based Services Waiver Program

Acronym	Meaning
CY	Current Year
DABS	Diagnostic Adaptive Behavior Scale
DAS-II	Differential Ability Scales-II
DD	Developmental Disabilities
DDS	Dentist
DEA	Drug Enforcement Administration
DEAP	Diabetes Education Accreditation Program
DECA	Devereux Early Childhood Assessment
DEG	Data Exchange Gateway
DESI	Drug Efficacy Study Implementation
DHP	Dental Health Plan
DIFS	Department of Insurance and Financial Services
DIT	Directed In-Service Training
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics & Supplies
DMP	Document Management Portal
DPNA	Denial of Payment for New Admissions
DO	Doctor of Osteopathy
DOB	Date of Birth
DOS	Date of Service
DPM	Doctor of Podiatric Medicine
DPO	Designated Provider Organization
DPOA	Durable Power of Attorney
DPOC	Directed Plan of Correction
DPS	Detroit Public Schools
DPT/CSAT	Division of Pharmacologic Therapies/Center for Substance Abuse Treatment
DQ	Developmental Quotient

Acronym	Meaning
DRG	Diagnosis Related Group
DSH	Disproportionate Share Hospital
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSME	Diabetes Self-Management Education
DTMB	Department of Technology, Management & Budget
DTT	Discrete Trial Training
DUB	Designated Unavailable Beds
DUR	Drug Utilization Review
E/M	Evaluation and Management
EAA	Environmental Accessibility Adaptations
EBG	Evidence-Based Guidelines
ECG	Electrocardiogram
ECR	Electronic Cost Report
ED	Emergency Department
EEG	Electroencephalogram
EFT	Electronic Funds Transfer
EGrAMS	Electronic Grants Administration and Management System
EH	eligible hospital (NOTE: Term applies to EHR Incentive Program only.)
EHR	Electronic Health Record
EIBI	Early Intensive Behavioral Intervention
EIN	Federal Employee ID number
EMT	Emergency Medical Technician
EMTALA	Emergency Medical Treatment and Active Labor Act
EOAE	Evoked Otoacoustic Emissions
EOB	Explanation of Benefit

Acronym	Meaning
EP	eligible professional (NOTE: Term applies to EHR Incentive Program only.)
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
ERP	Education Recognition Program
ESO	Emergency Services Only
ESRD	End Stage Renal Disease
ESR	Erythrocyte Sedimentation Rate
EVS	Eligibility Verification System
F/T	Full Time
FAP	Food Assistance Program
FDA	Food and Drug Administration
FFP	Federal Financial Participation
FFS	Fee-for-Service
FNP	Family Nurse Practitioner
FOC	Freedom of Choice
FPL	Federal Poverty Level B67
FQHC	Federally Qualified Health Center
FSR	Financial Status Report
FTE	Full-Time Equivalent
FYE	Fiscal Year End
GAAS	Generally Accepted Auditing Standards
GAF	Global Assessment of Functioning
GED	General Educational Development
GME	Graduate Medical Education
HAA	Hospital Access Agreement
HBP	Hospital Based Provider
HCAC	Health Care Acquired Condition
HCPCS	Healthcare Common Procedure Coding System

Acronym	Meaning
HCRD	Hospital and Clinic Reimbursement Division (Michigan Department of Health and Human Services)
HDM	Home Delivered Meals
HELP	Hawaii Early Learning Profile
HFA	Home for the Aged
HFCWO	High Frequency Chest Wall Oscillation
HHA	Home Health Agency
HHS	Health & Human Services (U.S. Department of)
HICN	Health Insurance Claim Number
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPPS	Health Insurance Prospective Payment System
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health Act
HKAFO	Hip-Knee-Ankle-Foot Orthosis
HLTCU	Hospital Long Term Care Unit
HMO	Health Maintenance Organization
HRSA	Health Resources and Services Administration
HSW	Habilitation Supports Waiver
HUAM	Home Uterine Activity Monitor
IBCLC	Internationally Board Certified Lactation Consultant
IBCLE	International Board of Lactation Consultant Examiners
ICA	Indigent Care Agreement
ICCD	International Center for Clubhouse Development (d/b/a Clubhouse International)
ICD	International Classification of Diseases
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities [previously known as Intermediate Care Facility for the Mentally Retarded (ICF/MR)]
ICO	Integrated Care Organization
ICR	Intensive Cardiac Rehabilitation

Acronym	Meaning
ID	Identification
IDA	Infant-Toddler Developmental Assessment
IDEA	Individuals with Disabilities Education Act
IDG	Interdisciplinary Group
IE	Independent Employment
IEP	Individualized Education Program
IFDSH	Indigent Fund Disproportionate Share Hospital
IFSP	Individualized Family Service Plan
IGT	Intergovernmental Transfer
IHCP	Individualized Health Care Plan
IME	Indirect Medical Education
INS	Immigration and Naturalization Services (INS)
IOP	Intensive outpatient
IPOS	Individual Plan of Service
IQ	Intelligence Quotient
IRA	Imminent Risk Assessment
IS	Intensity of Service
ISD	Intermediate School District
ISEP	Implementation, Sustainability and Exit Plan
ITFI	Infant-Toddler Family Instrument
IV	Intravenous; Indigent Volume
KAFO	Knee-Ankle-Foot Orthosis
KDE	Kidney Disease Education
LARA	Licensing and Regulatory Affairs (Department of)
LARC	Long Acting Reversible Contraceptive
LCD	Local Code Determination
LEEP	Loop Electrosurgical Excision Procedure

Acronym	Meaning
LHD	Local Health Department
LIF	Low-Income Families
LLP	Limited Licensed Psychologist
LOA	Leave of Absence
LOC	Level of Care
LOCD	(Michigan Medicaid Nursing Facility) Level of Care Determination
LOCM	Low Osmolar Contrast Material
LP	Licensed Psychologists
LPC	Licensed Professional Counselor
LPN	Licensed Practical Nurse
LRD	Lifetime Reserve Days
LSD	Local School District
LSO	Lumbar-Sacral Orthosis
LTACH	Long Term Acute Care Hospital
LTC	Long Term Care
LTE	Less Than Effective
MA	Medicaid
MAC	Monitored Anesthesia Care; Maximum Allowable Cost; Master Addictions Counselor
MACI	Medicaid Access to Care Initiative
MAER	Medicaid Allowable Expenditure Report
MAHS	Michigan Administrative Hearing System
MBI	Medicare Beneficiary Identifier
MCBAP	Michigan Certification Board of Addiction Professionals
MCC	Managed Care Carriers
MCF	Medical Care Facility
MCI	Michigan Children's Institute
MCIR	Michigan Care Improvement Registry

Acronym	Meaning
MCL	Michigan Compiled Law
MCLFS	Medicare Clinical Laboratory Fee Schedule
MCM	Medicare Carrier's Manual
MCO	Managed Care Organization
MD	Medical Doctor
MDCN	Medicare Data Communication Network
MDE	Michigan Department of Education
MDHHS	Michigan Department of Health and Human Services (formerly Michigan Department of Community Health [MDCH] and Michigan Department of Human Services [DHS])
MDS	Minimum Data Set
MDS-HC	Minimum Data Set for Home Care
MERF	Medical Eligibility Report Form
MHP	Medicaid Health Plan
MI	Mental Illness
MI Choice	Home and Community Based Waiver for the Elderly and Disabled
MI Enrolls	Michigan Enrolls
MIHP	Maternal Infant Health Program
MIP	Medicaid Interim Payment
MI-VRP	Michigan Vaccine Replacement Program
MMA	Magellan Medicaid Administration, Inc.
MMAP	Michigan Medicare/Medicaid Assistance Program
MMF	Michigan Medicaid Forms
MNT	Medical Nutrition Therapy
MOA	Memorandum of Agreement
MOMS	Maternity Outpatient Medical Services
MOU	Memorandum of Understanding
MPH	Masters of Public Health
MPHI	Michigan Public Health Institute

Acronym	Meaning
MPPL	Michigan Pharmaceutical Product List
MPRO	Michigan Peer Review Organization
MRADL	Mobility Related Activities of Daily Living
MRS	Michigan Rehabilitation Services
MSA	Metropolitan Statistical Area
MSHDA	Michigan State Housing Development Authority
MSP	Medicare Savings Program
MSW	Master of Social Work
MT-BC	Music Therapist - Board Certified
MTF	Military Treatment Facility
MTU	Miscellaneous Transaction Unit
MUE	Medically Unlikely Edit
NAC	National Autism Center
NADAC	National Average Drug Acquisition Cost
NCC	National Certified Counselor
NCCA	National Commission for Certifying Agencies
NCCI	Medicaid National Correct Coding Initiative
NCD	National Coverage Determination
NCPDP	National Council for Prescription Drug Program
NCQA	National Committee on Quality Assurance
NCTRC	National Council for Therapeutic Recreation Certification
NDC	National Drug Code
NEMT	Non-Emergency Medical Transportation
NF	Nursing Facility
NHC	Nursing Home Compare
NICU	Neonatal Intensive Care Unit
NLR	National Level Repository

Acronym	Meaning
NMTR	National Music Therapy Registry
NOC	Not Otherwise Classified
NP	Nurse Practitioner
NPI	National Provider Identifier
NPP	Non-Physician Practitioner
NPPES	National Plan and Provider Enumeration System
NRC	Nuclear Regulatory Commission
NREPP	National Registry of Evidence-based Programs and Practices
NUBC	National Uniform Billing Committee
OASIS	Outcome and Assessment Information Set
OB Profile	Routine prenatal laboratory services
OBRA 90	Omnibus Budget Reconciliation Act of 1990
OCE	Outpatient Code Editor
OCR	Office of Civil Rights; Optical Character Reader
OFIR	Office of Financial and Insurance Regulation
OMA	Office of Medical Affairs
OMB	Office of Management and Budget
ONC	Office of the National Coordinator for Health Information Technology
OPH	Outpatient Hospital
OPPC	Other Provider Preventable Condition
OPPS	Outpatient Prospective Payment System
OR	Operating Room
OSA	Obstructive Sleep Apnea
OT	Occupational Therapy; Occupational Therapist
OTA	Occupational Therapy Assistant
OTC	Over the Counter
OTP	Opioid Treatment Program

Acronym	Meaning
P&O	Prosthetics and Orthotics
P&T	Pharmacy & Therapeutics
P/T	Part Time
PA	Prior Authorization; Physician's Assistant
PACE	Program of All-Inclusive Care for the Elderly
PACER	Prior Authorization Certification Evaluation Review
PAHP	Prepaid Ambulatory Health Plan
PAS	Pre-admission Screening
PASARR	Pre-admission Screening/Annual Resident Review
PBM	Pharmacy Benefits Manager
PBRHC	Provider Based Rural Health Clinic
PC Pool	Primary Care Pool
PCP	Primary Care Physician; Person-Centered Planning
PDAC	Pricing, Data Analysis, and Coding
PDD-NOS	Pervasive Developmental Disorder - Not Otherwise Specified
PDN	Private Duty Nursing
PECFAS	Preschool and Early Childhood Functional Assessment Scale
PECOS	Provider Enrollment, Chain and Ownership System
PEDS	Parent's Evaluation of Developmental Status
PEME	Pre-Eligibility Medical Expenses
PERS	Personal Emergency Response System
PET	Program Enrollment Type
PHI	Protected Health Information
PHS	Public Health Service
PIHP	Prepaid Inpatient Health Plan
PNP	Pediatric Nurse Practitioner
POA	Present on Admission

Acronym	Meaning
POC	Plan of Care; Plan of Correction
POL	Physician's Office Laboratory
POS	Point of Service; Plan of Service; Place of Service
PPA	Patient Pay Amount
PPACA	Patient Protection and Affordable Care Act
PPC	Provider Preventable Condition
PPI	Proton Pump Inhibitor
PPO	Preferred Provider Organizations
PPR	Prospective Payment Rate
PPS	Prospective Payment System
PR	Pulmonary Rehabilitation
ProDUR	Prospective Drug Utilization Review
PSC	Pediatric Symptom Checklist
PT	Physical Therapy; Physical Therapist
PTA	Physical Therapy Assistant
PTAN	Provider Transaction Access Number
PTCA	Percutaneous Transluminal Coronary Angioplasty
Q/U/RM	Quality, Utilization and Risk Management
QAAF	Quality Assurance Assessment Factor
QAAP	Quality Assurance Assessment Program
QAS	Quality Assurance Supplement
QBHP	Qualified Behavioral Health Professionals
QDWI	Qualified Disabled Working Individual
QIDP	Qualified Intellectual Disabilities Professional [previously known as Qualified Mental Retardation Professional (QMRP)]
QMB	Qualified Medicare Beneficiary
QMHP	Qualified Mental Health Professional
QMI	Quality Measure Initiative

Acronym	Meaning
RA	Remittance Advice
RAI	Resident Assessment Instrument
RAP	Refugee Assistance Program
RARSS	Reimbursement and Rate Setting Section
RBRVS	Resource Based Relative Value Scale
RBT	Registered Behavior Technician
RD	Registered Dietitian
RDA	Recommended Dietary Allowance
RDRP	Rapid Dispute Resolution Process
RetroDUR	Retrospective Drug Utilization Review
RF	Reduction Factor
RFP	Request for Proposal
RHC	Rural Health Clinic
RN	Registered Nurse
RNR	Registered Nurse Reviewer
RSV	Respiratory Syncytial Virus
RUG	Resource Utilization Group
RVU	Relative Value Units
SADMERC	Statistical Analysis DME Regional Carrier
SARF	Screening, Assessment, Referral, and Follow-up
SBS	School Based Services
SCQ	Social Communication Questionnaire
SDF	Silver Diamine Fluoride
SE	Supported Employment
SED	Serious Emotional Disturbance
SEDW	Children's Serious Emotional Disturbance Home and Community Based Services Waiver
SFF	Special Focus Facility

Acronym	Meaning
SGA	Substantial Gainful Activity
SGD	Speech Generating Device
SHS	Short Hospital Stay
SI	Severity of Illness; Status Indicator
SI/IS	Severity of Illness and Intensity of Service
SIDS	Sudden Infant Death Syndrome
SLMB	Specified Low Income Medicare Beneficiary
SLP	Speech-Language Pathologist
SMA	State Medicaid Agency
SMP	State Medical Plan
SNF	Skilled Nursing Facility
SNNU	Special Newborn Nursery Unit
SOM	State Operations Manual
SQC	Substandard Quality of Care
SRS-II	Social Responsiveness Scale-II
SS	Social Security
SSA	Social Security Administration; State Survey Agency
SSG	Service Selection Guidelines
SSI	Supplemental Security Income
SSN	Social Security Number
ST	Speech-Language Therapy
STD	Sexually Transmitted Disease
SUBC	State Uniform Billing Committee
SVDCU	Sub-acute Ventilator-Dependent Care Unit
TABS	Temperament and Atypical Behavior Score
TB	Tuberculosis
TBI	Traumatic Brain Injury

Acronym	Meaning
TC	Technical Component
TCM	Targeted Case Management
TCN	Transaction Control Number
TE	Transitional Employment
TEFRA	Tax Equality and Fiscal Responsibility Act of 1982
TENS	Transcutaneous Electrical Nerve Stimulator
TEP	Temporary Eligibility Period
THC	Tribal Health Center
TIG	Telephone Intake Guidelines
TIN	Tax Identification Number
TIP	Temporarily Ineligible Participant
TJC	The Joint Commission
TLSO	Thoracic-Lumbar-Sacral Orthosis
TMA	Transitional Medical Assistance
TOB	Type of Bill
TPA	Therapeutic Pharmaceutical Agent
TPL	Third-Party Liability
TPN	Total Parenteral Nutrition
TTP	Thrombotic Thrombocytopenic Purpura
U&C	Usual and Customary
UMICAD	Upper Midwest Indian Council on Addiction Disorders
UPL	Upper Payment Limit
USPHS	U.S. Public Health Service
USPSTF	United States Preventive Services Task Force
USTF	Uniform Service Treatment Facility
VABS-2	Vineland Adaptive Behavior Scales - Second Edition
VB-MAPP	Verbal Behavior-Milestones Assessment and Placement Program

Acronym	Meaning
VBP	Value Based Purchasing
VFC	Vaccine for Children
VPI	Virginia Polytechnic Institute
WAC	Wholesale Acquisition Cost
WBC	White Blood Cell
WIC	Women, Infants and Children Program
WISC-IV	Wechsler Intelligence Scale for Children-IV
WISC-V	Wechsler Intelligence Scale for Children-V
WPPSI-III	Wechsler Preschool and Primary Scale of Intelligence-III
WPPSI-IV	Wechsler Preschool and Primary Scale of Intelligence-IV
YTD	Year-to-Date

DIRECTORY APPENDIX

This directory provides contact information referenced in the various chapters of the Medicaid Provider Manual, and is divided into the following topic areas:

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
PROVIDER ASSISTANCE			
Provider Inquiry M-F 8 am to 5 pm EST	800-292-2550	MDHHS /Provider Inquiry PO Box 30731 Lansing, MI 48909-8231 providersupport@michigan.gov	Provider resource for billing assistance including out-of-state and non-enrolled provider claims).
Atypical Providers M-F 8 am to 5 pm EST	800-979-4662	MDHHS/Provider Inquiry PO Box 30731 Lansing, MI 48909-8231 providersupport@michigan.gov	Provider and client resource for Home Help/Adult Foster Care/Non-Emergency Transportation services that involve questions of approved authorizations and payment information, along with submission of claims for personal care services.
CHAMPS Provider Enrollment On-Line System	1-800-292-2550	providersupport@michigan.gov	On-line provider enrollment application and information, on-line update of provider information, billing agent authorizations, etc.
Provider Enrollment Unit	517-335-5492 Fax 517-241-8233	MDHHS /Medicaid Payments Division Provider Enrollment Unit PO Box 30238 Lansing, MI 48909 providerenrollment@michigan.gov	Change provider Pay To address. Use the CHAMPS PE contact information for all questions related to the enrollment process.
CHAMPS	Helpline: 1-800-292-2550	www.michigan.gov/medicaidproviders >> CHAMPS	Resources for information; training

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Children's Special Health Care Services (CSHCS)	517-241-7186 Fax 517-241-8970	CSHCS Program 320 S. Walnut Lansing, MI 48913 www.michigan.gov/cshcs	General information regarding CSHCS program
CSHCS Customer Support	517-335-8986 Fax 517-335-9491 (submission of medical reports, applications, and all other information)	CSHCS Customer Support PO Box 30734 Lansing, MI 48909	Information about medical eligibility determinations, application process, coverage, requests for retroactive coverage, hospice, respite, or submission of client information updates.
MI Care Team		email address: MDHHS-MICareTeam@michigan.gov website: www.michigan.gov/micareteam	General information. Provider Resources, including: • MI Care Team Handbook • MSA-1030 • MDHHS-5515 • sample of Beneficiary Enrollment letter Consumer Resources • MI Care team sites • Map of participating counties
		email address: MDHHS-BHConsent@michigan.gov website: www.michigan.gov/bhconsent	form MDHHS-5515 and supporting resources, including FAQ
		email address: automatedbilling@michigan.gov website: www.michigan.gov/medicaidproviders >> Provider Enrollment >> Billing Agent -User Guide	Billing agent information
		email address: MDHHSEncounterData@michigan.gov	questions related to encounter file submission and FTS issues for MI Care Team organizations
		website: www.michigan.gov/tradingpartners >> HIPAA - Companion Guides >> Electronic Submissions Manual	information and instructions relating to submitting data electronically and the File Transfer Service (FTS)
BENEFICIARY ASSISTANCE			
Beneficiary Help Line M-F 8 am to 7 pm	800-642-3195	MDHHS Enrollment Services Section PO Box 30479 Lansing, MI 48909-7979	Beneficiary resource for all programs administered by MDHHS, billing problems, **mihealth** card replacements, etc.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Beneficiary Pharmacy Help Line 24/7/365	877-681-7540	Magellan Medicaid Administration, Inc.	Beneficiaries can receive answers to general pharmacy questions.
MI Enrolls (Michigan Enrolls) M-F 8 am to 7 pm	888-367-6557 TTY: 888-263-5897	Michigan Enrolls PO Box 30412 Lansing, MI 48909	Health plan enrollment, provider participation information, and health plan change.
MIChild/MOMS	888-988-6300 TTY: 888-263-5897	Michigan Enrolls PO Box 30412 Lansing, MI 48909 On-line application www.michigan.gov/mibridges	MIChild health plan enrollment, MIChild provider participation information, and MIChild health plan change.
Family Center for Children and Youth with Special Needs Family Phone Line M-F 8 am to 5 pm	800-359-3722 fax 313-456-4379	CSHCS Family Center Cadillac Place, Suite 3-350 3056 W. Grand Blvd. Detroit, MI 48202 email: cshcsfc@michigan.gov	**For parent use only.** Information regarding CSHCS, statewide Family Support Network, other resource information, transferring calls to CSHCS staff and providers.
Medicare Buy-In Unit	517-335-5488 Fax 517-335-0478	MDHHS /Buy-In Unit Lewis Cass Bldg. 320 S. Walnut St. Lansing, MI 48913 BuyInUnit@michigan.gov	Reviews Medicare/Medicaid dual eligible beneficiary information to determine if they qualify for the Medicare Buy-In/Medicare Savings Program.
ELIGIBILITY VERIFICATION			
CHAMPS Eligibility Inquiry	MDHHS Provider Inquiry Helpline 1-800-292-2550 for questions/ issues related to the eligibility response.	email: providersupport@michigan.gov Website: Log into CHAMPS using MILogin at https://milogintp.michigan.gov. Go to the Eligibility Inquiry hyperlink located on the 'Provider Portal' page under the 'Member' section. Benefit Plan Information: www.michigan.gov/mdhhs >> Resources >> Beneficiary Eligibility Verification >> Benefit Plans >> Benefit Plan ID table	For Medicaid providers to verify eligibility for the Medicaid, CSHCS, MOMS, and MIChild programs. Refer to the Benefit Plan ID table in the Beneficiary Eligibility Chapter for a complete list of Benefit Plan IDs that are provided in the eligibility response. Providers need to utilize the Benefit Plan ID(s) indicated in the eligibility response to determine coverage for a specific DOS.
CHAMPS 270/271 Batch Transaction		email: AutomatedBilling@michigan.gov Web Address: www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Electronic Billing >> HIPAA - Companion Guides	A HIPAA 270/271 Batch option is available in CHAMPS for providers and/or their contracted clearinghouse vendors to verify eligibility. Refer to the HIPAA 5010 270/271 Inquiry Response Companion Guide for more information and/or the Electronic Submission Manual for upload availability.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Web-DENIS	1-877-BLUE-WEB (1-877-258-3932) fax 248-486-2214	Blue Cross Blue Shield of MI Electronic Business Interchange Group, L830 53200 Grand River New Hudson, MI 48165 www.bcbsm.com For more information, including access information, refer to the MDHHS website at www.michigan.gov/medicaidproviders >> Beneficiary Eligibility Verification	Web-DENIS is BCBSM's secure browser-based internet site for eligibility verification. Medicaid providers can verify eligibility for the Medicaid, CSHCS, MOMS, and MIChild programs at no cost. Eligibility response data is provided from CHAMPS. Providers need to utilize the Benefit Plan ID(s) indicated in the eligibility response to determine coverage for a specific DOS.
Newborn ID Numbers	Fax 517-373-1437	MDHHS Enrollment Services Section PO Box 30479 Lansing, MI 48909-7979 MSA-ESS@michigan.gov	Fax or e-mail requests to obtain newborn ID numbers for billing Medicaid only when an eligibility inquiry does not locate the newborn. Eligibility information must be obtained using the CHAMPS Eligibility Inquiry with the ID number provided by MDHHS. When submitting a request, include newborn's name, gender, date of birth, mother's name, and mother's Medicaid ID number.
MOMS Eligibility	Fax 517-241-8556	Customer Services Division Attn: MOMS Program	ONLY if MOMS ID number is not available through the CHAMPS Eligibility Inquiry or **mihealth** card. Request must be on provider letterhead and include provider's phone number and contact person.
Eligibility Verification (out-of-state providers)	1-800-292-2550		For out-of-state providers without internet access to verify eligibility for Medicaid, CSHCS, MOMS, and MIChild programs within the last 12 months.
Michigan Public Health Institute (MPHI)		email: MedicaidEligibility@mphi.org Web Address: https://healthplanbenefits.mihealth.org	For Medicaid providers to verify eligibility for the Medicaid, CSHCS, MOMS, and MIChild programs at no cost. Eligibility response data provided from CHAMPS. Providers need to utilize the Benefit Plan ID(s) indicated in the eligibility response to determine coverage for a specific DOS.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
			MPHI offers: Web-based system called MI Health Plan Benefits. To obtain access, go to https://healthplanbenefits.mihealth.org >> Enrollment Form HIPAA X12 270/271 Realtime/batch transaction. For information, Enrollment Form, and Companion Guide, go to www.mihealth.org >> HIPAA 270/271 Transactions for Michigan Medicaid • MSA-1038 status tool: Search by Member ID or Name/DOB to determine the status of a submitted MSA-1038. Database is updated on a daily basis.
Medicare DSH Audits - Eligibility Verification for Dates Of Service Over 12 Months for Hospital Providers	Michigan Public Health Institute (MPHI): (877) 816-0737 CHAMPS = MDHHS Provider Inquiry: 800-292-2550	**MPHI**: Website: HIPAA X12 270/271 Realtime/batch Transaction website = http://www.mihealth.org/#HIPAA >> HIPAA 270/271 Transactions for Michigan Medicaid email: MedicaidEligibility@mphi.org **CHAMPS**: Website: www.michigan.gov/tradingpartners >> HIPAA –Companion Guides Mailing Address: MDHHS /Provider Inquiry P.O. Box 30731 Lansing, MI 48909-8231 email: providersupport@michigan.gov	The following options are available for hospital providers to verify eligibility for DOS over 12 months for Medicare DSH audits: • **MPHI** = 270/271 Realtime/Batch Transactions • **CHAMPS** = Member Eligibility Inquiry • **CHAMPS** = 270/271 Batch Transaction Hospital providers that contract with clearinghouse vendors to submit/receive their DSH inquiries must have the vendor listed as one of their approved billing agents on CHAMPS (PE subsystem).
PRIOR AUTHORIZATION (Authorization of Services)			
Program Review Division, Benefits Monitoring Program	855-808-0312 fax 517-335-0075	MDHHS Program Review Division P.O. Box 30170 Lansing, MI 48909-7979	Inquiries by beneficiaries and providers regarding the Benefits Monitoring Program
Program Review Division (FFS Medicaid & CSHCS)	800-622-0276 fax 517-335-0075	MDHHS Program Review Division PO Box 30170 Lansing, MI 48909	Prior authorization for all services except hospital, specified durable medical equipment, and pharmacy
Prior Authorization (MHP)	See Health Plan list on MDHHS website	Obtain specific health plan contact information at: www.michigan.gov/medicaid >> Program Resources >> Medicaid Health Plans	For beneficiaries enrolled in a health plan, providers are to contact the plan for authorization of services
Prior Authorization - Dental	800-622-0276 fax 517-335-0075	MDHHS Dental Prior Authorization PO Box 30154 Lansing, MI 48909	Prior authorization of dental services for Medicaid and CSHCS

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Prior Authorization - Specified DME and Medical Supplies (MDHHS Medicaid Telephone Prior Authorization Contractor)	800-727-7223	Michigan Peer Review Organization 22670 Haggerty Rd., Ste. 100 Farmington Hills, MI 48335-2611	Telephone prior authorization of specified DME and medical supplies (applies to applicable procedure codes requiring telephone prior authorization noted on the MDHHS Medical Supplier/Orthotists/ Prosthetists/DME Dealers page on the MDHHS website)
Prior Authorization (PACER) – Med/Surg Inpatient Admissions (Admissions & Certification Review Contractor)	800-727-7223	Michigan Peer Review Organization 22670 Haggerty Rd., Ste. 100 Farmington Hills, MI 48335-2611	Prior authorization for Medicaid and CSHCS admissions
Prior Authorization (PACER) Acute Care Hospital to Long Term Acute Care Hospital (LTACH)	800-727-7223	Michigan Peer Review Organization 22670 Haggerty Rd., Ste. 100 Farmington Hills, MI 48335-2611	Prior authorization for Medicaid, Healthy Michigan Plan, and CSHCS admissions.
Prior Authorization – Psychiatric Inpatient Admissions	Refer to local Community Mental Health Services Program		
Prior Authorization – Private Duty Nursing FFS Medicaid	800-622-0276 fax 517-241-7813	MDHHS Program Review Division PO Box 30170 Lansing, MI 48909	Prior authorization for FFS Medicaid PDN services.
Prior Authorization – Private Duty Nursing Children's Waiver & Habilitation Supports Waiver		Contact beneficiary's case manager/ supports coordinator at their local Community Mental Health Services Program (CMHSP)	Prior authorization for Children's Waiver and Habilitation Supports Waiver PDN services.
Prior Authorization – Ventilator-Dependent Care Units (MDHHS Medicaid Prior Authorization Contractor)	800-727-7223	Michigan Peer Review Organization 22670 Haggerty Rd., Ste. 100 Farmington Hills, MI 48335-2611	Authorization for Medicaid reimbursement in contracted ventilator dependent care units
Prior Authorization – NF Complex Care	800-622-0276 fax 517-241-7813	MDHHS Program Review Division PO Box 30170 Lansing, MI 48909	Authorization for increased NF per diem for complex care
Prior Authorization – Pharmacy (PBM Technical Call Center) 24/7/365	877-624-5204 fax 877-888-6370	Magellan Medicaid Administration, Inc. 4300 Cox Rd. Glen Allen, VA 23060	Non-clinical prior authorization and early refills
Pharmacy Clinical Call Center (PBM Clinical Call Center) 7 am – 7 pm EST, M – F After hours calls rollover to the PBM Technical Call Center	877-864-9014 fax 887-888-6370 fax 800-250-6950	Magellan Medicaid Administration, Inc. 4300 Cox Rd. Glen Allen, VA 23060	Prescribers call for prior authorization clinical reasons and non-preferred drug products. Pharmacies call for dollar amount limits and Medicare Part B coinsurance.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
BILLING RESOURCES			
Automated Billing Unit/ Electronic Billing Resources	fax 517-335-3766	Automated Billing Unit PO Box 30731 Lansing, MI 48909 AutomatedBilling@michigan.gov	Information regarding becoming an electronic biller and submitting electronic claims to MDHHS. 835 & 837 Companion Guides, Testing Instructions, and MDHHS Electronic Submission Manual are available at www.michigan.gov/tradingpartners
Beneficiary Co-Payments		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Co-Payment Requirements www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Co-Payment FAQ Healthy Michigan Plan: www.michigan.gov/healthymichiganplan >> Healthy Michigan Plan Provider Information	Beneficiary co-payment requirements; frequently asked questions
CDT Coding Manual (American Dental Assoc.)	800-947-4746		Procedure codes required for dental claims.
Centers for Medicare & Medicaid Services (CMS)		www.cms.gov	Provider resource for CMS guidelines, HCPCS Codes, and National Physician Fee Schedule Relative Value Files
CPT Coding Manual HCPCS Coding Manual ICD Coding Manual			Procedure and diagnosis coding required for professional and institutional claims. Available for purchase from a variety of vendors.
Electronic Healthcare Transactions		Web Address: www.michigan.gov/5010ICD10	Information regarding X12 version 5010 transactions and ICD-10 code sets
MDHHS Procedure Code Databases/Fee Screens, Documentation Requirements, Readmission Example, etc.	517-284-1245 fax 517-335-5136	www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information	MDHHS -covered procedure codes, parameters, fee screens, 15-day readmission example, OPPS Wraparound Code Lists for each provider type available on-line.
MDHHS Institutional Billing Resource		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information (>> "Inpatient Hospital" or "Outpatient")	Billing updates.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
MDHHS Sanctioned Providers List		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> List of Sanctioned Providers U.S. Department of Health & Human Services (HHS) Sanctioned Providers: https://exclusions.oig.hhs.gov MDHHS Licensing Actions: www.michigan.gov/healthlicense and www.michigan.gov/bchs MDHHS Licensing Actions: www.michigan.gov/mdhhs >> Doing Business with MDHHS >> Licensing	List of providers that are excluded from participation in Michigan Medicaid, CSHCS, etc.
Medicaid Code and Rate Reference Tool		Log into CHAMPS using MILogin at https://milogintp.michigan.gov. Go to the External Links menu located on the 'Provider Portal' page. Select 'Medicaid Code and Rate Reference' from the dropdown list.	Real-time information regarding MDHHS -covered procedure codes, parameters, and fee screens.
Medicare Crossover Claims		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Medicare Crossover	Information regarding Medicare Crossover billing and exclusions
Medicaid National Correct Coding Initiative (NCCI)	fax 317-571-1745	Medicaid National Correct Coding Initiative Correct Coding Solutions, LLC P.O. Box 907 Carmel, IN 46082-0907 https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html	Information regarding Medicaid NCCI. Questions regarding NCCI coding policies and edits may be directed to the CMS NCCI Contractor: Correct Coding Solutions, LLC.
National Uniform Billing Committee (NUBC) Manual		American Hospital Association National Uniform Billing Committee PO Box 92247 Chicago, IL 60675-2247 www.nubc.org	To obtain a NUBC manual.
National Uniform Claim Committee		www.nucc.org	To obtain CMS-1500 (02-12) claim forms or NUCC standard claim completion instructions.
Medicare Pricing, Data Analysis, and Coding (PDAC); Contractor: Noridian Administrative Services, LLC	877-735-1326 (9:00 a.m.-4:00 p.m. EST)	http://www.dmepdac.com	Enteral Product Classification List; DME information
Washington Publishing Co.		PMB 161 5284 Randolph Rd Rockville, MD 20852-2116 www.wpc-edi.com	Information regarding HIPAA compliant claim formats and code sets

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
CLAIM SUBMISSION/PAYMENT			
Document Management Portal		www.michigan.gov/medicaidproviders >> Document Management Portal	Document Management Portal information and tutorials
Vendor Registration and Electronic Funds Transfer		State Budget Office www.michigan.gov/SIGMAVSS	Register provider SSN or EIN/TIN, initiate receipt of electronic Medicaid payments
Friend of the Court	517-373-5975 Fax 517-373-8740	Friend of the Court Bureau State Court Administrative Office Michigan Hall of Justice PO Box 30048 Lansing, MI 48909 FOCB@courts.mi.gov	Qualifying medical support orders
MDHHS Cashier's Unit		MDHHS Cashier's Unit 235 S. Grand Ave., Ste. 801 PO Box 30437 Lansing, MI 48909	Refund payments to MDHHS, purchase Medicaid manual subscription
		MDHHS - Cashier's Unit Attn.: Bureau of Finance - MCU 235 S. Grand Ave., Ste. 801 PO Box 30437 Lansing, MI 48909	Provider returning overpayments
Paper Claim Submission		MDHHS PO Box 30043 Lansing, MI 48909	CMS-1500 (02-12), CMS-1450 (UB-04), and ADA 2012 claims are to be mailed to the address indicated. No other paper claim formats are accepted.
Pharmacy Paper Claim Submission		Magellan Medicaid Administration, Inc. Michigan Paper Claims Processing Unit PO Box C-85042 Richmond, VA 23261-5042	Address to submit paper pharmacy claims.
Sterilization & Hysterectomy Forms Submission	Fax 866-229-6675		Fax completed form according to Document Management Portal instructions. Form may be downloaded from the MDHHS website at: www.michigan.gov/medicaidproviders >> Policy, Letters & Forms
Third Party Liability Section	800-292-2550 (option #4) fax 517-346-9817	MDHHS /TPL PO Box 30479 Lansing, MI 48909-7979 TPL_Health@michigan.gov	Coordination of benefits issues

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
POLICY/FORMS/PUBLICATIONS			
Medicaid Policy Division		MDHHS /Medicaid Policy PO Box 30479 Lansing, MI 48909 MSAPolicy@michigan.gov	Policy questions, etc. Billing questions/problems and general policy questions should be directed to Provider Inquiry at 1-800-292-2550.
Draft Medicaid Policy	517-284-1245	MSADraftPolicy@michigan.gov	Proposed policies are distributed for a 30-day public comment period. Copies of proposed policies may be requested via e-mail or obtained from the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms
ListServ Communications		www.michigan.gov/medicaidproviders >> Listserv Instructions (under Resources)	Subscription instructions
Medicaid Forms Distribution		MDHHS Medicaid Program Policy Division PO Box 30479 Lansing, MI 48909 E-mail: MSA-Forms@michigan.gov	Many required forms are available in the Forms Appendix of this manual and on-line at: www.michigan.gov/medicaidproviders >> Policy, Letters & Forms
Medicaid Policy Manuals and Bulletins	517-284-1245 fax 517-335-5136	MSAPolicy@michigan.gov	Copies of policy bulletins. This information is also available on-line at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms
Michigan Medicaid Provider Manual (CD version)	Fax 517-335-5136	MDHHS /Medicaid Program Policy Division PO Box 30479 Lansing, MI 48909 MSA-Forms@michigan.gov	Michigan Medicaid Provider Manual on compact disc (CD)
Medicaid Publications		MDHHS Health Promotions & Publications 320 S. Walnut Lansing, MI 48933 www.michigan.gov/medicaidproviders >> Policy, Letters & Forms	Medicaid brochures and other publications
Numbered Letters		www.michigan.gov/medicaidproviders >> Policy, Letters & Forms	Copies of numbered letters
U.S. Department of Health & Human Services (HHS)		http://www.hhs.gov/opa/order-publications/#pub_sterilization-pubs	Consent for Sterilization form (HHS-687)

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
APPEALS			
Appeals (Beneficiary)	877-833-0870 or (517) 335-7519 Fax (517) 763-0146	Michigan Administrative Hearing System PO Box 30763 Lansing, MI 48909	Beneficiaries may request a hearing on an action to discontinue, terminate, suspend, or reduce public assistance or services. A hearing may also be requested on an action to deny a choice of provider assignment in the Benefits Monitoring Program (BMP).
Appeals (Provider)	877-833-0870 or 517-335-4900 Fax 517-241-7973	Michigan Administrative Hearing System PO Box 30807 Lansing, MI 48909 www.michigan.gov/medicaidproviders >> Michigan Administrative Hearing System for the Department of Health and Human Services (under Resources)	Ambulatory, hospital, PACE organizations, and nursing facility appeals
Appeals (Provider)		Web Address: http://www.michigan.gov/lara >> Office of Regulatory Reinvention >> Publications >> Michigan Administrative Code >> Select the Department >> Health and Human Services >> Medical Services Administration >> MSA Provider Hearings	Review and hearings process for providers promulgated in the administrative rules.
State Hospital Appeals Panel Coordinator		State Hospital Appeals Panel Coordinator Michigan Administrative Hearing System PO Box 30763 Lansing, Michigan 48909	Hospitals wishing to waive right to appeal through the administrative rules, R400.3406 through R400.3424, may elect to request a hearing before the State Hospital Appeals Panel
HEALTH PLAN INFORMATION			
Dental Health Plans		Web Address: www.michigan.gov/healthykidsdental	Information related to ***Healthy Kids Dental*** enrollees, services, claims, and Dental Health Plans.
Medicaid Health Plans	517-284-1162	www.michigan.gov/medicaid >> Program Resources >> Medicaid Health Plans	Information regarding Medicaid Health Plans

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Medicaid Health Plan Carveout		Medicaid Health Plan Pharmacy Program Carve-out https://michigan.fhsc.com >> Providers >> Drug Information >> Medicaid Health Plan Carveout Medicaid Health Plan Injectable Drugs and Biologicals Carve-out www.michigan.gov/medicaid >> Providers >> Billing & Reimbursement >> Provider Specific Information >> Medicaid Health Plan Carve-out	Drugs in the categories listed on the MHP carveout list are excluded from the MHP contract.
Pre-paid Inpatient Health Plan Contract Managers	517-241-5066	www.michigan.gov/mdhhs >> Keeping Michigan Healthy >> Behavioral Health and Developmental Disability >> Mental Health >> Community Mental Health Services	Information regarding Mental Health and Substance Use Disorder treatment services available through the Pre-paid Inpatient Health Plans
Delta Dental Customer & Claims Services Department	800-482-8915		Information related to ***Healthy Kids Dental*** enrollees, services, and claims
PIHP Contact Information, Service Areas		www.michigan.gov/mdhhs >> Keeping Michigan Healthy >> Behavioral Health and Developmental Disability >> Mental Health >> Community Mental Health Services	Contact information for Mental Health & Substance Abuse
HEALTHY MICHIGAN PLAN			
Preventive and Wellness Services		United States Preventive Services Task Force grade A and B services http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ Advisory Committee on Immunization Practices recommended vaccines http://www.cdc.gov/vaccines/hcp/acip-recs/index.html Institute of Medicine recommended preventive services for women http://www.iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx Current periodicity schedule by the American Academy of Pediatrics http://brightfutures.aap.org/clinical_practice.html	Resources for covered preventive and wellness services.
Healthy Michigan Plan Provider Webpage		www.michigan.gov/healthymichiganplan	Healthy Michigan Plan information and resources for providers

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
PROVIDER RESOURCES			
MDHHS Bureau of Epidemiology and Population Health; Division of Communicable Diseases	517-335-8165 517-335-9030 (After Hours) Fax 517-335-8263	MDHHS Bureau of Epidemiology and Population Health Division of Communicable Diseases 333 S. Grand Ave., 3rd Floor Lansing, MI 48909 www.michigan.gov/mdhhs >> Keeping Michigan Healthy >> Communicable & Chronic Diseases >> Communicable Disease Information and Resources	Disease reporting, commonly used forms, press releases and other useful information.
MDHHS Bureau of Family Health Services; Division of Immunization	517-335-8159 517-335-9030 (After Hours)	MDHHS Bureau of Family Health Services Division of Immunization 333 S. Grand Ave., 3rd Floor Lansing, MI 48909 www.michigan.gov/mdhhs >> Adult & Children's Services >> Children & Families >> Immunization Info for Families & Providers	Immunization schedules, commonly used forms, press releases and other useful information.
MDHHS Bureau of Laboratories – Data and Specimen Handling (DASH) Unit	517-335-8059 Fax 517-335-9871	MDHHS Bureau of Laboratories – Trace Metals Section 3350 N. Martin Luther King Jr. Blvd. P.O. Box 30035 Lansing, MI 48909 www.michigan.gov/mdhhslab www.michigan.gov/documents/DCH-0696_157219_7.pdf	Obtain clinic code; Download Blood Lead Test Request form (DHHS-0696)
MDHHS Bureau of Laboratories, Trace Metals Section	517-335-8244	Website: www.michigan.gov/mdhhslab	Lead testing (technical questions)
MDHHS Bureau of Laboratories – Warehouse	517-335-9040 Fax 517-335-9039	email: mdhhslab@michigan.gov	Order testing supplies
MDHHS Childhood Lead Poisoning Prevention Program	517-335-8885 Fax 517-335-8509	MDHHS Childhood Lead Poisoning Prevention Program PO Box 30195 Lansing, MI 48909 Web address: www.michigan.gov/lead	Education and outreach related to blood lead poisoning

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
MDHHS Diabetes and Other Chronic Diseases Section/Diabetes and Kidney Unit; Diabetes Self-Management Education Certification Program – Annual Statistical Data Report	517-373-2818 Fax 517-335-9461	MDHHS Diabetes and Kidney Unit WSB – 7th Floor P.O. Box 30195 Lansing, MI 48909-0001 www.michigan.gov/diabetes >> Diabetes Self-Management Education Certification Program	Information about DSME certification, including the Annual Statistical Data Report
MDHHS Diaper & Incontinence Supply Contract	800-737-0045 Fax 800-737-0012 Fax for hospital prescriptions: 800-737-0012 TTY: 800-737-0084	J & B Medical 4305 Pineview Dr., Ste. 100 Commerce Township, MI 48390	Volume purchase contract for select incontinence supplies. Refer to the Medical Supplier Chapter for additional information.
MDHHS Division of Family & Community Health	517-335-8492 Fax 517-335-8294	MDHHS Division of Family & Community Health Bureau of Family, Maternal and Child Health PO Box 30195 Lansing, MI 48909 email: newproviderapplication@michigan.gov website: www.michigan.gov/mihp	Certification/accreditation/enrollment for MIHP program providers, *Maternal Infant Health Program Operations Guide*, general program information
MDHHS Early Hearing Detection and Intervention (EHDI) Program)	Fax 517-335-8036	www.michigan.gov/mdhhs >> Adult & Children's Services >> Children & Families >> Early Hearing Detection and Intervention >> The Birth Hospital's Role in Newborn Hearing Screening >> Audiological/Medical Follow-Up Services Report DCH-0120	Report results of all hearing tests and screenings; Audiological/Medical Follow-Up Services Report form (DCH-0120)
MDHHS-File Transfer	Client Service Center = 1-800-968-2644	Log into MDHHS-File Transfer using MILogin: https://milogintp.michigan.gov Assistance with MILogin can be found online at www.michigan.gov/mdhhs-milogin-info	
MDHHS Bureau of Purchasing, Grants Division/Electronic Grants Section	517-241-8764	MDHHS Bureau of Purchasing Grants Division Electronic Grants Section 235 S. Grand Ave., Ste. 1201 Lansing, MI 48933	Local Health Department Agreements

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
MDHHS Healthy Homes Section	517-335-9390 Fax 517-335-8800	MDHHS Healthy Homes Section P.O. Box 30195 Lansing, MI 48909 Web address: www.michigan.gov/leadsafe	Obtain Protocol for Environmental Investigations for Children with Elevated Blood Lead Levels, a list of certified risk assessors, applications for training and certification, and education materials
MDHHS Hospital 15-Day Readmission Guidelines		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Inpatient Hospitals	Readmission guidelines for hospitals and Medicaid Health Plans
MDHHS Infant Oral Health Training	517-335-8879 Fax 517-346-9862	Education/Fluoride Coordinator Oral Health Program Michigan Department of Health and Human Services P.O. Box 30195 Lansing, MI 48909 oralhealth@michigan.gov www.michigan.gov/oralhealth www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Dental	Assistance for medical providers on training programs and other resource materials. Provides certification for, and monitoring of, medical providers on infant oral health.
MDHHS Injury and Violence Prevention Section	517-335-9518 Fax 517-335-9669	MDHHS Injury and Violence Prevention Section P.O. Box 30195 Lansing, MI 48909 www.michigan.gov/mdhhs >> Safety & Injury Prevention >> Injury & Violence Prevention	Public health prevention resources to reduce morbidity, mortality, and risk behaviors related to unintentional and intentional injuries
MDHHS Mobile Dentistry		www.michigan.gov/oralhealth >> Mobile Dentistry	Mobile Dental Facility Application
MDHHS Newborn Screening Section	517-335-8095	MDHHS Bureau of Laboratories Newborn Screening Section 3350 N. Martin Luther King Jr. Blvd. Lansing, MI 48906 www.michigan.gov/mdhhs >> Adult & Children's Services >> Hereditary Disorders	Blood samples and each newborn's pulse oximetry screening results are to be reported to the MDHHS Newborn Screening Section. Complete list of newborn blood screening disorders.
MDHHS OIG Post-Payment Audits	614-801-0495	AdvanceMed Midwestern 1530 E. Parham Rd. Henrico, VA 23228 www.michigan.gov/medicaidproviders >> Resources >> MDHHS OIG Post-Payment Audits	Audit resources for providers.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
MDHHS Oral Health Program		Email: OralHealth@michigan.gov Web Address: www.michigan.gov/oralhealth	Education and technical assistance on oral health resources regarding oral screenings, caries risk assessment, and fluoride varnish applications.
Advisory Committee on Immunization Practices (ACIP)		www.cdc.gov/vaccines/acip	Information regarding immunization and vaccine recommendations and standards of practice
American Academy of Pediatric Dentistry (AAPD)		http://www.aapd.org >> Policies and Guidelines >> Infant Oral Health Care (under Clinical Guidelines)	Guidelines on periodicity of examination, preventive dental services, anticipatory guidance and oral treatment
		http://www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf	Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling
		http://www.aapd.org/media/Policies_Guidelines/G_CariesRiskAssessment.pdf	Caries Risk Assessment Tool
American Academy of Pediatrics (AAP)		www.aap.org >> About the AAP >> Committees, Councils & Sections >> Section Websites >> Oral Health >> Resources	Oral health resources
		http://www.aap.org >> Professional Resources >> Clinical Support >> Connected Kids >> Materials >> Connected Kids Clinical Guide	Connected Kids: Safe, Strong, Secure clinical guide on youth violence and injury prevention
		http://brightfutures.aap.org >> Materials >> Practice Guides and Other Resources	Practice guides on oral health, mental health, and physical activity
		http://www.aap.org >> Professional Resources >> Red Book Resources	Tuberculosis information regarding risk and testing.
Clinical Laboratory Improvement Amendments (CLIA)		https://www.cms.gov/Regulations-and-guidance/Legislation/CLIA/Downloads/waivetbl.pdf	List of CLIA-waived lab tests.
Community Health Centers/Federally Qualified Health Centers		www.michigan.gov/mdhhs >> Assistance Programs >> Health Care Coverage >> Help Finding Health Care >> Free or Low Cost Primary Care from a Doctor or Nurse	Source for Free or Low Cost Primary Care
Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit		www.gladpc.org >> GLAD-PC Toolkit	Information, recommendations, educational resources, and tools to aid in the management of adolescent depression in primary care.
Hospital Post-Payment Reviews (MDHHS Post-Payment Review Hospital Audit Contractor)	800-727-7223	Michigan Peer Review Organization 22670 Haggerty Rd., Ste. 100 Farmington Hills, MI 48335-2611	Inpatient and outpatient hospital post-payment reviews

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Medicaid Health Plan Carve-out		www.michigan.gov/medicaid >> Providers >> Billing & Reimbursement >> Provider Specific Information >> Medicaid Health Plan Carve-out	A list of outpatient physician-administered drugs and biological products carved-out from the Michigan Medicaid Health Plans (MHPs)
Medicaid State Plan		Web Address: www.michigan.gov/medicaid >> Program Resources	
Mental Health Screening and Assessment Tools for Primary Care		www.aap.org >> Advocacy & Policy >> AAP Health Initiatives >> Clinical Resources >> Mental Health >> Key Resources >> Primary Care Tools >> Mental Health Screening and Assessment Tools for Primary Care	Listing of mental health screening and assessment tools.
Michigan Care Improvement Registry (MCIR)		http://www.mcir.org	All immunizations must be reported to the MCIR
Michigan's Great Start Trauma Informed System		www.michigan.gov/traumatoxicstress	To add a trauma informed approach into the comprehensive early childhood system known as Great Start.
OASIS		www.cms.hhs.gov/OASIS	Mandated assessment for Home Health services
OASIS HelpDesk	888-324-2647 or 517-241-2628		Assistance in transmitting OASIS data to the state repository
Office of Medical Affairs	517-335-5181	MDHHS /Office of Medical Affairs PO Box 30479 Lansing MI 48909	
Reimbursement & Audit	517-335-5330	MDHHS /Hospital and Clinic Reimbursement Division PO Box 30479 Lansing, MI 48909-7979 www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Inpatient Hospitals	Information on hospital and health plan rates and audits
Smiles for Life		www.smilesforlifeoralhealth.org	Comprehensive oral health curriculum designed to enhance the role of primary care clinicians in promoting oral health. Providers and staff are encouraged to complete the online Children's Oral Health Smiles for Life Course 6: Caries Risk Assessment, Fluoride Varnish and Counseling training module at www.smilesforlifeoralhealth.org and obtain certification prior to providing oral health screenings and fluoride varnish applications.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
State Survey Agency (Non-Long Term Care Facilities)	517-335-1980 fax 517-241-3354	Department of Licensing and Regulatory Affairs Bureau of Community and Health Systems Federal Survey and Certification Division 611 W. Ottawa Street PO Box 30664 Lansing, MI 48909 www.michigan.gov/bchs	Hospital, ESRD, OPT/CORF, RHC, Hospice, Home Health Agencies, Clinical Labs, FSOF/ASC, Psychiatric hospitals
United States Preventive Services Task Force (USPSTF)		www.uspreventiveservicestaskforce.org	Information regarding preventive service recommendations.
Women, Infants, and Children (WIC) Program	800-262-4784	www.michigan.gov/wiccc	Michigan WIC Client Portal site connects beneficiaries with a local WIC agency and provides additional resources regarding supplemental healthy foods, nutrition counseling and education, breastfeeding support, immunization screening, and referrals to other helpful services to pregnant, breastfeeding, and post-partum women, infants, and children younger than five years of age.
HOSPICE RESOURCES			
MDHHS Hospice Enrollment Coordinator	517-335-5567		Contact only if hospice services began prior to a health plan enrollment.
MATERNAL-CHILD EDUCATIONAL RESOURCES			
Infant Sleep Positioning	1-800-331-7437	www.tomorrowschildmi.org	Information/brochures related to infant sleep positioning.
		www.mihealth.org	Training for professionals, CEUs
MATERNAL INFANT HEALTH PROGRAM RESOURCES			
Early On Michigan	1-800-EarlyOn Fax 517-668-2505	https://1800earlyon.org/index.php	Early intervention services for infants and toddlers, birth to three years of age with developmental delay (s) or disabilities.
Great Start Collaborative		http://greatstartforkids.org/content/great-start-network	Helps parents find the best early learning settings for their children and helps providers and educators improve the care they give to their children.
LogistiCare Solutions	866-569-1902		Non-emergency medical transportation for qualifying beneficiaries in Wayne, Oakland, and Macomb counties

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Maternal Infant Health Program	Phone #: 1-833-644-6447 Fax #: 517-763-0366	http://www.michigan.gov/mihp	Information regarding MIHP enrollment and operations, including the MIHP Operations Guide, forms, and contact information.
Text4baby		https://ww.text4baby.org	Service providing information for pregnant and postpartum women
MENTAL HEALTH/SUBSTANCE ABUSE RESOURCES			
Children's Waiver Program	517-241-5757	Children's Waiver Program MDHHS -BHDDA Division of Quality Management & Planning Lewis Cass Bldg., 5th Floor 320 S. Walnut St. Lansing, MI 48913	Submission of Prior Review and Approval Request (PRAR) form and documentation
International Center for Clubhouse Development (ICCD)		http://www.iccd.org/certification.html	Information regarding Clubhouse International accreditation
		http://www.iccd.org/images/employment_guidelines_2012.pdf	Clubhouse International standards and guidelines
MDHHS-BHDDA Community Practices and Innovation Section, Division of Quality Management & Planning	517-335-0499	MDHHS-BHDDA Community Practices and Innovation Section Division of Quality Management & Planning 320 S. Walnut St. Lansing, MI 48913	Requests for approval of Clubhouse services
National Registry of Evidence-based Programs and Practices (NREPP)		www.samhsa.gov/nrepp	Clubhouse model
PIHP Provider Registry	517-373-2568	MDHHS -BHDDA Division of Program Development, Consultation & Contracts 320 S. Walnut Street Lansing, MI 48913	Information regarding how to register a new service provider, delete a service provider or change information about the service provider.
PIHP Special Program Approval	517-335-0499	MDHHS -BHDDA Community Practices and Innovation Section Division of Quality Management & Planning 320 S. Walnut St. Lansing, MI 48913	Information regarding how to obtain approval of new special programs: ACT, PSR, crisis residential, day program site, and intensive crisis stabilization.
MI CHOICE WAIVER RESOURCES			
Critical Incident Reporting	Phone: 517-241-8474 Fax: 517-241-7816	Home and Community-Based Services Section 400 S. Pine St. Lansing, MI 48909 https://webapp.ciminc.com/CompassMI	Information on critical incident reporting.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
MDHHS Audit Reports	Phone: 517-241-7599	email: MDHHS-AuditReports@michigan.gov	Required audit and any other related submissions.
MI Choice Contract	Phone: 517-241-8474 Fax: 517-241-7816	Home and Community-Based Services Section 400 S. Pine St. Lansing, MI 48909 https://egrams-mi.com/dch/user/home.aspx >> Medicaid/Long Term Care	MI Choice contract template and attachments.
MI Choice Intake Guidelines		View documents: www.michigan.gov/medicaidproviders >> MI Choice Vendor access for Waiver Agencies: https://webapp.ciminc.com/CompassMI	MI Choice Intake Guidelines documents and on-line access
MI Choice Waiver		www.michigan.gov/mdhhs >> Assistance Programs >> Health Care Coverage >> Services for Seniors >> MI Choice Waiver Program	Information regarding waiver services and regional contact information
MI Choice Waiver Diversions	Phone: 517-241-8474 Fax: 517-241-7816	Home and Community-Based Services Section 400 S. Pine St. Lansing, MI 48909 https://webapp.ciminc.com/CompassMI	Information for requesting diversion status for an applicant
MI Choice Waiver Program Provider Monitoring Plan	Phone: 517-241-8474 Fax: 517-241-7816	Home and Community-Based Services Section 400 S. Pine St. Lansing, MI 48909 https://egrams-mi.com/dch/user/home.aspx >> Medicaid/Long Term Care	Document defining procedures and standards used by MDHHS in reviewing agencies and providers.
MI Choice Waiver – Provider Information		www.michigan.gov/medicaidproviders >> MI Choice	Information for MI Choice providers
MDHHS Quality Management Plan	Phone: 517-241-8474 Fax: 517-241-7816	Home and Community-Based Services Section 400 S. Pine St. Lansing, MI 48909	Document addressing waiver agency quality assurance and improvement for MI Choice.
Minimum Data Set (MDS) - Section Q - Local Contact Agency (LCA)		www.michigan.gov/mdhhs >> Assistance Programs >> Health Care Coverage >> Services for Seniors >> MI Choice Waiver Program	A list of Local Contact Agencies that nursing facilities must contact when residents indicate a desire to return to the community.
Nursing Facility Transition	Phone: 517-241-8474 Fax: 517-241-7816	Home and Community-Based Services Section 400 S. Pine St. Lansing, MI 48909 https://webapp.ciminc.com/CompassMI	Information for intent to transition a nursing facility resident to MI Choice.
Waiting List Removal – Adequate Action Notice		www.michigan.gov/medicaidproviders >> MI Choice	MI Choice Waiting List Removal Adequate Action Notice template

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Waiting List Reporting		https://webapp.ciminc.com/CompassMI	Submit data for the waiting list.
MI HEALTH LINK			
Home and Community-Based Services Final Rule (CMS-2249F, CMS-2296F)		http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html	For providers or other interested individuals to access the HCBS Final Rule.
Medicaid State Plan Personal Care Services Individual and Agency County Rates		http://www.michigan.gov/documents/mdch/Individual_and_Agency_Hourly_Rates_Per_County_476167_7.pdf	Information regarding county rates for individual and agency providers of personal care services.
Medicaid State Plan Personal Care Services Payment Schedule		www.michigan.gov/homehelp	Table indicating the minimum schedule when payments should be made for personal care services during the MI Health Link continuity of care period for individuals who were receiving Adult Home Help services through MDHHS.
MI Health Link		www.michigan.gov/mihealthlink >> Providers	Information regarding how providers may participate in MI Health Link.
NON-EMERGENCY MEDICAL TRANSPORTATION			
MDHHS NEMT Database		www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Non-Emergency Medical Transportation (NEMT)	This database includes current information pertaining to NEMT reimbursement rates and services.
LogistiCare Solutions	866-569-1902		Non-emergency medical transportation for qualifying beneficiaries in Wayne, Oakland and Macomb counties.
NURSING FACILITY RESOURCES			
Certificate of Need Commission	517-241-3344 fax 517-241-2962	MDHHS Certificate of Need Evaluation Section South Grand Building, 4th Floor 333 S. Grand Ave. Lansing, MI 48933 www.michigan.gov/providers >> Certificate of Need	

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Complaints	Hotline: 800-882-6006 517-284-9798 fax 517-335-7167	Department of Licensing and Regulatory Affairs Bureau of Community and Health Systems Facility Complaint Intake Section PO Box 30664 Lansing, MI 48909 Delivery: 611 W. Ottawa, 1st Floor Lansing, MI 48933 www.michigan.gov/bchs	To file a complaint against a health care facility. Complaints on quality of care by nursing facilities, hospitals, home health agencies.
LTC Ombudsman	800-292-7852		Advocacy for nursing facility residents
MDHHS, LTC Services	517-373-6313	LTC Services PO Box 30479 Lansing, MI 48909-7979	Medicaid NF bed certification
MDS		www.cms.hhs.gov/medicaid/mds3.0/	Mandated assessment for NF residents
MDS RAI Manual		www.cms.gov >> Medicare >> Nursing Home Quality Initiative >> MDS 3.0 RAI Manual	Instruction manual for the MDS
Minimum Data Set (MDS) - Section Q - Local Contact Agency (LCA)		www.michigan.gov/mdhhs >> Assistance Programs >> Health Care Coverage >> Services for Seniors >> MI Choice Waiver Program	A list of Local Contact Agencies that nursing facilities must contact when residents indicate a desire to return to the community.
Medicare Part D	1-800-633-4227 TTY: 1-877-486-2048	www.medicare.gov	Questions regarding a beneficiary's eligibility for Medicare Part D, specific Medicare Part D drug coverage, or retroactive enrollment in Medicare Part D.
	1-800-803-7174	Michigan Medicare/Medicaid Assistance Program (MMAP)	Provides free education and personalized assistance to people with Medicare and Medicaid, their families, and caregivers (including the nursing facility).
Nurse Aide Customer Service	800-752-4724	www.michigan.gov/lara >> Community and Health Systems >> Nurse Aide Training Program	Questions regarding nurse aide training and testing
Nurse Aide Registry	517-284-8961 Fax 517-241-3354	www.michigan.gov/bchs >> Nurse Aide Registry	List of certified nurse aides
Nursing Facility Forms & Instructions, Calculation Examples, Rate Relief Worksheet		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Nursing Facilities	New Provider Information Packet, cost reporting forms, NF provider list, nurse aide testing reimbursement for facility and individual CNA, Cost-Settled Provider Detail Report (FD-622)

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Nursing Facility Rate Setting	517-335-5356 fax 517-335-5443	MDHHS /LTC Reimbursement & Rate Setting Section PO Box 30479 Lansing, MI 48909-7979 Delivery: Capitol Commons Center, 5th floor 400 S. Pine Lansing, MI 48933 email address: DARS@michigan.gov website: www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Nursing Facilities	Nursing facility rate setting and cost reporting information. New Provider Information Packet. Nursing Facility reimbursement.
Michigan Medicaid Nursing Facility Level of Care Determination		www.michigan.gov/medicaidproviders >> Michigan Medicaid Nursing Facility Level of Care Determination	Information and forms necessary to complete the Michigan Medicaid Nursing Facility Level of Care Determination to determine eligibility for NF level of care.
Payee Registration Helpline	888-734-9749 or 517-373-4111	www.michigan.gov/SIGMAVSS	Enroll with SIGMA Vendor Self Service (VSS) for payment issued outside claims processing
Pre-Eligibility Medical Expenses (PEME)	517-241-4302 fax 517-241-8556	MDHHS Medical Services Administration Attention: PEME P.O. Box 30479 Lansing, MI 48909-9634 Martina2@michigan.gov	MDHHS review of offsetting unpaid PEME
Quality Measure Initiative (QMI)		Email: MDHHS-NFQMI@michigan.gov Website: www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Nursing Facilities >> Nursing Facility Quality Measure Initiative	Additional resources and contact information related to the nursing facility QMI.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
RAI Coordinator	517-335-2086 fax 517-241-2635	Department of Licensing and Regulatory Affairs Bureau of Community and Health Systems Federal Survey and Certification Division RAI Coordinator 611 W. Ottawa St. PO Box 30664 Lansing, MI 48909 E-mail: najafih@michigan.gov Website: www.michigan.gov/bchs	Assistance with nursing facility MDS
State Survey Agency (Nursing Facilities)	517-335-1980 fax 517-241-2635	Department of Licensing and Regulatory Affairs Bureau of Community and Health Systems Federal Survey and Certification Division 611 W. Ottawa PO Box 30664 Lansing, MI 48909 www.michigan.gov/bchs	NH/SNF federal survey and certification
Informal Dispute Resolution (IDR) and Independent Informal Dispute Resolution (IIDR)	517-335-1980	Department of Licensing and Regulatory Affairs Bureau of Community and Health Systems Workforce Background Check PO Box 30664 Lansing, MI 48909 Delivery: 611 W. Ottawa, 1st Floor Lansing, MI 48933 Email: bchs-enforcement@michigan.gov www.michigan.gov/bchs >> Covered Providers >> Nursing Homes >> Dispute Resolution (IDR/IIDR)	For questions regarding completion or timeliness of IDR/IIDR process for long term care facilities.
MDHHS OBRA Office	517-241-5881	MDHHS /OBRA Office 5th Floor, Lewis Cass Building 320 S. Walnut Lansing, MI 48933	PASARR information, follow-up on submitted DCH-3878 (Level II evaluation)
Department of Technology, Management & Budget (DTMB)		www.michigan.gov/dtmb >> Agency Services >> Travel >> Travel Rates	Approved private vehicle mileage rate information.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Centers for Medicare & Medicaid Services	1-800-633-4227	Centers for Medicare & Medicaid Services 7500 Security Blvd Baltimore, Maryland 21244 http://www.cms.hhs.gov/Manuals/PBM/list.asp	Medicare Principles of Reimbursement (42 CFR 413), CMS Provider Reimbursement Manual (PRM-15 or Pub 15)
Beneficiary Benefit Plan ID(s) for the DOS including Patient Pay Amount, and MA Redetermination date (if on file)		Michigan Public Health Institute (MPHI) X12 270/271 Transaction testing information and companion guide: http://mihealth.org >> Trading Partners >> Medicaid Healthplan 270/271 Companion Guide v3.0 >> MPHI Companion Document v3.0 20070312.pdf MI Healthplan Benefits website access enrollment form: https://healthplanbenefits.mihealth.org >> Enrollment Form	Electronic Data Interchange (EDI) alternatives are available at no cost through MPHI for nursing facilities to verify Medicaid beneficiary eligibility
PHARMACY RESOURCES			
MDHHS Pharmacy Benefit Manager (PBM) 24/7/365	877-624-5204	Magellan Medicaid Administration, Inc. 4300 Cox Road Glen Allen, Virginia 23060 Web address: https://michigan.fhsc.com	General information, MPPL, claim submission instructions, etc. See Prior Authorization Section of this Directory for additional PBM contact information.
MDHHS Pharmacy Benefit Manager (PBM)	888-868-9219 Fax: 804-965-7647	Magellan Medicaid Administration, Inc. Michigan Medicaid – Pharmacy Provider Relations Unit 4300 Cox Rd. Glenn Allen, VA 23060 Website address: https://michigan.fhsc.com	Pharmacy remittance advice, EFT requests, and other services/inquiries
Medicaid Health Plan Pharmacy Benefit		www.michigan.gov/MCOpharmacy	Medicaid Health Plan Common Formulary
MAC Pricing Information 9 am - 5 pm EST, M – F	800-327-6226 Fax 888-656-1951	Magellan Medicaid Administration, Inc. Attn.: MAC Department 4300 Cox Rd. Glenn Allen, VA 23060 email address: StateMacProgram@magellanhealth.com Website address: https://michigan.fhsc.com	Maximum allowable cost (MAC) pricing information.
MDHHS Drug Dispensing Fees		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> Pharmacy	

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Refunds, Overpayments	877-624-5204 fax 887-888-6370	Magellan Medicaid Administration, Inc. 4300 Cox Rd. Glen Allen, VA 23060	Instruction regarding how to submit claims, refunds and overpayments.
List of Chronic Conditions for Medication Therapy Management Eligibility		www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider-Specific Information >> Pharmacy	
List of Drugs Past CMS Termination Dates		http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/prescription-drugs/medicaid-drug-rebate-program-data.html	
List of Rebate-Participating Labelers		https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/index.html	List of approved labelers who have signed rebate agreements with CMS.
List of Participating Entities in 340B Program		https://340bopais.hrsa.gov/coveredentitysearch	
Drug Rebate Specialist	Fax 517-241-7816	MDHHS Pharmacy Program Bureau of Medicaid Operations & Quality Assurance PO Box 30479 Lansing, MI 48909-7979 email address: MDHHSPharmacyServices@michigan.gov	PHS and DSH hospitals that bill the 340B prices on their drug claims are excluded from the drug rebates.
National Average Drug Acquisition Cost		https://data.medicaid.gov	
Provider Liaison Meeting Calendar		https://michigan.fhsc.com	Schedule of liaison meetings and contact information for questions and submission of agenda items.
Centers for Medicare & Medicaid Services		https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforprofs/trp.html	Information on Tamper Resistant Prescription Pad policy
PRIVATE DUTY NURSING RESOURCES			
Other Insurance for PDN	Fax 517-335-9422		Submit letters of explanation or EOB when required.
SCHOOL BASED SERVICES			
SBS Administrative Outreach Program Policy Specialist	517-284-1197 Fax 517-335-5136	SBS Administrative Outreach Specialist MDHHS Medicaid Policy Division PO Box 30479 Lansing, MI 48909-7979 MSAPolicy@michigan.gov	Submission of SSAE 16 audit.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
SBS Fee for Service Program Policy Specialist	517-284-1197 Fax 517-335-5136	SBS Administrative Outreach Specialist MDHHS Medicaid Policy Division PO Box 30479 Lansing, MI 48909-7979 MSAPolicy@michigan.gov	Submission of SSAE 16 audit (Fee For Service)
School Based Services		www.michigan.gov/medicaidproviders >> Billing & Reimbursement >> Provider Specific Information >> School Based Services	Databases, FAQs, cost reporting & training, software information, Random Moment Time Study Results
VISION SERVICES RESOURCES			
Vision Contract Manager		Vision Contract Manager MDHHS /Program Review Division PO Box 30170 Lansing MI 48909	Submit copy of DCH-0893
Vision Contractor (Classic Optical Laboratories)	888-522-2020 Fax 330-759-8300	Classic Optical 3710 Belmont Ave. PO Box 1341 Youngstown, OH 44501-1341 www.classicoptical.com	Contractor for provision of eyewear frames and lens
REPORTING FRAUD, ABUSE, OR MISUSE OF SERVICES			
Benefits Monitoring Program (BMP)	855-808-0312	MDHHS Program Review Division Benefits Monitoring Program P.O. Box 30170 Lansing, MI 48909-7979 email: MDHHS-MSA-BMP@michigan.gov	Report potential misutilization of services by Medicaid beneficiaries
MDHHS Office of Inspector General	1-855-MI-FRAUD (1-855-643-7283)	Michigan Department of Health and Human Services Office of Inspector General PO Box 30062 Lansing, MI 48909-7979 www.michigan.gov/fraud	Report suspected Medicaid provider fraud and/or abuse
Health Care Fraud Unit	800-242-2873 fax 517-241-6515	Health Care Fraud Division Department of the Attorney General Medicaid Fraud Control Unit PO Box 30218 Lansing, MI 48909 email: HCF@michigan.gov website: www.michigan.gov/ag >> Complaints	Report Medicaid provider fraud
MDHHS OBRA Office	517-373-8091	MDHHS /OBRA Office 5th Floor Lewis Cass Building 320 S. Walnut St. Lansing, MI 48933	Complaints/concerns about local CMHSP services to nursing facility residents

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Bureau of Community and Health Systems, Allegation Unit (MI Dept. of Licensing and Regulatory Affairs)	517-373-9196	www.michigan.gov/bpl >> File a Complaint	Complaints about licensed healthcare professionals (e.g. physicians, nurses, therapists, NF administrators)
Michigan Department of Civil Rights	800-482-3604		Report violations of handicapper rights.
Michigan Disability Rights Coalition	800-760-4600		
Office of Inspector General of the U.S. Department of Health & Human Services (HHS)	313-226-4258	Office of Inspector General of the U.S. Department of Health & Human Services (HHS) Room 512 – Federal Courthouse Detroit, MI 48226	Report violations of federal law
Welfare Fraud Hotline	800-222-8558 517-335-3900	MDHHS Office of Inspector General 235 S. Grand, Ste. 218 Lansing, MI 48933	Report suspected beneficiary fraud.
U.S. Department of Justice, Office of Civil Rights	800-552-6843		Report violations of handicapper rights.
OTHER HEALTH CARE RESOURCES/PROGRAMS			
Breast & Cervical Cancer Control Program	800-922-6266		Information regarding program services, eligibility, and enrollment
Children in Foster Care		1. www.michigan.gov/mdhhs >> Adult & Children's Services >> Foster Care >> Forms and Publications 2. http://www.brightfutures.org/mentalhealth/pdf/tools.html >> Pediatric Symptom Checklist 3. http://www.massgeneral.org/psychiatry/services/psc_forms.aspx 4. http://agesandstages.com	1. MDHHS Well Child Exam forms and Psychotropic Medication Informed Consent (DHS-1643) 2. Pediatric Symptom Checklist 3. Pediatric Symptom Checklist in other languages 4. Ages and Stages Questionnaire: Social-Emotional (ASQ:SE)
Children's Waiver Program	517-241-5757	MDHHS -BHDDA Division of Quality Management & Planning 320 S. Walnut Street Lansing, MI 48913	Information regarding the Children's Waiver program
Freedom to Work	Local MDHHS office	Local MDHHS office	Information regarding program eligibility
Habilitation Supports Waiver for Persons with Developmental Disabilities	517-335-1134	MDHHS - BHDDA Division of Quality Management & Planning 320 S. Walnut St. Lansing, MI 48913	Information regarding certification and re-certification of HSW enrollees; and HSW coverages.
Medicare Savings Program	local MDHHS office		Information regarding program eligibility and enrollment.

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Medicare Part D	1-800-633-4227 TTY: 1-877-486-2048	www.medicare.gov	Questions regarding a beneficiary's eligibility for Medicare Part D, specific Medicare Part D drug coverage, or retroactive enrollment in Medicare Part D.
	1-800-803-7174	Michigan Medicare/Medicaid Assistance Program (MMAP)	Provides free education and personalized assistance to people with Medicare and Medicaid, their families, and caregivers (including the nursing facility).
Mental Health Home-based Program	517-241-5772	MDHHS - BHDDA Division of Mental Health Services to Children and Families 320 S. Walnut St. Lansing, MI 48913	Information regarding how to obtain approval of new Mental Health Home-based Programs for children and families
MIChild	888-988-6300	www.michigan.gov/michild application at: www.michigan.gov/mibridges	Apply at local MDHHS office or online though MI Bridges
MDHHS Prenatal Smoking Cessation Program	517-335-9750		Information regarding the Smoke-Free Baby and Me intervention model.
National Autism Center (NAC)		www.nationalautismcenter.org	Information regarding Autism Spectrum Disorder
Program of All-Inclusive Care for the Elderly (PACE)	517-373-7493	MDHHS Long Term Care and Operations Support Section PO Box 30479 Lansing, MI 48909 www.michigan.gov/medicaidproviders >> Program for All-Inclusive Care for the Elderly (Under Additional Programs & Waivers)	
Special N Support	Local MDHHS office	Local MDHHS office	Information regarding program eligibility and enrollment
Supplemental Security Income (SSI)	Local MDHHS office	Local MDHHS office	Information regarding program eligibility and enrollment
Transitional Medical Assistance	Local MDHHS office	Local MDHHS office	Information regarding program eligibility and enrollment
Traumatic Brain Injury Program	800-642-3195	Local MDHHS office	Information regarding program eligibility and enrollment
MISCELLANEOUS CONTACT INFORMATION			
Centers for Disease Control and Prevention (CDC)		www.cdc.gov/growthcharts	Growth charts/graphing documents
Electronic Health Record (EHR) Incentive Program		www.michiganhealthit.org www.cms.gov/EHRIncentivePrograms	Information regarding the EHR Incentive Program

CONTACT/TOPIC	PHONE # FAX #	MAILING/EMAIL/WEB ADDRESS	INFORMATION AVAILABLE/PURPOSE
Federal Registers		http://www.ecfr.gov	
Sickle Cell Detection and Information	313-864-4406 800-842-0973 Fax 313-864-9980	Sickle Cell Disease Association of America - Michigan Chapter 18516 James Couzens Detroit, MI 48235 http://scdaami.org	Obtain sickle cell tests, tubes, forms, and envelopes A capillary blood sample may be mailed to SCDAA-MI
SS and SSI Information Line	800-772-1213		
State of Michigan Operator	517-373-1837		Telephone numbers for State of Michigan offices/employees.
DMEPOS Liaison Meetings		www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Medical Suppliers/Orthotists/ Prosthetists/DME Dealers	Information on scheduled DMEPOS liaison meetings
Medical Care Advisory Council (MCAC) Meetings		www.michigan.gov/medicaid >> Program Resources >> Medical Care Advisory Council	MCAC roster, meeting agendas and minutes, and meeting dates

GLOSSARY APPENDIX

Glossary Term	Definition
Acquisition Costs	The manufacturer's invoice price, minus primary discount, plus a percentage over cost, plus actual shipping costs. Acquisition cost does not include handling fees. (For the specific percentage over cost, refer to the archived MDHHS Medical Supplier/DME/Prosthetics and Orthotics Database Instructions posted on the MDHHS website.)
Ambulatory Payment Classification (APC)	The Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classification (APC) is a reimbursement method representing groups of outpatient visits according to clinical characteristics and costs associated with the diagnoses and the procedures rendered known as APCs.
Borderland	A county that is contiguous to the Michigan border and includes several major cities beyond the contiguous county lines.
Durable Medical Equipment (DME)	Equipment that can withstand repeated use, is reusable or removable, is suitable for use in any non-institutional setting in which normal life activities take place, is primarily and customarily used to serve a medical purpose and is generally not useful to an individual in the absence of illness, injury or disability.
The Emergency Medical Treatment and Active Labor Act (EMTALA)	42 USC 1395dd, that requires a Hospital to perform a medical screening examination of any individual presenting in its emergency department to determine if an emergency medical condition exists and to stabilize the individual's medical condition.
Encounter	A face-to-face contact between a patient and the provider of health care services who exercises independent judgment in the provision of health care services.
Hospital	Hospital means the licensed entity that executed the Hospital Access Agreement, which has the inpatient capacity necessary to provide covered services.
Hospital Based Provider (HBP)	A hospital-employed MD, DO, Certified Registered Nurse Anesthetist (CRNA), dentist, podiatrist, optometrist, or nurse-midwife.
Medicaid Deductible	Beneficiary must incur medical expenses each month equal to, or in excess of, an amount determined by the local MDHHS worker to qualify for Medicaid. Previously referred to as Medicaid Spend-down.
Medicaid Health Plan (MHP)	A Medicaid managed care plan that provides medical assistance through the delivery of Covered Services to Beneficiaries and that holds a Comprehensive Health Care Program Medicaid Contract with the State of Michigan.

Glossary Term	Definition
Medical Supplies	Health care related items that are required to address an individual's illness, injury or disability; are consumable, disposable or have a limited life expectancy, cannot withstand repeated use, and are suitable for use in any non-institutional setting in which normal life activities take place. Examples are: hypodermic syringes/needles, ostomy supplies, and dressings necessary for the medical management of the beneficiary.
Mobility Related Activities of Daily Living (MRADL)	Daily activities (e.g., grooming, dressing, etc.) the beneficiary is capable of performing with the aid of mobility equipment.
Noncompliance	Failure or refusal to follow instructions related to improving or stabilizing a condition.
Noncovered Service	A medical or health care service that is: ▪ Not covered by Medicaid; ▪ Not medically necessary; ▪ Not described in a MHP's Certificate of Coverage; ▪ Provided before or after a beneficiary is an Enrollee in a MHP; or ▪ Non-emergency services for which the Hospital did not secure PA.
Nursing Facility	A nursing home, county medical care facility, State Veterans' Home, or hospital long-term care unit, with Medicaid certification.
Orthotics	Orthotics assist in correcting or strengthening a congenital or acquired physical anomaly, or malfunctioning portion of the body.
Outpatient Hospital	A portion of a hospital, which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require inpatient hospitalization or institutionalization.
Outpatient Prospective Payment System (OPPS)	A Prospective Payment System (PPS) is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (i.e., DRGs for inpatient hospital services, APCs for outpatient hospital services). All services paid under the PPS are classified into groups called Ambulatory Payment Classifications (or APCs). Services in each APC are similar clinically and in terms of the resources they require. A payment rate is established for each APC.
Physician (MD or DO)	An individual licensed under the Michigan Public Health Code (1978 P.A. 368) to engage in the practice of medicine or osteopathic medicine and surgery.
Practitioner	A MD, DO, Podiatrist, Dentist, Oral-Maxillofacial Surgeon, Physician's Assistant, Nurse Practitioner, Certified Nurse Midwife, Certified Registered Nurse Anesthetist, Anesthesiologist Assistant, Physical Therapist, Psychologist, Occupational Therapist, Optometrist, Speech Therapist, and Audiologist.

Glossary Term	Definition
Prosthetics	Prosthetics artificially replace a portion of the body to prevent or correct a physical anomaly or malfunctioning portion of the body.
Provider	An individual, firm, corporation, association, agency, institution, or other legal entity which is providing, has formerly provided, or has been approved to provide medical assistance to a beneficiary pursuant to the medical assistance program.
Public Facility	A public facility is defined at one of the following sections of the Michigan Public Health Code (PA 368 of 1978, as amended): Section 333.2413, Section 333.2415, or Section 333.2421.
Rapid Dispute Resolution Process	The process implemented by MDHHS to administer and resolve claim disputes.
Readmission	Any admission/hospitalization of a beneficiary within 15 days of a previous discharge, whether the readmission is to the same or different hospital.
Reference Laboratory	An enrolled laboratory that receives a specimen from another referring laboratory for testing and that actually performs the test.
Referring Laboratory	A laboratory that receives a specimen to be tested and that refers the specimen to another laboratory for performance of the laboratory test.
Sanctioned Provider	A provider who has been suspended, terminated or excluded from furnishing, ordering, or prescribing items or services to Medicaid beneficiaries.
Spend-down	See Medicaid Deductible.
Sterilization	Any medical procedure, treatment, or operation for the sole purpose of rendering an individual (male or female) permanently incapable of reproducing.
Third Party Liability	A payment resource available from both private and public insurance and other liable third parties that can be applied toward the beneficiary's health care expense.
Transfer Trauma	Any adverse psychological and/or physical effects occasioned by the transfer of a nursing home patient who would be materially detrimental to the physical or mental health of the patient.
U & C Charge	The usual and customary charge to the general public. Customary charge means the amount the provider charges another third party payer or the general public (except in cases where the general public receives free or reduced charges) for the same or a similar service. This definition does not include negotiated or contracted payment rates. If the provider renders a covered service to a beneficiary that the provider offers for free or for a reduced fee to the general public, the provider may only bill Medicaid up to that customary charge as long as all other Medicaid requirements are met.

FORMS APPENDIX

INTRODUCTION

The Forms Appendix contains all MDHHS forms referenced within the Michigan Medicaid Provider Manual. Detailed instructions are provided for forms that are not self-explanatory (refer to the table below). The bookmarks link to each form. The Forms field in the table below also links to the appropriate forms. Hold the cursor over form number (the hand cursor will turn into a pointing finger). Double click the cursor to access the form directly from the table. Use the navigation arrows to move from page to page and form to appendix.

All forms are also available on the MDHHS website (refer to the Directory Appendix for website information). Most forms are available in PDF format as well as in a downloadable Word-enabled format.

Form Number	Form Name
MSA-2218	Acknowledgment of Receipt of Hysterectomy Information
MSA-1302	Benefits Monitoring Program Referral
MSA-1550	Beneficiary Verification of Coverage
MSA-4240	Certification for Induced Abortion
CMS-10231	Certification of Public Expenditure
MSA-1326	Certified Nurse Aide Training Reimbursement
MSA-1576	Complex Care Prior Approval-Request/Authorization for Nursing Facilities
MSA-1653-D	Complex Seating and Mobility Device Prior Approval-Request/Authorization
MSA-1959	Consent for Sterilization
MSA-0725	CSHCS Application for Payment of Health Insurance Premiums

Form Number	Form Name
MSA-1680-B	Dental Prior Approval Authorization Request
MSA-0892	Documentation of Medical Necessity for the Provision of Contact Lenses
DCH-1401	Electronic Signature Agreement
DCH-3890	Electronic Signature Verification Statement
MSA-181	Home Health Aide Prior Approval Request/Authorization
MSA-2565-C	Hospital Admission Notice
DCH-1164	Guarantee of Payment Letter for Pregnancy Related Services
MSA-1755	Medicaid Enrolled Birthing Hospital Agreement for Elective, Non-Medically Indicated Delivery Prior to 39 Weeks Completed Gestation
MSA-4114	Medical Eligibility Report (MERF)
DCH-3878	Mental Illness/Intellectual Disability/Related Condition Exemption Criteria Certification (For Use in Claiming Exemption Only)
MSA-1656	Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices
MSA-1656 – Addendum A	Mobility/Seating
MSA-1656 – Addendum B	Strollers, Gait Trainers, Standers, Car Seats, and Children's Positioning Chairs
MSA-1324	Nurse Aide Training and Testing Program Interim Reimbursement Request
MSA-115	Occupational Therapy – Physical Therapy – Speech Therapy Prior Approval Request/Authorization
MSA-6544-B	Practitioner Special Services Prior Approval – Request/Authorization

Form Number	Form Name
DCH-3877	Preadmission Screening (PAS)/ Annual Resident Review (ARR) (Mental Illness/ Intellectual Disability/Related Conditions Identification)
MSA-0732	Private Duty Nursing Prior Authorization – Request for Services
MDHHS-5405	Provider Electronic Signature Agreement Cover Sheet
MSA-0891	Provision of Low Vision Services and Aids Support Documentation
MSA-1580	Request for Authorization of Private Room Supplemental Payment for Nursing Facility
DCH-0078	Request to Add, Terminate or Change Other Insurance
SAMPLE 1	(Sample of) Continued Stay Notice of Non-Coverage
SAMPLE 2	(Sample of) Notice of Non-Coverage for Inpatient Hospital Admission
SAMPLE 3	(Sample of) Care Coordination Agreement
SAMPLE 4	(Sample of) Paper Remittance Advice
MSA-1653-B	Special Services Prior Approval – Request/Authorization
DCH-0893	Vision Services Approval/Order

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

Michigan Department of Health and Human Services

RECIPIENT STATEMENT:

I, _____, was told before the
(Print or Type Recipient Name)

hysterectomy was done that after the hysterectomy I would not be able to become pregnant.

_____

(Recipient or Representative Signature) (Date)

_____

(Interpreter Signature, if required to inform the recipient of the above information) (Date)

PHYSICIAN STATEMENT:

The hysterectomy for the above named recipient is solely for medical indications. This hysterectomy is not primarily or secondarily for family planning reasons, to render the above named recipient permanently incapable of reproducing, i.e. sterilization. It was explained to the above named recipient prior to the hysterectomy that the hysterectomy will render her permanently incapable of reproducing.

_____

(Physician Signature) (Date)

Authority: Title XIX of the Social Security Act Completion: Is Voluntary, but is required if Medical Assistance program payment is desired.	The Department of Health and Human Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to your local MDHHS office.

MSA-2218 (Rev. 6-2015) Formerly DSS-2218 which may be used

Michigan Department of Health and Human Services
Medical Services Administration

BENEFITS MONITORING PROGRAM REFERRAL

SECTION 1 – Purpose of Submission

☐ PCP Designation ☐ Specialty Referral ☐ Discharge from Practice

SECTION 2 – Beneficiary Information

Beneficiary Name (Last, First, Middle)			mihealth Card Number
Street Address			Home Telephone Number
City	State	ZIP Code	Work or Other Telephone Number

SECTION 3 – Referring Provider Information

Provider Name			Individual NPI Number	Specialty
Group Name (If applicable)			Group NPI Number	
Business Address			Are you the PCP? ☐ **YES** ☐ **NO**	
City	State	ZIP Code	Telephone Number	Fax Number

SECTION 4 – Referred Provider Information

Provider Name			Individual NPI Number	Specialty
Group Name (If applicable)			Group NPI Number	
Business Address			Telephone Number	Fax Number
City	State	ZIP Code	Anticipated Duration of Need ☐ Acute/Short-Term ☐ Chronic/Long-Term	

SECTION 5 – Drugs Subject to Abuse

MDHHS must authorize all prescribers of drugs subject to abuse for BMP-enrolled beneficiaries. Do you anticipate a need for the referred provider to prescribe medications in these classes?

☐ **YES** ☐ **NO** ☐ **Unable to determine**

Include the beneficiary's current medication list with form submission.

SECTION 6 – Additional Information/Comments (including diagnoses)

Provider Signature	Date of Authorization

Benefits Monitoring Program Referral (MSA-1302)
Instructions for Completion and Submission

General Instructions

This form should ONLY be used for beneficiaries enrolled in the Benefits Monitoring Program (BMP).* Enrollment may be verified through the CHAMPS Eligibility Inquiry response as additional information. The form is to be completed by the beneficiary's BMP Authorized Provider(s). For additional program information, refer to the Michigan Medicaid Provider Manual (Beneficiary Eligibility Chapter, Benefits Monitoring Program Section) available on the MDHHS website.

MDHHS requests that the MSA-1302 be typewritten to facilitate processing.

Form Completion

Section 1	Check the appropriate box to communicate purpose of the submission.
Section 2	Beneficiary Information.
Section 3	Referring (or Primary Care) Provider Information.
Section 4	Referred Provider Information. Note: This section may be left blank when making a PCP designation only.
Section 5	Check the appropriate box to communicate the anticipated need for MDHHS to authorize the referred provider to write prescriptions for drugs subject to abuse for this beneficiary. Include the beneficiary's current list of medications with form submission.
Section 6	Fill in the reason for referral, including diagnosis. Include any additional information that would assist in MDHHS review. When using this form to communicate a discharge from practice, include a copy of the communication from your office to the patient for MDHHS records.

Copy Distribution

- Original – Referring Provider File
- Copy – Referred Provider
- Copy – Michigan Department of Health and Human Services (MDHHS), Medical Services Administration, Benefits Monitoring Program

Form Submission

The MSA-1302 and any supplemental information (e.g. medication list, medical records, forged prescriptions, etc.) must be mailed or faxed to:

MDHHS – Medical Services Administration
Benefits Monitoring Program
PO Box 30170
Lansing, MI 48909

Fax Number: (517) 335-0075

The MDHHS Program Review Division may be reached via telephone at (800) 622-0276.

* Previously known as Beneficiary Monitoring Program.

AUTHORITY: Title XIX of the Social Security Act.
COMPLETION: Is Voluntary, but is required if Medical Assistance program payment is desired.

BENEFICIARY VERIFICATION OF COVERAGE

Michigan Department of Health and Human Services
Medical Services Administration

I understand that Medicaid, Healthy Michigan Plan, or MIChild only covers payment for elective abortions under limited circumstances.

These are:

- ☐ Elective abortion to terminate a pregnancy to save the life of the mother,
- ☐ Elective abortion to terminate a pregnancy that was the result of rape, or
- ☐ Elective abortion to terminate a pregnancy that was the result of incest.

I certify that I am eligible for Medicaid, Healthy Michgan Plan, or MIChild coverage for an elective abortion based upon the circumstance that I have checked above. I understand that if I have given false information to obtain coverage for an elective abortion I can be prosecuted for fraud. I also understand that a copy of this verification will be sent to the local Michigan Department of Health and Human Services (MDHHS) office or to a police agency when appropriate.

Beneficiary Name (typed or printed)			Beneficiary Signature	
Beneficiary Address				
City	State	ZIP Code	Date Signed	mihealth card

WITNESSED BY:

Witness Name (typed or printed)			Witness Signature
Witness Address			
City	State	ZIP Code	Date Signed

Authority: Title XIX and Title XXI of the Social Security Act. **Completion:** Is Voluntary, but is required if payment from the Medicaid, Healthy Michigan Plan, or MIChild programs is sought.	The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

CERTIFICATION FOR INDUCED ABORTION

Michigan Department of Health and Human Services
Medical Services Administration

Medicaid, Healthy Michigan Plan, or MIChild payments for abortion services are limited to cases in which the life of the mother would be endangered if the pregnancy were continued or cases in which the pregnancy was the result of rape or incest. To receive payment for abortion services, a physician must determine and certify that the abortion is necessary to save the life of the mother or is to terminate a pregnancy that resulted from rape or incest.

INSTRUCTIONS:

- TYPE or PRINT ALL Information below.
- The Physician completing this form is responsible for providing a copy of the completed form to any other provider assisting in this procedure (e.g., hospital, anesthesiologist, laboratory) for billing purposes.
- Send a copy of the completed form with the claim. (Refer to the Medicaid Provider Manual, Directory Appendix, Claim Submission/Payment.)

Any questions regarding this form should be referred to Provider Inquiry at 800-292-2550 or e-mail ProviderSupport@michigan.gov .

Beneficiary Name	mihealth Number	Date of Service	
Beneficiary Address (no. & street, apt./lot #, etc.)	City	State	ZIP Code

Appropriate box **must** be checked for payment to be made.

By signing below, I certify that:

☐ **the life of the mother would be endangered if the pregnancy were continued. (List the medical condition(s) that exists.)**

_____

_____

_____

_____

☐ **the pregnancy terminated through this procedure was the result of rape or incest. Information included in the medical record supports this claim.**

In cases of rape or incest, was a police report filed?
☐ **YES** ☐ **NO** (If **NO**, explain)

If appropriate, was a report filed with the local MDHHS office?
☐ **YES** ☐ **NO** (If **NO**, explain)

NOTE **Payment for service is not dependent upon a report being filed with the police or the local MDHHS office.**

Physician Name (Type or Print)			Handwritten Signature of Physician	
Address (No. & Street, Ste., etc.)				
City	State	ZIP Code	Date Signed	Provider NPI Number

Authority: Title XIX and Title XXI of the Social Security Act. **Completion**: Is voluntary, but is required if payment from Medicaid, Healthy Michigan Plan, or MIChild programs is sought.	The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

CERTIFICATION OF PUBLIC EXPENDITURE (CPE)

GOVERNMENTAL PROVIDER USE ONLY: CERTIFICATION OF TOTAL COMPUTABLE PUBLIC EXPENDITURE

1 Governmental Provider Name and Address:

Provider Name
1234 Health Services Drive
Anytown, USA 99999

2 Reporting Period (School Fiscal Year):

From:

To:

Medicaid Provider Number:
(National Provider Identifier (NPI) Number)

3 a. Type of Report:

[ ] Partial Period Report

[ ] Quarterly Cost Report

[X] Full Year Cost Report

b. Total Computable Certified Public Expenditure by Component:

[X]
Medicaid
Medical Services

Total Computable Expenditure
(From Exhibit 11, Line 23)

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED HEREIN MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.

CERTIFICATION STATEMENT BY OFFICER OF THE PROVIDER

I HEREBY CERTIFY that:

1. I have examined this statement, the accompanying supporting exhibits, the allocation of expenses, services and activities, and the attached worksheets for the period from _____ to _____ and that to the best of my knowledge and belief they are true and correct statements prepared from the books and records of the governmental provider in accordance with applicable instructions.

2. The expenditures included in this statement are based on the actual cost of recorded expenditures and reflect the reporting provider's cost of serving Medicaid recipients.

3. I am the officer authorized by the referenced governmental provider to submit this form and I have made a good faith effort to assure that all information reported is true and accurate.

4. The required amount of State and/or local funds were used to pay for total computable allowable expenditures included in this statement, and such State and/or local funds were in accordance with all applicable Federal requirements for the non-Federal share match of expenditures (including that the funds were not Federal funds in origin, or are Federal funds authorized by Federal law to be used to match other Federal funds, and that the claimed expenditures were not used to meet matching rquirements under other Federally funded programs).

5. The total computable expenditures identified herein are submitted in accordance with 42 CFR 433.51.

6. I understand that this certification of public expenditures serves as the basis for Federal matching funds; that such expenditures were allowable to the State Medicaid program in accordance with all procedures, instructions, and guidance issued by and to the single state agency during the reporting period; and that falsification or concealment of a material fact may be prosecuted under Federal or State civil or criminal law.

SIGNATURE (officer of the governmental provider)

DATE

TITLE

PHONE NUMBER

Michigan Department of Health and Human Services

Nurse Aide Training and Competency Evaluation Program

Certified Nurse Aide Training Reimbursement

PURPOSE: The Certified Nurse Aide (CNA) must present this information to his/her Medicaid and/or Medicare certified nursing facility employer to apply for reimbursement of eligible CNA training and testing costs. Reimbursement is not available to CNAs working in other residential or patient care settings.

CNA:

Last Name	First Name	Middle Initial
Social Security Number	Birthdate	Driver License/Identification

I incurred the following expenses to become a CNA (Certified Nurse Aide).

TRAINING: *(Attach receipts)*

Approved Program Name: _____ Amount: $ _____

Location: _____ Date of Payment: _____

Completion Date of Training: _____

COMPETENCY EVALUATION: *(Attach receipts)*

Clinical Skills Test

Site: _____ Date: _____ Amount: $_____

Site: _____ Date: _____ Amount: $_____

Site: _____ Date: _____ Amount: $_____

Knowledge Test

Site: _____ Date: _____ Amount: $_____

Site: _____ Date: _____ Amount: $_____

Site: _____ Date: _____ Amount: $_____

Rescheduling Fee (No-Show)

Date: _____ Amount: $_____

Date: _____ Amount: $_____

Date: _____ Amount: $_____

Initial Registration Fee Date: _____ Amount: $_____

Registration Document Renewal Date: _____ Amount: $_____

Check appropriate box, sign and date*:*

☐ **I have not received any payment for any of these expenses from another source, such as another nursing home, a vocational training program, etc.**

☐ **I have received payment from another source for the listed expenses:**

Amount: $ _____ Date: _____ Source: _____

Amount: $ _____ Date: _____ Source: _____

Amount: $ _____ Date: _____ Source: _____

I understand that the information I have provided may be audited.

CNA Signature: _____ Date: _____

NURSING FACILITY: (Retain this information for documentation of NATCEP costs.)

Facility Name: _____

Provider NPI Number: _____ LARA - BCHS License Number: _____

Michigan Department of Health and Human Services

COMPLEX CARE PRIOR APPROVAL – REQUEST/AUTHORIZATION FOR NURSING FACILITIES

PRIOR AUTHORIZATION NUMBER

Fax: MDHHS Program Review Division (517) 241-7813

The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.

SECTION I:

Provider's Name	NPI Number		Phone Number
Provider's Address (Number, Street, Ste., City, State, Zip)			Fax Number
Beneficiary's Name (Last, First, Middle Initial)	Sex ☐ **M** ☐ **F**	Birth Date	mihealth Card Number

SECTION II: CARE STAFFING AND SUPPLIES

List the average number of nursing hours and supplies, vent, etc. required for this beneficiary's care that EXCEED the standard level of care and the corresponding rate of pay. *Attach additional information if necessary.*

Excess Nursing Hours	Charges Per Hour/Day	Total
RN _____ Hours Per Day	$ _____ Per hour	$ _____
LPN _____ Hours Per Day	$ _____ Per hour	$ _____
Aide _____ Hours Per Day	$ _____ Per hour	$ _____
Excess Daily Supplies		
Medical Supplies (e.g., vent)		
1.	$ _____ Per day	$ _____
2.	$ _____ Per day	$ _____
3.	$ _____ Per day	$ _____
4.	$ _____ Per day	$ _____
TOTAL		$ _____

SECTION III: ADDITIONAL COMMENTS

(250-Character Limit)

SECTION IV: PROVIDER CERTIFICATION

The patient named above (parent or guardian if applicable) understands the necessity to request prior approval for the services indicated. I understand that services requested herein require prior approval and, if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of a material fact may lead to prosecution under applicable Federal or State law.

_____ _____

Provider Signature Date

MDHHS USE ONLY

Review action: APPROVED ☐ INSUFFICIENT DATA ☐ DENIED ☐ NO ACTION ☐ APPROVED AS AMENDED ☐	Consultant remarks		
Start Date	**End Date**	**Units – Number of Days**	**Total Daily Rate**
			$

_____ _____

Consultant Signature Date

Authority: Title XIX of the Social Security Act.
Completion: Completion is required for Medicaid reimbursement.

MSA-1576 (5/15) - Previous editiions are obsolete.

Michigan Department of Health and Human Services

Complex Seating and Mobility Device Prior Approval - Request/Authorization Completion Instructions

The MSA-1653-D must be used by Medicaid enrolled DME Providers. Note: Requests for new complex seating or mobility devices submit with a completed Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices" form (MSA-1656).

MDHHS requests that the MSA-1653-D be typewritten to facilitate processing. A Word fill-in enabled version of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms. The form is generally self-explanatory. For complete information on required modifiers, documentation, and appropriate quantity amounts, refer to the following documents:

- Standards of Coverage portion of the provider-specific chapters of the Medicaid Provider Manual.
- Billing & Reimbursement for Professionals Chapter of the Medicaid Provider Manual.
- Provider-specific databases on the MDHHS website. www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.

Completion of this form is as follows:

Box 1	MDHHS Use Only
Box 11	Beneficiary address. If beneficiary resides in Nursing Facility include the Nursing Facility name, address and phone number.
Box 17	Complete this box ONLY for wheelchair requests. • For repairs or parts, complete MSA-1653-D. (Do not include MSA-1656.) • For new or replacement (due to a change in beneficiary basic medical functional status requests), stop at this point and complete MSA-1656. Both forms must be submitted for Prior Authorization consideration.
Box 20	Enter brand name, model catalog or part number. DME, orthotics and prosthetics, must provide the brand name, model, and catalog or part number.
Box 21	Enter a complete description of the item requested.
Box 22	Enter the HCPCS Procedure Code.
Box 23	Enter the applicable HCPCS Modifier.
Box 28	Enter the beneficiary's primary and secondary diagnoses or the CSHCS qualifying diagnosis (list both the code and description). DME/POS providers must submit the prescription/CMN with this form.
Box 29	Any additional remarks regarding the request should be listed in this box such as verbal authorization date, retroactive date of service if being requested. Provide other insurance coverage for services requested.
Box 31	Must be completed for all requests.

Form Submission

PA request forms and required documentation for all eligible Medicaid beneficiaries must be mailed or faxed to:

MDHHS - Medical Services Administration
Program Review Division
P.O. Box 30170
Lansing, Michigan 48909

Fax Number: (517) 335-0075

To check the status of a PA request, contact the MDHHS - Medical Services Administration, Program Review Division via telephone at **1-800-622-0276.**

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable programs is sought.

Michigan Department of Health and Human Services

Complex Seating and Mobility Device Prior Approval - Request/Authorization

1. PRIOR AUTHORIZATION NUMBER (MDHHS USE ONLY)

The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.

2. PROVIDER'S NAME (LAST, FIRST, MIDDLE INITIAL)	3. NPI NUMBER		4. PHONE NUMBER
5. PROVIDER'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)			6. FAX NUMBER
7. BENEFICIARY'S NAME (LAST, FIRST, MIDDLE INITIAL)	8. SEX ☐ M ☐ F	9. BIRTH DATE	10. MIHEALTH CARD NUMBER
11. BENEFICIARY'S ADDRESS (NUMBER, STREET, APT./LOT NUMBER, CITY, STATE, ZIP). IF RESIDES IN NURSING FACILITY INDICATE NAME OF FACILITY, ADDRESS AND PHONE NUMBER.			
12. NAME OF DESIGNATED CONTACT PERSON (E.G., BENEFICIARY, PARENT, GUARDIAN, ETC.)			13. PHONE NUMBER
14. OTHER INSURANCE NAME	15. POLICY NUMBER		16. FAX NUMBER
17. AUTHORIZATION TYPE: ☐ **NEW WHEELCHAIR/REPLACEMENT** ☐ **REPAIR** ☐ **RENTAL ONLY**			18 **MSA-1656 SUBMITTED ON**

19. LINE	20. BRAND NAME, MODEL CATALOG OR PART NUMBER	21.DESCRIPTION OF SERVICE	22. PROCEDURE CODE	23. MODIFIER	24. QUANTITY	25. CHARGE	26. COVERED BY OTHER INSURANCE? YES	26. NO	27. DATE LAST REPLACED (MM/DD/YYYY)
01							☐	☐	
02							☐	☐	
03							☐	☐	
04							☐	☐	
05							☐	☐	
06							☐	☐	
07							☐	☐	
08							☐	☐	
09							☐	☐	

FOR ADDITIONAL ITEMS ADD PAGE WITH DESCRIPTION, PROCEDURE CODE(S), MODIFIER(S), QUANTITY, CHARGE, IF COVERED BY OTHER INSURANCE, AND IF APPLICABLE DATE OF LAST REPLACED.

28. DIAGNOSES (CODES AND DESCRIPTIONS) REQUIRING THE ABOVE SERVICES.	29. ADDITIONAL REMARKS, INCLUDING OTHER INSURANCE COVERAGE, FOR SERVICES REQUESTED.

30. INDICATE ANY OTHER SERVICES PROVIDED TO THIS BENEFICIARY DURING THE PAST YEAR.

31. DME PROVIDER CERTIFICATION: THE PATIENT NAMED ABOVE (PARENT OR GUARDIAN IF APPLICABLE) UNDERSTANDS THE NECESSITY TO REQUEST PRIOR APPROVAL FOR THE SERVICES INDICATED. I UNDERSTAND THAT SERVICES REQUESTED HEREIN REQUIRE PRIOR APPROVAL AND, IF APPROVED AND SUBMITTED ON THE APPROPRIATE INVOICE, PAYMENT AND SATISFACTION OF APPROVED SERVICES WILL BE FROM FEDERAL AND/OR STATE FUNDS. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY LEAD TO PROSECUTION UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

DME'S SIGNATURE DATE

ADDITIONAL DME'S SIGNATURE DATE

MDHHS USE ONLY

32. REVIEW ACTION: ☐ APPROVED ☐ DENIED ☐ RETURN ☐ NO ACTION ☐ APPROVED AS AMENDED

33. CONSULTANT REMARKS

CONSULTANT SIGNATURE AND DATE

Michigan Department of Health and Human Services

Complex Seating and Mobility Device
Prior Approval - Request/Authorization

Additional Page (Use only if requesting additional mobility items)

Beneficiary Name: _____ Mihealth Number: _____

19. LINE	20. BRAND NAME, MODEL CATALOG OR PART NUMBER	21. DESCRIPTION OF SERVICE	22. PROCEDURE CODE	23. MODIFIER	24. QUANTITY	25. CHARGE	26. COVERED BY OTHER INSURANCE?		27. DATE LAST REPLACED
							YES	NO	(MM/DD/YYYY)
10							☐	☐	
11							☐	☐	
12							☐	☐	
13							☐	☐	
14							☐	☐	
15							☐	☐	
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30							☐	☐	
31							☐	☐	
32							☐	☐	
33							☐	☐	
34							☐	☐	

FOR ADDITIONAL ITEMS ADD PAGE WITH DESCRIPTION, PROCEDURE CODE(S), MODIFIER(S), QUANTITY, CHARGE, IF COVERED BY OTHER INSURANCE, AND IF APPLICABLE DATE OF LAST REPLACED.

CONSENT FOR STERILIZATION

Michigan Department of Health and Human Services

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from

_____. When I first asked for the
(Doctor or Clinic)

information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____
(Month / Day / Year)

I, _____
(Name of Individual Being Sterilized)

hereby consent of my own free will to be sterilized by

_____
(Name of Doctor and Professional Degree)

by a method called _____ .

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health and Human Services OR Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.

_____ Date: _____
(Signature of Person Giving Consent) *(Month / Day / Year)*

You are requested to supply the following information, but it is not required: *Ethnicity and race designation (please check)*

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Race (mark one or more):

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____ Date: _____
(Interpreter's Signature) *(Month / Day / Year)*

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed the
(Name of Individual)
consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____ _____
(Signature of person obtaining consent) *(Date)*

_____
(Facility)

_____
(Facility Address)

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon

_____ **on** _____
(Name of individual to be sterilized) *(Date of sterilization)*

I explained to him/her the nature of the sterilization operation _____, the fact that it is intended
(specify type of operation)
to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
  Individual's expected date of delivery: _____
- ☐ Emergency abdominal surgery: _____
  (describe circumstances)

_____

_____ Date: _____
(Signature of Physician and Professional Degree) *(Month / Day / Year)*

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is Voluntary, but is required if Medical Assistance program payment is desired.

The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.

INSTRUCTIONS TO COMPLETE CONSENT FOR STERILIZATION FORM

1. Name of the physician or clinic giving information to the beneficiary. The "M.D." or "D.O." designation must be included.
2. Name of the sterilization procedure to be performed (e.g., Tubal Ligation or Vasectomy).
3. Beneficiary's complete birth date (month, day, and year). The beneficiary must be 21 years of age at the time they sign the form.
4. Beneficiary's full name. If a name change is indicated on the Medicaid card by the time surgery is performed, both names must be indicated.
5. Name of physician performing the sterilization. If the physician is unknown, "doctor on call" may be indicated.
6. Name of surgery to be performed (e.g., Tubal Ligation or Vasectomy).
7. Beneficiary's handwritten signature. A beneficiary who cannot write should sign with an "X." The "X" signature must be witnessed. The witness' handwritten signature must appear below item 7.
8. Date the consent form was signed (month, day and year). This date must be more than 30 days and less than 180 days before the date the sterilization is performed. If it is less than 30 days, see instructions for "alternative final paragraphs."
9. Race and ethnicity designation is optional.
10. Interpreter's Statement. This information is only required if the beneficiary is unable to understand English. The language used for interpretation must be specified (e.g., Spanish). The interpreter's handwritten signature and date must appear. The date must be the same date the beneficiary signed the form.
11. Name of beneficiary.
12. Name of sterilization procedure (e.g., Tubal Ligation or Vasectomy).
13. The handwritten signature of the person obtaining consent.
14. Date consent is taken (month, day and year). This date must be before the date sterilization is performed (#18).
15. Name of provider or clinic (e.g., office of John Doe, M.D., doctor's office, ABC Clinic, XYZ Hospital).
16. Street address, city, state, and zip code. No P.O. boxes allowed.
17. Beneficiary's full name.
18. Date of sterilization (month, day, and year). The surgery date must be the same as indicated on the claim.
19. Name of sterilization procedure (e.g., Tubal Ligation, Vasectomy).
20. Instructions for use of alternative final paragraphs.
21. If at least 30 days have passed since the date the beneficiary signed the consent form and the date of sterilization, paragraph "1" applies and paragraph "2" should be crossed out.
22. If the date the sterilization was performed is less than 30 days and more than 72 hours of the beneficiary signing the consent form, paragraph "2" applies and paragraph "1" should be crossed out. The applicable box should be checked.
23. For premature delivery, the expected date of delivery must be given.
24. Physician's signature. This can be a stamped signature if counter initialed.
25. Date physician signed the consent form. This date must be on or after the date of surgery. This can be typed or stamped.

If abdominal surgery was performed, the circumstances must be explained and operative notes submitted with the claim.

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is Voluntary, but is required if Medical Assistance program payment is desired.

Michigan Department of Health and Human Services
Children's Special Health Care Services (CSHCS)

Application for Payment of Health Insurance Premiums

SECTION ONE – CSHCS Identifying Information

1. Name of Client (Last, First MI)	2. CSHCS ID Number	
3. Client's Contact Phone Number - -	4. Client's Date of Birth (MM/DD/YYYY) / /	
5. Does Client have Medicare Part B? ☐ **YES** ☐ **NO**	6. Does Client have Medicare Part D? ☐ **YES** ☐ **NO**	7. Does Client have MIChild? ☐ **YES** ☐ **NO**

SECTION TWO – Insurance Information

Is this case for:

☐ **COBRA** - Answer questions 8-24

☐ **Insurance Premium (new or continuing coverage)** - Answer questions 13-24

8. Reason COBRA was offered **OR** may be available:	
9. Date of qualifying event / /	10. Date of COBRA notice to employee / /
11. Date COBRA election form was signed (if applicable) / /	12. Has first COBRA payment been made? ☐ **YES** ☐ **NO** If yes, list date / /
13. Is insurance coverage through employer? ☐ **YES** ☐ **NO**	14. Name of employee (if applicable)
15. Name of employer (if applicable)	16. Name of insurance contact person
17. Phone number of insurance contact person ( )	18. Name of insurance company
19. Insurance contract number/group number	20. Premium cost per month for client's coverage $.
21. Date next premium is due / /	22. Date of contract renewal *(when rate could change)* / /
23. Name and address of company where premium payments are to be sent:	
24. Reason family is unable to pay premium:	

SECTION THREE – Health and Medical Information

25. What is the client's CSHCS covered diagnosis?			
26. What does the health insurance cover:	☐ **HOSPITAL**	☐ **DOCTOR VISITS**	☐ **PRESCRIPTIONS**
	☐ **VISION**	☐ **DENTAL**	
27. What are the expected future medical needs for the CSHCS client?			

28. Is it likely the client's insurance will cover these medical needs? Explain.
29. What special health care needs are **not** covered by the client's health insurance?

30. Are there other health insurance coverages for which the client might be eligible (e.g. Medicare Part B, Medicare Part D, other private health insurance, etc)? ☐ **YES** ☐ **NO**

Explain:

31. Additional Comments:

Attach the following information:

- Copy of the billing statement from the insurance carrier or a statement from the employer verifying the cost of the insurance premium.
- Copies of Explanation of Benefit (EOB) statements or expenditure summaries from the private health insurance carrier or Medicare.
- Copy of the completed COBRA election form if health insurance coverage is to be maintained under the provisions of COBRA.
- Pharmacy report documenting the cost of the prescriptions and the amount paid by the private health insurance carrier or Medicare if the coverage includes a prescription benefit.

Mail this application and attachments to:
MDHHS/CSHCS
Insurance Specialist
320 S. Walnut St., 6th Floor
Lansing, MI 48913

OR

Fax: 517-335-8055

For questions call:
Family Phone Line: 1-800-359-3722 and
ask for the Insurance Specialist

SECTION FOUR – Verification and Signature

- **By signing this application form, I am certifying that the information is accurate and complete to the best of my ability.**
- **I understand that I may need to show proof of this information.**
- **I understand that the information shared might relate to HIV, ARC, or AIDS if the Client has those conditions.**

Signature of Legally Responsible Party or Adult Client **Date Signed**

_____

MDHHS USE ONLY

MDHHS Action ☐ **APPROVED** ☐ **DENIED**	
	MDHHS Signature **Date**

Copy Distribution:
Client/Family
LHD

AUTHORITY: Title V of the Social Security Act
COMPLETION: Is voluntary, but is required if CSHCS program services are desired.

The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.

DENTAL PRIOR APPROVAL AUTHORIZATION REQUEST

Instructions for MSA-1680-B

The Dental Prior Approval Authorization Request form (MSA-1680-B) is to be used for persons with Medicaid coverage in the Fee for Service dental benefit and persons enrolled in Children's Special Health Care Services (CSHCS). For beneficiaries enrolled in ***Healthy Kids Dental, Healthy Michigan Plan Health Plans, Integrated Care Organizations and pregnant women enrolled in a Medicaid Health Plan,*** providers should contact the assigned plan for authorization requirements.

The MSA-1680-B must be completed by private dentists or community-based dental clinics (e.g., local health departments, Federally Qualified Health Centers (FQHC)). MDHHS requires that the MSA-1680-B be typewritten, handwritten forms will not be accepted.

The status of a prior authorization request may be reviewed in CHAMPS. Additionally, providers will receive a Prior Authorization determination letter. Approved services are required to be completed before the end of the Prior Authorization. To request an extension, the provider must submit a copy of the determination letter and required documentation within 15 days prior to the end date of the current authorization. If the original prior authorization is over one year old, a new prior authorization request must be submitted.

For further information on the prior authorization of dental services, please see the Prior Authorization Section, Dental Chapter of the Medicaid Provider Manual.

Dental providers treating CSHCS beneficiaries are required to submit the beneficiary's CSHCS qualifying diagnosis related to the services being requested. For authorization of orthodontics and/or crown and bridge services for beneficiaries enrolled in CSHCS, please see the Children's Special Health Care Services Dental Services Section, Dental Chapter of the Medicaid Provider Manual.

The completed MSA-1680-B may be mailed, faxed, or submitted via CHAMPS, depending whether Radiograph films are necessary, to:

Michigan Department of Health and Human Services
Dental Prior Authorization
P.O. Box 30154
Lansing, MI 48909
Fax: (517) 335-0075

Questions should be directed to Dental Prior Authorization at 1-800-622-0276.

If submitting electronically, the completed MSA-1680-B and all radiographs must be attached, as required by policy.

Radiographs will only be returned upon request, as indicated in box 17.

Michigan Department of Health and Human Services

DENTAL PRIOR APPROVAL AUTHORIZATION REQUEST

www.michigan.gov/mdhhs

FAX: 517-335-0075

1. Prior Authorization Number (MDHHS use only)

☐ Medicaid ☐ CSHCS

Note: The provider is responsible for eligibility verification. Authorization does not guarantee beneficiary eligibility or payment. MDHHS requires that the MSA-1680-B be typewritten, handwritten forms will not be accepted.

2. Provider Name (Last, First, Middle Initial)

3. Provider Street Address

4. City | State | ZIP Code

5. Provider Fax Number ( ) -

6. Provider Phone Number ( ) -

7. Provider NPI No.

8. Group NPI No.

9. Beneficiary Name (Last, First, Middle Initial)

10. Birth Date / /

11. Sex ☐ M ☐ F

12. MI Health Card Number

13. Phone Number ( ) -

14. Does patient live in a nursing home? ☐ Yes ☐ No

If Yes, Facility Name

15. Is Patient Covered by Any Other Dental Plan? ☐ Yes ☐ No

If Yes, Plan Name

16. CSHCS Diagnosis – ICD Diagnosis Code and Description

.

17. Are Radiographs Attached? ☐ Yes ☐ No

If yes, Number of Radiographs and Date Taken / /

Radiographs will only be returned upon request.

Check here for return of Radiographs ☐

18. Is Treatment for Orthodontics? ☐ Yes ☐ No

Is Treatment Plan Enclosed? ☐ Yes ☐ No

19. Is this Initial Placement of Prosthesis?

☐ Max. ☐ Yes ☐ No ☐ Mand. ☐ Yes ☐ No

If "No", please document Reason for Replacement:

20. Indicate missing teeth with an "X" - teeth to be extracted with a " / ".

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

A B C D E F G H I J

T S R Q P O N M L K

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

21. Indicate teeth extracted since Radiographs:

22. Status of Current Prosthesis:

	Part	Full	Date Inserted	Can Be Worn? Yes	Can Be Worn? No	Can Be Repaired? Yes	Can Be Repaired? No	Used Now Yes	Used Now No
Max				☐	☐	☐	☐	☐	☐
Mand				☐	☐	☐	☐	☐	☐

EXAMINATION AND TREATMENT REQUESTED

LINE	23. Tooth	24. Procedure Code	25. Consultant Use Only	26. Description of Service
1				
2				
3				
4				
5				
6				
7				
8				
9				

27. Address 5 Year Prognosis for Partial Dentures

28. Other Pertinent Dental or Medical History

29. PROVIDER CERTIFICATION: The patient named above (parent, if minor, or authorized representative) understands the necessity to request prior approval for the services indicated above. I understand the services requested herein require prior approval and if submitted on the proper invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of material fact may be prosecuted under applicable Federal and State Law.

Provider's Name (printed/typed): Provider Signature: Date:

For MDHHS Consultant Use Only

30. Consultant Remarks

31. Review Action

Approved ☐ Denied ☐

Returned ☐ No Action ☐

Approved as amended ☐

32. Consultant Signature Date

AUTHORITY: Title XIX of the Social Security Act

COMPLETION: Is Voluntary, but is required if payment from applicable program is sought.

The Department of Health and Human Services is an equal opportunity employer, services and programs provider.

Documentation of Medical Necessity for the Provision of Contact Lenses

(This form is to be completed and attached to DCH-0893 when requesting prior authorization for the provision of contact lenses. Prior authorization is NOT required for beneficiaries with aphakia who are under six years of age.)

Beneficiary's Name _____ **Medicaid ID Number** _____

Indicate the diagnosis(es) which best describes the beneficiary's condition:

- ☐ Anirida
- ☐ Anisometropia or Antimetropia
- ☐ Aphakia
- ☐ Irregular Corneas *****
- ☐ Keratoconus ***** (If vision can not be improved to 20/40 or better with eyeglasses.)
- ☐ Other conditions with no alternative treatment (e.g., Aniseikonia (with documentation), Keratoconjunctivitis Sicca)

_____

_____

Diagnosis(es) Code: _____

Current spectacle correction:			**Best spectacle correction:**		
R	_____ **VA**	_____	**R**	_____ **VA**	_____
L	_____ **VA**	_____	**L**	_____ **VA**	_____
ADD	_____		**ADD**	_____	

Has the beneficiary previously worn contact lenses? ☐ YES ☐ NO
If yes, explain:

_____

Is the beneficiary currently wearing contact lenses? ☐ YES ☐ NO
If yes, indicate reason for new lenses:

_____

Keratometry (diopters)

R _____ @ _____ ; _____ @ _____

L _____ @ _____ ; _____ @ _____

Mire Quality

R _____

L _____

*** A corneal topography for Keratoconus and Irregular Cornea diagnoses may be requested.**

Type of contact lens requested:

A. Hydrogels

	R	L
Power		
Series (Brand Name)		
Additional Specifications		
Manufacturer		
Manufacturer's wholesale cost		

B. Rigid Gas Permeable or Hybrid

	R	L
Base Curve		
Power		
Diameter		
Additional Specifications		
Complete description of contact lens parameters		
Material of the contact lens		
Manufacturer of the contact lens		
Brand Name		
Manufacturer's wholesale cost		
Number of lenses required to provide one-year supply		
Prescription expiration date		

Expected obtainable visual acuity with contact lenses at distance:

R _____ **L** _____

Approximate wearing time per day (specify number of hours):_____ _____

Are eyeglasses to be worn simultaneously, as an over-correction, with the contact lenses? ☐ Yes ☐ No

Provide your assessment of beneficiary's ability to insert, remove, maintain, and wear contact lenses:

_____

_____

_____

_____ _____

Provider's Signature **Provider's Name (Print)**

Date: _____

Authority: Title XIX of the Social Security Act
Completion: Is Voluntary, but is required if Medical Assistance program payment is desired.

The Michigan Department of Health and Human Services is an equal opportunity employer, services, and programs provider.

ELECTRONIC SIGNATURE AGREEMENT

Michigan Department of Health and Human Services

Employer or Employing Entity Name	Employer Identification Number	NPI
Individual Name (Doctor, Dentist, Nurse, etc.)		NPI

The undersigned Individual and Employing Entity attest that they have entered into an agreement effective on the date indicated below. Both parties agree an authorized representative of the Employing Entity has the authority to sign and submit the electronic Michigan Department of Health and Human Services Medical Assistance Provider Enrollment Trading Partner Agreement and to maintain enrollment information through the MDHHS CHAMPS Provider Enrollment Subsystem. Both parties also agree that the Employing Entity listed above is liable and bound by all information submitted on his or her behalf as if the Employing Entity had submitted changes to CHAMPS directly.

Individual Signature	Date
Employing Entity Signature	Date
Individual MILogin User ID	Date

ELECTRONIC SIGNATURE VERIFICATION STATEMENT

Michigan Department of Health and Human Services

The DCH-3890 form must be submitted by the Medicaid provider as verification of electronic signature security.

By signing this form, providers attest that measures are in place to protect the security of this electronic signature.

This signature verification form will be in effect until such date that the signatory party changes.

Field Name	Instructions
Provider Name	The name of the Medicaid enrolled provider (for the School Based Services Program this is one of the 56 Intermediate School Districts, Michigan School for the Deaf or Detroit Public Schools).
Program/Application	The name of the program or application (i.e., FQHC, PCG financial certification, School Based Services (MAER).
NPI (National Provider Identifier)	The unique identification number for covered health care providers mandated by the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard.
User ID	User identification for the MILogin portal or software user identification.
Local School District Name	Only applicable to the School Based Services Program. The name of the Michigan local school district.
Individual Printed Name	The printed name of the individual that will be submitting the electronic signature verifying the validity of cost submitted to the State of Michigan.
Individual Signature	The signature of the individual that will be submitting the electronic signature verifying the validity of cost submitted to the State of Michigan.
Date	Date of form completion and signature.

Pursuant to 42 CFR § 433.51, this Electronic Signature Verification Statement is intended to document a physical copy of my signature as part of the documentation required for the submission of visits and financial data.

I understand that this electronic signature is created with a unique combination of my computer login name and secure password. This unique combination is to ensure that all documentation is completed under this combination is done by me.

By signing this statement, I confirm that I will keep my password secure and that I will not inappropriately disclose this information to others. I also confirm that all documentation entered under my login name and password is true and correct. This form will remain in effect until the individual named on the form changes.

Provider Name	Program/Application	NPI

User ID	Local School District Name

Individual Printed Name

Individual Signature	Date

Form Submission

The completed original DCH-3890 must be mailed:

Michigan Department of Health and Human Services
Bureau of Medicaid Operations
Hospital and Clinic Reimbursement Division
Rate Review Section
PO Box 30479
Lansing, MI 48909

Questions should be directed to MDHHS Medical Services Administration, Rate Review Section, via telephone at **517-335-5330.**

Authority: Public Act 305 § 450.832 and 42 CFR § 433.51 **Completion:** Mandatory for payment.	The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

Michigan Department of Health and Human Services
Completion Instructions for MSA-181
Home Health Aide Prior Approval Request/Authorization

General Instructions

The MSA-181 must be used by Medicaid enrolled and home health agencies to request Prior Authorization (PA) for home health aide services. MDHHS requires that the MSA-181 be typewritten; handwritten forms will not be accepted. A Word fill-in enabled version of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Forms.

This form must be used to request Prior Authorization (PA) for home health aide services for beneficiaries with Medicaid. A request to begin services may be submitted by a person other than the home health agency such as the hospital Discharge Planner or physician. When this is the case, the person submitting the request must do so in consultation with the beneficiary (parent or guardian if applicable), and home health agency who will be assuming responsibility for the care of the beneficiary.

PA may be authorized for a period not to exceed ninety days. If need for home health aide services are medically necessary, a subsequent request for PA must be submitted. The provider should retain a copy of the PA form until the approval or denial is returned.

Refer to the Medicaid Provider Manual, Home Health Chapter, Prior Authorization Subsection, for the listing of required documentation to accompany each request.

Completion of this form is as follows:

Item#	Instructions
1	Prior Authorization Number. MDHHS use only.
2	The Home Health Agency Provider Name.
3	The Medicaid enrolled provider's name and National Provider Identifier (NPI).
4-9	The Home Health Agency provider's telephone number (including area code), address and fax number (including area code).
10	**Initial:** The authorization request is the initial prior authorization request for the beneficiary under this treatment plan. **Continuing:** The treatment authorization request is to continue treatment for additional calendar month(s) of service under this treatment plan.
11-19	Beneficiary information. Provide complete name, sex, mi health card number, date of birth, complete address (including city, state, and zip code), and phone number.
20-21	Enter the beneficiary's diagnosis(es) code(s) and and onset date that relate to the service being requested.
22	The beneficiary's most recent hospital discharge date for the requesting prior authorization period.
23-25	Hospital information including complete address and phone number, anticipated discharge date, and name and contact information of Discharge Planner, if beneficiary is currently hospitalized.
26	The start date of the last approved authorization period.
27	The previous total number of home health aide visits rendered (since services were first started).
28	The date home health services were first started.
29	For this current request being submitted, indicate requested start and end dates, total quantity of procedure code G0156 (i.e. visits) requested, and the planned visit frequency during the requested authorization period.
30	Indicate if the current authorization request is an increase or decrease from previous authorization, or if a change is being requested for the currently approved authorization period.
31	List the beneficiary's current medications relevant to the medical diagnosis.
32	Documentation of the beneficiary's cognitive status.
33	Identify the beneficiary's ability to complete range of motion for upper and lower extremities.

34	Evaluation includes OASIS coding of the beneficiary. **OASIS Coding** 06 **Independent** – Patient completes the activity by him/herself with no assistance from a helper. 05 **Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity. 04 **Supervision or touching assistance** – Helper providers VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. 03 **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort. 02 **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01 **Dependent** – Helper does ALL the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity. **If activity was not attempted, code reason:** 07 **Patient refused** 09 **Not applicable** 88 Not attempted due to **medical condition or safety concerns**
35	Indicate the service and frequency of the service for this authorization request.
36	Identify the medical need for additional services. Service request must be specific, include supportive documentation of the beneficiary's current level of function and the medical necessity of requested service(s).
37	List all other services in the home. Must include the frequency of the service(s) and payer(s). Failure to disclose all services in the home may result in recoupment of Medicaid dollars for home health aide reimbursement.
38	Signature certifies that Parent/Guardian of beneficiary attests that information provided on this form is accurate and complete to the best of their ability. All unsigned requests will be returned for signature.
39	The Physician's signature certifies that (1) the Home Health agency requesting the services understands the medical necessity for obtaining prior authorization for Home Health services and; (2) the information provided on this form is accurate and complete. All unsigned requests will be returned for signature.
40	The licensed supervising professional's signature certifies that (1) the licensed, registered nurse, physical therapist, occupational therapist, or speech/language therapist provides supervision of the home health aide; (2) the services are medically necessary for obtaining prior authorization for Home Health aide services and; (3) the information provided on this form is accurate and complete. All unsigned requests will be returned for signature.
41-42	MDHHS use only

RETURN COMPLETED FORM AND REQUIRED DOCUMENTATION TO:

MDHHS
Program Review Division
PO Box 30170
Lansing, MI 48909

OR

Fax to: 517-335-0075

Questions should be directed to MDHHS - Medical Services Administration, Program Review Division via telephone at **1-800-622-0276.**

Authority: Title XIX of the Social Security Act.	**Completion**: Is voluntary but is required if payment from applicable programs is sought.
The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.	

HOME HEALTH AIDE
PRIOR APPROVAL REQUEST/AUTHORIZATION

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

The provider is responsible for eligibility verification.
Approval does not guarantee beneficiary eligibility or payment.

1. Prior Authorization Number (MDHHS USE ONLY)

MDHHS requires this form to be typewritten; handwritten forms will not be accepted.

2. Home Health Agency Provider Name	3. Provider NPI Number	4. Provider Phone Number	5. Provider Fax Number

6. Home Health Agency Provider Address (Number, Street, Building, Suite Number, etc.)	7. City	8. State	9. Zip Code

10. Home Health Aide Authorization Request ☐ Initial ☐ Continuing

11. Beneficiary Name (Last, First, Middle Initial)	12. Beneficiary Date of Birth	13. Sex	14. mihealth ID Number	15. Beneficiary Telephone Number
		☐ M ☐ F		- -

16. Beneficiary Address (Number, Street, Apt/Lot, etc.)	17. City	18. State	19. ZIP Code

20. Medical ICD Diagnosis(es) Code(s) Requiring Home Health Services	21. Onset Date	22. Most Recent Hospital Discharge Date

23. Primary Caregiver(s)	24. Relationship(s) to Beneficiary	25. Primary Caregiver(s) Phone Number(s)
		- -
		- -

26. Date of Last Authorization	27. Number of Previous Visits	28. Date Home Health Aide Service(s) Started	29. Current Request Requested Start Date: Requested End Date: Requested Qty Code G0156: Visit Frequency:	30. Number of Visits Requested compared to Last Authorization ☐ Increase ☐ Decrease ☐ Change to current authorization

Beneficiary's Current Functional Level and Services

31. List Current Medications:

32. Cognitive: ☐ Alert/oriented ☐ Able to Direct Care ☐ Impaired/Developmental Delay ☐ Disoriented ☐ Unresponsive

33. Range of Motion Exercises: Upper Extremity: ☐ Independent ☐ Requires Assistance / Dependent

Lower Extremity: ☐ Independent ☐ Requires Assistance / Dependent

34. SCORE: (see instructions)	06	05	04	03	02	01	07	09	88	35. Services & frequency to be performed by aide
Bathing/Skin Care	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grooming	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Oral Hygiene	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Transfers	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Positioning	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ambulation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Medication Management, if applicable	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Laundry	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Vital Signs										☐

36. Other Services (Must specify service(s) include documentation of current level of function and medical necessity for each)

Beneficiary Name: _____ mihealth ID Number: _____

37. Other Services Currently Received By Beneficiary (Check All)				Frequency	Payer
Skilled Nursing Visits	☐ No	☐ Yes			
Private Duty Nursing	☐ No	☐ Yes			
Physical Therapy	☐ No ☐ Home	☐ Yes ☐ School	☐ Outpatient		
Occupational Therapy	☐ No ☐ Home	☐ Yes ☐ School	☐ Outpatient		
Speech Therapy	☐ No ☐ Home	☐ Yes ☐ School	☐ Outpatient		
Home Help	☐ No	☐ Yes			
Community Living Services (CLS)	☐ No	☐ Yes			
Other Behavioral Health Services	☐ No	☐ Yes	Specify:		
Waiver Services	☐ No	☐ Yes	Specify:		
Hospice	☐ No	☐ Yes			
Other Services	☐ No	☐ Yes	Specify:		

☐ Home Health Agency Plan of Care Attached (Most Recent Plan Of Care Must Accompany Request)

☐ Copy of Oasis Must Be Attached With Initial Request And Annually Thereafter

38. PATIENT (PARENT / GUARDIAN IF APPLICABLE) CERTIFICATION	39. PHYSICIAN CERTIFICATION	40. LICENSED SUPERVISING PROFESSIONAL CERTIFICATION
I, the patient (parent/guardian) named above, understand the necessity to request prior authorization for the medically necessary services indicated. I understand that services requested herein require prior authorization and, if approved and submitted by the agency on the appropriate invoice, payment of authorized services will be from general and/or state funds. I understand that any false claims, statements or documents, or concealment of a material fact may lead to prosecution under applicable federal and/or state law. I hereby attest that information provided on this form is accurate and complete to the best of my ability.	I certify that I have examined the patient named above and have determined that home health aide services are medically necessary, as supervised by a licensed, registered nurse or other authorized licensed professional. I understand that home health aide services require prior authorization to validate that such services are deemed medically necessary in accordance with Michigan Medicaid Provider Manual policy. I understand that any false claims, statements or documents, or concealment of a material fact may lead to prosecution under applicable federal and/or state law. I hereby attest that information provided on this form is accurate and complete to the best of my ability.	I hereby attest as a licensed professional (registered nurse, physical therapist, occupational therapist, or speech/language pathologist) that supervision of the home health aide is under my authority and deemed medically necessary. I understand that services requested herein require prior approval and, if approved and submitted on the appropriate invoice, payment of approved services will be from federal and/or state funds. I understand that any false claims, statements or documents, or concealment of a material fact may lead to prosecution under applicable federal and/or state law. I hereby attest that information provided on this form is accurate and complete to the best of my ability.
PATIENT NAME (PARENT / GUARDIAN) PRINTED SIGNATURE DATE	PHYSICIAN NAME PRINTED SIGNATURE DATE	SUPERVISING PROFESSIONAL NAME PRINTED SIGNATURE DATE

MDHHS USE ONLY

41. REVIEW ACTION:
☐ APPROVED ☐ DENIED
☐ RETURN ☐ NO ACTION
☐ APPROVED AS AMENDED

42. CONSULTANT REMARKS AND AUTHORIZATION PERIOD IF APPROVED:
☐ See CHAMPS ☐ KEEP IN FILE

_____ ☐ KEEP IN FILE

_____ ☐ KEEP IN FILE

_____
CONSULTANT SIGNATURE / DATE

Michigan Department of Health and Human Services

HOSPITAL NEWBORN NOTICE

INSTRUCTIONS

The MSA-2565-C serves as notice of birth of a newborn for the purposes of obtaining a Medicaid ID number. It must be completed only if the hospital is unable to submit notice of the birth through the Michigan Electronic Birth Certificate system.

- The hospital must retain **THE ORIGINAL** of the Hospital Newborn Notice in the beneficiary's file. A copy **MUST** be sent to the local MDHHS office.
- A copy of the MSA-2565-C will be returned to the hospital, noting the eligibility status of the newborn.
- Item 6 must state the name of the mother.
- A copy of the CHAMPS Eligibility Inquiry or HIPAA 271 transaction response with the mother's Benefit Plan ID information should be attached to the form; or the form must contain the county, district, unit, worker, and case number data from the eligibility response separated by slashes (e.g., 33/01/01/08/1234567890).

AUTHORITY: P.A. 280 of 1939 and Federal 42 CFR of 435
Title XIX of the Social Security Act

COMPLETION: Is voluntary

Michigan Department of Health and Human Services

HOSPITAL NEWBORN NOTICE

1. Newborn Name *(Last, First, Middle)*	2. Newborn Gender ☐ M ☐ F	3. Newborn Birth Date / /	4. Newborn Social Security No. *(If Available)* - -
5. Home Address *(No. & Street, including apartment number)*	City	State	Zip Code
6. Name of Newborn's Mother *(Last, First, Middle)*	7. Phone No. ( ) -		
8. Mother Social Security No. *(If Available)* - -	9. Mother Birth Date / /		
10. Home Address *(No. & Street, including apartment number)*	City	State	Zip Code
11. Name of Provider	12. National Provider ID Number		
13. Provider Address *(No. & Street)*	City	State	Zip Code
14. Attending Physician Name	15. Hospital Case No. *(If Applicable)*		

16. Present Status of Patient *(Check ONE)*

☐ Still a Patient ☐ Discharged (Date): / / ☐ Deceased (Date): / /

17. Indicate Medicare or Private Health Insurance coverage available to patient and complete the following as applicable

☐ Medicare ☐ No Other Insurance Coverage Available

☐ Private Health Insurance (Complete items 18 thru 23 below)

18. Name of Policyholder (Private Health Ins.)	19. Policyholder's SS No. - -
20. Name of Insurance Company	
21. Location (City) / State	Zip Code
22. Group / Policy Number	23 Cert. / Contract No.

PATIENT CERTIFICATION

I certify that the information furnished by me in applying for hospital services under Michigan Public Acts 321 of 1966, 280 of 1939, and 368 of 1978 is correct. Further, I declare and hereby affirm that I have disclosed to the facility named in section **9** above, the name(s) and address (es) of all parties liable or who may be liable, in whole or in part, for payment of care received in the named facility. By accepting services, I hereby authorize the named facility to release all information and records for purposes of determining the respective liability and / or liabilities of all parties responsible, in whole or in part, for the payment of services received in this facility. I hereby authorize and assign directly to the named facility any or all benefits I may be entitled to and otherwise payable to me for the period of service in this facility.

24. Signature of Patient's Representative / Date Signed / /	25. Signature of Person Completing This Form / Date Signed / /

STATEMENT OF ELIGIBILITY (To be completed by MDHHS for MA eligibility)

Eligibility is:

☐ **DENIED** (Contact Patient Representative for Explanation) ☐ **APPROVED** (see the Billing Information below)

Eligible Person's Name	Program	Grantee Name				
Recipient ID No.	MA Eligibility Effective Date	Grantee Client ID No.				MDHHS Case No.
Patient Pay Amount $	Patient Pay Amt. Effective Date	County	District	Section	Unit	Worker Name
Insurance, Medicare, Third Party Name		Signature of Worker				

MSA-2565-C (08/17) Previous editions are obsolete.

I - XXXXXX

STATE OF MICHIGAN
DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

RICK SNYDER
GOVERNOR

NICK LYON
DIRECTOR

GUARANTEE OF PAYMENT FOR PREGNANCY-RELATED SERVICES

NOTICE TO PRENATAL CARE PROVIDERS
PHARMACY, LABORATORY AND DIAGNOSTIC SERVICES AGENCIES

Today's Date	Expected Date of Confinement / **Due Date**
Beneficiary's Name	Beneficiary's Date of Birth
Address (Number and Street) Apt. No.	Medicaid Case Number (if available)
City, State, ZIP Code	Medicaid Beneficiary ID Number (if available)

IMPORTANT: All of the above information MUST be completed.

The Michigan Department of Health and Human Services (MDHHS) **GUARANTEES PAYMENT** of the pregnancy-related services listed below for 45 days from the date listed above. This document should be considered as proof of coverage until the beneficiary receives a **mihealth card or a beneficiary ID number**. Michigan Medicaid-covered maternity services and fee screens apply.

Subsequent to the 45 days, MDHHS will continue to provide medical coverage for eligible women through the Maternity Outpatient Medical Services (MOMS) Program or the Michigan Medicaid Program for prenatal care, delivery, and other pregnancy-related services for the duration of the pregnancy. Medically necessary ambulatory postpartum care will be covered for 60 days after the pregnancy ends. Inpatient hospital coverage is limited to delivery-related services only.

Pregnancy-related covered services during the eligibility period include:

1. Prenatal care
2. Pharmaceuticals and prescription vitamins
3. Laboratory
4. Labor and Delivery – will cover both professional fees and inpatient hospitalization
5. Postpartum Care through 60 days after the pregnancy ends
6. Radiology and Ultrasound
7. Maternal Infant Health Program (MIHP) services until delivery
8. Outpatient hospital care
9. Childbirth education
10. Other pregnancy-related care with prior authorization

If you have questions regarding billing or you are providing a medical service that is not listed above, please refer to page 2 of this letter for instructions on billing and prior authorization procedures.

If you require this document for your files, please make a copy and return the original to the beneficiary.
Guarantee of payment applies only for providers enrolled in the Michigan Medicaid Program.

Name of Contact Person	Signature		Date
Phone Number ( )			
Name of Issuing Agency			
Agency's Mailing Address (Number and Street) (Suite)	City	**MI**	ZIP Code

DISTRIBUTION: Original: Beneficiary
Copy: Issuing Agency File Copy

Chris Priest, Director
Medical Services Administration

PROVIDER BILLING INSTRUCTIONS
for
GUARANTEE OF PAYMENT FOR PREGNANCY-RELATED SERVICES (DCH-1164)

ELIGIBILITY:

MOMS eligibility may be obtained through the Community Health Automated Medicaid Processing System (CHAMPS) (Eligibility Inquiry and/or 270/271 transaction). MDHHS will issue a beneficiary ID number to be used when billing for services. If the beneficiary receives full Medicaid and enrolls in a Medicaid Health Plan, the health plan's policies and procedures will apply. If you are not a participating provider with the health plan, the beneficiary should be referred to the health plan before services are rendered.

BILLING INSTRUCTIONS:

- Electronic submission of claims is the preferred method for quick and accurate claim reimbursement.
- All services must be billed within one year of the date of service. Pharmacy services should be billed within six months of the date of service.
- Claims must be completed following standard Medicaid billing and reimbursement guidelines contained in the Billing and Reimbursement Chapters of the Medicaid Provider Manual. Claims must be submitted to the same location where you submit your Medicaid Claims.
- Private insurance must be billed first, if applicable.
- This Guarantee of Payment insures the MDHHS will provide coverage for pregnancy related services. You must hold your claim for services provided until the beneficiary receives her **mihealth** card or a beneficiary ID number can be identified in CHAMPS (Eligibility Inquiry and/or 270/271 transaction) with MOMS eligibility, identified with Benefit Plan ID MOMS, for the date of service. You must provide the beneficiary ID number on the claim to receive payment. Do not use the "I" number that appears in the upper right hand corner of the Guarantee of Payment letter.
- MOMS claim adjudication information will be included in the weekly remittance advice, merged alphabetically with Medicaid and other MDHHS-administered programs. The remittance advice is your claim status. If a claim does not appear on a remittance advice within 45 days, the account should be resubmitted for processing. Should you have other questions about your claim, you may contact the Medicaid Provider Inquiry line at 1-800-292-2550 or by e-mail at providersupport@michigan.gov.

All MOMS covered services are subject to the published policies and procedures applicable under the Medicaid program as they relate to health care and claim submission requirements.

PRIOR AUTHORIZATION:

If your service does not meet the definition of pregnancy-related services listed on page one of this letter, or if the service normally requires prior authorization by the Medicaid program, submit your request for authorization, by mail or by fax. Refer to the Directory Appendix in the Medicaid Provider Manual for contact information.

PHARMACY SERVICES:

Pharmacy services provided to MOMS beneficiaries must be billed to the Pharmacy Benefits Manager. Refer to the Michigan Pharmaceutical Product List to identify products that may require prior authorization. To obtain prior authorization, you may write, call or fax your request to the Pharmacy Benefits Manager. Refer to the Directory Appendix in the Medicaid Provider Manual for contact information.

Pharmacies who provide MOMS services, when presented with this Guarantee of Payment letter (DCH-1164), have the option of billing the Pharmacy Benefits Manager as indicated below:

A. Pharmacies will need to hold the electronic claim (electronic preferred) until MOMS eligibility, identified with Benefit Plan ID MOMS, is in CHAMPS (Eligibility Inquiry and/or 270/271 transaction) for the date of service. Then bill the Pharmacy Benefits Manager via the on-line system, if the electronic claim is used.
B. Submit the appropriate HIPAA compliant National Council for Prescription Drug Programs (NCPDP) electronic claim or submit a Universal Claim Form, along with a copy of the Letter, to the Pharmacy Benefits Manager per the instructions in their manual.
C. Pharmacies will need to hold the electronic claim until MOMS eligibility, identified with Benefit Plan ID MOMS, is in CHAMPS (Eligibility Inquiry and/or 270/271 transaction) for the date of service and obtain a copy of the Guarantee of Payment letter (DCH-1164) as proof of coverage in order to fill the prescription(s).

AUTHORITY:	Title XIX of the Social Security Act	The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.
COMPLETION:	Is Voluntary, but is required if Medical Assistance program payment is desired.	

Michigan Department of Health and Human Services

MEDICAID ENROLLED BIRTHING HOSPITAL AGREEMENT FOR ELECTIVE, NON-MEDICALLY INDICATED DELIVERY PRIOR TO 39 WEEKS COMPLETED GESTATION

Instructions for MSA-1755

The Medicaid Enrolled Birthing Hospital Agreement for Elective, Non-Medically Indicated Delivery Prior to 39 Weeks Completed Gestation form (MSA-1755) is to be completed by all Medicaid enrolled birthing hospitals in the State of Michigan.

The purpose of this form is to serve as an attestation that each Medicaid enrolled birthing hospital utilizes evidence-based guidelines (EBGs) to address elective, non-medically indicated delivery prior to 39 weeks completed gestation for Medicaid beneficiaries.

To complete the form, hospitals must indicate whether they have elective delivery EBGs in place. If the hospital utilizes guidelines that are not listed on the form, hospitals may use the space provided on the form to explain. Hospitals may also submit copies of their elective delivery policies.

The form must be signed by both the Chief Executive Officer (CEO) and the Chief Medical Officer (CMO) of the facility.

The completed MSA-1755 must be mailed or faxed to:

Attn: Inpatient Hospital Policy
Michigan Department of Health and Human Services
Medical Services Administration, Program Policy Division
PO Box 30479
Lansing, Michigan 48909-7979
Fax: (517) 335-5136

Questions should be directed to Provider Support at ProviderSupport@michigan.gov.

Michigan Department of Health and Human Services

MEDICAID ENROLLED BIRTHING HOSPITAL AGREEMENT FOR ELECTIVE, NON-MEDICALLY INDICATED DELIVERY PRIOR TO 39 WEEKS COMPLETED GESTATION

The purpose of this agreement is to certify that Medicaid enrolled birthing hospitals utilize evidence-based guidelines (EBGs) to address elective, non-medically indicated delivery prior to 39 weeks completed gestation for Medicaid beneficiaries.

NOTE: This agreement must be signed by both the Chief Executive Officer (CEO) and the Chief Medical Officer (CMO) of the facility.

Complete the following:

Hospital Name _____ **National Provider Identifier** _____

attests that the following elective delivery EBGs are utilized:

Yes	No	(Indicate Yes or No for each statement)
☐	☐	Medical indications for elective, non-medically indicated delivery prior to 39 weeks completed gestation are defined in hospital policy.
☐	☐	Hospital staff is not authorized to schedule an elective, non-medically indicated delivery prior to 39 weeks completed gestation.
☐	☐	Providers are required to obtain permission from physician leadership (e.g., the head of the obstetrics department) before performing an elective, non-medically indicated delivery prior to 39 weeks completed gestation.
☐	☐	Provider education materials are used to educate providers on the risks of elective, non-medically indicated delivery prior to 39 weeks completed gestation.
☐	☐	Patient education materials are used to educate patients on the risks of elective, non-medically indicated delivery prior to 39 weeks completed gestation.
☐	☐	Hospital involvement in an initiative that addresses elective, non-medically indicated delivery prior to 39 weeks completed gestation (e.g., Michigan Health & Hospital Association [MHA] Keystone Center's initiative in obstetrics, Trinity Health System's Perinatal Patient Safety Initiative [PPSI], Ascension Health System's Handling All Neonatal Deliveries Safely [HANDS]).
☐	☐	Other. Explain in the space provided below. If more space is needed, attach explanation on a separate document.

Along with this completed agreement, MDHHS will also accept a copy of each facility's elective delivery policy.

I certify that the responses in this attestation agreement are accurate, complete and current as of the date signed.

Signature of Chief Executive Officer	**Signature of Chief Medical Officer**
PRINT Name of CEO	PRINT Name of CMO
Telephone Number / Date	Telephone Number / Date

AUTHORITY:	Title XIX of the Social Security Act	Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.
COMPLETION:	Is Required.	

Michigan Department of Health and Human Services
Children's Special Health Care Services

CSHCS MEDICAL ELIGIBILITY REPORT

Instructions for Form MSA-4114

Purpose:

This form is used to determine if an individual is medically eligible for the Children's Special Health Care Services (CSHCS) program. The condition must require the services of a medical and\or surgical sub-specialist at least annually, as opposed to being managed exclusively by a primary care physician. A current list of covered diagnoses is maintained on the MDHHS website at www.michigan.gov/mdhhs. In addition, some diagnoses must meet severity or chronicity criteria (e.g. asthma).

This form should be completed for the following persons:

- Anyone **UNDER 21** years of age with a potentially eligible condition. Psychiatric, emotional and behavioral disorders, attention deficit disorder, developmental delay, intellectual disability, autism, or other mental health diagnoses are **not** conditions covered by the CSHCS program.
- Anyone, regardless of age, with cystic fibrosis or hereditary coagulation defects commonly known as hemophilia.

Completion Instructions:

- Read this instruction page thoroughly. Then separate attached forms.
- **TYPE** or **PRINT** clearly in INK.
- The **Physician's Signature** (or the Attending Physician if a Hospital) and the **Date Signed** are **REQUIRED**.
- Attach supporting medical documentation.
- If desired, make a photocopy for your records.
- **FAX** the completed form to **the CSHCS Division at 517-335-9491.**

Other Information:

- If this request is approved, the client is medically eligible for the CSHCS program.
- For actual program coverage, the client or the client's family MUST APPLY to join the CSHCS program by completing form **MSA-0737**, APPLICATION FOR CHILDREN'S SPECIAL HEALTH CARE SERVICES.
- If the family does NOT receive an application after notification of approval, call **1-800-359-3722**.

For questions and/or problems, or help to translate, call the Beneficiary Help Line at 1-800-642-3195 (TTY 1-866-501-5656).
Spanish: Si necesita ayuda para traducir o entender este texto, por favor llame al telefono **1-800-642-3195** (TTY 1-866-501-5656)
Arabic: 1-800-642-3195 (TTY 1-866-501-5656)

إذا كان لديكم أيّ سؤال، يرجى الإتصال بخط المساعدة على الرقم المجاني ١-٨٠٠-٦٤٢-٣١٩٥

AUTHORITY: Title V of the Social Security Act
COMPLETION: Completion is voluntary, but is required if coverage under the Children's Special Health Care Services program is desired.

The Department of Health and Human Services is an equal opportunity employer, services and programs provider.

Michigan Department of Health and Human Services
Children's Special Health Care Services (CSHCS)

MEDICAL ELIGIBILITY REPORT

CLIENT INFORMATION:

CLIENT'S Name (Last, First, Middle)		Date of Birth	Sex ☐ **MALE** ☐ **FEMALE**
CLIENT'S Address (Number, Apt. No., Lot No.)		Social Security Number	HOME Phone Number ( ) -
City	State / ZIP Code	County	WORK Phone Number ( ) -
Does client have other health insurance? ☐ **NO** ☐ **YES** (Co. Name):		Is client enrolled in Medicaid? ☐ **NO** ☐ **YES** (Medicaid ID No.):	

Racial/ Ethnic Heritage (Check all that apply) (You are not required to complete this information.)
☐ Alaska Native ☐ American Indian ☐ Arabic ☐ Asian ☐ African American/Black ☐ Hispanic or Latino
☐ Caucasian/White ☐ Multi-racial/Ethnic ☐ Native Hawaiian/Other Pacific Islander ☐ Other:

PARENT(S) OR LEGALLY RESPONSIBLE PARTY INFORMATION: (Check appropriate boxes and complete information.)

☐ FATHER or ☐ LEGALLY RESPONSIBLE PARTY Name		☐ MOTHER or ☐ LEGALLY RESPONSIBLE PARTY Name	
Street Address (if different from client's)		Street Address (if different from client's)	
City	State / ZIP Code	City	State / ZIP Code
Social Security Number	Relationship to Client	Social Security Number	Relationship to Client
HOME Phone Number ( ) -	WORK Phone Number ( ) -	HOME Phone Number ( ) -	WORK Phone Number ( ) -

CLIENT MEDICAL NEEDS INFORMATION:

DIAGNOSIS *(If Newborn, give birth weight)* **Primary:**	**Other:**
SEVERITY/COMPLICATIONS/CHRONICITY	
HISTORY	
TREATMENT PLAN (Include names of specialists involved, and any special needs such as surgery, medications, supplies, therapies, equipment)	
What care will this client need? ☐ **HOSPITAL** ☐ **HOME CARE** ☐ **Other** (explain) -	Requested Coverage Begin Date
PROGNOSIS:	

HOSPITAL Name			Hospital Case Record Number
Hospital Contact Person (Name and Title)			Hospital Phone Number ( ) -
PHYSICIAN'S Name (Print)			Physician's Phone Number ( ) -
Physician's Address (Number and Street)			Physician's Signature ***(REQUIRED)*** / Date Signed
City	State	ZIP Code	

For CSHCS Use Only

☐ **APPROVED** - **The client must now complete enrollment process for coverage.** This client is **medically eligible** for the CSHCS Program for diagnosis code(s): _____

☐ **DISAPPROVED** - This client is **NOT** medically eligible for the CSHCS Program. Reason: _____

☐ Eligible for diagnostic evaluation at: _____

☐ Pending / Other:

CSHCS Signature / Date

MSA-4114 (05/15) Previous editions may be used

MENTAL ILLNESS/INTELLECTUAL DISABILITY/RELATED CONDITION EXEMPTION CRITERIA CERTIFICATION

Michigan Department of Health and Human Services
(For Use in Claiming Exemption Only)
Level II Screening

INSTRUCTIONS:

- Must be completed, signed and dated by a nurse practitioner, physician's assistant or physician.
- The patient being screened shall require a comprehensive LEVEL II evaluation UNLESS any of the exemption criteria below is met and certified by a physician's assistant, nurse practitioner or physician. Indicate which exemption applies.

Patient Name	Date of Birth	
Name of Referring Agency	Referring Agency Telephone Number	
Referring Agency Address (Number, Street, Building, Suite Number, etc.)		
City	State	Zip Code

Exemption Criteria

☐ **COMA:** **Yes,** I certify the patient under consideration is in a coma/persistent vegetative state.

☐ **DEMENTIA:** **Yes,** I certify the patient under consideration has dementia as established by clinical examination and evidence of meeting ALL 5 criteria below.

Yes, I certify the patient under consideration does not have another primary psychiatric diagnosis of a serious mental illness.

Yes, I certify the patient under consideration does not have an intellectual disability, developmental disability or a related condition.

Specify the type of dementia:

1. Has demonstrable evidence of impairment in short-term or long-term memory as indicated by the inability to learn new information or remember three objects after five minutes, and the inability to remember past personal information or facts of common knowledge.
2. Exhibits at least one of the following:
   - Impairment of abstract thinking, as indicated by the inability to find similarities and differences between related words; has difficulty defining words, concepts and similar tasks.
   - Impaired judgment, as indicated by inability to make reasonable plans to deal with interpersonal, family and job-related issues.
   - Other disturbances of higher cortical function, i.e., aphasia, apraxia and constructional difficulty.
   - Personality change: altered or accentuated premorbid traits.
3. Disturbances in items 1 or 2 above significantly interfere with work, usual activities or relationships with others.
4. The disturbance has NOT occurred exclusively during the course of delirium.

5. **EITHER:**

   a. Medical history, physical exam and/or lab tests show evidence of a specific organic factor judged to be etiologically related to the disturbance, **OR**

   b. An etiologic organic factor is presumed in the absence of such evidence if the disturbance cannot be accounted for by any non-organic mental disorder.

☐ **HOSPITAL EXEMPTED DISCHARGE:**

Yes, I certify that the patient under consideration:

1. is being admitted after a hospital stay, **AND**
2. requires nursing facility services for the condition for which he/she received hospital care, **AND**
3. is likely to require less than 30 days of nursing services.

Physician/Physician Assistant/Nurse Practitioner Signature and Credentials	Date

Name (Typed or Printed)	Telephone Number

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, however, if NOT completed, Medicaid will not reimburse the nursing facility.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

COPY DISTRIBUTION:
ORIGINAL- Nursing Facility retains in Patient file
COPY - Attach to form DCH-3877 and send to Local Community Mental Health Services Program (CMHSP)
COPY - Patient Copy or Legal Representative

INSTRUCTIONS FOR COMPLETING LEVEL II SCREENING

The **DCH-3878** is to be used ONLY when the individual identified on a **DCH-3877, Preadmission Screening (PAS)/Annual Resident Review (ARR)** as needing a LEVEL II evaluation meets one of the specified exemptions from LEVEL II screening. If the individual under consideration meets one of the following exemptions, he/she may be admitted or retained at a nursing facility without additional evaluation. However, a completed copy of the DCH-3878 must be attached to the **DCH-3877** and sent to the local Community Mental Health Services Program (CMHSP).

Must be completed, signed and dated by a nurse practitioner, physician's assistant or physician.

Complete the following information to match the **DCH-3877**: Patient Name, DOB, and Referring Agency (including agency address and telephone number).

Use an **"X"** to indicate which exemption applies to the individual under consideration.

DEMENTIA:

- Review the 5 criteria listed under the dementia exemption category. Do NOT check this exemption unless the individual meets all 5 criteria. Any individual who meets some, but not all 5 criteria will be subject to a LEVEL II evaluation. If the individual under consideration meets this exemption category, specify the type of dementia.
- Do not mark the Dementia Exemption if there is a primary diagnosis of a serious mental illness. Do not mark Dementia Exemption if there is a diagnosis of intellectual disability, developmental disability or a related condition.

Dementia diagnoses include the following:

1. Dementia of the Alzheimer's Type
2. Vascular Dementia
3. Dementia due to Other General Medical Conditions
4. Substance - Induced Persisting Dementia
5. Dementia Not Otherwise Specified

Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices Completion Instructions

This form should be completed for NEW or REPLACEMENT mobility device(s) and seating systems. It must be submitted with the Complex Seating and Mobility Device Prior Approval - Request/Authorization (MSA-1653-D). The evaluation and justification must be submitted within 90 days of the date the evaluation was completed.

The appropriate Addendum(s) must accompany the MSA-1656 & MSA-1653-D.

BENEFICIARY INFORMATION: Complete beneficiary name, date of birth, sex, **mihealth** number, ordering physician and physician specialty. The beneficiary name and **mihealth** number must be entered at the top of each subsequent page.

SECTIONS 1 THROUGH SECTION 11 MUST BE COMPLETED BY A LICENSED/CERTIFIED MEDICAL PROFESSIONAL.

NOTE: A licensed/certified medical professional means an occupational or physical therapist, a physiatrist or rehabilitation RN who has at least two years' experience in rehabilitation seating; and is not an employee of, or affiliated in any way with, the Medical Supplier with the exception of hospitals with integrated delivery models that include the supplier of the equipment and the provider of the clinical evaluation. A PTA or OTA may not evaluate for, complete or sign this document.

SECTION	INSTRUCTIONS
1	Indicate the beneficiary name, mihealth number, ordering/referring physician name, specialty and National Provider Identifier (NPI).
2	Medical history is used to gather information in regards to the beneficiary's physical status and progression of disease. Estimate weight if unable to weigh at time of evaluation. The acronym "WFL" means "within functional limits."
3	Home Environment questions reflect the current setting in which the beneficiary lives.
4	Community Activities of Daily Living (ADL) reflects the beneficiary's transportation situation to the community and/or school, if applicable. Indicate if the mobility equipment fits into the vehicle and if the family can lift the mobility equipment into a vehicle.
5	This information reflects the need for pressure relief. If the beneficiary has current decubiti, the evaluator should indicate the stage as defined by the **National Pressure Ulcer Advisory Panel (NPUAP) at www.npuap.org**.
6	**Mandatory for all requests.** Describes the beneficiary's ADL functional ability without mobility devices. The acronym "UE" means "upper extremity." Answer the items regarding visual perception, problem solving and comprehension only if requesting a power mobility item.
7	Evaluation includes measurements of the beneficiary. Relevant measures include adjustments for clothing. Complete the Manual Muscle Test (MMT) for hand only if requesting a power mobility item. This measurement should be of the appropriate hand/digits that will be used to operate specialty controllers.

Modified Ashworth Scale

0	No increase in muscle tone
1	Slight increase in muscle tone, manifested by a catch and release or by minimal resistance at the end of the range of motion when the attached part is moved in flexion or extension
1+	Slight increase in muscle tone, manifested be a catch, followed by minimal resistance throughout the remainder (less than half) of the ROM
2	More marked increase in muscle tone through most of the ROM, but affected part easily moved
3	Considerable increase in muscle tone, passive movement difficult
4	Affected part rigid in flexion or extension

H = **Hypotonia** O = **Observation**

Manual Muscle Evaluation

100%	5	N	Normal	Complete ROM against gravity with full resistance
75%	4	G	Good	Complete ROM against gravity with some resistance
50%	3	F	Fair	Complete ROM against gravity
25%	2	P	Poor	Complete ROM with gravity eliminated
10%	1	T	Trace	Evidence of contractibility but no joint motion
0%	0	O	Zero	No evidence of contractility

C = Complete; IC = Incomplete; ✳ = Pain

SECTION	INSTRUCTIONS	
	If evaluator is not able to test beneficiary due to cognition, age, etc., then information for MMT can be based on observation (not on self-report).	
8	Check all items that apply for mobility goals. Section is to be used if evaluator has any other comments to establish medical need, functional goals, etc.	
9	Evaluator should list all equipment the beneficiary currently owns or uses. Include brand, model, serial number, description and date of purchase/rental.	
10	To be completed if beneficiary is in a nursing facility. This section should be completed and signed by the Director of Nursing, Facility Administrator or Ordering/referring Physician. This page must accompany the MSA-1653-D and appropriate Addendum(s) when submitting to the MDHHS Program Review Division.	
11	To be completed by the evaluator and, if applicable, all team members involved in the evaluation. Enter date of evaluation, evaluator's name, title, telephone number, place of employment and address. If team evaluation, in Section 11, list all participants and titles (attach additional pages if necessary). The attestation page must accompany the MSA-1653-D and appropriate Addendum(s) when submitting to the Michigan Department of Health and Human Services (MDHHS) Program Review Division.	
Notes	**The applicable addendums must accompany the MSA-1656 & MSA-1653-D when requesting the authorization. Failure to include the appropriate addendum(s) may cause a delay in the authorization process.**	
	Addendum A: To be completed when requesting new or replacement manual wheelchairs with accessories, power mobility devices, and/or seating systems.	**Addendum B:** To be completed when requesting new or replacement strollers, standers, gait trainers and children's positioning chairs.
	Note: For beneficiaries residing in a nursing facility, return the completed MSA-1656, addendum(s) and MSA-1653-D to the requesting nursing facility. For beneficiaries in the community, the MSA-1656, addendum(s) and MSA-1653-D are forwarded to the ordering physician for their review.	

SUBMIT TO:

Michigan Department of Health and Human Services
Program Review Division
PO Box 30170
Lansing, Michigan 48909 **Fax: (517) 335-0075**

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable.

The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices

This form must be completed by physical therapist, occupational therapist, physiatrist, or rehabilitation registered nurse. Incomplete information will result in the form being returned to the evaluator for completion.

SECTION 1: BENEFICIARY INFORMATION

Beneficiary Name: _____ mihealth Number: _____
Ordering/Referring Physician: _____ NPI: _____
Physician Specialty:

SECTION 2: MEDICAL HISTORY

Primary Diagnosis: _____ Onset date:	Secondary Diagnosis: _____ Onset date:

If spinal cord injury or spina bifida indicate the level of injury/impairment:

Relevant past and future surgeries:

Bowel Mgmt: ☐ Continent ☐ Incontinent ☐ Colostomy (Indicate type):

Bladder Mgmt: ☐ Continent ☐ Incontinent ☐ Catheter (Indicate type):

Cardio Status: ☐ WFL ☐ Impaired	Neuro Status: Seizures ☐ YES ☐ NO If YES, Frequency/Duration: /	Respiratory Status: ☐ WFL ☐ Impaired
Baclofen pump present? ☐ YES ☐ NO If YES, date Implanted: _____ Botox? ☐ YES ☐ NO If YES, date of last injection: _____ Other explain:		Sip 'N Puff controller requested? ☐ YES ☐ NO If YES, additional information maybe be required:
Height: _____ Weight: _____	Explain recent changes or trends in weight:	

List medication(s) currently prescribed:

How does the management or severity of the above conditions/impairments affect the need for the equipment requested?

SECTION 3: HOME ENVIRONMENT

Beneficiary resides in: ☐ House ☐ Condo/town home ☐ Apartment ☐ Assisted Living /AFC/Group Home ☐ Nursing Facility

Does beneficiary live alone? ☐ YES ☐ NO If NO, does beneficiary have a caregiver? ☐ YES ☐ NO

If YES, who provides the care? ☐ Family member ☐ RN ☐ LPN ☐ Other (explain)

How many hours per day are provided by the caregiver?

SECTION 4: COMMUNITY ADL (Transportation)

What is the beneficiary's mode of transportation? (Check all that apply.)

☐ Car ☐ Van/SUV ☐ Van w/ Lift ☐ Truck ☐ Taxi Cab ☐ Bus ☐ School Bus ☐ Ambulance ☐ Other

Does the beneficiary attend school or work? ☐ YES ☐ NO

Is the beneficiary transported in the current or requested wheelchair? ☐ YES ☐ NO If NO, explain why the beneficiary cannot be transported in the current or requested chair?

Explain:

SECTION 5: SENSATION AND SKIN ISSUES

Sensation ☐ Intact ☐ Impaired ☐ Absent ☐ Hypersensitive	**Pressure Relief** ☐ Dependent ☐ Independent ☐ Type of assistance needed How does the beneficiary perform pressure relief?	
Does beneficiary have a history of skin decubiti and/or flap surgery? ☐ YES ☐ NO If YES, indicate location:	Does beneficiary have a current decubiti? ☐ YES ☐ NO If YES, describe:	Does beneficiary have other skin issues? ☐ YES ☐ NO If YES, describe:

Beneficiary Name: _____ mihealth Number: _____

SECTION 6: MOBILITY ASSESSMENT *(Mandatory for all requests)*

Functional Ability Without Mobility Device(s)

Sitting:

	Static	Dynamic
WFL	☐	☐
Uses UE for balance	☐	☐
Contact guard assist	☐	☐
Standby assist	☐	☐
Minimum assist	☐	☐
Moderate assist	☐	☐
Maximum assist	☐	☐
Dependent/unable	☐	☐

Standing:

	Static	Dynamic
WFL	☐	☐
Uses UE for balance	☐	☐
Contact guard assist	☐	☐
Standby assist	☐	☐
Minimum assist	☐	☐
Moderate assist	☐	☐
Maximum assist	☐	☐
Dependent/unable	☐	☐

Transfers:

☐ Independent ☐ Type of assistance needed:

How does beneficiary transfer:

☐ Pivot
☐ Sliding
☐ Mechanical Lift
☐ Other: (Explain)

Ambulation within 1 minute:
☐ Independent > or = 150 ft.
☐ Ambulates with assist > or = 150 ft. Explain type of assistance:
☐ Ambulates with device > or = 150 ft.
☐ Ambulates short distance only ____ ft.
☐ Unable to ambulate
☐ Limited due to endurance - Explain:

Explain how this affects equipment ordered?

Complete only if power mobility item is requested (e.g., power wheelchair, scooter, power assisted wheels, etc.)

Visual perception: Has visual acuity and perception that permits safe and independent operation of the equipment requested. ☐ YES ☐ NO

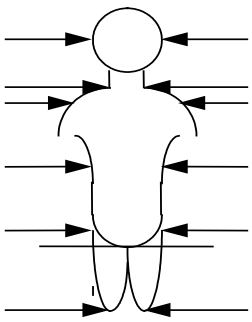
Problem solving: Has problem solving skills appropriate to operate requested power mobility item. ☐ YES ☐ NO
If beneficiary is unable, who will complete? Explain:

Comprehension: Understands and is able to follow directions and conversations that are complex or abstract; understands either spoken or written language. ☐ YES ☐ NO
If NO, explain:

SECTION 7: MODIFIED ASHWORTH SCALE AND MANUAL MUSCLE EVALUATION INFORMATION

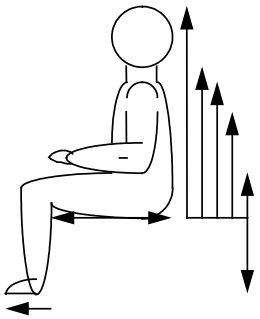
See Form Completion Instructions for Modified Ashworth Scale and Manual Muscle Evaluation.

Width at the:



Head: ____
Neck: ____
Shoulder: ____
Trunk: ____
Hips: ____
Feet: ____

Height:



	L	R
Crown:	____	____
Occiput:	____	____
Shoulder:	____	____
Axilla:	____	____
Elbow:	____	____
Seat Depth:	____	____
Leg Length:	____	____
Foot Length:	____	____

Primitive reflexes present:
☐ Asymmetrical Tonic Neck Reflex
☐ Symmetrical Tonic Neck Reflex
☐ Startle Reflex
☐ Other; Explain:

Explain how this relates to equipment ordered:

Beneficiary Name: _____ mihealth Number: _____

Head & Neck	☐ Maintains upright without support ☐ Rotated	☐ Maintains upright with support ☐ Laterally Flexed	☐ Flexed ☐ Cervical Hyperextension	☐ Extended ☐ Absent head control
	ROM (Range of Motion) ☐ AROM ☐ AAROM ☐ PROM	MMT/O (Manual Muscle) ☐ Test ☐ Observation	TONE	Explain how this affects equipment ordered:
	Left / Right	Left / Right		
Shoulder	____ Flexion ____ ____ Abduction ____ ____ Internal Rotation ____ ____ External Rotation ____	____ Flexion ____ ____ Abduction ____ ____ Internal Rotation ____ ____ External Rotation ____	☐ Normal ☐ Hypertonia Modified Ashworth Scale: ____ ☐ Hypotonia	
Elbow	____ Flexion ____ ____ Extension ____ ____ Pronation ____ ____ Supination ____	____ Flexion ____ ____ Extension ____ ____ Pronation ____ ____ Supination ____	☐ Normal ☐ Hypertonia Modified Ashworth Scale: ____ ☐ Hypotonia	
Wrist	____ Flexion ____ ____ Extension ____	____ Flexion ____ ____ Extension ____	☐ Normal ☐ Hypertonia Modified Ashworth Scale: ____ ☐ Hypotonia	
Hand	____ Grip Strength ____ ____ Pinch Strength ____			
Knee	____ Flexion ____ ____ Extension ____	____ Flexion ____ ____ Extension ____	☐ Normal ☐ Hypertonia Modified Ashworth Scale: ____ ☐ Hypotonia	
Ankle & Foot	____ Dorsiflexion ____ ____ Plantarflexion ____ ____ Inversion ____ ____ Eversion ____	____ Dorsiflexion ____ ____ Plantarflexion ____ ____ Inversion ____ ____ Eversion ____	☐ Normal ☐ Hypertonia Modified Ashworth Scale: ____ ☐ Hypotonia ☐ Clonus: ☐ Left ☐ Right	

SECTION 8: GOALS

Check all that apply.

- ☐ Independence with mobility in the home and mobility related activities of daily living (MRADLs) in the community (independence is - no help or oversight provided, and has physically demonstrated independence in operating requested equipment)
- ☐ Assisted mobility/occasional assistance with wheelchair propulsion (e.g., verbal cueing, pushing up a ramp or onto a bus, over curbs, etc.)
- ☐ Dependent mobility
- ☐ Optimize pressure relief
- ☐ Proper positioning and/or correction of a physiological condition. Explain:
- ☐ Other: (Explain)

SECTION 9: LIST TYPE OF EQUIPMENT PRESENTLY OWNED OR USED BY THE BENEFICIARY

Brand	Model	Serial Number	Description	Date of Purchase

SECTION 10: MOBILITY ASSESSMENT - FOR BENEFICIARIES IN A NURSING FACILITY ONLY

This section is to be completed by the Nursing Facility Director of Nursing, Nursing Facility Administrator or ordering/referring physician.

Nursing Facility Name:		NPI:	Date of Admission:
Mobility History:	☐ Uses nursing facility per diem chair	☐ Uses own personal chair	
Wheelchair Description: *(Currently used or owned)*	Brand:	Model No:	Serial No:
	Components:		

Customized Wheelchair Documentation (Required documentation to accompany this form)

☐ Most Recent MDS ☐ Past Two Months of Nursing Notes ☐ Current Plan of Care that relates to the equipment ordered

Director of Nursing Signature Date

Print Name

Ordering Physician Signature Date

Print Name

SECTION 11: EVALUATOR (PT, OT, PHYSIATRIST OR REHAB RN) ATTESTATION AND SIGNATURE/DATE

I certify that I conducted the evaluation and have completed the information presented in Sections 1 - 9, and that there is no financial arrangement with the selected durable medical equipment provider and/or the evaluating clinician. I certify that the equipment requested is the most economical alternative that meets the beneficiary's basic medical and functional needs. I certify that the information contained in this form is true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Enter Date Here
Evaluation Date

Enter Text Here
Evaluator Name/Title (Print)

Enter Text Here
Place of Employment and Address

NPI Phone Number

Evaluator Signature Date

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable.

The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices Addendum A: Mobility/Seating

This form must be completed by a physical therapist, occupational therapist, physiatrist, or rehabilitation registered nurse. The evaluator must complete requested and/or current equipment, warranty information and economic alternative information.
NOTE: Only complete sections that apply to the requested equipment/accessories.

Incomplete information will result in the form being returned to the evaluator for completion.

Beneficiary Name: _____ Mihealth Number: _____

SECTION(s)	☐ Requested	☐ Current ☐ None
Manual wheelchair with accessory add-ons.	☐ Propels a wheelchair 60 feet, turns around, maneuvers the chair to a table, bed, toilet, negotiates at least a 3% grade, maneuvers on rugs and over door sills ☐ Cannot propel manual wheelchair without caregiver assist. ☐ Cannot propel manual wheelchair, used for transport only. ☐ Medical reason for power assisted wheels: Chair width _____inches. Chair depth _____inches. ☐ Tilt ☐ Tilt & Recline Medical reasons for function indicated: Hours of continuous wheelchair use per day: ☐ > 4 hours ☐ < 4hours; if < 4 hours, how many? _____	Specify brand, model and serial numbers, age of current base: Chair width _____inches. Chair depth _____ inches. Length of warranty: _____ Warranty begin date: _____ Where will requested device be used? *(i.e., home, school, community)*
	☐ Requested	☐ Current ☐ None
Power wheelchair with standard joystick	☐ Able to propel manual wheelchair _____ feet. ☐ YES ☐ NO Beneficiary is able to drive a power wheelchair independently _____ feet, turns around, maneuvers the chair to a table, bed, toilet, negotiates at least a minimum of a 3% grade, maneuvers on rugs and over door sills. If NO, explain: Chair width _____inches. Chair depth _____inches. **Power** functions requested: *(Check all that apply.)* ☐ Recline ☐ Elevating seat ☐ Center mount elevating leg rests ☐ Tilt ☐ Tilt & Recline ☐ Elevating leg rests ☐ YES ☐ NO Able to perform, manipulate or work all seat functions without assistance? ☐ YES ☐ NO Requires verbal and/or physical assistance to manipulate seat functions? ☐ YES ☐ NO Has pressure relief plan of care with equipment? If YES, (explain) _____ Hours of continuous wheelchair use per day: ☐ > 4 hours ☐ < 4hours; if < 4 hours, how many? _____	Specify brand, model and serial numbers, age of current base: Chair width _____inches. Chair depth _____ inches. Length of warranty: _____ Warranty begin date: _____ Where will requested device be used? *(i.e., home, school, community)* **Manual** functions requested: ☐ Tilt ☐ Tilt & Recline

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable.

The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.

Beneficiary Name: _____ Mihealth Number: _____

Equipment	☐ Requested Beneficiary's ability to use	☐ Current ☐ None
Power wheelchair with alternate controls	☐ Able to propel manual wheelchair _____ feet. ☐ YES ☐ NO Beneficiary is able to drive a power wheelchair independently _____ feet, turns around, maneuvers the chair to a table, bed, toilet, negotiates at least a minimum of a 3% grade, maneuvers on rugs and over door sills. If NO, please explain: Chair width _____inches. Chair depth _____inches.	Specify brand, model and serial numbers, age of current base: Chair width _____inches. Chair depth _____ inches. Length of warranty: _____ Warranty begin date: _____ Where will requested device be used? *(i.e., home, school, community)*

Power functions requested: *(Check all that apply.)*

☐ Recline ☐ Elevating seat ☐ Center mount elevating leg rests
☐ Tilt ☐ Tilt & Recline ☐ Elevating leg rests

Manual functions requested:
☐ Tilt ☐ Tilt & Recline

☐ YES ☐ NO Able to perform, manipulate or work all seat functions without assistance?
☐ YES ☐ NO Requires verbal and/or physical assistance to manipulate seat functions?
☐ YES ☐ NO Has pressure relief plan of care with equipment?

Explain:

Specify control needed:

Medical need for control indicated:

Indicate the beneficiary's ability to use in their environment:

Hours of continuous wheelchair use per day: ☐ > 4 hours ☐ < 4hours; if < 4 hours, how many? _____

	☐ Requested	☐ Current ☐ None
Power wheelchair standing feature	☐ Beneficiary has a history of pressure ulcers on pelvis, buttocks, hips or back ☐ Will be used for pressure relief in lieu of tilt, recline, tilt/recline, and custom seating ☐ Pressure relief is done by the beneficiary without assistance If assistance with pressure relief is required, indicate amount and frequency needed: _____	Specify brand, model and serial numbers, age of current base: Chair width _____inches. Chair depth _____ inches. Length of warranty: _____ Warranty begin date: _____ Where will requested device be used? *(i.e., home, school, community)*

Chair width _____inches. Chair depth _____inches.

Indicate current pressure relief plan of care (including frequency and duration):

Is beneficiary/caregiver compliant with current pressure relief plan of care? ☐ YES ☐ NO

If NO, explain:

Beneficiary Name: _____ Mihealth Number _____

Equipment	☐ Requested	☐ Current ☐ None
Scooter	☐ Able to propel manual wheelchair _____ feet. ☐ Independent trunk balance, ☐ Adequate bilateral hand functions to work tiller. Chair width _____inches. Chair depth _____inches.	Specify brand, model and serial numbers, age of current base: Chair width _____inches. Chair depth _____ inches. Length of warranty: _____ Warranty begin date: _____ Where will requested device be used? *(i.e., home, school, community)*

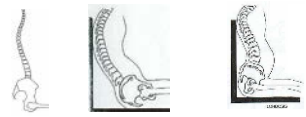
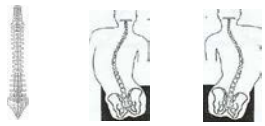
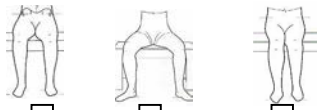
	Device Type *(attach additional page(s) if necessary)*	
All Accessories / Add Ons	☐ Head & Neck	☐ Feet ☐ Footbox
	☐ Arms	☐ Other - Describe
Medical Reason	List and specify Medical Reason for brand(s) and model(s) requested for this beneficiary:	

Growth adaptability of device	**Requested**	**Current**
REQUIRED	Seat width: (inches) _____	Seat width: (inches) _____
	Back height: (inches) _____	Back height: (inches) _____
	Seat depth: (inches) _____	Seat depth: (inches) _____
	Maximum frame growth: (inches)	Maximum frame growth: (inches)

Beneficiary Name: _____ Mihealth Number _____

SEATING SYSTEM

Medical/functional Reason
☐ New growth > 3 inches depth and/or > 2 inches width
☐ Change in width and depth; width inches _____ depth in inches _____
☐ Orthopedic change; explain: _____
☐ Needs corrective forces to assist with maintaining or improving posture. _____
☐ Accommodate beneficiary's posture (e.g., current seating postures are not flexible, etc.). _____
☐ Other medical changes that affect the need for new positioning; specify: _____

POSTURE:				**COMMENTS:**
	Lateral View	AP View	Superior View	
TRUNK	Anterior / Posterior  ☐ WFL ☐ ↑ Thoracic Kyphosis ☐ ↑ Lumbar Lordosis ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	Left Right  ☐ WFL ☐ Convex Left ☐ Convex Right ☐ c-curve ☐ s-curve ☐ multiple ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	Rotation-shoulders and upper trunk  ☐ Neutral ☐ Left anterior ☐ Right anterior ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	☐ Hypertonia ☐ Hypotonia
	Anterior View	Superior View	ROM	MMT/O
HIPS	Position  ☐ Neutral ☐ Abduct ☐ Adduct ☐ Fixed ☐ Subluxed ☐ Partly Flexible ☐ Dislocated ☐ Flexible	Windswept  ☐ Neutral ☐ Right ☐ Left ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	Hip Flexion/Extension Limitations: (PROM in Degrees) Hip Internal/External Range of Motion Limitations:	
	Lateral View	AP View	Superior View	
PELVIS	Anterior / Posterior  ☐ Neutral ☐ Posterior ☐ Anterior ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	Obliquity  ☐ WFL ☐ R elev ☐ L elev ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	Rotation-Pelvis  ☐ WFL ☐ Right Anterior ☐ Left Anterior ☐ Fixed ☐ Flexible ☐ Partly Flexible ☐ Other	If spinal curvature present, indicate degree.

Beneficiary Name: _____ Mihealth Number _____

Requested Seating System		Current Seating System ☐ None	
Length of warranty? _____ Mobility device to be used with:		Length of warranty: _____ Warranty begin date: _____ Mobility device is used with:	
☐ Planar/Non-custom contour	☐ Custom *	☐ Planar/Non-custom contour	☐ Custom *
Manufacturer:	Type:	Manufacturer:	Type:
Components include: ☐ Seat only ☐ Back only ☐ Back and Seat	Components include: ☐ Seat only ☐ Back only ☐ Back and Seat	Date provided: Components include: ☐ Seat only ☐ Back only ☐ Back and Seat	Date provided: Components include: ☐ Seat only ☐ Back only ☐ Back and Seat
Lateral Components Include:	Lateral Components Include:	Lateral Components Include:	Lateral Components Include:
☐ Trunk ☐ Hip ☐ Thigh ☐ Knee ☐ Abductor ☐ Anti-thrust	☐ Trunk ☐ Hip ☐ Thigh ☐ Knee ☐ Abductor ☐ Anti-thrust	☐ Trunk ☐ Hip ☐ Thigh ☐ Knee ☐ Abductor ☐ Anti-thrust	☐ Trunk ☐ Hip ☐ Thigh ☐ Knee ☐ Abductor ☐ Anti-thrust
Other Components - List:	Other Components - List:	Additional Components: ☐ Yes ☐ No If Yes, describe:	Additional Components: ☐ Yes ☐ No If Yes, describe:
If requesting custom seating, specify why planar/non-custom contour does not meet beneficiary's medical needs.			

* For definition of custom refer to MDHHS Medicaid Provider Manual, Medical Supplier Chapter, sections Standard Equipment and Custom-Fabricated Seating, and section Standards of Coverage

EVALUATOR (PT, OT, PHYSIATRIST OR REHAB RN) ATTESTATION AND SIGNATURE/DATE

I certify that I conducted the evaluation and have completed the information in the appropriate Sections of the MSA-1656-Addendum A and that there is no financial arrangement with the selected durable medical equipment provider and/or the evaluating clinician. I certify that the equipment requested is the most economical alternative that meets the beneficiary's basic medical and functional needs. I certify that the information contained in this form is true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____
Evaluation Date

Evaluator Name/Title (Print)

Place of Employment and Address

NPI Phone Number

Evaluator Signature Date

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices Addendum B: Strollers, Gait Trainers, Standers, Car Seats, and Children's Positioning Chairs

This form must be completed by a physical therapist, occupational therapist, physiatrist, or rehabilitation registered nurse. The Evaluator must complete requested and/or current equipment information, warranty information and economic alternative information.

NOTE: Only complete sections that apply to the requested equipment/accessories. If requesting an equipment/accessories complete Current/None area of the section.

Incomplete information will result in the form being returned to the evaluator for completion.

Beneficiary Name: _____ Mihealth Number: _____

SECTION	☐ Requested	☐ Current ☐ None
Equipment	**Beneficiary's ability to use**	
Stroller	☐ Transport only ☐ Primary mobility device Indicate medical special needs for use and adaptions needed: .	Specify brand, model and serial numbers, age of current device: Length of warranty: _____ Warranty begin date: _____ Where is or will this device be used? *(i.e., home, school, community)*
	☐ Requested	☐ Current ☐ None
Gait trainer *(if less than age 21)*	☐ Is independent with gait trainer. ☐ Requires assistance with mobility using gait trainer. Describe: How many times per day will beneficiary use gait trainer: How far can beneficiary ambulate with gain trainer/device? _____ft. Indicate the expected performance with the requested equipment: Is beneficiary/caregiver compliant with current mobility plan of care? ☐ Yes ☐ No If No, explain:	Specify brand, model and serial numbers, age of current device: Length of warranty: _____ Warranty begin date: _____ Where is or will this device be used? *(i.e., home, school, community)*
	☐ Requested	☐ Current ☐ None
Children's positioning chairs *(if less than age 21) e.g., feeder seat, high/low seat, activity chair, etc.*	☐ Home inaccessible to mobility device. ☐ Beneficiary is > 40 lbs. with limited head and trunk control ☐ Beneficiary has current active seizures ☐ Beneficiary is unable to eat or be safely fed in current mobility device ☐ Crown to hip measurement on Mat evaluation is > 26" If beneficiary is < 40 lbs. or < 26", explain why commercially available products or other mobility devices will not meet the beneficiary's medical/functional needs:	Specify brand, model and serial numbers, age of current device: Length of warranty: _____ Warranty begin date: _____ Where is or will this device be used? *(i.e., home, school, community)*

Beneficiary Name: _____ Mihealth Number: _____

	☐ Requested	☐ Current ☐ None
Equipment	**Beneficiary's ability to use**	**Where device is used**
Car seat	Indicate medical special needs for use and adaptions needed:	Specify brand, model and serial numbers, age of current device: Length of warranty: _____ Warranty begin date: _____ Where is or will this device be used? *(i.e., home, school, community)*

	☐ Requested	☐ Current ☐ None
Stander *(If less than age 21)*	☐ Is dependent with standing ☐ Walks with assistive device ☐ Walks with gait trainer ☐ Required for post-op care Specify treatment plan and state any surgical or other interventions that affect standing:	Specify brand, model and serial numbers, age of current device: Length of warranty: _____ Warranty begin date: _____ Where is or will this device be used? *(i.e., home, school, community)*
	Indicate current standing plan of care (including how many times per day and how long):	
	Is the beneficiary/caregiver compliant with standing plan of care? ☐ YES ☐ NO If NO, explain:	

	☐ Requested	☐ Current ☐ None
Growth adaptability of device	Seat width: _____ Seating system height: _____ Seat depth: _____ Frame adaptablility: _____	Seat width: _____ Seating system height: _____ Seat depth: _____ Frame adaptablility: _____

Equipment	**Device Type** *(attach additional page(s) if necessary)*	**Medical Reason**
All Accessories / Add Ons	☐ Head & Neck Type:	
	☐ Arms Type:	
	☐ Feet Type:	
	☐ Other - Describe	
Medical Reason	Specify Medical Reason for brand(s) and model(s) requested for this beneficiary:	

Beneficiary Name: _____ Mihealth Number: _____

EVALUATOR (PT, OT, PHYSIATRIST OR REHAB RN) ATTESTATION AND SIGNATURE/DATE

I certify that I conducted the evaluation and have completed the information in the appropriate Sections of the MSA-1656-Addendum B and that there is no financial arrangement with the selected durable medical equipment provider and/or the evaluating clinician. I certify that the equipment requested is the most economical alternative that meets the beneficiary's basic medical and functional needs. I certify that the information contained in this form is true, accurate, and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____
Evaluation Date

Evaluator Name/Title (Print)

Place of Employment and Address

NPI Phone Number

Evaluator Signature Date

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable.

The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.

Michigan Department of Health and Human Services

NURSE AIDE TRAINING AND TESTING PROGRAM INTERIM REIMBURSEMENT REQUEST

Interim reimbursement request data is used to establish the amount of per diem add-on reimbursement to be included in the Medicaid Program per diem payment rate. The total amount of add-on reimbursement for the nurse aide training and testing program during the fiscal year will be adjusted through the annual settlement determination of the training and testing costs apportioned to Medicaid inpatient days.

Information included in this request may reflect estimated costs and projections for the time period indicated.

Send completed request to: LTC REIMBURSEMENT AND RATE SETTING SECTION
MEDICAL SERVICES ADMINISTRATION
MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
PO BOX 30479
LANSING MI 48909-7979

NOTE: Review detailed "Instructions" on page 3.

1. Provider Cost Period **From:** **To:**	3. Name of Training Contractor (if used)		
2. Training Conducted By ❑ **In-House Staff** ❑ **Centralized Training** ❑ **Outside Contractor** (complete items 3, 4 & 5) **From:** **To:**	4. Contractor Address		
	5. City	State	Zip Code

6. Was the facility designated a "LOCKOUT FACILITY" by the Department of Licensing And Regulatory Affairs at any time during the cost reporting period?
❑ **NO** ❑ **YES** **From:** **To:**

7. Estimated Nurse Aide Training Program Costs for the Period (from Page 2, Line 11)	
8. Estimated Total Inpatient Days for the Period	
9. Estimated Nurse Aide Training Program Cost Per Day (line 7 divided by line 8)	

CERTIFICATION STATEMENT: To be Signed by Provider and/or Authorized Representative

I certify that this claim for adjustment is true, accurate, and prepared with my knowledge and consent, and does not contain untrue, misleading or deceptive information. In the event the actual allowable costs do not support the increased rate, the provider will reimburse the State for excess amounts received. I further agree that retrospective cost settlements will be made in accordance with the State Plan, as applicable.

10. Signature of Provider and/or Authorized Representative Date	13. Name of Facility		
	14. Street Address		15. County No.
11. Typed Name	16. City	State **MI**	Zip Code
12. Phone Number	17. NPI No.	18. Provider License No.	

Authority: Title XIX of the Social Security Act Completion: Is Voluntary, but is required if Medical Assistance Program payment is desired.	The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.

MSA-1324 (12/15) Obsolete previous editions.

ESTIMATED NURSE AIDE TRAINING AND TESTING COSTS
Worksheet

NOTE: Review detailed "Instructions" on page 4.

1. Facility Training Staff:
- a. Salaries and Wages
- b. Fringe Benefits
- c. Payroll Taxes
- d. Total Training Staff (1a + 1b + 1c) — **1** 0

2. Nurse Aide Training Consultants — **2**

3. Nurse Aide Student Staff:
- a. Wages
- b. Fringe Benefits
- c. Payroll Taxes
- d. Total Student Staff (3a + 3b + 3c) — **3** 0

4. Training Program Supplies — **4**

5. Training Program Transportation:
- a. Training Staff
- b. Student Staff
- c. Total Transportation (5a + 5b) — **5** 0

6. Outside Contracted Approved Nurse Aide Training:
- a. Paid Directly by Facility
- b. Reimbursed to Employee Staff
- c. Total Outside Training (6a + 6b) — **6** 0

7. Nurse Aide Testing Fees:
- a. Paid Directly by Facility
- b. Reimbursed to Employee Staff
- c. Total Testing Fees Paid (7a + 7b) — **7** 0

8. Other Training Program Costs (Specify):
- a. — **8a**
- b. — **8b**

9. Total Training Program Cost Before Equipment Allowance (Sum of Lines 1 thru 8b) — **9** 0

10. Training Program Equipment Use Allowance: (equipment specific to training program)
- a. Number of months in reporting period
- b. Reporting period training program use allowance.
  Line 10.a. 0 divided by **12**, times **15%** = **0.00%**
- c. Equipment purchased in Current Year (CY) and Prior 6 years:

CY minus 6 years	$	times Line 10.b.% =	0
CY minus 5 years	$	times Line 10.b.% =	0
CY minus 4 years	$	times Line 10.b.% =	0
CY minus 3 years	$	times Line 10.b.% =	0
CY minus 2 years	$	times Line 10.b.% =	0
CY minus 1 year	$	times Line 10.b.% =	0
Current Year	$	times Line 10.b.% =	0

- d. Total equipment use allowance (Sum of 10.c. line amounts) — **10d** 0

11. Estimated Total Nurse Aide Training Program Costs (Sum of Line 9 and Line 10d.) — **11** 0

MSA-1324 INSTRUCTIONS (REQUEST)

PURPOSE

This form is for the provider to obtain Medicaid Program reimbursement outside the routine nursing care rate per diem for OBRA nurse aide training and testing programs. The form must be completed in order to receive interim reimbursement for those providers that have been determined to be a lockout facility, or for those facilities incurring costs in excess of interim reimbursement. Costs will be retrospectively settled to reflect the Medicaid Program's appropriate share of actual allowable training and testing costs.

Training and testing program costs claimed for services and supplies furnished to or purchased by the facility from organizations related to the provider by common ownership or control must adhere to the related party allowable cost principles. Expenses for such transactions should not exceed expenses for like items or services in an arms-length transaction with other non-related organizations, or the cost to the related organization.

Administrative overhead costs and space costs in nursing facilities conducting in-house training are not considered training and testing program costs. The costs reported must be specifically incurred in conducting the approved nurse aide training and testing program.

Supporting accounting records such as class attendance rosters or training participation logs, purchase orders, vendor invoices, contracts, documentation verifying amounts reimbursed to employees for approved training program expenses incurred by the employee prior to employment at the facility (e.g., canceled check, training program receipt) must be maintained for audit purposes. Supporting materials should be readily identifiable as training related cost documentation and must indicate the type of training involved.

Training Program Approval Requirement - Only costs incurred relative to a Department of Licensing And Regulatory Affairs (LARA) Bureau of Community and Health Systems approved Nurse Aide Training Program may be claimed on this schedule. An approved program may be conducted by the provider's facility or by a separate entity from the provider. The provider **must not report and make claim** for Medicaid Program reimbursement on this schedule for any costs incurred and associated with providing training **by the lockout facility** during the lockout time period. Allowable nurse aide training program costs during the lockout time period are limited to the costs incurred in obtaining training and testing outside the facility from an approved nurse aide training program.

Note: If the facility maintains separate cost center reporting for the training program, enter the appropriate costs as identified.

ITEM EXPLANATION

1. Provider's Cost Reporting Period
   Enter the fiscal period coinciding with the provider's cost reporting period.
2. Mode of Training
   It is possible that providers may utilize both in-house staff and outside contractors. If a chain organization or group home ownership uses an approved central training program, indicate the training as "in-house" and check "centralized training." If multiple outside contractors are used, indicate each contractor and the time periods utilized.

6. Lockout Facility
   A facility identified by the LARA Bureau of Community and Health Systems as a "lockout facility" cannot conduct an approved training and testing program, cannot be a training/clinical practice site for another approved program, and cannot conduct clinical skills testing. The facility is notified of the lockout determination action by the LARA Bureau of Community and Health Systems.

8. Estimated Total Inpatient Days for the Period
   Indicate the appropriate number of LTC total inpatient days of care estimated to be rendered during the time period reported on this form.

13. Name of Facility
    Enter the provider name under which Medicaid payments are issued to the provider.

15. County Number
    Enter the two-digit county number.

14-16. Provider Location
    Enter street address, city (village and/or township) and zip code of the facility's physical location.

17. Provider NPI Number
    Enter the Nursing Facility's ten-digit provider NPI number.

18. Provider's License Number
    Enter the three-digit license number.

MSA-1324 INSTRUCTIONS (WORKSHEET)

1. Facility Training Staff
Payroll-related costs for facility employees incurred by the approved program's direct training time or the nurse aide training program's preparation time.

2. Nurse Aide Training Consultants
Costs incurred for non-facility staff engaged to provide instruction or consultation for the facility's approved nurse aide training program.

3. Nurse Aide Student Staff
Payroll costs for facility employees incurred while the student is engaged in the approved training program or traveling to and from the off-site approved training location, or is engaged in off-site testing or traveling to and from the off-site testing location.

4. Training Program Supplies
Cost incurred for supplies and materials used in conducting an approved training program.

5. Training Program Transportation
Travel or transportation costs incurred by facility staff conducting the approved training program activity and testing, or for off-site nurse aide training and testing. Identify costs separately for training staff and student staff.

6. Outside Contracted Approved Nurse Aide Training Program
Paid Directly By Facility - Costs incurred to obtain nurse aide training through an outside entity approved training program. Payment for subject training is made directly from the nursing facility to the training entity and the nurse aide trainees are employed by the nursing facility
Reimbursed To Employee Staff - Costs incurred to reimburse a facility employee who had personally paid for an approved nurse aide training program prior to becoming an employee at the facility. Reasonable and necessary expenses incurred by the employee through participation and completion of a Bureau of Community and Health Systems approved training program for which the aide has made payment are eligible for remuneration. Only the cost of tuition and books are reimbursed. The aide must be hired by a facility within 12 months after incurring this expense. The facility must obtain receipts and retain documentation from the employee to verify the expense.

7. Nurse Aide Testing Fees
Paid Directly By Facility - Costs incurred for State-run testing. Payment for testing fees is made directly from the nursing facility to the testing authority for aides employed at the facility.
Reimbursed To Employee Staff - Costs incurred to reimburse a facility employee who had personally paid for State-run testing prior to becoming an employee at the facility. The aide must be hired by a facility within 12 months after paying the testing fee. The facility must obtain receipts and retain documentation from the employee to verify the expense.

8. Other Training Program Costs
Costs incurred that are not classified in the identified cost categories 1-7.

Rental costs for space located off-site of the facility are reimbursable under training and testing only if the space is used solely for the training and testing program. Space costs not meeting this requirement are reimbursable within the plant cost component of Michigan's prospective reimbursement system. Reasonable rental expense for training equipment necessary to the approved training program is an eligible cost.

Enter the detail and cost of these individual expenses in the yellow shaded cells. The total of these items will be automatically calculated by use of the F9 key.

9. Total Training Program Cost Before Equipment Allowance
Subtotal of Lines 1 through 8b costs. This total will be automatically calculated by use of the F9 key.

10. Training Program Equipment Use Allowance
An annual cost allowance is made for equipment purchased specifically for the Bureau of Community and Health Systems approved nurse aide training program. Such equipment purchases are not included in the plant asset costs of the facility for routine nursing care. An annual allowance of 15 percent of the equipment purchase price is reported as a cost of the training program for as long as the equipment is used in the program, but cannot exceed seven years.

The use allowance is an annual percentage adjustment made to the 15 percent amount if the cost report period differs from 12 months. Line 10.a. and Line 10.b. will automatically be calculated.

Enter line 10.c. the cost of the equipment purchased as required in the yellow shaded cells.

Michigan Department of Health and Human Services
Completion Instructions for MSA-115
Occupational Therapy - Physical Therapy - Speech Therapy
Prior Approval Request/Authorization

General Instructions

The MSA-115 must be used by Medicaid-enrolled outpatient hospitals, outpatient therapy providers, nursing facilities and home health agencies to request prior authorization (PA) for therapy services. MDHHS requires that the MSA-115 be typewritten, handwritten forms will not be accepted. Fill-in enabled copies of this form can be downloaded from the Michigan Department of Health and Human Services (MDHHS) website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms. The PA request must be complete and of adequate clarity to permit a determination of the appropriateness of the service without examination of the beneficiary.

PA may be authorized for a period not to exceed six months for outpatient therapy providers and outpatient hospitals, or two months for home health agencies and nursing facilities. If continued treatment is necessary, a subsequent request for PA must be submitted. The provider should retain a copy of the PA form until the approval or denial is determination is received.

For complete information on covered services, PA, and documentation requirements, refer to the Therapy Services Chapter of the Michigan Medicaid Provider Manual located at the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Medicaid Provider Manual.

Attachments/Additional Documentation

All additional attachments/documentation submitted with the request must contain the beneficiary name and **mihealth** card number, provider name and address, and the provider's National Provider Identifier (NPI) number.

When requesting the initial PA, the provider must attach a copy of the initial evaluation and treatment plan to the PA request.

Form Completion

The following fields must be completed unless stated otherwise:

Box Number(s)	Instructions
Box 1	MDHHS use only.
Box 2 - 3	The Medicaid enrolled provider's name and NPI.
Box 4 - 6	The provider's telephone number (including area code), address and fax number (including area code).
Box 7- 10	The beneficiary's name (last, first, and middle initial), sex, **mihealth** card number, and birth date (in the eight-digit format: MM/DD/YYYY). The information should be taken directly from the **mihealth** card and should be verified through the Community Health Automated Medicaid Processing System (CHAMPS) (Eligibility Inquiry and/or 270/271 transaction).
Box 11	The date the beneficiary was most recently admitted to the hospital or facility.
Box 12	Enter the beneficiary's diagnosis(es) code(s) and description(s) that relate to the service being requested.
Box 13	The date of onset must be entered. The approximate date of exacerbation must be cited if the beneficiary has a chronic disease (e.g., arthritis) and recently suffered such exacerbation.
Box 14 -16	The therapist's name, office telephone number (including area code), and applicable license/certification number.
Box 17	**Initial:** The treatment authorization request is the initial prior authorization request for the beneficiary under this treatment plan. **Continuing:** The treatment authorization request is to continue treatment for additional calendar month(s) of service under the treatment plan.
Box 18	The date MDHHS approved the last approved prior authorization request for the given diagnosis.
Box 19	The requested date range for which treatment is to be rendered, in a eight-digit format (e.g mm/dd/yyyy to mm/dd/yyyy).

Box Number(s)	Instructions
Box 20	The date treatment was started for the given diagnosis (if treatment was initiated previously).
Box 21	The total number of sessions rendered since the development of the treatment plan.
Box 22	Goals must be measurable. In functional terms, the provider's expectation for the beneficiary's ultimate achievement and the length of time it will take (e.g., ambulation unassisted for 20 feet; able to dress self within 15 minutes; oral expression using 4-5 word phrases to express daily needs). See Medicaid Provider Manual for additional documentation requirements.
Box 23	Documentation of the beneficiary's progress from the prior period to the current time in reference to the measurable and functional goals stated in the treatment plan. Documentation of the beneficiary's nursing and family education may be included. The final month of anticipated treatment should include the discharge plan for the carry-over of achieved goals to supportive personnel. See Medicaid Provider Manual for additional documentation requirements.
Box 24	Indicate if the beneficiary is receiving therapy services through school-based services program.
Box 25	Indicate the treatment plan frequency (e.g., 1x/week, 3x/week, 1x/month, etc.) and duration per visit in 15-minute increments, i.e., units (e.g. 2 units/visit, 4 units/visit, etc.).
Box 26	Complete a separate line for each unique HCPCS code/modifiers combination.
Box 27	The Therapies Database on the MDHHS website lists the HCPCS codes that describe covered services. The database is located at the MDHHS website www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.
Box 28	The Billing & Reimbursement Chapter in the Medicaid Provider Manual list the required modifiers used to describe covered services for therapy providers. The Medicaid Provider Manual is located at the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters, & Forms >> Medicaid Provider Manual.
Box 29	The total number of units the service is to be provided during the requested treatment period.
Box 30	The authorized prescribing practitioner must indicate if this is an initial certification or a re-certification and sign and date. Signature is required each time a request is made.
Box 31	The therapist certification is the signature of an authorized representative. The business office of a hospital may designate the director of the department providing the service as its representative. All unsigned requests will be returned for signature.
Box 32-35	MDHHS use only.

Form Submission:
PA request forms for all eligible Medicaid beneficiaries must be submitted electronically*, mailed or faxed to:

MDHHS – Program Review Division
P.O. Box 30170
Lansing, Michigan 48909
Fax Number: **(517) 335-0075**

If submitting electronically, the completed MSA-115 must be uploaded along with the supporting clinical documentation required.

To check the status of a PA request, contact the Program Review Division via telephone at **1-800-622-0276** or electronically via the **CHAMPS Provider Portal** located at https://milogintp.michigan.gov.

Authority: Title XIX of the Social Security Act.	**Completion**: Is voluntary but is required if payment from applicable programs is sought.
The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.	

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

OCCUPATIONAL THERAPY - PHYSICAL THERAPY – SPEECH THERAPY
PRIOR APPROVAL REQUEST/AUTHORIZATION

1. PRIOR AUTHORIZATION NUMBER (MDHHS USE ONLY)

The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment. All fields must be completed and typewritten.

2. TREATMENT SITE (Medicaid enrolled provider's name)	3. PROVIDER NPI NUMBER	4. PHONE NUMBER
5. ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)		6. FAX NUMBER

7. BENEFICIARY NAME (LAST, FIRST, MIDDLE INITIAL)	8. SEX ☐ M ☐ F	9. MIHEALTH CARD NUMBER	10. BIRTH DATE	11. ADM. DATE

12. ICD DIAGNOSIS(ES) CODE(S) AND DESCRIPTION(S) TO BE TREATED/EVALUATED	13. ONSET DATE

14. THERAPIST NAME (LAST, FIRST, MIDDLE INITIAL)	15. OFFICE PHONE NUMBER	16. LICENSE/CERTIFICATION NUMBER

17. TREATMENT AUTHORIZATION REQUEST ☐ INITIAL ☐ CONTINUING	18. LAST AUTHORIZATION	19. TREATMENT MONTHS / / to / /	20. DATE STARTED	21. # PREV. SESSIONS

22. GOALS (NOTE: SEE MEDICAID PROVIDER MANUAL FOR ADDITIONAL DOCUMENTATION REQUIREMENTS.)

SHORT TERM GOALS	LONG TERM GOALS

23. PROGRESS SUMMARY (NOTE: SEE MEDICAID PROVIDER MANUAL)

24. SCHOOL THERAPY PROGRAMS ☐ YES ☐ NO

25. TREATMENT REQUESTED
FREQUENCY:
DURATION VISIT: (UNITS)

26. LINE NO.	27. PROCEDURE CODE	28. MODIFIER	29. TOTAL UNITS PER PA
01			
02			
03			
04			
05			

30. PHYSICIAN CERTIFICATION

I certify ☐ re-certify ☐ that I have examined the patient named above and have determined that skilled therapy is necessary; that services will be furnished on an in-patient and/or out-patient basis while the patient is under my care; that I approve the above treatment goals and will review every 60 days or more frequently if the patient's condition requires.

PRESCRIBING PRACTITIONER'S NAME (TYPE OR PRINT)

PRESCRIBING PRACTITIONER'S SIGNATURE DATE

MDHHS USE ONLY

32. REVIEW ACTION:
- APPROVED ☐
- RETURNED ☐
- DENIED ☐
- NO ACTION ☐
- APPROVED AS AMENDED ☐

33. AUTHORIZATION PERIOD APPROVED

34. CONSULTANT REMARKS

☐ See CHAMPS

31. THERAPIST CERTIFICATION

The patient named above (parent or guardian if applicable) understands the necessity to request prior approval for the services indicated. I understand that services requested herein require prior approval and, if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of a material fact may lead to prosecution under applicable Federal or State law.

THERAPIST'S SIGNATURE DATE

35. CONSULTANT SIGNATURE DATE

Michigan Department of Health and Human Services

Practitioner Special Services Prior Approval - Request/Authorization Completion Instructions

The MSA-6544-B must be used by Medicaid enrolled providers to request provider services that require prior authorization (PA) (e.g. out-of-state care and genetic testing).

MDHHS requests that the MSA-6544-B be typewritten to facilitate processing. A Word fill-in enabled version of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms. For information on required modifiers, documentation, and appropriate quantity amounts, refer to the following documents:

- Standards of Coverage portion of the provider-specific chapters of the Medicaid Provider Manual.
- Billing & Reimbursement for Professionals Chapter of the Medicaid Provider Manual.
- Provider-specific databases on the MDHHS website. www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.
- For more detailed information on procedure codes refer to CHAMPS – External Links – Medicaid Code and Rate Reference.

Completion of this form is as follows:

Box 1	MDHHS Use Only
Box 22	Indicate whether this is the first request for services or if this is a renewal request for ongoing services
Box 24	Enter a complete description of the services, procedures, lab test, etc. requested
Box 25	Enter the HCPCS Procedure Code.
Box 26	Enter the applicable HCPCS Modifier.
Box 27	Enter the quantity of the services requested. If an injectable drug is requested, indicate the number of billing units requested.
Box 28	Enter the dates for which the requested procedure or service will take place.
Box 29	Enter the beneficiary's primary and secondary diagnoses or the CSHCS qualifying diagnosis (list both the code and description)
Box 30	Any additional remarks regarding the request should be listed in this box such as verbal authorization date, retroactive date of service if being requested. Provide other insurance coverage for services requested.
Box 31	Check each box that corresponds to documentation included in the request. No request should leave all boxes unchecked.
Box 32	Must be completed for all requests.

Form Submission

PA request forms and required documentation for all eligible Medicaid beneficiaries must be mailed or faxed to:

MDHHS - Medical Services Administration
Program Review Division
P.O. Box 30170
Lansing, Michigan 48909

Fax Number: (517) 335-0075

The status of a PA request may be reviewed in CHAMPS. For additional questions, contact the MDHHS - Medical Services Administration, Program Review Division via telephone at **1-800-622-0276.**

Michigan Department of Health and Human Services

PRACTITIONER SPECIAL SERVICES
PRIOR APPROVAL – REQUEST/AUTHORIZATION

1. PRIOR AUTHORIZATION NUMBER (MDHHS USE ONLY)

The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.

2. Reason for PA Request:

☐ OUT OF STATE CARE ☐ CLINICAL PROCEDURE ☐ OFFICE ADMINISTERED DRUG OR BIOLOGICAL ☐ SURGERY

☐ OTHER _____

3. PROVIDER'S NAME (LAST, FIRST, MIDDLE INITIAL)	4. NPI NUMBER	5. PHONE NUMBER
6. PROVIDER'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)		7. FAX NUMBER

8. BENEFICIARY'S NAME (LAST, FIRST, MIDDLE INITIAL)	9. SEX ☐ **M** ☐ **F**	10. BIRTH DATE	11. MIHEALTH CARD NUMBER
12. BENEFICIARY'S ADDRESS (NUMBER, STREET, APT./LOT NUMBER, CITY, STATE, ZIP)			

13. HOSPITAL/ FACILITY NAME	14. HOSPITAL/ FACILITY NPI

15. REFERRING/ORDERING PHYSICIAN'S NAME (LAST, FIRST, MIDDLE INITIAL)	16. NPI NUMBER	17. PHONE NUMBER
18. REFERRING/ORDERING PHYSICIAN'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)		19. FAX NUMBER
20. CONTACT NAME		21. CONTACT PHONE NUMBER - -

22. ☐ INITIAL REQUEST ☐ RENEWAL REQUEST

23. LINE NO.	24. DESCRIPTION OF SERVICE	25. PROCEDURE CODE	26. MODIFIER	27. QUANTITY	28. ANTICIPATED DATE(S) OF SERVICE
01					
02					
03					
04					

29. DIAGNOSES (CODES AND DESCRIPTIONS) REQUIRING THE ABOVE SERVICES.	30. ADDITIONAL REMARKS, INCLUDING OTHER INSURANCE COVERAGE ON THE DATE OF SERVICE.

31. Identify all relevant clinical documentation that has been submitted to support medical necessity: *If this is an out-of-state request, in addition to clinical documentation, include a letter of medical necessity that explains A) why services cannot be provided in state, B) what in-state services have already been exhausted, and C) the plan to transition care back to the state of Michigan.*

☐ H&P ☐ PROGRESS NOTES ☐ CONSULTATIONS ☐ LABS

☐ PATHOLOGY REPORT ☐ OPERATIVE REPORT ☐ RADIOLOGY REPORTS ☐ PHOTOS ****INCLUDE PHOTOS FOR ALL COSMETIC AND RECONSTRUCTIVE SURGERIES**

☐ DISCHARGE SUMMARY ☐ LETTER OF MEDICAL NECESSITY ☐ OTHER DIAGNOSTICS:_____

32. **PROVIDER CERTIFICATION:** THE PATIENT NAMED ABOVE (PARENT OR GUARDIAN IF APPLICABLE) UNDERSTANDS THE NECESSITY TO REQUEST PRIOR APPROVAL FOR THE SERVICES INDICATED. I UNDERSTAND THAT SERVICES REQUESTED HEREIN REQUIRE PRIOR APPROVAL AND, IF APPROVED AND SUBMITTED ON THE APPROPRIATE INVOICE, PAYMENT AND SATISFACTION OF APPROVED SERVICES WILL BE FROM FEDERAL AND/OR STATE FUNDS. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY LEAD TO PROSECUTION UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

PROVIDER'S SIGNATURE: DATE:

MDHHS USE ONLY

33. REVIEW ACTION: ☐ APPROVED ☐ DENIED ☐ RETURN ☐ NO ACTION ☐ APPROVED AS AMENDED

34. CONSULTANT REMARKS

CONSULTANT SIGNATURE AND DATE:

PREADMISSION SCREENING (PAS)/ANNUAL RESIDENT REVIEW (ARR)

(Mental Illness/Intellectual Disability/Related Conditions Identification)

Michigan Department of Health and Human Services

Level I Screening

☐ **PAS**
☐ **ARR**
☐ **Change in Condition**
☐ **Hospital Exempted Discharge**

SECTION I – Patient, Legal Representative and Agency Information

Patient Name (First, MI, Last)			Date of Birth (MM/DD/YY)	Gender ☐ **Male** ☐ **Female**	
Address (number, street, apt. or lot #)			County of Residence	Social Security Number - -	
City	State	ZIP Code	**Medicaid** Beneficiary ID Number	**Medicare** ID Number	
Does this patient have a court-appointed guardian or other legal representative? ☐ **No** ☐ **Yes** ➔			If Yes, give Name of Legal Representative		
County in which the legal representative was appointed			Address (number, street, apt. number or suite number)		
Legal Representative Telephone Number - -			City	State	ZIP Code
Referring Agency Name			Telephone Number - -	Admission Date (actual or proposed)	
Nursing Facility Name (proposed or actual)			County Name		
Nursing Facility Address (number and street)			City	State	ZIP Code

Sections II and III of this form must be completed by a registered nurse, licensed bachelor or master social worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or a physician.

SECTION II – Screening Criteria (All 6 items must be completed.)

1. ☐ No ☐ Yes..... The person has a current diagnoses of **Mental Illness** or **Dementia** (*Circle one*)
2. ☐ No ☐ Yes..... The person has received treatment for **Mental Illness** or **Dementia** (*within the past 24 months) (Circle one)*
3. ☐ No ☐ Yes..... The person has routinely received one or more prescribed antipsychotic or antidepressant medications within the last 14 days.
4. ☐ No ☐ Yes..... There is presenting evidence of mental illness or dementia, including significant disturbances in thought, conduct, emotions, or judgment. Presenting evidence may include, but is not limited to, suicidal ideations, hallucinations, delusions, serious difficulty completing tasks, or serious difficulty interacting with others.
5. ☐ No ☐ Yes..... The person has a diagnosis of an intellectual disability or a related condition including, but not limited to, epilepsy, autism, or cerebral palsy and this diagnosis manifested before the age of 22.
6. ☐ No ☐ Yes..... There is presenting evidence of deficits in intellectual functioning or adaptive behavior which suggests that the person may have an intellectual disability or a related condition. These deficits appear to have manifested before the age of 22.

Note: If you check "Yes" to items 1 and/or 2, circle the word "**Mental Illness**" or "**Dementia**."

Explain any "Yes"

Note: The person screened shall be determined to require a comprehensive Level II OBRA evaluation if any of the above items are "Yes" UNLESS a physician, nurse practitioner or physician's assistant certifies on form DCH-3878 that the person meets at least one of the exemption criteria.

SECTION III – CLINICIAN'S STATEMENT: I certify to the best of my knowledge that the above information is accurate.

Clinician signature		Date	Name (type or print)
Address (number, street, apt. number or suite number)			Degree/license
City	State	ZIP Code	Telephone Number - -
AUTHORITY: Title XIX of the Social Security Act **COMPLETION:** Is voluntary, however, if NOT completed, Medicaid will not reimburse the nursing facility.			The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

DISTRIBUTION: If any answer to items 1 – 6 in SECTION II is "Yes", send **ONE copy** to the local Community Mental Health Services Program (CMHSP), **with a copy of form DCH-3878** if an exemption is requested. The nursing facility must retain the original in the patient record and provide a copy to the patient or legal representative.

PREADMISSION SCREENING (PAS)/ANNUAL RESIDENT REVIEW (ARR)

Mental Illness/Intellectual Disability/Related Conditions Identification

Instructions for Completing Level I Screening

This form is used to identify prospective and current nursing facility residents who meet the criteria for possible mental illness or intellectual disability, or a related condition and who may be in need of mental health services.

Sections II and III must be completed by a registered nurse, licensed bachelor or master social worker, licensed professional counselor, psychologist, physician's assistant, nurse practitioner or physician.

Preadmission Screening or Hospital Exempted Discharge: The referral source completing the Level I Screening (DCH-3877), must complete and provide a copy to the proposed nursing facility **prior to admission. Check the appropriate box in the upper right hand corner.**

Annual Resident Review or Change in Condition: This form must be completed by the nursing facility. **Check the appropriate box in the upper right hand corner.**

Section II – Screening Criteria – All 6 items in this section must be completed. The following provides additional explanation of the items.

1. **Mental Illness:** A current primary diagnosis of a mental disorder as defined in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

   Current Diagnosis means that a clinician has established a diagnosis of a mental disorder within the past 24 months. Do NOT mark "Yes" for an individual cited as having a diagnosis "by history" only.

2. **Receipt of treatment for mental illness or dementia within the past 24 months** means any of the following: inpatient psychiatric hospitalization; outpatient services such as psychotherapy, day program, or mental health case management; or referral for psychiatric consultation, evaluation, or prescription of psychopharmacological medications.

3. **Antidepressant and antipsychotic medications** mean any currently prescribed medication classified as an antidepressant or antipsychotic, plus Lithium Carbonate and Lithium Citrate.

4. **Presenting evidence** means the individual currently manifests symptoms of mental illness or dementia, which suggests the need for further evaluation to establish causal factors, diagnosis and treatment recommendations. Further evaluation may need to be completed if evidence of suicidal ideation, hallucinations, delusion, serious difficulty completing tasks or serious difficulty interacting with others.

5. **Intellectual Disability/Related Condition:** An individual is considered to have a severe, chronic disability that meets **ALL** 4 of the following conditions:

   a. It is manifested before the person reaches **age 22**.
   b. It is likely to continue indefinitely.
   c. It results in substantial functional limitations in **3 or more** of the following areas of major life activity: self-care, understanding and use of language, learning, mobility, self-direction, and capacity for independent living.
   d. It is attributable to:
      - Intellectual Disability such that the person has significant subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period;
      - cerebral palsy, epilepsy, autism; or
      - any condition other than mental illness found to be closely related to Intellectual Disability because this condition results in impairment in general intellectual functioning OR adaptive behavior similar to that of persons with Intellectual Disability, and requires treatment or services similar to those required for these persons.

6. **Presenting evidence** means the individual manifests deficits in intellectual functioning or adaptive behavior, which suggests the need for further evaluation to determine the presence of a developmental disability, causal factors, and treatment recommendations. These deficits appear to have manifested before the age of 22.

NOTE: When there are one or more "Yes" answers to items 1 – 6 under SECTION II, complete form DCH-3878, Mental Illness/Intellectual Disability/Related Condition Exemption Criteria Certification only if the referring agency is seeking to establish exemption criteria for a dementia, state of coma, or hospital exempted discharge.

Michigan Department of Health and Human Services
Completion Instructions for MSA-0732
Private Duty Nursing Prior Authorization – Request for Services

The MSA-0732 form (page 2) must be submitted every time services are requested, i.e., before services can begin and for each specified authorization period thereafter, no less than 15 days prior to the end of the current authorization period.

MDHHS requests that the MSA-0732 be typewritten to facilitate processing. A Word fill-in enabled version of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Forms.

This form must be used to request Prior Authorization (PA) for Private Duty Nursing (PDN) services for beneficiaries with Medicaid coverage under 21 years of age. Private Duty Nursing is not a benefit under Children's Special Health Care Services (CSHCS). Beneficiaries with CSHCS coverage may be eligible for PDN under Medicaid. A request to begin services may be submitted by a person other than the PDN such as the hospital Discharge Planner, CSHCS case manager, physician, or physician's staff person. When this is the case, the person submitting the request must do so in consultation with the PDN who will be assuming responsibility for the care of the beneficiary. If services are being requested for more than one beneficiary in the home, a separate form must be completed for each beneficiary.

Refer to the Medicaid Provider Manual, Private Duty Nursing Chapter, Prior Authorization Subsection, for the listing of required documentation to accompany each request.

Completion of this form is as follows:

Item#	Instructions
1	Prior Authorization Number. MDHHS use only.
2	Check specific box as to whether this is an initial or renewal request. If a renewal, check the INCREASE UNITS or DECREASE UNITS box only if this request demonstrates an increase or decrease in time from the previous authorization period. Time is authorized and billed in 15-minute incremental units (1 unit = 15 minutes).
3 - 7	PDN provider information. Provide complete agency name, or name of individual (last, first, and middle initial). Designate whether RN or LPN. Include NPI number, phone number, address, and fax number.
8 - 14	Beneficiary information. Provide complete name and birth date (month, day, and year); sex, mihealth card number, complete address, county, and primary diagnosis using the appropriate ICD code only.
15 - 18	Other insurance information if applicable, including name of company and beneficiary's group/policy and certificate/contract numbers.
19 - 25	Hospital information including complete address and phone number, anticipated discharge date, and name and contact information of Discharge Planner, if beneficiary is currently hospitalized.
26 - 30	Ordering physician information. Provide complete name (including MD or DO); NPI number, phone number, address, and fax number.
31 - 35	Description of the service(s) to be provided utilizing HCPCS code T1000 and modifier TD for RN or TE for LPN. Use modifier TT if caring for more than one beneficiary. Include the number of total units per month required to provide the service(s) with the start date and end date, if known.
36 - 40 **43 - 49**	Home environment information, including number of siblings residing in the home (include step and foster child(ren) if applicable) and if they receive PDN. Provide child's name and mihealth card number if receiving PDN. Also provide the number of other individuals in the home requiring care (e.g., elderly parent, grandparent, disabled spouse, sibling), name(s) and number of caregivers for the beneficiary for whom services are being requested, and whether the caregiver(s) either work and/or attend school outside of the home. If so, how many hours are spent working and/or attending school. (Additional pages may be required.)
41 - 42	Current school information if child is or will be attending school during the authorization period when PDN services are being provided. Include number of hours per day and per week, including travel time.
50 - 56	If more than one PDN or PDN agency is involved, their name(s), phone number(s), fax number(s), and which PDN will be managing the care plan (i.e., the provider named in items 2 – 6, or the provider named in this space).
57	List all other services in the home. Failure to disclose all services in the home may result in recoupment of Medicaid dollars for PDN reimbursement.
58	The Provider's signature certifies that (1) the individual PDN or agency requesting the services understands the necessity for obtaining prior authorization for PDN and; (2) The information provided on this form is accurate and complete.
59	Signature certifies that Parent/Guardian of beneficiary attests that information provided on this form is accurate and complete to the best of their ability.
60	MDHHS use only

Form Submission

The completed MSA-0732 (page 2) and required documentation must be mailed or faxed to:

Michigan Department of Health and Human Services **Fax:** (517) 241-7813
Program Review Division
P.O. Box 30170
Lansing, MI 48909

Questions should be directed to MDHHS - Medical Services Administration, Program Review Division via telephone at **1-800-622-0276.**

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable programs is sought.

The Michigan Department of Health and Human Services is an equal opportunity employer, services and programs provider.

Michigan Department of Health and Human Services

PRIVATE DUTY NURSING
PRIOR AUTHORIZATION – REQUEST FOR SERVICES

1. PRIOR AUTHORIZATION NUMBER **(MDHHS USE ONLY)**

The provider is responsible for eligibility verification. Authorization does not guarantee beneficiary eligibility or payment.

2. INDICATE IF THIS REQUEST IS: ☐ INITIAL ☐ RENEWAL ☐ INCREASE UNITS ☐ DECREASE UNITS

3. PROVIDER'S NAME (AGENCY NAME, OR INDIVIDUAL'S NAME (IF INDEPENDENT RN/LPN)	4. NPI NUMBER	5. PHONE NUMBER
6. PROVIDER'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)		7. FAX NUMBER
8. BENEFICIARY'S NAME (LAST, FIRST, MIDDLE INITIAL)	9. SEX ☐ M ☐ F / 10. BIRTH DATE	11. MIHEALTH CARD NUMBER
12. BENEFICIARY'S ADDRESS (NUMBER, STREET, APT./LOT NUMBER, CITY, STATE, ZIP)	13. COUNTY	14. PRIMARY DIAGNOSIS (ICD CODE)
15. OTHER INSURANCE? ☐ YES ☐ NO / 16. HEALTH INSURANCE COMPANY NAME	17. GROUP / POLICY NUMBER	18. CERTIFICATE / CONTRACT NUMBER

19. IS BENEFICIARY CURRENTLY HOSPITALIZED? ☐ YES ☐ NO IF YES, PROVIDE FACILITY NAME, ADDRESS, PHONE NUMBER, DISCHARGE PLANNER BELOW. ANTICIPATED DISCHARGE DATE:

20. HOSPITAL NAME	21. HOSPITAL ADDRESS (NUMBER, STREET, CITY, STATE, ZIP)	22. PHONE NUMBER
23. NAME OF DISCHARGE PLANNER	24. DISCHARGE PLANNER'S PHONE NUMBER	25. DISCHARGE PLANNER'S FAX NUMBER
26. ORDERING PHYSICIAN'S NAME (LAST, FIRST, MIDDLE INITIAL, MD OR DO)	27. NPI NUMBER	28. PHONE NUMBER
29. PHYSICIAN'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)		30. FAX NUMBER

31. DESCRIPTION OF SERVICE	32. HCPCS/MODIFIER CODE(S)	33. UNITS PER MONTH	34. START DATE	35. END DATE

36. NUMBER OF SIBLINGS	37. DOES ANYONE ELSE RECEIVE PDN SERVICES? ☐ YES ☐ NO	38. IF YES, PROVIDE CHILD'S NAME RECEIVING PDN SERVICES	39. CHILD'S MIHEALTH CARD NUMBER
40. NUMBER OF OTHER INDIVIDUALS IN HOME REQUIRING CARE	41. IS THE BENEFICIARY CURRENTLY IN SCHOOL? ☐ YES ☐ NO	42. IF YES, HOW MANY HOURS? _____ PER DAY _____ PER WEEK (INCLUDE TRAVEL TIME)	

43. NUMBER OF CAREGIVERS	44. CAREGIVERS NAME AND RELATIONSHIP TO BENEFICIARY	45. WORK OR ATTEND SCHOOL? ☐ YES ☐ NO	46. NUMBER OF HRS/DAYS AT WORK AND/OR SCHOOL
	47. CAREGIVERS NAME AND RELATIONSHIP TO BENEFICIARY	48. WORK OR ATTEND SCHOOL? ☐ YES ☐ NO	49. NUMBER OF HRS/DAYS AT WORK AND/OR SCHOOL

50. IS MORE THAN ONE PDN/PDN AGENCY INVOLVED? ☐ YES ☐ NO	51. NAME OF OTHER PERSON/AGENCY	52. NPI NUMBER	53. PHONE NUMBER / 54. FAX NUMBER
55. WHO WILL BE MANAGING THE PDN CARE PLAN?		56. PHONE NUMBER (IF DIFFERENT THAN #5 ABOVE)	

57. OTHER THAN PDN, DOES THE BENEFICIARY RECEIVE OTHER SERVICES IN THE HOME? ☐ YES ☐ NO IF YES, LIST OTHER SERVICES IN THE HOME

PROVIDER'S SIGNATURE DATE

58. CERTIFICATION: THE PATIENT NAMED ABOVE (PARENT OR GUARDIAN IF APPLICABLE) UNDERSTANDS THE NECESSITY TO REQUEST PRIOR AUTHORIZATION FOR THE SERVICES INDICATED. I UNDERSTAND THAT SERVICES REQUESTED HEREIN REQUIRE PRIOR AUTHORIZATION AND, IF APPROVED AND SUBMITTED ON THE APPROPRIATE INVOICE, PAYMENT AND SATISFACTION OF AUTHORIZED SERVICES WILL BE FROM FEDERAL AND/OR STATE FUNDS. **I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY LEAD TO PROSECUTION UNDER APPLICABLE FEDERAL AND/OR STATE LAW. PROVIDER CERTIFIES THAT INFORMATION PROVIDED ON THIS FORM IS ACCURATE AND COMPLETE TO THE BEST OF THEIR ABILITY.**

59. PARENT GUARDIAN OF BENEFICIARY CERTIFIES THAT INFORMATION PROVIDED ON THIS FORM IS ACCURATE AND COMPLETE TO THE BEST OF THEIR ABILITY.

PARENT/GUARDIAN SIGNATURE DATE

MDHHS USE ONLY

60. REVIEW ACTION:
APPROVED ☐ INSUFFICIENT DATA ☐
DENIED ☐ NO ACTION ☐
APPROVED AS AMENDED ☐

CONSULTANT SIGNATURE DATE

PROVIDER ELECTRONIC SIGNATURE AGREEMENT COVER SHEET

Michigan Department of Health and Human Services

Instructions:

- Provider should retain a COPY in the office
- MUST be submitted with DCH-1401, Electronic Signature Agreement.

Mail to:

Provider Enrollment Section
Michigan Department of Health and Human Services
PO Box 30238
Lansing, MI 48909

Fax: 517-241-8233

Reason for Submission (check all that apply)

☐ Revalidation	☐ New Tax ID/SSN (List Provider Enrollment staff contact name)
☐ Domain Access ☐ Group ☐ Individual ☐ Both	☐ Other (List reason)
☐ Domain Administrator Contact Information	

Contact Information (REQUIRED)

Name	Email Address	Phone Number
MILogin User ID	Provider's NPI Number	
Provider's Date of Birth	Provider's Home Address	

Provider Enrollment Office Use Only

☐ Provided Domain Administrator contact information

☐ Sent/Gave to team lead for processing

☐ Sent to processor with W-9 attached

☐ Opened for revalidation

AUTHORITY: 42 CFR 455.104 **COMPLETION:** Voluntary, but required for access to CHAMPS.	The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

MDHHS
Michigan Department of Health & Human Services

Provision of Low Vision Services and Aids Support Documentation

To facilitate processing of your request for low vision services and aids, this form must be completed. Failure to provide complete documentation will result in automatic disapproval of your request. Do not use abbreviations as their use may result in misinterpretation and possible disapproval. A Vision Services Approval/Order form (DCH-0893) must accompany this documentation. (Exception: High add bifocals do not require prior approval; hence, a completed DCH-0893 should be sent directly to the State's vision contractor.)

_____ _____

Beneficiary's Name **Medicaid ID Number**

Based on the Low Vision Evaluation provide the following information:

A. HISTORY

1. History of onset of low vision (including, but not limited to, onset, duration, etiology, and any ocular surgery):

_____

_____

_____

_____

_____

2. Present spectacle correction:

R _____ **VA** _____ **ADD** _____ **VA** _____

L _____ **VA** _____ **ADD** _____ **VA** _____

3. Contact Lenses: (If worn)

Power R _____ **Type R** _____

Power L _____ **Type L** _____

4. Low vision aids presently in use:

Magnifiers: _____ Electronic Projection Magnifier: _____

Microscopics: _____

Telescopics: _____ Filers/typoscopes/visors: _____

Loupes: _____ Other: _____

5. Relevant Systemic Conditions:

_____

_____

_____

_____

_____

B. BENEFICIARY'S GOALS

_____

_____

_____

_____

_____

C. SUMMARY FINDINGS

1. Ocular Diagnosis(es):
   R _____ **L** _____

2. Vision Impairment Diagnosis:
   R _____ **L** _____

3. Nature and Extent of Visual Fields:

   _____

   _____

   _____

4. Specifications of best conventional spectacle correction:

At distance	**R**	_____	**VA**	_____
	L	_____	**VA**	_____
At near	**R**	_____	**VA**	_____
	L	_____	**VA**	_____

D. RECOMMENDED TREATMENT

1. No treatment at this time. Follow-up for monitoring (check one):

   ☐ 3 Months ☐ 6 Months ☐ 9 Months ☐ 12 Months

2. Referral for medical and/or surgical treatment:

   _____

   _____

3. Description of Recommended Low Vision Aids:

A. VA **R**_____ **L** _____ Description, manufacturer and catalog number _____	
Describe specific use:	
Describe benefit:	
Acquisition Cost	Professional Fee

B. VA **R**_____ **L** _____ Description, manufacturer and catalog number _____	
Describe specific use:	
Describe benefit:	
Acquisition Cost	Professional Fee

C. VA **R**_____ **L** _____ Description, manufacturer and catalog number _____	
Describe specific use:	
Describe benefit:	
Acquisition Cost	Professional Fee

E. OTHER RECOMMENDATIONS - DESCRIBE BENEFITS

_____

_____

_____

_____

_____

F. PROGNOSIS

_____

_____

_____

_____

Signature of Examiner _____

Examiner (Print) _____ **Date** _____

REQUEST FOR AUTHORIZATION OF PRIVATE ROOM SUPPLEMENTAL PAYMENT FOR NURSING FACILITY

Michigan Department of Health and Human Services

This is my written request for authorization of supplemental payment for a single room for:

Name of Beneficiary/Resident	Medicaid ID Number
Facility Contact	Facility Telephone Number - -
Facility Name	Facility Fax Number - -
Facility Address	

The basis for this request is:

☐ I believe a single room is medically necessary. (If medically necessary, the Medicaid daily rate already pays for a single room.)

☐ I believe a single room is not medically necessary, but is needed for the following reason(s):

_____

_____

I understand that I must accept responsibility for paying the difference between the facility's two-person room and single room rates that are listed below. I will pay any difference in the rates that may change over time, as long as a single room is needed.

Two-person room rate: $ _____ per day

Single room rate: $ _____ per day

Printed Name of Requestor	Telephone Number - -
Address	Relationship to Beneficiary/Resident

Signature of Requester	Date

MAIL TO: Long Term Care Services
Michigan Department of Health and Human Services
PO Box 30479
Lansing, MI 48909-7979

FAX TO: 517-241-8995

Note: If no response is received within 10 working days, contact 517-241-4293.

Completion Instructions for DCH-0078
Request to Add, Terminate or Change Other Insurance

Form DCH-0078 is a formal request for change in other insurance status and must be submitted by the Medicaid provider, Medicaid Health Plan, Local Health Department or the Michigan Department of Health and Human Services caseworker to add, terminate, or change beneficiary insurance information other than Medicaid.

INSTRUCTIONS:

To add, terminate or change other insurance on-line, visit https://www.Michigan.gov/ReportTPL to access the form and instructions.

To submit the form via fax or mail:

- PRINT or TYPE to complete the form
- Place a check mark in the appropriate "Add," "Terminate," or "Change" field
- Sections denoted by * are mandatory to be completed
- Attach clear copy of insurance card (front and back) when adding insurance (if available)
- Retain a COPY in beneficiary file
- Submit form and applicable attachments

via: Fax Number: **517-346-9817**

Mail to: Michigan Department of Health and Human Services
Third Party Liability Division
Bureau of Medicaid Operations
PO Box 30479
Lansing MI 48909

Allow 7-10 business days for the request to be completed. To verify the request has been completed, view the beneficiary eligibility information in the Community Health Automated Medicaid Processing System (CHAMPS).

AUTHORITY: Title V and Title XIX of the Social Security Act.
COMPLETION: Is voluntary.

The Michigan Department of Health and Human Services is an equal opportunity employer, services, and programs provider.

Michigan Department of Health and Human Services

REQUEST TO ADD, TERMINATE OR CHANGE OTHER INSURANCE

ADD ☐ **TERMINATE** ☐ **CHANGE**

SECTION 1 – Medicaid Provider/Medicaid Health Plan/LHD/MDHHS Caseworker Information *

Requestor Name	Date	County/Local Health Department
Phone Number ( )	FAX Number ( )	Case Number (if available)

SECTION 2 – List of Beneficiaries/Clients to Add, Terminate or Change Insurance *

Beneficiary/Client Name	Date of Birth	mihealth ID	Beneficiary/Client Name	Date of Birth	mihealth ID
Beneficiary/Client Name	Date of Birth	mihealth ID	Beneficiary/Client Name	Date of Birth	mihealth ID
Beneficiary/Client Name	Date of Birth	mihealth ID	Beneficiary/Client Name	Date of Birth	mihealth ID

SECTION 3 – Policyholder Information *

Policyholder Name (Last, First, Middle)	Date of Birth	Employer Name	
Social Security Number		Employer City and State	
Type of Coverage (use an "X") ☐ **Traditional** ☐ **Managed Care** (Preferred Provider Organization, Health Maintenance Organization, Point of Service)			
Health Insurance Company Name		Group / Policy Number	Certificate / Contract Number
Pharmacy Insurance Name	Dental Insurance Name	Vision Insurance Name	

SECTION 4 – Reason For Change

☐ **Divorce** ➔ Date of Divorce		☐ **Military Discharge** ➔ Date of Discharge	
☐ **Coverage Termination** ➔ Date of Termination		☐ **Employment Termination** ➔ Date of Termination	
☐ **OTHER** (explain): ➔ Date of Change	Reason:		

Attachments: Attach documentation to substantiate a request to terminate or change insurance coverage, such as a letter from an insurance company or employer.

COMMENTS:

SUBMIT:

MDHHS - THIRD PARTY LIABILITY DIVISION

FAX (517) 346-9817

AUTHORITY: Title V and Title XIX of the Social Security Act.
COMPLETION: Is voluntary.

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SAMPLE NOTICE OF NON-COVERAGE

(Hospital Letterhead)

(Name of Patient) (Date of Notice)
(Address)
(City, State, Zip)

(Medical Record Number)
(Beneficiary Number)
(Attending Physician's Name)
(Admission Date)

Dear (Name of Patient)

SUBJECT: CONTINUED STAY NOTICE OF NON-COVERAGE

As a Medicaid beneficiary, it is important for you to understand that there are circumstances when Medicaid does not pay for hospital care or certain services provided in the hospital. Medicaid pays for hospital care when the services are medically necessary and delivered in the most appropriate setting.

The Utilization Review Committee of (Name of Hospital) has reviewed the medical services you have received for (Specify services or condition) from (Date of Admission) to (Date of Notice). The Review Committee has determined that your continued stay in an acute care hospital is not medically necessary, and the medical services you are receiving for (Specify services or condition) could be safely rendered in another less costly setting. You should discuss with your attending physician the arrangements for the health care you may require.

You will not be responsible for payment of the services which are rendered by this hospital from (Date of Admission) through the date you receive this notice, except for payment of deductible, coinsurance, or any convenience services or items not covered by Medicaid. If you decide to stay in the hospital, you will be responsible for payment of all services provided to you by this hospital beginning the day after you receive this notice.

For example: If you receive this notice on _____ you will be responsible for payment of services provided beginning_____.

The Michigan Peer Review Organization (MPRO) is the review organization authorized by the Medicaid Program to re-review on behalf of the patient or his/her physician any hospital denied to Medicaid patients in the State of Michigan.

If you disagree with this decision and you remain in the hospital, you or your representative may request an immediate review by MPRO. You may request this by calling:

Michigan Peer Review Organization
Attention: Medicaid PACER Program
22670 Haggerty Rd., Ste. 100
Farmington Hills, MI 48335-2611
Telephone: 1-800-727-7223

"SAMPLE"
NOTICE OF NON-COVERAGE

(Hospital Letterhead)

(Name of Patient) (Date of Notice)
(Address)
(City, State, Zip)

(Medical Record Number)
(Beneficiary Medicaid Number)
(Attending Physician's Name)
(Admission Date – *if applicable*)

Subject: NOTICE OF NON-COVERAGE FOR INPATIENT HOSPITAL ADMISSION

Dear (Name of Patient):

As a Medicaid beneficiary, it is important for you to understand that there are circumstances when Medicaid does not pay for hospital care or inpatient services provided in the hospital. Medicaid pays for hospital care when the services are medically necessary and delivered in the most appropriate setting.

NOTICE OF NON-COVERAGE

(Name of Hospital) Utilization Review (UR) Committee has reviewed your physician's request for your hospital admission. The request has been denied. The hospital's UR Committee has determined that your admission to (Name of Hospital) for treatment of (Specify services or condition) is either: 1) not medically necessary, or 2) that the medical services you may require for the treatment of your condition can be safely rendered in another less costly setting. You should discuss arrangements for any health care treatment you may require with your physician.

APPEAL RIGHTS

The Michigan Peer Review Organization (MPRO) is the review organization authorized by the Medicaid Program to review on behalf of the patient or his/her physician any hospital care denied to Medicaid patients in the State of Michigan.

If you disagree with this decision, you or your representative must request an immediate review by MPRO. You must request this review by calling:

Michigan Peer Review Organization
Attention: Medicaid PACER Program
22670 Haggerty Road, Suite 100
Farmington Hills, MI 48335-2611
Telephone: 1-800-727-7223

If MPRO confirms the hospital's initial decision, you will be notified in writing of its decision. If you decide to proceed with the admission to the hospital, you will be responsible for the payment of all services provided to you by the hospital beginning with the date of admission.
If MPRO overturns the hospital's decision, you will also be notified in writing of MPRO's decision. The hospital will contact your physician and make arrangements for your admission to the hospital. Medicaid will cover the cost of your hospital stay except for the payment of any deductible, coinsurance, or convenience services or items not covered by Medicaid.

Maternal Infant Health Program Provider and Medicaid Health Plan Care Coordination Agreement

This agreement is made and entered into this _____ day of _____, in the year _____ by and between _____ (Medicaid Health Plan) and _____ (Maternal Infant Health Program provider).

A. Legal Basis

Whereas, in order to expand enrollment, the Michigan Department of Health and Human Services (MDHHS) has established a competitive bid process that has resulted in contracts with Medicaid Health Plans (MHPs) that are deemed to be qualified to provide specified health care services to Medicaid beneficiaries; and

Whereas, Medicaid-covered maternal and infant health services will be provided through arrangements between MDHHS, MDHHS contracted MHPs, and selected Maternal Infant Health Program (MIHP) providers.

Now, therefore, the MHP and the MIHP provider agree as follows:

B. Terms of Agreement

This agreement will be effective _____ in the year _____. This agreement will be subject to amendment due to changes in the contract between MDHHS and the MHP or changes to the MIHP Medicaid policy certification requirements.

This agreement is effective upon execution and will continue for the length of MHP and MDHHS contract period. Either party may cancel this agreement for cause upon 30 days written notice. Reasons for cause include: breach of duty or obligation; fraud or abuse; federal or state sanctions; and failure to comply with state law or rules the Medicaid Provider Manual, or the MIHP Operations Guide. The terminating party is required to notify MDHHS at least 30 days prior to termination. This agreement will automatically terminate when an MIHP provider fails to maintain the certification requirements of MDHHS.

Once a signed agreement is obtained from both parties, the provisions of this agreement will be extended for a timeframe consistent with the MHP and MDHHS contract period, and the MIHP provider maintaining certification with MDHHS. Either party may cancel this agreement upon 30 days written notice. MDHHS must be notified of the termination of this agreement.

C. Purpose, Administration and Point of Authority

MIHP services are home-visiting preventive services provided to pregnant women, mothers, and their infants to promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development. These support services are to be provided by a multidisciplinary team of health care professionals consisting of a qualified licensed registered nurse, licensed social worker and, if available, a registered dietitian and/or infant mental health specialist.

MIHP services are intended to supplement regular prenatal/infant care and to assist physicians (MD, DO), certified nurse midwives (CNMs), and nurse practitioners (NPs) contracted with MHPs. In compliance with MIHP and MHP guidelines, MIHP providers are to coordinate care with medical care providers, mental health providers, and the MHPs, as well as assist in the coordination of transportation services as needed for health care, support services and pregnancy-related appointments.

MDHHS/MHP Contracts and MHP/MIHP Care Coordination Agreements will be available for review upon request by MDHHS. The intent of the Care Coordination Agreement is to explicitly describe the services to be coordinated and the essential aspects of collaboration between the MHP and the MIHP provider.

The MHP shall designate in writing to the MIHP provider the person who has authority to administer this agreement. The MIHP provider shall designate in writing to the MHP the person who has authority to administer this agreement.

D. Areas of Responsibility

Mutually Served Consumers

Mutually served consumers refers to MHP beneficiaries who also qualify for MIHP services. All pregnant and infant Medicaid beneficiaries may qualify for MIHP services. The intent of establishing written procedures between the MHP and the MIHP provider is to assure service coordination and continuity of care for persons receiving services from both entities.

Services to be Provided by the MHP

The MHP will provide Medicaid covered services to Medicaid beneficiaries as required by the MHP contract with MDHHS. MIHP services are voluntary. Beneficiaries may refuse MIHP services at any time.

The MHP will notify all Medicaid beneficiaries enrolled in the MHP of the availability of MIHP services at the time of enrollment. The MHP shall provide a referral for MIHP services for those pregnant and infant Medicaid beneficiaries who are not currently receiving MIHP services or receiving equivalent maternal or infant support services from an evidence-based home visiting program. Referrals can be made in person, by letter, email, fax, or telephone.

Services to be Provided by the MIHP Provider

The MIHP provider will provide the following services:

- Psychosocial and nutritional screening and assessment;
- Plan of care development;
- Professional intervention services by a multidisciplinary team consisting of a qualified licensed registered nurse and licensed social worker and, when available, a registered dietitian and/or an infant mental health specialist;
- Coordination with the MHP for transportation services as needed for health care, substance use disorder treatment, support services, oral health services, and/or pregnancy-related appointments.
- Referral to community services (e.g. mental health, substance use disorder);
- Referral to or provision of childbirth or parenting education classes;
- Coordination with medical care providers; and
- Coordination with the MHP.

MIHP providers will bill and receive reimbursement for MIHP services provided to MHP members as noted in the provider contract established with the applicable MHP.

E. Medical Coordination

Both parties agree to establish a process for clinical staff to communicate on a regular basis to review the care coordination plans and status of mutually served beneficiaries in accordance with applicable privacy laws such as HIPAA, the Mental Health Code and 42 CFR Part 2. This may involve the sharing of written documents and verbal reports. Both parties will collaborate on development of referral procedures and effective means of communicating the need for individual referrals. The MIHP provider will provide the MHP with names of MHP beneficiaries receiving MIHP services on a regular basis, utilizing a standardized form. Communication may include assessment/screening results, the plan of care, and discharge summaries upon request.

The MIHP and MHP will accept and use the MDHHS behavioral health consent form (Consent to Share Behavioral Health Information for Care Coordination Purposes form [MDHHS-5515]) to disclose medical information protected under the Mental Health Code or substance use disorder information under 42CFR Part 2.

F. Grievance and Appeals

MIHP providers and MHPs are required to establish internal processes for resolution of grievances and appeals from Medicaid beneficiaries. Medicaid beneficiaries may file a grievance or appeal on any aspect of service provided to them by the MIHP or the MHP in accordance with MIHP and MHP grievance and appeal policies.

The MIHP provider is required to direct beneficiaries to the MHP's grievance and appeal process as appropriate. The MHP is required to direct beneficiaries to the MIHP provider's grievance and appeal process as appropriate.

Both parties will participate in grievance and appeal policies and shall cooperate in identifying, processing, and promptly resolving all grievances and appeals. Both parties are responsible for informing the other about their grievance and appeal process.

G. Dispute Resolution

Both parties agree to participate in a dispute resolution process in the event that the MHP or the MIHP provider contests a decision or action by the other party related to the terms of this agreement.

The dispute resolution process should include:

- Request to the other party for reconsideration of the disputed decision or action.
- Appeal to MDHHS regarding a disputed decision by an MHP, or for a disputed decision by an MIHP provider.

H. Transportation

The MHP and the MIHP provider each have specific requirements for coordinating transportation services for Medicaid beneficiaries. These responsibilities are outlined in the MHP contract with MDHHS, the contract between the MIHP and the MHP and in the Maternal Infant Health Program Chapter of the Medicaid Provider Manual.

The MIHP provider may coordinate transportation in accordance with the established MIHP/MHP provider agreement or refer the Medicaid beneficiary to utilize the MHP transportation benefit to access MHP covered services, substance use disorder treatment, oral health services, support services and/or pregnancy-related appointments.

Transportation must be arranged and provided within a reasonable timeframe to meet the needs of the beneficiary. The provision or arrangement of transportation may not be delayed due to disagreements between the MIHP and MHP regarding financial responsibility for transportation. Disputes as to payment of transportation services may be handled through the dispute resolution process.

I. Quality Improvement

Both parties agree to have mechanisms in place to conduct Quality Improvement activities to monitor the coordination of services. The MIHP provider and the MHP shall participate in quality improvement programs and shall cooperate in conducting reviews and audits of care.

J. Governing Laws

Both parties agree that performance under this agreement will be conducted in compliance with all federal, state and local laws, regulations, guidelines, and directives.

K. Signatures

Maternal Infant Health Program Provider	**Medicaid Health Plan**
_____	_____
Signature	Signature
_____	_____
Title	Title
_____	_____
Date	Date
_____	_____
Business Address	Business Address
_____	_____
Business Telephone	Business Telephone

Billing Provider NPI: 1111111111 **Name**: Example O. Provider **EIN/TIN**: 010101010 **Vendor ID**: XX0000000 **Pay Cycle**: XX **RA Number**: 78176112 **RA Date**: 10/12/2017

FINANCIAL ADJUSTMENTS

Adjustment Type	Previous Balance	Adjustment Amount	Remaining Balance
Balance Owed by Tax ID	$0.00		$0.00

CLAIM SUMMARY

Category	Count
Paid	64
Credited	0
Denied	29
GA	0

Total Approved	$261,244.79	Total Adjusted	$0.00	Total Paid	$261,244.79

Warrant/EFT #: 000032295 Warrant/EFT Date: 10/12/2017

1642718380000003

Billing Provider NPI: 1111111111 **Name**: Example O. Provider **EIN/TIN**: 010101010 **Vendor ID**: XX0000000 **Pay Cycle**: XX **RA Number**: 78176112 **RA Date**: 10/12/2017

Gross Adj ID Beneficiary Name Beneficiary ID Patient Account # Medical Record #	Original TCN TCN Type of Bill	Submitter ID Rendering Provider NPI	Invoice Date Service Date(s)	Revenue Procedure Modifier	PPS DRG APC	Qty	Billed Amount	Approved Amount	Category	Reason	Remark
Patient, One XXXXXXXXXX XXXXXXXXXXXXXX XXX XXXXXXXXX	XXXXXXXXXXXXXXX XX	0059	09/27/2017 07/31/2017-07/31/2017				$4,605.51	$0.00	D		MA32
	XXXXXXXXXXXXXXX		-	0022		1	$0.00	$0.00	D		N522, N56
	XXXXXXXXXXXXXXX		07/31/2017-07/31/2017	0130		1	$760.00	$0.00	D	B7	M53, N522
	XXXXXXXXXXXXXXX		-	0250		7	$394.06	$0.00	D	B7	N522
	XXXXXXXXXXXXXXX		-	0270		1	$103.19	$0.00	D	B7	N522
	XXXXXXXXXXXXXXX		-	0410		0	$3,969.00	$0.00	D	B7	N522
Patient, Two XXXXXXXXXX XXXXXXXXXXXXXX XXX XXXXXXXXX	XXXXXXXXXXXXXXX XX	12901	09/27/2017 08/01/2017-08/31/2017				$13,129.74	$0.00	D		
	XXXXXXXXXXXXXXX		-	0022		13	$0.00	$0.00	D		N56
	XXXXXXXXXXXXXXX		-	0022		8	$0.00	$0.00	D		N56
	XXXXXXXXXXXXXXX		-	0022		10	$0.00	$0.00	D		N56
	XXXXXXXXXXXXXXX		-	0130		13	$9,880.00	$0.00	D	B7	
	XXXXXXXXXXXXXXX		-	0130		8	$6,080.00	$0.00	D	B7	
	XXXXXXXXXXXXXXX		-	0130		10	$7,600.00	$0.00	D	B7	N362
	XXXXXXXXXXXXXXX		-	0430		68	$2,505.67	$0.00	D	B7	N301, N674
	XXXXXXXXXXXXXXX		-	0434		1	$99.65	$0.00	D	B7	N301, N674
Patient, Three XXXXXXXXXX XXXXXXXXXXXXXX XXX XXXXXXXXX	XXXXXXXXXXXXXXX XX	0059	10/03/2017 09/01/2017-09/30/2017				$7,650.00	$5,532.10	P		N48
	XXXXXXXXXXXXXXX		09/01/2017-09/30/2017	0120		30	$7,650.00	$5,532.10	P	142, 45	
Patient, Four XXXXXXXXXX XXXXXXXXXXXXXX XXX XXXXXXXXX	XXXXXXXXXXXXXXX XX	0059	10/03/2017 09/01/2017-09/30/2017				$7,650.00	$4,690.10	P		

1642718380000004

Michigan Department of Health and Human Services

Special Services Prior Approval - Request/Authorization Completion Instructions

The MSA-1653-B must be used by Medicaid enrolled DME, Medical Suppliers, Orthotists, Prosthetists, Hearing Aid Dealers, Audiologists and Cochlear Manufacturers.

MDHHS requests that the MSA-1653-B be typewritten to facilitate processing. A Word fill-in enabled version of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms. The form is generally self-explanatory. For information on required modifiers, documentation, and appropriate quantity amounts, refer to the following documents:

- Standards of Coverage portion of the provider-specific chapters of the Medicaid Provider Manual.
- Billing & Reimbursement for Professionals Chapter of the Medicaid Provider Manual.
- Provider-specific databases on the MDHHS website. www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.

Completion of this form is as follows:

Box 1	MDHHS Use Only
Box 12	Check Yes if beneficiary is in a Nursing Facility or No if the beneficiary is not in a Nursing Care Facility. If Yes, include the Nursing Facility name, address and phone number.
Box 20	Enter a complete description of the item requested, including manufacturer, model, style, etc. DME, orthotics and prosthetics, must provide the brand name, model, and catalog or part number.
Box 21	Enter the HCPCS Procedure Code.
Box 22	Enter the applicable HCPCS Modifier.
Box 25	Enter the beneficiary's primary and secondary diagnoses or the CSHCS qualifying diagnosis (list both the code and description). DME/POS providers must submit the prescription/CMN with this form.
Box 26	Any additional remarks regarding the request should be listed in this box such as verbal authorization date, retroactive date of service if being requested. Provide other insurance coverage for services requested.
Box 28	Must be completed for all requests.

Form Submission

PA request forms and required documentation for all eligible Medicaid beneficiaries must be mailed or faxed to:

MDHHS - Medical Services Administration
Program Review Division
P.O. Box 30170
Lansing, Michigan 48909

Fax Number: (517) 335-0075

To check the status of a PA request, contact the MDHHS - Medical Services Administration, Program Review Division via telephone at **1-800-622-0276.**

AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable programs is sought.

Michigan Department of Health and Human Services

SPECIAL SERVICES
PRIOR APPROVAL – REQUEST/AUTHORIZATION

1. PRIOR AUTHORIZATION NUMBER (MDHHS USE ONLY)

The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.

2. PROVIDER'S NAME (LAST, FIRST, MIDDLE INITIAL)	3. NPI NUMBER	4. PHONE NUMBER
5. PROVIDER'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)		6. FAX NUMBER

7. BENEFICIARY'S NAME (LAST, FIRST, MIDDLE INITIAL)	8. SEX ☐ M ☐ F	9. BIRTH DATE	10. MIHEALTH CARD NUMBER

11. BENEFICIARY'S ADDRESS (NUMBER, STREET, APT./LOT NUMBER, CITY, STATE, ZIP)
12. DOES BENEFICIARY RESIDE IN A NURSING FACILITY? ☐ **YES** ☐ **NO** **IF YES, PROVIDE** FACILITY NAME, ADDRESS, PHONE NUMBER.

13. REFERRING/ORDERING PHYSICIAN'S NAME (LAST, FIRST, MIDDLE INITIAL)	14. NPI NUMBER	15. PHONE NUMBER
16. REFERRING/ORDERING PHYSICIAN'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)		17. FAX NUMBER

18. LINE NO.	19. BRAND NAME, MODEL CATALOG OR PART NUMBER	20. DESCRIPTION OF SERVICE	21. PROCEDURE CODE	22. MODIFIER	23. QUANTITY	24. CHARGE
01						
02						
03						
04						
05						
06						
07						

25. DIAGNOSES (CODES AND DESCRIPTIONS) REQUIRING THE ABOVE SERVICES.	26. ADDITIONAL REMARKS, INCLUDING OTHER INSURANCE COVERAGE, FOR SERVICES REQUESTED.

27. INDICATE ANY OTHER SERVICES PROVIDED TO THIS BENEFICIARY DURING THE PAST YEAR.

28. PROVIDER CERTIFICATION: THE PATIENT NAMED ABOVE (PARENT OR GUARDIAN IF APPLICABLE) UNDERSTANDS THE NECESSITY TO REQUEST PRIOR APPROVAL FOR THE SERVICES INDICATED. I UNDERSTAND THAT SERVICES REQUESTED HEREIN REQUIRE PRIOR APPROVAL AND, IF APPROVED AND SUBMITTED ON THE APPROPRIATE INVOICE, PAYMENT AND SATISFACTION OF APPROVED SERVICES WILL BE FROM FEDERAL AND/OR STATE FUNDS. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY LEAD TO PROSECUTION UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

PROVIDER'S SIGNATURE DATE

MDHHS USE ONLY

29. REVIEW ACTION:				30. CONSULTANT REMARKS
APPROVED	☐	RETURN	☐	
DENIED	☐	NO ACTION	☐	
APPROVED AS AMENDED ☐				

CONSULTANT SIGNATURE DATE

VISION SERVICES APPROVAL/ORDER COMPLETION INSTRUCTIONS FOR DCH-0893

Michigan Department of Health and Human Services

GENERAL INSTRUCTIONS

The DCH-0893 must be used by Medicaid enrolled vision providers to request Prior Approval (PA) and/or order optical hardware for vision services. MDHHS requests that the DCH-0893 be typewritten to facilitate processing. A fill-in enabled copy of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy, Letters & Forms. The request for PA must be complete and of adequate clarity to permit a determination of the appropriateness of the service without examination of the beneficiary. The form is generally self-explanatory. The following instructions are to assist in completing the DCH-0893.

Note:

- If prior authorization is required, attach documentation of medical necessity and the detailed training plan (if applicable) pursuant to the Medicaid Provider Manual.
- If applicable, complete and attach form MSA-0891 (Provision of Low Vision Services and Aids Support Documentation).
- If applicable, complete and attach form MSA-0892 (Documentation of Medical Necessity for the Provision of Contact Lenses).

Item	Instructions
1	MDHHS use only
2 - 3	Related to the ordering provider.
4	Provide the date the service and/or hardware is being ordered.
5 – 7	Related to the ordering provider
8 – 9	Related to the prescribing provider
10	Ordering Provider Signature requires a hand-written signature (i.e., a stamped signature is unacceptable).
11 - 15	Beneficiary information which can be obtained from the mihealth card or, for Children's Special Health Care Services (CSHCS) enrollees, from the Client Eligibility Notice.
16	The diagnosis(es) code(s) reflecting the greatest specificity for the diagnosis(es) from the International Classification of Diseases (ICD). If appropriate, each eye's diagnosis(es) must be included.
17 – 21	Relate to services and materials being requested and applicable charges. • Lines 01 through 07 are available for lenses, frames, and/or special characteristics (e.g., prisms, high adds) or other services (e.g., contact lens, orthoptics), if applicable. • Item 18 (Procedure Code) must reflect the appropriate CPT/HCPCS procedure code. • Item 19 (Modifier) must reflect a valid modifier applicable for the listed procedure code. • Item 20 (Quantity) must reflect the appropriate quantity for each procedure code. Each spectacle lens procedure code represents one lens. When requesting approval for, or ordering, a pair of spectacle lenses using the same procedure code, use a quantity of "2." • Item 21 (Charge) is completed only for items without fee screens requiring prior approval. Enter your usual and customary charge.
22 – 24	Relate to the type/style of lens(es) and frame requested.
25	Enter all lens specifications. The width and style must be consistent with the procedure code appearing in Item 18.
26	Additional instructions to the vision contractor necessary for proper fabrication.
27	Specifications from the beneficiary's previous lens(es). This is applicable for diopter changes or replacements, as well as when requesting frames only. **NOTE:** The only time this item is left blank is for initial spectacles.
28 – 29	MDHHS use only.

Submission Instructions

Prior Approval

PA requests should be received by the MDHHS Vision Contract Manager no more than 30 calendar days from the date of order. If received beyond 30 days, the provider must include a detailed explanation of why the form submission was delayed.

The provider should retain a copy of the completed form for their file and **mail or fax** the DCH-0893 to:

MDHHS Vision Contract Manager
Program Review Division
PO Box 30170
Lansing, MI 48909

Fax: 517-335-0075

Upon completion of the PA process, a copy of the DCH-0893 is returned to the provider.

Optical Hardware Order

Orders placed with the vision contractor must be received no more than 30 calendar days after the date of order. If beyond the 30 days, the contractor will return the order to the provider who must explain to the Medicaid Program Review Division why the form submission was delayed and request an exception from the time limit.

When placing an order with the contractor, the provider should retain a copy of the completed form for their file and submit the DCH-0893 to:

Classic Optical Laboratories
3710 Belmont Avenue
PO Box 1341
Youngstown, OH 44501-1341

Telephone: 888-522-2020
Fax: 888-522-2022
Online Address: http://www.classicoptical.com

Note: Optical hardware orders may also be submitted through an online process with the vision contractor. To utilize on-line submission, contact Classic Optical Laboratories for additional information.

VISION SERVICES APPROVAL / ORDER

Michigan Department of Health and Human Services

1. Prior Authorization Number (MDHHS Use Only)

The provider is responsible for eligibility verification. Approval does NOT guarantee beneficiary eligibility or payment.

2. Ordering Provider Name (Last, First, Middle Initial)	3. Ordering Provider NPI Number	4. Date of Order (MM/DD/YYY)
5. Address (No. & Street, Suite, etc.) City State Zip Code	10. Ordering Provider Certification The patient named below (parent or guardian if applicable) understands the necessity to request vision services and/or prior approval for the vision services indicated. I understand that services requested herein may require prior approval and, if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of material fact may lead to prosecution under applicable Federal and State law. Ordering Provider Signature	
6. Provider Fax Number 7. Provider Phone Number		
8. Individual Prescribing Provider Name (Last, First, Middle Initial)		
9. Individual Prescribing Provider NPI Number		
11. Beneficiary Name (Last, First, Middle Initial)	12. Birth Date	13. mihealth Card Number
14. Beneficiary Address (No. & Street, Apt./Lot #, City, State, Zip Code)	15. Sex ☐ Male ☐ Female	16. ICD Diagnosis Code

	17. Description of Service(S)	R	L	18. Proc. Code	19. Mod.	20. Quantity	21. Charge
01		☐	☐				
02		☐	☐				
03		☐	☐				
04		☐	☐				
05		☐	☐				
06		☐	☐				
07		☐	☐				

Note: If prior authorization is required, attach documentation of medical necessity pursuant to Medicaid Provider Manual.

22. Lens Type: ☐ Plastic ☐ Glass ☐ Polycarbonate ☐ Lens(es) Only ☐ Frame Only

23. Lens Style: ☐ Single Vision ☐ Bifocal ☐ Trifocal ☐ Hi Index ☐ Cataract

24. Frame Name	C-Size	Manufacturer	
Color	Eye Size	Bridge Size	Temple Style & Length

25. LENS SPECIFICATIONS

	SPHERE	CYLINDER	AXIS	PRISM POWER & BASE DIRECTION	MRP	
					HORIZONTAL	HEIGHT
R						
L						
	ADD	SEGMENT HEIGHT	WIDTH & STYLE	SEGMENT INSET	TOTAL INSET	PD
R						Far:
L						Near:

26. Special Instructions to Laboratory:

27. PREVIOUS LENS SPECIFICATIONS

	SPHERE	CYLINDER	AXIS	ADD	PRISM/ DIRECTION	LENS STYLE
R L						

MDHHS USE ONLY

28. Review Action: ☐ Approved ☐ Insufficient Data ☐ Approved as Amended ☐ Denied ☐ No Action

29.Consultant Comments	Initials and Date