Michigan Medicaid Policy | MMP

BULLETIN

BEHAVIORAL AND PHYSICAL HEALTH AND AGING SERVICES ADMINISTRATION

MDHHS

Bulletin Number: MMP 25-09

Distribution: All Providers

Issued: February 28, 2025

Subject: Updates to the MDHHS Medicaid Provider Manual; Psychological and Neuropsychological Evaluation Coverage Responsibility Clarification

Effective: April 1, 2025

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

The Michigan Department of Health and Human Services (MDHHS) has completed the April 2025 update of the online version of the MDHHS Medicaid Provider Manual. The manual will be available April 1, 2025 at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Medicaid Provider Manual.

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

The attachments describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change.

Psychological and Neuropsychological Evaluation Coverage Responsibility Clarification

MDHHS is clarifying coverage responsibility for psychological and neuropsychological evaluations. Psychological and neuropsychological evaluations provided by professionals in the Medicaid Health Plan (MHP) network for mild to moderate conditions remain MHP responsibility. When the assessment is driven by medical need, the MHP is responsible for coverage. The Prepaid Inpatient Health Plan (PIHP) is responsible for further evaluation when severe concerns are suspected and treatment if the beneficiary is determined eligible for PIHP services or becomes engaged with PIHP services due to identified need.

Medicaid fee-for-service (FFS) is responsible for coverage of behavioral health screening including, but not limited to, psychological and neuropsychological screening for FFS beneficiaries when performed by the primary care provider (PCP) or other qualified provider. Psychological and neuropsychological evaluation, assessment, and treatment not included

under the PIHP benefit and/or provided by a non-PIHP enrolled provider is also covered for FFS beneficiaries. The PIHP is responsible for further evaluation and treatment if the FFS beneficiary is determined eligible for PIHP services or becomes engaged with PIHP services due to identified need.

Clarification is being added to the Beneficiary Eligibility subsection of the General Information section within the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of the MDHHS Medicaid Provider Manual.

Manual Maintenance

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

Questions

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

An electronic copy of this document is available at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Approved

Meghan E. Groen, Director
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Medicaid Provider Manual
April 2025 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans	Addition of: **Benefit Plan ID:** HHO **Benefit Plan Name:** Opioid Health Home **Benefit Plan Description:** Substance Use Disorder Health Home, dba Opioid Health Home (HHO), services are intended for Medicaid beneficiaries with a diagnosis of opioid use disorder, alcohol use disorder, stimulant use disorder in addition to having or being at risk of any other chronic condition. Individuals to whom these conditions apply may be determined by the State to be eligible to receive HHO services. HHO services include a personalized care management plan and intense care coordination that addresses the totality of a beneficiary's physical, social, and recovery-oriented needs. **Type:** Managed Care Organization **Funding Source:** XIX **Covered Services:** AI, CQ	
Billing & Reimbursement for Professionals	6.10.A. Reimbursement Considerations and Billing Guidelines	Text was re-titled and re-located as: 6.6 Centering Pregnancy™ Subsections were re-numbered as applicable.	
Behavioral Health and Intellectual and Developmental Disability Supports and Services	1.6 Beneficiary Eligibility	The 2nd paragraph was removed and new text was added. ~~Regarding neuropsychiatric testing, the MHP is responsible for screening by the primary care provider (PCP). The PIHP is responsible for testing, assessment and/or evaluation. If results of the completed testing, assessment and/or evaluation do not determine the need for specialty behavioral health services for serious emotional disturbance (SED) or intellectual/developmental disabilities (I/DD)/Autism, the beneficiary should be referred back to the PCP for treatment or subsequent referral to the appropriate practitioner in the MHP network.~~	Updated language to further define payment responsibility.

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		NOTE: When the assessment is driven by medical need, the MHP is responsible for coverage. Refer to the Practitioner chapter for further information. Psychological and neuropsychological evaluation provided by professionals in the MHP network for mild to moderate conditions (e.g., attention deficit hyperactivity disorder [ADHD], anxiety disorders, obsessive-compulsive disorder [OCD], tic disorders) are the responsibility of the MHP. The PIHP is responsible for further evaluation when severe concerns are suspected (i.e., Autism Spectrum Disorder [ASD], Intellectual Disability and serious emotional disturbance [SED]) and treatment if the beneficiary is determined eligible for PIHP services or becomes engaged with PIHP services due to identified need. If results of the completed screening do not determine the need for specialty behavioral health services such as SED or Autism, the beneficiary should be referred back to the primary care provider (PCP) for treatment or subsequent referral to the appropriate practitioner in the MHP network. Medicaid fee for service (FFS) is responsible for coverage of behavioral health screening including, but not limited to, psychological and neuropsychological screening for FFS beneficiaries when performed by the PCP or other qualified provider. Psychological and neuropsychological evaluation, assessment, and treatment not included under the PIHP benefit and/or provided by a non-PIHP enrolled provider is also covered for FFS beneficiaries. The PIHP is responsible for further evaluation and treatment if the FFS beneficiary is determined eligible for PIHP services or becomes engaged with PIHP services due to identified need. Refer to the Non-Physician Behavioral Health Appendix of this chapter and the Practitioner chapter for additional information regarding program coverage of behavioral health services provided by non-PIHP enrolled providers.	

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	2.3 Location of Service	The 5th paragraph was revised to read: Medicaid does not cover services delivered to beneficiaries with a Serious Mental Illness (SMI) in Institutions for Mental Diseases (IMD) for individuals between ages 21 and 64, as specified in §1905(a)(B) of the Social Security Act when the length of stay in the IMD is more than 15 days during the month. However, per Michigan's 1115 Behavioral Health Demonstration, Medicaid does cover services delivered to beneficiaries with a Substance Use Disorder (SUD) in IMDs for individuals between ages 21 and 64 when the stay in the IMD is more than 15 days during the month. Medicaid does not cover services provided to children with serious emotional disturbance in Child Caring Institutions (CCI) unless it is licensed as a "children's therapeutic group home" as defined in Section 722.111 Sec.1(f) under Act No. 116 of the Public Acts of 1973, as amended, or it is for the purpose of transitioning a child out of an institutional setting (CCI). Medicaid may also be used for the purpose of transitioning a child out of ~~Hawthorn Center~~ a State Hospital. For both the CCI and ~~Hawthorn Center~~ State Hospital, the following mental health services initiated by the PIHP (the child needs to be open to the PIHP/CMHSP) may be provided within the designated timeframes: • The assessment of a child's eligibility and needs for the purpose of determining the community based services necessary to transition the child out of a CCI or ~~Hawthorn Center~~ State Hospital. This should occur up to 180 days prior to the anticipated discharge from a CCI or ~~Hawthorn Center~~ State Hospital . • Intensive Care Coordination with Wraparound (ICCW) planning, case management or supports coordination. This should occur up to 180 days prior to discharge from a CCI or ~~Hawthorn Center~~ State Hospital.	Update.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.21.B. Peer Specialist Services	In the table following the last paragraph, text for **'Supervision Requirements'** was revised to read: ~~The Centers for Medicare & Medicaid Services (CMS) requires that peer support specialists be supervised by a Qualified Mental Health Professional (QMHP) as defined by the Health and Aging Services Administration. The amount, duration and scope of supervision can vary depending on the demonstrated competency and experience of the peer support provider, as well as the service array, and may range from direct oversight to periodic care consultation.~~	Changed due to CMCS new information provided to states.

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		Peer supervisors may include MDHHS certified peers who have over two continuous years in recovery and over two years in the direct provision of services. Other peer supervisors must be credentialed, certified, licensed or degreed in the field within which the peer is working. The following category and information were added to the table: **Continuing Education Requirements**: • Must complete the 32 hours of approved continuing education bi-annually as determined by MDHHS.	Updated from approved requirements in 2023 by MDHHS as the certification body.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.21.C Peer Recovery Coach Services	Text for 'Supervision Requirements' was revised to read: ~~The peer recovery coach shall be supervised by a Substance Abuse Treatment Specialist (SATS) or Substance Abuse Treatment Practitioner (SATP) when in a setting that receives Medicaid reimbursement. Programs funded by the Substance Abuse Block Grant (SABG) and/or Public Act 2 (PA2) funding shall receive ongoing supervision by a case manager, treatment practitioner, prevention staff, or an experienced Certified Peer Recovery Coach who has over two continuous years in recovery and over two years in the direct provision of recovery coach services and supports.~~ Peer supervisors may include MDHHS certified peers who have over two continuous years in recovery and over two years in the direct provision of peer services. Other peer supervisors must be credentialed, certified, licensed or degreed in the field within which the peer is working. The following category and information were added to the table: **Continuing Education Requirements**: • Must complete the 32 hours of approved continuing education bi-annually as determined by MDHHS.	Changed due to CMCS new information provided to states. Updated from approved requirements in 2023 by MDHHS as the certification body.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.24 Prevention Direct Service Models	In the 1st paragraph, the 1st bullet point was revised to read: • ~~Child Care Expulsion Prevention (NOTE: This program is also known as~~ Infant and Early Childhood Mental Health Consultation (IECMHC) In the table in the 2nd paragraph, the first title was revised to read: ~~Child Care Expulsion Prevention (CCEP) (~~Infant and Early Childhood Mental Health Consultation (IECMHC) The 1st and 2nd paragraphs were revised to read: ~~CCEP, an infant and early childhood mental health consultation model,~~ Infant and Early Childhood Mental Health Consultation (IECMHC) provides consultation to child care providers and parents/caregivers who care for children under the age of six who are experiencing behavioral and emotional challenges in their child care settings (non K-12 settings). Sometimes these challenges may put children at risk of suspension and/or expulsion from the child care setting. ~~CCEP~~ IECMHC aims to reduce expulsion and increase the number of parents/caregivers and child care providers who successfully nurture the social and emotional development of children 0-5 in child care settings.	The change in title reflects the current national terminology for this service.

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		~~CCEP~~ IECMHC programs provide short-term child/family-centered mental health consultation for children with challenging behaviors which includes: • Observation and identification of provider capacity to meet the social and emotional needs of the infant, toddler or young child within their care ~~functional assessment at home and at child care~~. • ~~Individualized plan of service developed by a team comprised of the family, child care provider, other identified support person(s) that the family identifies.~~ • Strategies are identified for implementation by the IECMH Consultant in partnership with the childcare providers and Great Start Readiness Program provider and caregivers. • Intervention (e.g., coaching, training and support for parents/caregivers and providers to build their reflective capacity, learn new ways to interact with the child to build their social-emotional skills and resilience, by providing educational resources for parents and providers, modifying the physical environment, connecting family to community resources, providing counseling for families in crisis, and referral for ongoing mental health services, if needed).	Language changes to clarify that the work of the IECMH Consultant is not in conflict with case services coordination or case management.
		In the table in the 2nd paragraph, under **'Infant Mental Health'**, the 1st paragraph was revised to read: Provides home-based parent-infant support and therapeutic intervention services, using the evaluated Infant Mental Health Home Visiting model (perinatal people, birth to 36 months), to families where the parent's condition and life circumstances, or the characteristics of the infant, threaten the parent-infant attachment and the consequent social, emotional, behavioral and cognitive development of the infant. Services reduce the incidence and prevalence of abuse, neglect, developmental delay, behavioral and emotional disorder and promote healthy attachment, resilience and optimal mental health for both the infant and parent/primary caregiver. PIHPs or their provider networks may provide infant mental health services, in the home or community based setting, as a specific service when it is not part of a MDHHS-certified home-based program.	This model is therapeutic, and language added clarifies this intervention. The Infant Mental Health Home Visiting model delineates all the therapeutic components of the model for perinatal people and their infant/toddler, up to 36 months of age. Clarification of location of services to home or community-based setting is added to ensure that families are being serviced in natural settings.

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		In the table in the 2nd paragraph, under **'Parent Education**, text was revised to read: Provided to parents using evaluated/evidence-based practice group models that promote nurturing parenting attitudes and skills, teaching developmental stages of childhood (including social-emotional developmental stages), teach positive approaches to child behavior/discipline and interventions the parent may utilize to support healthy social and emotional development, and to remediate problem behaviors. For specific group models of Parent Education, a parent with lived experience may be trained in the model and work in partnership with the Child Mental Health Professional who is trained in the delivery of the Parent Education model. Provider qualifications: • Child Mental Health Professional who is trained in the evaluated/evidence-based practice group model. • Parent with lived experience who is trained in the model and works with the Child Mental Health Professional in the delivery of the model.	Most evaluated models are "evidence-based practice models." The addition of the parent with lived experience to partner with the Child Mental Health Professional in the implementation of parent education aligns with the Bureau's policy on Family Driven-Youth Guided.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	12.2 Medication Assisted Treatment (MAT)	The 3rd paragraph was revised to read: The State assures that ~~Methadone~~ Medications for Opioid Use Disorder (MOUD) for MAT is provided by Opioid Treatment Programs (OTPs) that meet the requirements in 42 CFR Part 8.	Updates were made to reflect current language, as well as changes to 42 CFR Part 8 that impact Opioid/Narcotic Treatment Programs.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	12.2.A. MAT Methadone Within OTPs	The subsection title was revised to read: MAT ~~Methadone~~ MOUD Within OTPs	

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Behavioral Health and Intellectual and Developmental Disability Supports and Services	12.2.A.1. Provision of Services	Text was revised to read: ~~Opiate~~ Opioid-dependent beneficiaries may be provided chemotherapy using ~~methadone~~ MOUD as ~~an adjunct to~~ a treatment service. Provision of such services must meet the following criteria: • Services must be provided under the supervision of a physician licensed to practice medicine in Michigan. • The physician must be licensed to prescribe controlled substances, as well as licensed to work at ~~a methadone program~~ an OTP. • The ~~methadone~~ MOUD component of the substance ~~abuse~~ use disorder treatment program must be: ➢ licensed as such by the state; ➢ certified by the Division of Pharmacologic Therapies/Center for Substance Abuse Treatment (DPT/CSAT); ➢ licensed by the Drug Enforcement Administration (DEA); and ➢ accredited by a DPT/CSAT and state-approved accrediting organization (The Joint Commission [TJC] and the Commission on Accreditation of Rehabilitation Facilities [CARF]). • ~~Methadone~~ MOUD must be administered by an appropriately-licensed MD/DO, physician assistant, nurse practitioner, clinical nurse specialist, registered nurse, licensed practical nurse, or pharmacist.	
Behavioral Health and Intellectual and Developmental Disability Supports and Services	12.2.A.2. Covered Services	The 1st bullet point was revised to read: • ~~Methadone~~ Medications for Opioid Use Disorder (MOUD)	

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Behavioral Health and Intellectual and Developmental Disability Supports and Services	12.2.A.3. Eligibility Criteria	The 1st and 2nd paragraphs were revised to read: Medical necessity requirements shall be used to determine the need for ~~methadone~~ MOUD as ~~an adjunct~~ a treatment and recovery service. All ~~six~~ dimensions of the American Society of Addiction Medicine (ASAM) Criteria must be addressed:	
Behavioral Health and Intellectual and Developmental Disability Supports and Services	12.2.A.4. Continuum of Care	The 1st, 2nd, and 3rd paragraphs were revised to read: Decisions to admit an individual for ~~methadone~~ MOUD maintenance must be based on medical necessity criteria, satisfy the LOC determination using the ~~six~~ dimensions of the ASAM Criteria, the person meets diagnostic criteria for a moderate to severe opioid use disorder (OUD); the individual has an active moderate to severe OUD, or OUD in remission, or is at high risk for recurrence or overdose ~~and have an initial diagnostic impression of opioid dependency for at least one year based on current DSM criteria~~. Admission procedures require a screening examination to ensure that the patient meets criteria for admission and that there are no contraindications to treatment with MOUD. A full physical examination must be completed within 14 calendar days following an individual's admission to the OTP. ~~This examination must include a medical assessment to confirm the current DSM diagnosis of opioid dependency of at least one year, as was identified during the screening process.~~ The physician may refer the individual for further medical assessment as indicated. Consistent with the LOC determination, individuals requesting ~~methadone~~ MOUD must be presented with all appropriate options for substance use disorder treatment, such as:	

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		Under '**Special Circumstances for Admissions'**, and then under **'Pregnant Women'**, the 5th and 6th bullet points were revised to read: • OTPs must obtain informed consent from pregnant women, and all women admitted to ~~methadone~~ MOUD treatment who may become pregnant, stating that they will not knowingly put themselves and their fetus in jeopardy by leaving the OTP against medical advice. • Because ~~methadone~~ MOUD and ~~opiate~~ opioid withdrawal are not recommended during pregnancy due to the increased risk to the fetus, the OTP shall not discharge pregnant women without making documented attempts to facilitate a referral for continued treatment with another provider. Under '**Special Circumstances for Admissions**', the category for **'Pregnant Adolescents'** was removed. Under '**Special Circumstances for Admissions**', the category for **'Non-Pregnant Adolescents'** was re-titled as **'~~Non-Pregnant~~ Adolescents'**. Text was revised to read: • ~~An individual under 18 years of age is required to have had at least two documented unsuccessful attempts at short-term detoxification and/or drug-free treatment within a 12-month period to be eligible for maintenance treatment.~~ • No individual under ~~18~~ 14 years of age may be admitted to maintenance treatment unless a parent, legal guardian, or responsible adult (designated by the relevant state authority) consents, in writing, to such treatment.	

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		~~Minors under 15 years of age must also have the permission of the State Opioid Treatment Authority and the Drug Enforcement Administration. (Refer to Administrative Rules for Substance Use Disorder Service Programs in Michigan, R 325.14409(5).)~~ ➢ ~~A copy of this signed informed consent statement must be placed in the individual's medical record.~~ ➢ ~~This signed consent is in addition to the general consent that is signed by all individuals receiving methadone and must be filed in their medical record. (Refer to 42 CFR subpart 8.12(e)(2).)~~	

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		Under **'Medical Maintenance Phase'**, the 1st[t] paragraph and the 1st and 2nd bullet points were revised to read: When the maximum therapeutic benefit of counseling has been achieved, it may be appropriate for the individual to enter the medical maintenance (~~methadone~~ medication only) phase of treatment and recovery; that is if it has been determined that ongoing use of the medication is medically necessary and appropriate for the individual. The following criteria are to be considered when making the decision to move to medical maintenance: • ~~Two years of continuous treatment.~~ • ~~Abstinence from illicit drugs and from abuse of prescription drugs~~ Absence of active substance use disorders for the period indicated by federal and state regulations ~~(at least two years for a full 30-day maintenance dosage)~~. Under **'Discontinuation/Termination Criteria'**, the 1st paragraph and the 1st bullet point were revised to read: Discontinuation/termination from ~~methadone~~ MOUD treatment refers to the following situations: • Beneficiaries must discontinue treatment with ~~methadone~~ MOUD when treatment is completed with respect to both the medical necessity for the medication and for counseling services.	

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		Under **'Completion of Treatment'**, text was revised to read: The decision to discharge a beneficiary must be made by the OTP's physician, with input from clinical staff, the beneficiary, and the parent, legal guardian, or responsible adult (designated by the relevant state authority/CPS). Completion of treatment is determined when the beneficiary has fully or substantially achieved the goals listed in their individualized treatment and recovery plan and no longer needs ~~methadone~~ MOUD as a medication. As part of this process, a reduction of the dosage to a medication-free state (tapering) should be implemented within safe and appropriate medical standards. Under **'Administrative Discontinuation'**, the 2nd paragraph was revised to read: Non-compliance is defined as actions exhibited by the beneficiary which include, but are not limited to: • ~~The repeated or continued use of illicit opioids and non-opioid drugs (including alcohol).~~ • Toxicology results that do not indicate the presence of methadone metabolites. (The same actions are taken as if illicit drugs, including non-prescribed medication, were detected.) ~~In both of the aforementioned circumstances,~~ OTPs must perform toxicology tests for methadone metabolites, opioids, cannabinoids, benzodiazepines, cocaine, amphetamines, and barbiturates ~~(Administrative Rules for Substance Use Disorder Service Programs in Michigan, R 325.14406)~~. OTPs must test the beneficiary for alcohol if use is prohibited under their individualized treatment and recovery plan or the beneficiary appears to be using alcohol to a degree that would make dosing unsafe. • Repeated failure to submit to toxicology sampling as requested.	

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		~~• Repeated failure to attend scheduled individual and/or group counseling sessions, or other clinical activities such as psychiatric or psychological appointments.~~ • Failure to manage medical concerns/conditions, including adherence to physician treatment and recovery services and use of prescription medications that may interfere with the effectiveness of ~~methadone~~ MOUD and may present a physical risk to the individual. • Repeated failure to follow through on other treatment and recovery plan related referrals. (Repeated failure should be considered on an individual basis and only after the OTP has taken steps to assist beneficiaries to comply with activities.) Under **'Administrative Discontinuation'**, in the 3rd paragraph, the 4th bullet point was revised to read: • Diversion of controlled substances, including ~~methadone~~ MOUD Under **'Administrative Discontinuation'**, in the 4th paragraph, the 2nd bullet point was revised to read: • **Enhanced Tapering Discontinuation -** This involves an accelerated decrease of the ~~methadone~~ MOUD dose (usually by 10 mg or 10 percent a day). The manner in which ~~methadone~~ MOUD is discontinued is at the discretion of the OTP physician to ensure the safety and well-being of the beneficiary.	

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Behavioral Health and Intellectual and Developmental Disability Supports and Services	14.3.H.1. Coverage	In the last paragraph, text after the 5th bullet point was revised to read: • OHSS is not intended to ~~compensate or~~ supplant services, such as respite, for the relief of the primary caregiver or legal guardian living in the same home ~~or to replace a parent's obligations and parental rights of minor children living in a family home~~. • OHSS is not intended to replace a parent's or legal guardian of a minor's obligations and parental rights of minor children living in a family home. • OHSS is not an alternative to inpatient psychiatric treatment or other appropriate levels of care to meet the beneficiary's needs and is not available to prevent potential suicide or other self-harm behaviors.	The language change is to provide clarity in terms of when OHHS cannot be used.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	15.1.J. Overnight Health and Safety Supports (OHSS)	In the last paragraph, text after the 5th bullet point was revised to read: • OHSS is not intended to ~~compensate or~~ supplant services, such as respite, for the relief of the primary caregiver or legal guardian living in the same home ~~or to replace a parent's obligations and parental rights of minor children living in a family home~~. • OHSS is not intended to replace a parent's or legal guardian of a minor's obligations and parental rights of minor children living in a family home. • OHSS is not an alternative to inpatient psychiatric treatment or other appropriate levels of care to meet the beneficiary's needs and is not available to prevent potential suicide or other self-harm behaviors.	
Behavioral Health and Intellectual and Developmental Disability Supports and Services	21.3 Enrollment (Section 21 – Certified Community Behavioral Health Clinic Demonstration)	Text was revised to read: All eligible Medicaid beneficiaries will be automatically enrolled into the CCBHC benefit plan. ~~CCBHCs and Prepaid Inpatient Health Plans (PIHPs) have the authority to add~~ Additional beneficiaries may be added as appropriate. Non-Medicaid individuals are not automatically enrolled in the CCBHC benefit plan but should be tracked using encounter reporting and other methods outlined in the CCBHC Demonstration Handbook. MDHHS reserves the right to review and verify all enrollments.	Language error; clarification of the enrollment process.

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Behavioral Health and Intellectual and Developmental Disability Supports and Services	21.6.A. Agreements with CCBHCs	Text was revised to read: A formal relationship is evidenced by a contract, Memorandum of Agreement (MOA), Memorandum of Understanding (MOU), or such other formal arrangements describing the parties' mutual expectations and establishing accountability for services to be provided and funding to be sought and utilized. ~~The CCBHC maintains clinical responsibility for the services provided for CCBHC consumers by the DCO.~~ CCBHC maintains responsibility for ensuring the DCO complies with CCBHC requirements, including compliance with contracted services delivered and financial components of the demonstration.	Language update to be consistent with CCBHC Handbook and corresponding federal certification language.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	21.8 Reporting Requirements	Text was revised to read: CCBHCs are responsible for the reporting of encounter data, clinical outcomes data, quality data, and other data as federally required or requested by MDHHS. ~~MDHHS will require the PIHP to collect, maintain, and organize CCBHC reporting data; MDHHS will also require the PIHP to send all reports to MDHHS in accordance with state and federally defined timelines.~~ Data will be used to assess the impact of the demonstration on access to services, quality and scope of services, and costs of providing a comprehensive array of behavioral health services.	Language updated to more accurately reflect flexibility in who submits demonstration-related reporting.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	21.8.A. Cost Reporting	Text was revised to read: CCBHCs must submit an annual cost report with supporting data to ~~the PIHP and~~ MDHHS. Cost reports and supporting data are based on CCBHC financial records and must follow the templates provided by the state. When reporting costs, the CCBHC must adhere to the 45 Code of Federal Regulations (CFR) §75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for the U.S. Department of Health and Human Services (HHS) Awards and 42 CFR §413 Principles of Reasonable Cost Reimbursement. The CCBHC records must be detailed, orderly, complete, and available for review or audit.	Language updated to more accurately reflect flexibility in who submits demonstration-related reporting.

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Behavioral Health and Intellectual and Developmental Disability Supports and Services – Children with Serious Emotional Disturbances Home and Community-Based Services Waiver Appendix	2.7.A. Coverage	In the last paragraph, text after the 5th bullet point was revised to read: • OHSS is not intended to ~~compensate or~~ supplant services, such as respite services, for the relief of the primary caregiver or legal guardian living in the same home ~~or to replace a parent's obligations and parental rights of minor children living in a family home~~. • OHSS is not intended to replace a parent's or legal guardian of a minor's obligations and parental rights of minor children living in a family home. • OHSS is not an alternative to inpatient psychiatric treatment or other appropriate levels of care to meet the beneficiary's needs and is not available to prevent potential suicide or other self-harm behaviors.	
Early and Periodic Screening, Diagnosis and Treatment	6.6 Tobacco, Alcohol or Drug Use Assessment	The 1st sentence was revised to read: A tobacco, alcohol or drug use assessment must be performed annually at each preventive health care well child visit beginning at 11 years of age and as indicated by the AAP periodicity schedule or when there are circumstances suggesting the possibility of substance abuse beginning at an earlier age.	Request to include referencing AAP periodicity schedule language vs. updating language per new 2024 AAP periodicity schedule.
Hospital	Section 1 – General Information	The 1st paragraph was revised to read: This chapter applies to services provided to Fee for Service (FFS) beneficiaries in an inpatient and/or outpatient hospital setting unless otherwise indicated. Medically necessary services provided to Medicaid beneficiaries by an enrolled hospital are generally covered by Medicaid, administered through the Michigan Department of Health and Human Services (MDHHS). The attending provider is the individual who has the primary responsibility for the treatment and care of the beneficiary. Depending on the setting and professional licensure regulations, the specific provider type can vary. Services described in this chapter must also be available to Medicaid Health Plan (MHP) enrollees; however, the MHPs may implement different authorization and service criteria. For billing purposes, a revenue code is identified as a specific accommodation, ancillary service or billing calculation for all institutional claims.	Correction.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Hospital Reimbursement Appendix	Section 1 – Outpatient	The last paragraph was revised to read: Reimbursement for outpatient hospital services will be monitored and adjustments will be made to the MDHHS reduction factor, as necessary, to ensure spending limits fall within the MDHHS appropriation. A wage index of 1.0 is applied for all hospitals. Medicare's APC weights are utilized. Services reimbursed at a percent of charges are paid a percentage of the individual hospital's charges for the service (i.e., pass-through payments). Updates of hospitals' Medicaid cost-to-charge ratios are done in conjunction with updates to the inpatient operating ratios. The default Medicaid cost-to-charge ratio is the average statewide Medicaid outpatient cost-to-charge ratio for out-of-state ratios. To maintain budget neutrality, CAHs that convert to rural emergency hospitals will retain the enhanced OPPS reduction factor for reimbursement.	Clarification.
Hospital Reimbursement Appendix	1.7 Outlier Payments	Text was revised to read: MDHHS follows Medicare's APC outlier payment policy. The MDHHS reduction factor is not applied to outlier payments. Submitted charges are used for all lines on a claim, including the packaged lines, for outlier calculations.	Clarification.
Hospital Reimbursement Appendix	1.8 Services Paid a Percent of Charges	Text was revised to read: Services that are paid a percent of charges are paid at a percentage of the hospital's charges for that service (e.g., pass-through payments). Each hospital's current Medicaid outpatient cost-to-charge ratio is used for the initial OPPS implementation. Updates of the Medicaid outpatient cost-to-charge ratios are done in step with inpatient operating ratio updates. For out-of-state hospitals, the default Medicaid cost-to-charge ratio is the average statewide Medicaid outpatient cost-to-charge ratio. The MDHHS reduction factor is not applied to services paid a percent of charge.	Clarification.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Laboratory	4.13 Specimen Collection	In the 1st paragraph, the following bullet point was added: • Specimens obtained by the Local Health Department (LHD) for blood lead analysis sent to the State Laboratory or outside clinical laboratory that is CLIA-certified to perform blood lead analysis. Refer to the Local Health Department chapter for additional information. The 2nd[d] paragraph was revised to read: Procedure code 36415 (routine venipuncture for collection of specimen[s]) must be used when billing Medicaid for the drawing, packaging, and mailing of the blood sample. LHDs may report either capillary or venipuncture for blood lead draws. Only one collection fee for each beneficiary encounter, regardless of the number of specimens drawn, will be allowed. Blood specimen collection may only be billed when the laboratory is not owned, operated, or financially associated with the provider site in which the specimen was collected.	Clarification.
Maternal Infant Health Program	2.12 Childbirth Education	The following paragraph was added: Refer to the Hospital Chapter for additional information regarding coverage requirements for childbirth education.	Clarification.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Maternal Infant Health Program	2.19 Authorization for Program Exceptions	The 1st paragraph was revised to read: In limited situations, when beneficiary needs surpass outlined MIHP program parameters, the MIHP Operations Team may recommend additional visits for MIHP services, as required, in the following circumstances: • Initiation of services for a child over 12 months of age; • Continuation of services beyond 18 months of age (e.g., to assist beneficiaries facing end-of-life concerns (mother or infant) or in cases where an alternative program is unfeasible); ~~and~~ • Professional observation indicating that a beneficiary will benefit from MIHP services after being assessed with no risks using the appropriate program assessment tool (Risk Identifier).; and • Maternal professional visit during a NICU stay following the mother's discharge from labor and delivery stay.	Clarification.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Non-Emergency Medical Transportation	Section 3 – Transportation Authorization	The 4th, 5th, and 6th paragraphs were revised to read: Reimbursement for special ~~transportation~~ allowances requires a completed Medical Verification for Transportation (DHS-5330) to serve as documentation of medical need and must be retained in the beneficiary's file. Special ~~transportation~~ allowances includes medically needing a wheelchair lift-equipped vehicle, Medi-Van vehicle, attendant, ~~prior authorization,~~ and other special circumstances supported by medical documentation. ~~(For prior authorization requirements, refer to the Prior Authorization (PA) section of this chapter.)~~ Medicaid FFS authorizing parties may accept the submission of a complete DHS-5330 form via fax and secure email. Transportation providers and beneficiaries may submit original forms if they choose, but sending original forms is not required for authorization. Providers and beneficiaries are encouraged to keep an original or copy of forms submitted to MDHHS for reimbursement. ~~The~~ A DHS-5330 must be completed annually. A local MDHHS office can authorize NEMT without a DHS 5330 for beneficiaries who do not require special ~~transportation~~ allowances. Additionally, verification of medical need is not required when the transportation is to obtain medical evidence (i.e., employability, incapacity, or disability) or to meet the needs of children for protective services. An initial verification of medical need for special ~~transportation~~ allowances is required by the beneficiary's primary care physician (PCP). A completed DHS-5330 signed by the beneficiary's PCP, or a physician's assistant or nurse practitioner working under the supervision of the PCP, serves as documentation of medical need and must be retained in the beneficiary's file. In situations when a beneficiary's PCP, or a physician's assistant or nurse practitioner working under the supervision of the PCP, is unavailable and unable to complete a DHS-5330 in a timely manner, another licensed provider may complete the form. Example providers include, but are not limited to, a physician specialist, clinical nurse specialist, certified nurse midwife, registered nurse, social worker, dentist, and other licensed providers. The licensed provider must be knowledgeable about the beneficiary's medical needs, capable of accurately completing the form, and providing direct medical, behavioral or dental services to the beneficiary.	Removing references to Special Transportation and replacing with Special Allowances as well as removing references to Prior Authorization.

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CHAPTER	SECTION	CHANGE	COMMENT
Non-Emergency Medical Transportation	Section 8 – Prior Authorization (PA)	The 1st paragraph was revised to read: Transportation may require PA in certain situations. The PA request must be submitted in writing before the service is provided unless an urgent situation exists and the circumstances are documented. Payment authorization will not be given for PA requests submitted more than 30 days after the service is provided. The PA request, along with the DHS-5330 (when required), must be submitted to the PRD for review. (Refer to the Directory Appendix for contact information.) Prior authorization may be requested for up to six months for prolonged treatment requiring multiple transports.	
Nursing Facility Certification, Survey & Enforcement Appendix	5.19 Immediate Jeopardy	Text after the 2nd paragraph was revised to read: Adjusted annually, Civil Money Penalties (CMP) of $3,050 to $10,000 per day will be imposed for each day an Immediate Jeopardy was identified before removal. Following removal of the Immediate Jeopardy, CMPs will continue until the facility is found to be in substantial compliance but will be selected from a lower fine range of $50 to $3,000 per day. The upper range of CMPs will apply for a minimum of one day, even if the Immediate Jeopardy is removed immediately after identification and notification. No CMP will apply on the day the facility is determined to be in substantial compliance. The SSA may consider using a Per Instance Civil Money Penalty of $1,000 to $10,000, adjusted annually, when the beginning date of the deficiency cannot be determined, or when a Civil Money Penalty is combined with other enforcement actions, e.g., a discretionary denial of payment for new admissions, directed plan of correction, or directed in-service training. Pursuant to 42 CFR §488.430(a), multiple per instance CMPs may be imposed for the same type of noncompliance and per instance CMPs (PI-CMPs) and per day CMPs (PD-CMPs) to be imposed on the same survey.	CMS issued final rule in August of 2024 which allows for both per instance and per day CMPs to be applied concurrently.
Nursing Facility Certification, Survey & Enforcement Appendix	5.21 Opportunity to Correct	The last paragraph was revised to read: LARA may impose ~~either~~ a per day Civil Money Penalty, ~~or~~ a per instance Civil Money Penalty, or both for past noncompliance, for days of noncompliance after the finding is made, or a combination thereof. Amounts will be determined by LARA based on facility history, repeating deficiencies, high numbers of deficiencies, culpability of the provider, failure to achieve or maintain substantial compliance, and for increasing noncompliance.	CMS issued final rule in August of 2024 which allows for both per instance and per day CMPs to be applied concurrently.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Cost Reporting & Reimbursement Appendix	6.1.A. Required Information	In the 2nd paragraph, the 5th bullet point was revised to read: • Medicaid Cost Report with supporting documentation for cost finding statistics utilized on the report, including appropriate approved time study information where applicable	Clarification.
Nursing Facility Cost Reporting & Reimbursement Appendix	13.5 Minor Equipment	The 1st paragraph was revised to read: Where minor equipment is concerned, the SMA recognizes that the inventory costs of such equipment may not truly reflect the cost of equipment purchased and in use by the nursing facility provider. Differences in the capitalization policies of providers and their desire to limit property record controls over certain classes of small assets cause variations in the recorded costs of assets generally considered depreciable. Medicaid will only recognize an appropriate amount for minor equipment costs where the original equipment acquisition cost was recorded in the accounting records as capital asset cost and had not previously recorded the minor equipment acquisition as current period operations expense. If the cost was capitalized on the financial statements, then it must be reported on Worksheet 3.	Update to the cost report instructions.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Nursing Facility Level of Care Determination	3.8 Passive Redetermination of Functional Eligibility	Text was revised to read: Providers are responsible for reassessing LOCD eligibility prior to the End Date of the current LOCD or when there is a significant change in the beneficiary's condition. The Minimum Data Set (MDS) ~~for nursing facility residents~~ and interRAI Home Care Assessment System (iHC) ~~for MI Choice Waiver Program participants~~ contain items that correspond to the items in the LOCD. Under certain conditions, MDHHS will use a passive redetermination process based upon information from the beneficiary's most recent assessment and program enrollment or admission. When this ~~assessment~~ data is available, MDHHS will apply an algorithm that uses the common assessment items to allow CHAMPS to generate a new LOCD for the beneficiary. ~~Currently, passive redetermination is only available to nursing facility residents, including those in the MI Health Link program, and MI Choice Waiver program participants because MDHHS does not have electronic assessment data available for PACE or the MI Health Link HCBS waiver program. When MDHHS has electronic assessment data from those programs, MDHHS will use the passive redetermination process to allow CHAMPS to generate a new LOCD for the beneficiary.~~ An LOCD generated by CHAMPS can be adopted by all LTSS programs.	All provider types (MI Choice, PACE, MI Health Link and nursing facilities) are submitting electronic assessment data to MDHHS.
Pharmacy	Section 1 – General Information	The last paragraph was revised to read: Throughout this chapter, the terms Medicaid and MDHHS are used to refer to ~~the~~ Michigan Medicaid FFS, Healthy Michigan Plan, CSHCS, and MOMS programs~~,~~ and to Plan First Family Planning benefit plans unless otherwise noted.	Adding benefit plans to clarify the sentence.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Practitioner	5.5 Observation Care	The 1st paragraph was revised to read: Medicaid covers practitioner evaluation and management services related to hospital observation care. Observation care services are a well-defined set of specific, clinically-appropriate hospital outpatient services. Professional services include the ongoing short-term treatment, assessment, and reassessment necessary to determine whether a beneficiary will require further treatment as a hospital inpatient or if they are able to be discharged from the hospital. In most cases, the decision whether to discharge a beneficiary from the hospital or to admit the beneficiary as an inpatient can be made in less than 24-48 hours. ~~the length of time of the observation stay~~	Correction.
Practitioner Reimbursement Appendix	3.2 Eligible Primary Care Services	The following bullet points were removed: • ~~99324 through 99337 for new and established patient domiciliary, rest home or custodial care E/M services~~ • ~~99441 through 99443 for non-face-to-face telephone E/M services.~~	Update to accommodate deletion of code set 99324-99337 and 99441-99443 by the CPT® Editorial Panel effective 1/1/2023 and 12/31/2024, respectively.
Special Programs	7.5.A. Other Billing Considerations	The 3rd paragraph was revised to read: When billing for a telemedicine session, synchronous or asynchronous, MiDPP providers are expected to adhere to current MDHHS telemedicine policy ~~and modifiers~~ as found in the Telemedicine Chapter of this manual. Refer to the Michigan Medicaid Telemedicine Fee Schedule for the list of current codes acceptable for MiDPP telemedicine claims. (Refer to the Directory Appendix for fee schedule website information.)	
Therapy Services	1.7 Therapy for Beneficiaries with Autism Spectrum Disorder	Subsection was relocated; re-numbered as 4.5.	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Therapy Services	1.7 Other Insurance	New subsection text reads: 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. Providers should refer to the Coordination of Benefits chapter for more information. Medicaid is not liable for payment of services denied because coverage rules of the primary health insurance were not followed.	Contains information previously found in: 4.1.G. Prescription Requirements (OT) 4.2.G. Prescription Requirements (PT) 4.3.E. Prescription Requirements (SLT)
Therapy Services	2.7 Physical Therapists, Occupational Therapists, and Speech-Language Pathologists Private Practice	Text was revised to read: 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 proprietor, partnership, or group practice. These providers are eligible for direct reimbursement.	
Therapy Services	Section 3 – Prior Authorization Requests	The 1st paragraph was revised to read: Prior authorization is required for certain therapy services before the services are rendered, dependent upon the Standards of Coverage for each provider type. To determine which therapy services require prior authorization, and when, refer to the Standards of Coverage and Service Limitations section of this chapter, the Medicaid Code and Rate Reference tool in CHAMPS, and/or the MDHHS Therapies Database on the MDHHS website. (Refer to the Directory Appendix for website information.)	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Therapy Services	3.1 Form and Completion Instructions	Text after the 1st paragraph was revised to read: 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 required signatures and 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 facility address, and the provider's billing 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~~ must be submitted with the appropriate therapy modifier to distinguish the discipline under which the service is being requested. When the therapy is habilitative, a modifier that represents the nature of the therapy being requested must also be reported. Requests for maintenance therapy services should also contain the appropriate maintenance modifier. Refer to the Billing & Reimbursement Chapters for additional modifier information. ~~For all Medicaid Fee-for-Service (FFS) beneficiaries, the MSA-115 must be mailed or faxed to the MDHHS Program Review Division. Providers can check the status of a prior authorization request in CHAMPS or by contacting the MDHHS Program Review Division via telephone. (Refer to the Directory Appendix for website and contact information.)~~ ~~Prior authorization requests may also be submitted electronically via FFS Direct Data Entry (DDE) in CHAMPS. (Refer to the General Information for Providers chapter of this manual for additional information.) A copy of the MSA-115 must be attached to each electronic prior authorization request.~~	

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CHAPTER	SECTION	CHANGE	COMMENT
		For all Medicaid Fee-for-Service (FFS) beneficiaries, prior authorization requests should 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 PA request. Prior authorization requests (MSA-115) may also be faxed or mailed to the MDHHS Program Review Division. Providers can check the status of a PA request in CHAMPS or by contacting the MDHHS Program Review Division via telephone. (Refer to the Directory Appendix for website and contact information.) A copy of the prior authorization determination letter must be retained in the beneficiary's medical record.	
Therapy Services	3.2 Emergency/Verbal Prior Authorization	The 1st and 2nd paragraphs were revised to read: 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 the initiation of a therapy service is required during MDHHS nonworking hours, providers ~~must contact~~ may perform the service and call the Program Review Division by the end of 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."~~	
Therapy Services	Section 4 – Standards of Coverage and Service Limitations	Section 4 – Standards of Coverage and Service Limitations was re-formatted. Text was re-formatted into three (3) individual sections: • Section 5 – Occupational Therapy • Section 6 – Physical Therapy • Section 7 – Speech Language Therapy)	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Therapy Services	Section 4 – Special Coverage Considerations (new section)	New section text reads: Services under this section must also meet the requirements outlined within the occupational, physical, and speech-language therapy sections of this chapter. The following reflects subsection new location numbering. Note indicates previous location of policy: 4.1 Duplication of Services (*previously found in 4.1, 4.2, and 4.3)* 4.3 Serial Casting (*previously found in 4.1 and 4.2)* 4.4 Supplies, Equipment, and Room Costs (*previously found in 4.1, 4.2, and 4.3)* 4.5 Therapy for Beneficiaries with Autism Spectrum Disorder (*previously found in 1.7)* 4.6 Access to Services for School-Aged Beneficiaries (*previously found in 4.1, 4.2, and 4.3)* 4.7 Aquatic Therapy (*previously found in 4.1 and 4.2)* 4.8 Group Therapy (*previously found in 4.1, 4.2, and 4.3)* 4.9 Co-Treatment Therapy (*previously found in 4.1, 4.2, and 4.3)* 4.9.A. Prior Authorization (*previously found in 4.1, 4.2, and 4.3)* 4.9.B. Billing Requirements (*previously found in 4.1, 4.2, and 4.3)*	
Therapy Services	4.2 Telemedicine (new subsection)	New subsection text reads: Medicaid allows select therapy services to be provided via telemedicine when performed by private practice and outpatient hospital therapy providers. Services allowed via telemedicine will be represented by applicable CPT/HCPCS codes from the telemedicine fee schedule. Therapy services provided via telemedicine are intended to be an additional treatment tool and complement in-person services where clinically appropriate for the individual beneficiary. Refer to the Telemedicine Chapter, Physical Therapy, Occupational Therapy, and Speech Therapy Services subsection, for additional information regarding telemedicine services.	Clarifying information from bulletin MMP 23-10.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Therapy Services	Section 5 – Occupational Therapy (new section)	Section contains policy information previously located under Section 4 - Standards of Coverage and Service Limitations. Due to re-formatting of the chapter, this new section includes the following subsections specific to Occupational Therapy: • 5.1 Standards of Coverage and Service Limitations • 5.2 Prescription Requirements • 5.3 Service Requirements These subsections may contain revisions to text. Providers should also reference the Special Coverage Considerations section for additional policy which was re-located.	
Therapy Services	Section 6 – Physical Therapy (new section)	Section contains policy information previously located under Section 4 - Standards of Coverage and Service Limitations. Due to re-formatting of the chapter, this new section includes the following subsections specific to Physical Therapy: • 6.1 Standards of Coverage and Service Limitations • 6.2 Prescription Requirements • 6.3 Service Requirements These subsections may contain revisions to text. Providers should also reference the Special Coverage Considerations section for additional policy which was re-located.	

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Therapy Services	Section 7 – Speech-Language Therapy (new section)	Section contains policy information previously located under Section 4 - Standards of Coverage and Service Limitations. Due to re-formatting of the chapter, this new section includes the following subsections specific to Speech-Language Therapy: • 7.1 Standards of Coverage and Service Limitations • 7.2 Prescription Requirements • 7.3 Service Requirements • 7.4 Evaluations and Follow-Up for Speech-Generating Devices/Voice Prostheses These subsections may contain revisions to text. Providers should also reference the Special Coverage Considerations section for additional policy which was re-located.	
Acronym Appendix		Addition of: ADHD - attention deficit hyperactivity disorder CMCS - Center for Medicaid and CHIP Services IECMHC - Infant and Early Childhood Mental Health Consultation MOUD – Medications for Opioid Use Disorder OCD - obsessive-compulsive disorder PD-CMP - per day Civil Money Penalty PI-CMP - per instance Civil Money Penalty	
Acronym Appendix		Removal of: ~~MMA - Magellan Medicaid Administration, Inc.~~	Magellan is now Prime Therapeutics, LLC.

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Medicaid Provider Manual
April 2025 Updates

BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MMP 24-33 (NOTE: This is in addition to those reported in the January 2025 update (MMP 24-33)	8/30/2024	Ambulance	2.9 Non-Emergency	The text box at the end of the subsection was removed. ~~MDHHS pays for MHP enrolled beneficiaries on a fee-for service (FFS) basis only if the non-emergency transport was medically necessary and was for Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) related services. When submitting claims, providers are to enter in the Remarks section that the ambulance transport was to receive PIHP/CMHSP services.~~
		Non-Emergency Medical Transportation	Section 3 – Transportation Authorization	The 2nd paragraph was revised to read: The Medicaid program contracts with Medicaid Health Plans (MHPs) and Integrated Care Organizations (ICOs), selected through a competitive bid process, to provide services to Medicaid beneficiaries. MHPs and ICOs are responsible for providing NEMT services to their enrollees for all Medicaid covered services ~~covered under the managed care contract~~. (For additional information, refer to the Medicaid Health Plans and MI Health Link chapters of this manual.)

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MMP 24-41	8/30/2024	Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.31 Wraparound Services for Children and Adolescents	The subsection title was revised to read: ~~Wraparound~~ Intensive Care Coordination with Wraparound (ICCW) Services for Children and Adolescents Subsection text was revised to read: ~~NOTE: Wraparound is an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) State Plan service when delivered to children/youth under 21 years of age.~~ ~~Wraparound is not exclusive to children/youth served under the SEDW; however, all children/youth being served under the SEDW must be enrolled in and receiving Wraparound services. Participation in the SEDW for children/youth and their families is voluntary. Wraparound is mandatory for children/youth and their families if they choose to participate in the SEDW.~~ ~~Wraparound is an individualized, holistic, comprehensive, youth-guided, and family-driven planning process. This voluntary process utilizes a collaborative team consisting of the child/youth and their family, physical and mental health providers, other child-serving systems, natural and professional supports, and community partners that are involved with the child/youth and family. The planning process follows four stages: Hello-Engagement and team preparation, Help-Initial plan development, Heal-Implementation, and Hope-Transition.~~

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				ICCW is an evidence-informed approach to ensuring comprehensive coordination and holistic planning for children, youth, young adults, and their families with the most intensive needs. ICCW is an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) State Plan service when delivered to children, youth, and young adults under 21 years of age. ICCW requires the development of a Wraparound Team. The Team must be coordinated prior to the development of and adjustments to the Wraparound Plan. Wraparound Teams include, but are not limited to, the youth, child, or young adult and their family, natural supports, professional supports, and community partners. In the limited circumstance in which a child, youth, young adult, or parent/caregiver is unable to attend a Wraparound Team meeting, Care Coordinators are responsible for ensuring voice and choice. When a child, youth, or young adult is being served under the Waiver for Children with Serious Emotional Disturbances (SEDW), ICCW is recommended to support the child, youth, young adult and their family through the planning process. At the preference of the child/youth, young adult and their family, Targeted Case Management (TCM) may be utilized instead of ICCW. Care Coordination includes organization, coordination, linkage, monitoring of services and supports, and advocacy on behalf of the child, youth, or young adult and their family. Coordination and collaboration span across multiple systems, programs, and resources in alignment with systems of care philosophy. Wraparound is the individualized, family-driven and youth-guided planning process facilitated by Care Coordinators that are trained and certified in the Wraparound Planning Process.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				The Wraparound Planning Process follows four stages: 1) Hello-Engagement and Team preparation, 2) Help-Initial plan development, 3) Heal-Implementation, and 4) Hope-Transition. The Wraparound Planning Process utilizes a collaborative Wraparound Team approach including a child, youth, or young adult and their family and their choice of professional and natural supports. Care Coordinators facilitate the Wraparound plan development, considering all life domains. The Child and Family Team's plan is built on strengths and driven by underlying needs. The plan provides realistic strategies to meet meaningful, measurable and attainable outcomes that the Child and Family Team develop. Ongoing evaluation of the Child and Family Team's plan occurs during each Child and Family Team meeting and adjustments are made as needed. ~~Children/youth and families served in Wraparound shall meet two or more of the following criteria:~~ • ~~Children/youth who are involved in multiple child/youth serving systems.~~ • ~~Children/youth who are at risk of out-of-home placements or are currently in out-of-home placement.~~ • ~~Children/youth who have received other mental health services with minimal improvement in functioning.~~ • ~~The risk factors exceed capacity for traditional community-based options.~~ • ~~Numerous providers are working with multiple children/youth in a family and the identified outcomes are not being met.~~ ~~Targeted Case Management cannot be authorized when Wraparound is authorized. Case management functions through home-based services may not be reimbursed when Wraparound is authorized.~~

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				Children, youth, or young adults, birth to age 21, are eligible for ICCW if they meet all the following criteria: • Serious Emotional Disturbance, Serious Mental Illness, and/or Intellectual/Developmental Disability; • Presenting with complex behavioral needs; and • Have an identified community. AND two or more of the criteria listed below: • Currently in or at risk of out-of-home placement. • Involved in two or more child, youth, or young adult-serving systems, including but not limited to: Mental/Behavioral Health, Juvenile or Adult Criminal Justice, Child Welfare, Adult Protective Services, Education (special education or other school support services). • Has received other case management or case management-like services, and higher intensity is required to meet needs. • Lack of an identified support system. • Presenting with complex medical needs and stabilization has not been reached. • Has a functional impairment related to school activities, attendance, or performance. This includes, but is not limited to, experiencing multiple suspensions and/or expulsions. • Displays significant physical and/or emotional distress after experiencing a traumatic event. Traumatic events may include, but are not limited to, natural disasters, acts of violence, abuse, neglect.

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BULLETINS INCORPORATED*

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
				TCM cannot be authorized in the Individual Plan of Service (IPOS) when ICCW is authorized in the IPOS. Home-based services and ICCW may be authorized concurrently. Case-management functions performed through home-based services may not be billed at the same, specific date/time that ICCW is also being billed to avoid same-time duplication of services. ~~Medicaid providers must request and receive MDHHS approval through a certification process defined by MDHHS prior to Wraparound provision. Certification must occur every three years. Programs are to be certified to ensure adherence to Medicaid policy requirements and fidelity to the Wraparound model.~~
			3.31.A. Organizational Structure	Subsection text was revised to read: The required organizational structure of Wraparound ICCW must include a Child and Family Team, ~~Wraparound facilitator~~ ICCW Care Coordinator, ~~Wraparound~~ ICCW supervisor, and Community Team. • ~~Wraparound Facilitator~~ ICCW Care Coordinator Caseload Ratio (dedicated caseload): ➢ ~~10 Total Wraparound Child and Family Teams~~ ➢ ~~12 Total Wraparound Child and Family Teams if at least 2 of the 10 Wraparound Child and Family Teams (mentioned above) are in the Hope phase of the planning process.~~ ➢ 1:12 Care Coordinator to Wraparound Teams. ➢ The dedicated ratio may increase to a maximum of 1:15 when at least three Wraparound Teams are in the Hope phase.

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				➢ Care Coordinators may not have more than one provider role with a family. If Care Coordinators are providing other mental health services, including crisis response, they may not provide ICCW to the same child, youth, or young adult and their family. ➢ If coordinators are assigned to other programs as well as ICCW, the number of child/youth and family teams they facilitate shall correlate to the percentage of their position dedicated to providing Wraparound facilitation. • ~~Wraparound Facilitator Caseload Ratio (mixed caseload):~~ ➢ ~~15 Total children/youth across all services and programs (including the 10-12 Wraparound Child and Family Teams).~~ ➢ ~~20 Total children/youth across all services and programs (including the 10-12 Wraparound Child and Family Teams) if less than 5 of the 10-12 Child and Family Teams are in the Hello or Help phase.~~ ➢ ~~Wraparound facilitators may not have more than one provider role with any one family (i.e., may not be both the home-based therapist and Wraparound facilitator for the same child/youth and family).~~ ➢ ~~If facilitators are assigned to other programs as well as Wraparound, the number of Wraparound child/youth and family teams they facilitate shall correlate to the percentage of their position dedicated to providing Wraparound facilitation.~~ • ICCW providers must request approval to provide ICCW from MDHHS through a certification process defined by MDHHS, and certification must occur every three years. Programs must be certified to ensure adherence to Medicaid policy requirements and fidelity to the ICCW model.

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			3.31.B. Qualified Staff	Subsection text was revised to read: ~~Wraparound facilitators~~ ICCW Care Coordinators must: • ~~Complete the MDHHS New Facilitator training within 90 days of hire. The Medicaid encounter cannot be reported until after completion of the initial training unless provisional approval has been applied for and granted by MDHHS.~~ ➢ ~~Provisional approval is granted upon submission of a completed provisional approval application that must be signed by the Wraparound facilitator, Wraparound supervisor, and Wraparound administrator. The Wraparound facilitator must also complete, submit, and pass a provisional approval test.~~ • ~~Complete a minimum of two MDHHS Wraparound trainings per calendar year.~~ • ~~Demonstrate proficiency in facilitating the Wraparound process, as monitored by their supervisor.~~ • ~~Participate in and complete MDHHS required evaluation and fidelity tools.~~ • ~~Possess a bachelor's degree in any field and be a CMHP or be supervised by a CMHP.~~ • ~~Wraparound facilitators and those who provide supervision to facilitators will attend additional training (16 hours) related to provision of support to children/youth and their families served in the waiver annually as required by MDHHS.~~

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				• Possess a minimum of a bachelor's degree in any field. • Receive certification in ICCW through MDHHS-provided training or have been granted provisional approval prior to provision. • Maintain certification in ICCW: ➢ Complete one annual ICCW booster. ➢ Complete at least two MDHHS-provided trainings related to ICCW. ➢ Complete an additional 16 hours of training (annually) related to provision of support to children, youth, or young adults and their families when providing ICCW to those served under the SEDW. • Participate in and complete MDHHS-required evaluation and fidelity measurements. • Provide full scope of ICCW and facilitate the Wraparound Planning Process to model fidelity to develop a Wraparound Plan. • Participate in Person-Centered Planning Process training, including Self Determination. • Facilitate the Person-Centered Planning Process in alignment with family-driven and youth-guided guidelines in adherence to applicable policy to develop an Individual Plan of Service (IPOS). • Obtain certification in MichiCANS if responsible for the completion of the annual MichiCANS. • Demonstrate knowledge of State Plan and SEDW service array and community resources and programs. • Attend Community Team meetings as needed to support their Wraparound Teams. • Care Coordinators may not have more than one provider role with a family. If Care Coordinators are providing other mental health services, including crisis response, they may not provide ICCW to the same child, youth, or young adult and their family.

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				• If coordinators are assigned to other programs as well as ICCW, the number of child/youth and family teams they facilitate shall correlate to the percentage of their position dedicated to providing Wraparound facilitation. ~~Wraparound~~ ICCW supervisors shall: • ~~Wraparound supervisors must be certified in Wraparound prior to service provision and/or supervision of Wraproud facilitators.~~ • ~~The responsibility for directing, coordinating, and supervising the staff/program shall be assigned to a specific staff position which meets the requirements of a Child Mental Health Professional (CMHP).~~ • ~~Attend two MDHHS Wraparound trainings annually, one of which shall be a Wraparound supervisor-specific training.~~ • ~~Participate on the Community Team.~~ • ~~Provide individualized, weekly supervision and coaching to the Wraparound staff and maintain a supervision log. Supervision logs will be available at site reviews and re-enrollment. Supervision logs should show evidence of ongoing evaluation of each component for all Wraparound phases, periodic review of documentation, and quarterly (at minimum) review of progress toward outcomes.~~ • ~~Ensure documentation of attendance at required trainings is maintained for all Wraparound staff and available for review upon request.~~ • ~~Wraparound facilitators and those who provide supervision to facilitators will attend additional training (16 hours) related to provision of support to children/youth and their families served in the waiver annually as required by MDHHS.~~

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				• Oversee ICCW, including evaluation. • Receive/process referrals and assign children, youth, or young adults and their families to Care Coordinators. • Adhere to policies/procedures that align with ICCW. • Organize and facilitate Community Team meetings quarterly, at minimum. • Be designated as a Child Mental Health Professional (CMHP) (when overseeing provision to SED youth) and/or Qualified Intellectual Disabilities Professional (QIDP) (when overseeing provision to Intellectual/Developmental Disabilities [I/DD] youth). • Participate in Person-Centered Planning Process training, including Self Determination. • Obtain certification in MichiCANS if providing supervision to a Care Coordinator who is responsible for completion of the annual MichiCANS. • Receive certification in ICCW through MDHHS-provided training prior to supervision of Care Coordinators. • Maintain certification in ICCW: ➢ Complete one annual ICCW booster. ➢ Complete at least two MDHHS-provided trainings related to ICCW, one of which must be supervisor specific. ➢ Complete an additional 16 hours of annual training related to provision of support to children, youth, or young adults and their families when supervising the provision of ICCW to those served under the SEDW.

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				• Provide weekly, individualized supervision and coaching to Care Coordinators and maintain a supervision log. • Maintain partnership with child, youth, or young adult and family community programs, systems, and partners. • Ensure Care Coordinators have knowledge of State Plan and SEDW service array and community resources and programs. • Ensure families and staff have access to a directory of community resources, systems, and programs. ICCW Program Administrators shall: • Attend ICCW 101 Training. • Attend one annual ICCW booster. • Provide direct oversight of ICCW Supervisors. • Provide local oversight of ICCW. • Align internal policies and procedures, contracts and/or memorandums of understanding with Wraparound philosophy and ICCW policy. • Broker services as needed. • Secure local partnership with child, youth, or young adult and family community programs, systems and partners.

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				The Community Team shall: • ~~Include representation from system partners, other child serving agencies and local community agencies.~~ • ~~Provide support to Wraparound staff, supervisors, and child/youth and family teams and address barriers and needs to improve outcomes for children, youth and families.~~ • ~~Work as a collaborative body to improve community service delivery to children, youth and families.~~ • ~~Provide support to other child serving community agencies who are experiencing challenges meeting the needs of children, youth and families with complex needs.~~ • ~~Implement additional activities and responsibilities that reflect the individual needs of the community.~~ • Include children, youth, young adults and parents/caregivers with lived experience and local system and community partners. • Work collaboratively to address barriers, provide support, and identify available community services and programs for children, youth, and families.
			3.31.C. Amount and Scope of Service	Text was revised to read: • ~~Child and Family Teams shall meet once per week, at minimum, during the Hello and Help phases.~~ • ~~Child and Family Teams shall meet twice monthly, at minimum, during the Heal phase. The Heal phase begins once the plan has been developed and the team agrees stabilization has been achieved.~~ • ~~Child and Family Teams shall meet monthly, at minimum, during the Hope phase. The Hope phase begins when the team agrees that the child/youth and family are ready to graduate from the Wraparound process.~~

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				Amount of Service: • Wraparound Teams shall meet once per week, at minimum, during the Hello and Help phases. • Wraparound Teams shall meet twice monthly, at minimum, during the Heal phase. The Heal phase begins once the plan has been developed and the Team agrees stabilization has been achieved. • Wraparound Teams shall meet monthly, at minimum, during the Hope phase. The Hope phase begins when the Team agrees that the child, youth, or young adult and family are ready to graduate from the Wraparound Planning Process and no longer show a need for ICCW. • When a child, youth, or young adult is in placement and the Care Coordinator is facilitating transition planning back to the home and community, the meeting frequency may reflect the needs of the child, youth, or young adult. Only upon Wraparound Plan development or adjustment may the frequency of Team meetings decrease. ➢ Upon discharge, frequency of meetings should align with the phase that the Wraparound Team is in. • The Care Coordinator must review services at intervals defined in the Individual Plan of Service (IPOS). A formal review of the IPOS shall not occur less often than annually to review progress toward goals and objectives and to assess beneficiary satisfaction. • Frequency and scope (face-to-face and telephone) of other ICCW monitoring activities must reflect the intensity of the child, youth or young adult's health and welfare needs.

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				Scope of Service: • Ensure child, youth, or young adult and their family understand the ICCW and the Wraparound Planning Process. When SEDW is being utilized, orient child, youth, or young adult and their family to the SEDW process and service array. • Ensure documentation from other service providers and systems partners (physicians, medication prescribers, mental health, education, child welfare, juvenile justice, community services, etc.) involved with the child, youth, or young adult and their family is available and utilized to support identified needs. • Coordinate communication among service providers and systems partners (physicians, medication prescribers, mental health, education, child welfare, juvenile justice, community services, etc.) who are involved with the child, youth, or young adult and their family. • Ensure child, youth, or young adult and their family are linked to relevant supports, community service providers and systems partners to expand support network and address identified needs. • Support and empower the Wraparound Team to advocate on behalf of the child, youth, or young adult and family. • Ensure child, youth, or young adult and their family and Wraparound Team have access to informational material that supports the ability to address identified needs (guidance on navigation of specific services or systems, psychoeducation materials, parent education materials, etc.). • Ensure Intake has been completed or is scheduled to be completed. • Ensure service provider is providing all medically necessary services that the child, youth, or young adult and their family choose and taking appropriate action when those services are unavailable.

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				• Facilitate the brokerage of services and supports as identified through the Wraparound Planning Process. • Ensure Family-Driven, Youth-Guided Process is included to develop the IPOS. • Utilize the Wraparound Planning Process to ensure successful transition of the child, youth, or young adult back into their home and community. • Facilitate the Wraparound Planning Process with model fidelity to the MDHHS model to develop and update the Wraparound Plan as needed or required. • Facilitate the Family-Driven, Youth-Guided Process to develop and complete annual updates to the IPOS. • Ensure an annual MichiCANS is completed by the appropriate entity.
			3.31.D.1. Telemedicine	Text was revised to read: • ~~The following requirements apply to the child/youth and their parents/primary caregivers. Professional and natural supports may join Child and Family Team meetings either in-person or via simultaneous audio/visual telemedicine during all phases, according to the preference of the child/youth and their parents/primary caregivers.~~ • All Child and Family Team meetings are to be provided in-person during the Hello and Help phases.

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				• Child and Family Team meetings may be provided either in-person or via simultaneous audio/visual telemedicine during the Heal and Hope phases, according to the preference of the child/youth and their parents/primary caregivers, with the following exceptions: ➢ Development of the transition plan (Hope phase) is to be completed in-person. ➢ Graduation activities (Hope phase) are to be completed in-person. ➢ Child and Family Team meetings are to be provided in-person for the first 60 days upon a child/youth transitioning back to their home and community from out-of-home placement. ➢ In-person Child and Family Team meetings are to be provided once per month, at minimum, for children/youth served under the SEDW during both the Heal and Hope phases.
			3.31.D.2. Child Caring Institutions (CCI) and State Hospitals	Text was revised to read: • ~~Wraparound services are~~ ICCW is covered by Medicaid for up to 180 days while in placement for the purpose of transition back to the community; Wraparound must be suspended once the child/youth has been placed for more than 180 days. When Wraparound-enrolled children/youth are placed at a CCI, including a Qualified Residential Treatment Program (QRTP), or State Hospitals, transition planning should begin immediately in conjunction with the Wraparound Child and Family Team and facility staff.

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				➢ ~~Children/youth meeting eligibility criteria for Wraparound should be referred to the Wraparound provider and/or Community Mental Health Services Program (CMHSP) in the community in which the child/youth resides. Children/youth that are in a CCI, including QRTPs, or State Hospitals, and not enrolled in Wraparound, should be referred to the Wraparound provider and/or CMHSP in the community in which the child/youth will be residing.~~ ➢ A child, youth, or young adult who meets eligibility criteria for ICCW should be referred to the service planning provider in the community in which they reside. ➢ The ~~Wraparound provider~~ Care Coordinator will work with the child/youth and their caregiver(s) to develop a Child and Family Team. The Child and Family Team will work collaboratively with facility staff and other child-serving systems to facilitate a comprehensive and holistic plan of services and supports that will enable the child/youth to return to their community. • The child/youth must have an identified ~~home and~~ community to transition. • Medicaid does not cover services provided to persons/children involuntarily residing in non-medical public facilities (such as jails, prisons or juvenile detention facilities). Refer to the Program Requirements section, Location of Services subsection of this chapter for additional information regarding provision within a CCI and ~~Hawthorn Center~~ State Hospitals.

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			3.31.E. Child and Family Team Plan and Wraparound Planning Process	Text was revised to read: ~~The Child and Family Team's plan shall reflect a family-driven/youth-guided approach, and shall include the following: individualized, strength-based, measurable outcomes and action-step strategies to meet the needs of the child/youth and family. Services and supports identified in the Wraparound planning process shall be available to the child/youth and family and provided as outlined in the plan.~~ The Wraparound Planning Process must be provided with fidelity in accordance with the MDHHS ICCW model. The Person-Centered Planning Process must be provided according to MDHHS policy, including Family Driven and Youth Guided policy. The Safety/Crisis Plan, Wraparound Plan and the Individual Plan of Service (IPOS) are the resulting plans from the utilization of the Wraparound Planning Process and the Person-Centered Planning Process. The Wraparound plan should drive development and/or adjustment of the IPOS. The following planning process activities and supporting documentation shall be completed for each child/youth and family: • ~~Safety/Crisis Plan~~ • ~~Family Vision Statement~~ • ~~Needs Assessment~~ • ~~Strengths Narrative~~ • ~~Child and Family Team Mission Statement~~ • ~~Child and Family Team Plan~~ • ~~Child and Family Team Meeting Minutes~~ • ~~Transition Plan~~ • ~~Graduation Summary~~

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				Safety/Crisis Plan • Safety/Crisis Plans must be developed upon the initial meeting with the child, youth, or young adult and their family. • Existing Safety/Crisis Plans are to be reviewed with the child, youth, or young adult and their family following initial utilization and as needed to determine if modifications are necessary. • Safety/Crisis plans must be developed with fidelity to the MDHHS Wraproud model. **Wraparound Plan** • The Wraparound Plan must be developed within 30 days of initial service provision. • The Wraparound Plan's strategies are to be reviewed at each Team meeting, and Team adjustments to strategies are to be completed by the Care Coordinator. • The Wraparound Plan's outcomes are to be reviewed at least monthly, and Team adjustments to the Plan are to be completed by the Care Coordinator. • Wraparound Plan elements must be developed with fidelity to the MDHHS Wraparound model to ensure fidelity.

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				Individual Plan of Services (IPOS) • The IPOS Pre-Plan must be developed in the Wraparound Team meeting during the Hello phase. ➢ The annual IPOS Pre-Plan must be developed within the Wraparound Team meeting. • The IPOS must be developed in the Help phase following development of the Wraparound Plan. If there is an existing IPOS, it must be updated to reflect the newly developed Wraparound Plan. Each service provider is responsible for providing the narrative for their clinical intervention. • The annual IPOS must be developed within the Wraparound Team meeting, driven by the existing Wraparound Plan. Each service provider is responsible for providing the narrative for their clinical intervention. • IPOS elements must comply with Michigan Administrative Code R330.7199 requirements. **Wraparound Team Meeting Minutes** • Meeting minutes must be developed following each Wraparound Team meeting and distributed to all Wraparound Team members. • Meeting minutes elements must comply with documentation requirements for MDHHS Wraparound model fidelity monitoring.

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				Graduation Summary • The Graduation summary must be completed within the last month of the Hope phase and distributed to the child, youth, or young adult, and their family. • The Graduation summary elements must be developed with fidelity to the MDHHS Wraparound model.
			3.31.F. Evaluation and Outcomes Measurement	Text was revised to read: The enrolled provider will comply with the State of Michigan ~~Wraparound~~ ICCW evaluation requirements. Current evaluation requirements are: • ~~MDHHS requires the timely and thorough completion of (1) the Family Status Report (initially, quarterly, upon graduation, and one additional follow-up time), (2) Team Membership form (quarterly and upon changes), and (3) Fidelity form (at 6 and 12 months).~~ ➢ ~~"One additional follow-up time" refers to the Family Status Report that is required to be completed for children/youth and their families 3- 6 months after transition to ensure improvements have been maintained, that the child/youth is stable, and the family is adequately supported.~~ • The enrolled ICCW provider will comply with MDHHS ICCW evaluation requirements as determined by the department. • Additional evaluation tools will be completed as identified and requested by MDHHS. • Adherence to ~~Wraparound~~ ICCW model fidelity may be reviewed at enrollment, re-enrollment, and at technical assistance visits through file review, family interviews, and evaluation and fidelity tools.

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		Behavioral Health and Intellectual and Developmental Disability Supports and Services – Children With Serious Emotional Disturbances Home and Community-Based Services Waiver Appendix	Section 2 – Covered Waiver Services	The 1st paragraph was revised to read: Each beneficiary must have a comprehensive Wraparound Plan and IPOS that specify the services and supports that the beneficiary and family will receive. The Wraparound Plan is to be developed through the Wraparound Planning Process. Each beneficiary must have a Wraparound Facilitator who is responsible to assist the beneficiary/family in identifying, planning and organizing the Child and Family Team, developing the Wraparound Plan, and coordinating services and supports. (Refer to the ~~Wraparound~~ Intensive Care Coordination with Wraparound (ICCW) Services for Children and Adolescents section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of this Manual for additional information.)
			2.11 Wraparound Services	The 1st paragraph was revised to read: (Refer to the ~~Wraparound~~ Intensive Care Coordination with Wraparound (ICCW) Services for Children and Adolescents subsection of the Covered Services section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of this Manual.)
MMP 24-49	10/31/2024	Community Transition Services	Section 2 – Beneficiary Eligibility for Community Transition Services	The 4th bullet point was revised to read: • meet one of the following: ➢ be at risk of inappropriate institutionalization due to being served in an institution but do not meet the level of care for that institution; ~~or~~ ➢ indicate on the Freedom of Choice form that they no longer choose to receive long term services and supports in an institutional setting; or ➢ the beneficiary does not currently reside in a nursing facility or other institution but is at risk of returning to the nursing facility without the provision of CTS.

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			Section 3 – Covered Services	Text was revised to read: To qualify for CTS, beneficiaries must receive monthly monitoring and at least one of the transition services outlined in the Transition Navigation Case Management subsection of this chapter every three months. Transition services are not available through a self-directed arrangement.
			3.2 Community Transition Services	In the 2nd paragraph, the 1st[t] bullet point was revised to read: • Security deposits and fees for community living~~, including fees for a birth certificate, credit checks, or housing application fees required to obtain a lease on an apartment or home~~,
			3.5 Home and Community-Based Services Personal Care	The 3rd paragraph was revised to read: ~~HCBS Personal Care Services provided while the beneficiary is in the institution are limited to a one- to three-day trial period in the community-based residence.~~ Claims for this service will not be billed until the beneficiary has transitioned to the community.

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			3.6 100% State Funded Services (new subsection; following subsection was re-numbered)	New subsection text reads: MDHHS allows the following services to be provided to beneficiaries when they are necessary to facilitate a transition to the community. These services are not eligible for Federal Financial Participation. • First month's rent. • Payment of delinquent debt that interferes with securing a home in the community. • A limited quantity of groceries. • Fees necessary for community living, including fees for a birth certificate, credit checks, or housing application fees required to obtain a lease on an apartment or home. • Non-emergency, non-medical transportation while in the institution which is limited to visiting potential community-based residences and travel to businesses or agencies to address barriers to community-based living. Examples include going to the bank to open an account or the local Secretary of State office to obtain a State Identification Card. • Appliances necessary for community-based living. • Court costs for adding or removing guardianship or conservatorship. • Personal Care Services provided while the beneficiary is in the institution. These are limited to a one- to three-day trial period in the community-based residence.

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			7.3 Prior Authorization	Text was revised to read: The prior authorization process is used to approve a specific reimbursement rate for one-time items/services received by a beneficiary. The nature of some CTS makes them inappropriate for fee or frequency screens. There may be instances when a beneficiary has a legitimate need for an item or service that is more expensive than the fee or frequency screen allows. ~~In these situations, the prior authorization process is used to approve a specific reimbursement rate for items/services received by a beneficiary.~~ Procedure codes must be submitted along with the prior authorization request. Until CHAMPS is programmed to accept prior authorizations for CTS, the Exceptions Process in the NFT Portal must be used. ~~Once functionality exists in CHAMPS, the prior authorization request will be entered and submitted into CHAMPS.~~ Claims for all Medicaid-eligible beneficiaries must be submitted in CHAMPS. Providers will use the Professional Invoice claim. Claims may be submitted into CHAMPS via direct data entry or 837P files. Refer to the General Information for Providers and the Billing & Reimbursement for Providers chapters of this manual for claim submission instructions.

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			7.4 Examples of Non-Billable Services or Tasks	Text was revised to read: Some tasks performed by transition agencies are not billable. Some examples of these tasks are: • TN travel time (non-face-to-face visits) • TN time off (sick leave, vacation) • Unsuccessful attempts to contact the beneficiary or others on their behalf • Staff meetings and trainings • Contact with support staff within the agency • Filing • Reviewing case files for quality assurance • Activities provided by anyone who does not qualify as a TN • Fees for community living
MMP 24-50	11/20/2024	Federally Qualified Health Centers	2.4 Advisory Committee on Immunization Practices (ACIP) Vaccines	Text was revised to read: FQHCs providing Advisory Committee on Immunization Practices (ACIP) recommended vaccines for beneficiaries 19 years of age and older in FQHC settings will be reimbursed outside of the Prospective Payment System (PPS) methodology. Reimbursement for ACIP recommended vaccines will be made up to the applicable Medicaid fee screen rates. Refer to the Medical Clinics and/or Federally Qualified Health Centers databases on the MDHHS website or the Medicaid Code and Rate Reference tool for additional information. (Refer to the Directory Appendix for website information.) FQHCs obtaining vaccines at a lower than normal cost through the 340B Program must report the 340B acquisition price on the claim.

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MMP 24-53	11/19/2024	Nursing Facility Level of Care Determination	3.6 Verification Review of LOCD	The 1st paragraph was revised to read: The purpose of the verification review (LOCD-VR) is to determine if the LOCD was conducted properly according to policy and resulted in the correct deterstmination of eligibility. A randomly selected sample of LOCDs will be reviewed by MDHHS or its designee. CHAMPS will randomly select a statistically significant sample of LOCDs entered in the system. Upon submission of the LOCD in the system, CHAMPS will immediately notify the provider if the LOCD was selected for review with a pop-up message. The provider is required to submit all relevant documentation used to support the LOCD including, but not limited to, observation notes, assessment reports, physician orders or notes, caregiver reports, cognitive test results, time studies, nursing or case management notes, intervention reports, or evidence of other medical or community services provided. The related CHAMPS LOCD Application ID must be indicated on all documents for tracking purposes. Documents must be uploaded electronically in CHAMPS within ~~one business~~ four calendar days of the LOCD being selected for verification review in CHAMPS.
			3.8.A. LOCD Doors Addressed by Passive Assessment	Text was revised as follows: Door 5: The passive redetermination process cannot confirm ~~all~~ the criteria.
MMP 24-54	11/19/2024	Nursing Facility Certification, Survey & Enforcement Appendix	2.3 Criteria for Evaluation of Medicaid Bed Certification Applications	Subsection text was replaced in its entirety. New text reads as follows: The State Medicaid Agency (SMA) (MDHHS Behavioral and Physical Health and Aging Services Administration [BPHASA]) will collaborate with the State Survey Agency (SSA) (Department of Licensing and Regulatory Affairs [LARA]) when making a determination regarding the approval or denial of any application for Medicaid bed certification and provider enrollment. MDHHS will grant Medicaid bed certification if the application meets all the following:

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				• A verification from the SSA that the beds listed in the applications are Medicare-certified. • The SSA finds that the facility named in the application is in substantial compliance with federal regulations at the time of application. • If there is an accepted submitted plan of correction for any survey activity occurring following the date of the application submission, the facility named in the application will be deemed to have satisfactory survey performance.
			2.4.D. Bed Certification Process for a New Nursing Facility or Newly Licensed Nursing Facility Beds	The following text was added: Medicaid may enter into a provisional enrollment with a provider (or the owner or management company) that does not meet the above criteria if: • The applicant and the owner or management company take actions acceptable to MDHHS to correct, improve or remedy any conditions or concerns that would result in denial of the application; and • The applicant and the owner or management company attains and maintains compliance with the criteria above during the period of the provisional Medicaid enrollment. Failure of the provider to comply with the terms of the conditional agreement will result in termination without appeal of the provisional Medicaid enrollment.
MMP 24-55	11/27/2024	Nursing Facility Cost Reporting & Reimbursement Appendix	6.1.J. Retroactive Rate Changes	In the 1st paragraph, the 3rd bullet point was removed: • ~~For those providers that were retrospectively settled because they were granted Rate Relief.~~
			10.2 Retroactive Rate Changes	In the 1st paragraph, the last bullet point was removed: • ~~Class I nursing facilities approved for Rate Relief for the rate year period.~~

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			10.5.C. Class Average Variable Costs (AVC)	The 1st paragraph was revised to read: The Class Average Variable Cost is defined as the total indexed variable costs for all facilities in the Class divided by the total resident days for all facilities in the class for a cost reporting year. An AVC is calculated for Class I and Class III nursing facilities. The Class AVC is used for rate calculations for nursing facilities that meet the qualifying criteria as a new provider for Medicaid participation. ~~and determining provider eligibility for Class I nursing facility rate relief.~~
			10.5.D.1. Class I Nursing Facility VCL Exception – New Provider Rate Relief	The subsection was deleted in its entirety.

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			10.14 Rate Relief for Class I Nursing Facilities (The following subsection was re-numbered.)	The subsection was deleted in its entirety. Includes the following subsections: • 10.14.A. Eligibility Criteria • 10.14.B. Rate Relief Petition Process • 10.14.C. Rate Relief Agreement • 10.14.D. Rate Relief Period • 10.14.E. Withdrawal of Rate Relief Agreement • 10.14.F. Rate Relief Appeals • 10.14.G. Rate Relief for a New Provider in a Medicaid-Enrolled Nursing Facility With a Variable Rate Base Less Than or Equal to 80 Percent of the Class Average Variable Cost • 10.14.G.1. Rate Relief Methodology • 10.14.H. Rate Relief for a Current Provider or a New Provider in a Medicaid Enrolled Nursing Facility With a Variable Rate Base Between 80 Percent and 100 Percent of the Class Average Variable Cost • 10.14.H.1. Rate Relief Methodology • 10.14.I. Rate Relief for a Current Provider in a Medicaid Enrolled Nursing Home Facility With a Variable Rate Base Less Than or Equal to 60 Percent of the Variable Cost Limit • 10.14.I.1. Rate Relief Methodology
		Directory Appendix	Nursing Facility Resources	'Contact/Topic' information was revised as follows: Nursing Facility Forms & Instructions, Calculation Examples~~, Rate Relief Worksheet~~

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MMP 24-56	11/27/2024	Hospital Reimbursement Appendix	7.1.A. Indigent Volume Data and Disproportionate Share Hospital Eligibility Form	The 2nd paragraph was revised to read: The Indigent Volume (IV) worksheet is to be completed as part of the hospital's annual Medicaid Cost Report and returned to MDHHS. The Medicaid Cost Report will not be accepted without the IV worksheet. Effective state fiscal year 2024, the DSH Eligibility Status Verification form for discontinued DSH pools is not required.
			7.2 Regular DSH Payments	The following text was added: Effective State Plan rate year 2024, the DSH pools and methodology described in the Regular DSH Payments section are discontinued.
			7.3 Special DSH Payments	The following text was added: Effective State Plan rate year 2024, the special DSH pools and methodology described in the Special DSH Payments section are discontinued.
			7.5 Disproportionate Share Hospital (DSH) Process	The following text was added as the 1st paragraph: Effective State Plan rate year 2024, DSH payments will be limited to the Institute for Mental Diseases (IMD) pool. All other regular and special DSH Pools will be discontinued effective State Plan rate year 2024.

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				Under 'Step 1. Initial DSH Calculation', the 2nd paragraph was revised to read: MDHHS will share Initial DSH Calculations with hospitals. Non-IMD hospitals will be able to decline DSH funds following the Initial DSH Calculation findings. If a hospital declines DSH funds during the Initial DSH Calculation step, the decision is irrevocable and the hospital is not eligible for any DSH funds for that state FY. Hospitals may also request a downward adjustment to their DSH ceiling during the Initial DSH Calculation step. Upon receipt of this feedback from hospitals, each hospital's calculated DSH ceiling will be reduced to the requested amount. No hospital will receive a DSH payment in excess of its initial DSH ceiling.
MMP 24-58	11/27/2024	Medical Supplier	Section 1 – Program Overview	In the 6th paragraph, the following term/definition was added to the table: **Complex Rehabilitation Technology (CRT) Equipment** CRT equipment is a subcategory of DME that can be individually configured to meet the medical/functional needs of beneficiaries with complex physical or functional limitations (e.g., traumatic brain injury, amyotrophic lateral sclerosis, spina bifida, etc.). CRT equipment includes specialized manual and power wheelchairs with additional options/accessories, adaptive seating and positioning, standing frames, gait trainers. Individually configured means the equipment has various sizes, features, and modifications that a qualified CRT provider can apply specific to the beneficiary by measuring, fitting, programming, adjusting or adapting the equipment consistent with the beneficiary's medical/functional needs as identified by the evaluation of a qualified health care professional (QHCP).

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			1.1 Provider Types	The following text was added to the table: **Complex Rehabilitation Technology (CRT) Supplier** Medical Supplier with a CRT subspecialty that supplies CRT and accessories. Examples: • Specialized manual and power wheelchairs • Gait trainers • Standing systems/frames • Adaptive seating and positioning equipment
			1.1.B. Complex Rehabilitation Technology (CRT) Provider (new subsection)	New subsection text reads: In addition to the DME requirements in the Provider Enrollment subsection, CRT providers must be enrolled as a CRT provider and accredited with one of the Medicare Accreditation Organizations (AO) as a CRT provider. The CRT provider must have at least one employee who is a qualified CRT provider and is: • Certified as a CRT professional by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) or by the National Registry of Rehabilitation Technology Suppliers (NRRTS). • Participates in evaluations performed by a QHCP and the selection of appropriate CRT equipment/accessories. • Provides beneficiary training in the proper use of the CRT equipment/accessories. • Has the capability to provide servicing and repair for all CRT equipment/accessories the CRT provider offers. • Upon delivery of CRT equipment/accessories, provides the beneficiary with written information regarding how to obtain service and repair.

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				The CRT provider is responsible for renewing their accreditation with the AO as required by the Centers for Medicare and Medicaid Services (CMS). Non-CRT DME providers are approved on a case-by-case basis to provide CRT equipment and accessories when a CRT provider is not available in the beneficiary's geographic location. Non-CRT DME providers must comply with all the requirements indicated in the Provider Enrollment subsection.
			1.8.B. Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices Form	The following text was added: CRT equipment and accessories requires the complex needs beneficiary to be evaluated by: • A QHCP*: ➢ Physiatrist; or ➢ Licensed Physical Therapist; or ➢ Licensed Occupational Therapist; or ➢ A rehabilitation Registered Nurse (RN), who has at least two-years' experience in rehabilitation seating (if applicable); or ➢ Other licensed health care professional (e.g., physician, nurse practitioner, physician assistant, etc.) working within their scope of practice; and • A qualified CRT professional (the CRT professional must be present at the time of the evaluation). If a CRT professional is not available in the beneficiary's geographic location, the QHCP may perform the evaluation and coordinate provision of the equipment through an MDHHS-authorized non-CRT DME provider. *The QHCP must not have a financial relationship with the CRT provider, unless the CRT provider is owned by a hospital and the QHCP is employed by the same hospital to work in the inpatient or outpatient setting.

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			1.9.C. Repairs and Replacement Parts	The following text was added after the 3rd paragraph: The repair and/or replacement of CRT equipment and accessories is limited to DME providers that are enrolled with Medicaid as a CRT provider. Non-CRT providers are approved on a case-by-case basis when an enrolled CRT provider is not available in the beneficiary's geographic location. (Refer to the Complex Rehabilitation Technology (CRT) Equipment/Accessories subsection for additional information.)
			2.6.A. Specialized Adaptive Car Seats	The following text was added to 'Standards of Coverage': The provision of specialized adaptive car seats is limited to DME providers enrolled as CRT-providers. (Refer to the Complex Rehabilitation Technology (CRT) Equipment/Accessories subsection for additional information.)
			2.6.B. Activity/Positioning Chairs	The following text was added to 'Standards of Coverage': The provision of activity/positioning chairs is limited to DME providers enrolled as CRT providers. (Refer to the Complex Rehabilitation Technology (CRT) Equipment/Accessories subsection for additional information.)
			2.6.C. Standers	The following text was added to 'Standards of Coverage': The provision of standers is limited to DME providers enrolled as CRT providers. (Refer to the Complex Rehabilitation Technology (CRT) Equipment/Accessories subsection for additional information.)
			2.6.D. Gait Trainers/Walkers	The following text was added to 'Standards of Coverage': The provision of gait trainers is limited to DME providers enrolled as CRT providers. (Refer to the Complex Rehabilitation Technology (CRT) Equipment/Accessories subsection for additional information.)

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			2.8 Complex Rehabilitation Technology (CRT) Equipment/Accessories (new subsection; the following subsections were re-numbered)	New subsection text reads: Pursuant to Public Act 103 and Public Act 104 of 2024, effective January 1, 2025, MDHHS established a CRT-equipment/accessories DME benefit by identifying specific Healthcare Common Procedure Coding System (HCPCS) codes as CRT equipment and accessories. Per Public Acts 103 and 104 of 2024, Medicaid fee-for-service (FFS) and Medicaid Health Plans (MHPs) are prohibited from including CRT equipment and accessories into competitive bidding, selective contracting, or similar initiatives. **CRT Definition** CRT equipment is a subcategory of DME that can be individually configured to meet the medical/functional needs of beneficiaries with complex physical or functional limitations (e.g., traumatic brain injury, amyotrophic lateral sclerosis, spina bifida, etc.). CRT equipment includes specialized manual and power wheelchairs with additional options/accessories, adaptive seating and positioning, standing frames, gait trainers, etc. (Refer to the Complex Rehabilitation Technology (CRT) Healthcare Common Procedure Coding System (HCPCS) Codes list posted on the Medical Suppliers/Orthotists/ Prosthetists/DME Dealers webpage. Refer to the Directory Appendix for website information.) Individually configured means the equipment has various sizes, features, and modifications that a qualified CRT provider can apply specific to the beneficiary by measuring, fitting, programming, adjusting or adapting the equipment consistent with the beneficiary's medical/functional needs as identified by the evaluation of a QHCP.

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				Standards of Coverage The provision of CRT equipment and accessories (including repairs to and replacement of) is limited to DME providers who are enrolled with Medicaid as CRT providers. (Refer to the Provider Enrollment subsection and the Complex Rehabilitation Technology (CRT) Equipment/Accessories subsection for CRT/non-CRT DME provider enrollment information.) Refer to product-specific sections of this chapter for standards of coverage and documentation requirements. **Evaluation** In addition to the documentation and evaluation requirements indicated in the specific DME equipment subsections of this chapter, all CRT equipment requires the complex needs beneficiary to be evaluated by a QHCP. (Refer to the Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices Form subsection for additional information.) A qualified CRT professional must be present at the time of the evaluation. The QHCP must not have a financial relationship with the CRT provider, unless the CRT provider is owned by a hospital and the QHCP is employed by the same hospital to work in the inpatient or outpatient setting. If a CRT professional is not available in the beneficiary's geographic location, the QHCP may perform the evaluation and coordinate provision of the equipment through an MDHHS-authorized non-CRT DME provider. **PA Requirements** All CRT equipment and accessories require PA.

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				Non-CRT DME Providers MDHHS may approve a non-CRT DME provider to supply CRT equipment and accessories on a case-by-case basis through PA if an enrolled CRT provider is not available in the beneficiary's geographic location. MDHHS will consider the experience, education and training of the non-CRT DME provider's technician to determine whether the non-CRT DME provider may provide CRT equipment/accessories to individual beneficiaries. • Delivery of CRT equipment prior to January 1, 2025: ➢ Non-CRT DME providers may perform repairs to base CRT equipment for the life of the equipment if the provider is the same provider who delivered the original equipment to the beneficiary prior to January 1, 2025. ➢ For future PA repair requests of the base equipment, the non-CRT DME provider must include in the documentation submitted with the PA request the original PA number and the make/brand/model and serial number of the base equipment. ➢ If PA is not required for the part, the non-CRT DME provider must report the original PA number and the make/brand/model and serial number of the base equipment in the claim notes section on direct data entry (DDE) claims or loop/segment 2300/NTE on the ASC X12N 837P 5010 electronic claim.

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				• PA of CRT equipment prior to January 1, 2025: ➢ Non-CRT DME providers who received PA approval for CRT base equipment and accessories with an authorization start date before January 1, 2025, may supply the approved equipment if it is delivered to the beneficiary within six months of the authorization period start date. Repairs to this equipment may be performed by the non-CRT DME provider for the life of the base equipment. Refer to the above repair instructions for CRT base equipment provided prior to January 1, 2025.
			2.47.A. Definitions	The following text was added to '**Wheelchairs**': Some wheelchairs are classified as CRT equipment. Refer to the Complex Rehabilitation Technology (CRT) Equipment/Accessories subsection and the Complex Rehabilitation Technology (CRT) Healthcare Common Procedure Coding System (HCPCS) Codes document posted on the MDHHS website. (Refer to the Directory Appendix for website information.) The following text was added to '**Pediatric Mobility Product**': Some pediatric mobility products are classified as CRT equipment. Refer to the Complex Rehabilitation Technology (CRT) Equipment/Accessories subsection and the Complex Rehabilitation Technology (CRT) Healthcare Common Procedure Coding System (HCPCS) Codes document posted on the MDHHS website. (Refer to the Directory Appendix for website information.) The following text was added to '**Licensed Medical Professional**': CRT equipment and accessories require an evaluation by a QHCP. Refer to the Complex Rehabilitation Technology (CRT) Equipment/Accessories subsection for additional information.

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			2.47.B. Standards of Coverage	The following text was added as an introductory paragraph for the subsection: Some wheelchairs, pediatric mobility and seating systems are classified as CRT equipment and may only be provided by a DME provider enrolled as a CRT provider. Refer to the Complex Rehabilitation Technology (CRT) Equipment/Accessories subsection of this chapter and the Complex Rehabilitation Technology (CRT) Healthcare Common Procedure Coding System (HCPCS) Codes document posted on the MDHHS website for additional information. (Refer to the Directory Appendix for website information.) All CRT equipment and accessories require prior approval.
			2.47.C. Prior Authorization for Purchase, Rentals, Repairs, and/or Replacement of Mobility Devices	Under **'Prior Authorization'**, the following bullet point was added to the 5th paragraph: • All CRT equipment and accessories. (Refer to the Complex Rehabilitation Technology (CRT) Equipment/Accessories subsection for additional information.) Under **'Prior Authorization Exceptions'**, the following text was added after the 1st paragraph: NOTE: All CRT equipment and accessories require PA regardless of diagnosis. (Refer to the Complex Rehabilitation Technology (CRT) Equipment/Accessories subsection for additional information.)
		Acronym Appendix		Addition of: NRRTS - National Registry of Rehabilitation Technology Suppliers RESNA - Rehabilitation Engineering and Assistive Technology Society of North America

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MMP 24-61	12/23/2024	Special Programs	Section 12 - Targeted Case Management - Services for Children with Medical Complexity (new section)	A new section was developed to incorporate policy. The section is comprised of the following subsections: 12.1 General Information 12.2 Beneficiary Eligibility 12.3 Enrollment 12.3.A. Provider Referrals 12.3.B. Eligibility Determination 12.3.B.1. Primary Point of Contact and Intake Meeting 12.3.C. Beneficiary Consent 12.3.D. Transfer of Care 12.3.E. Ongoing CMC TCM Service Participation 12.3.F. CMC TCM Disenrollment 12.3.G. Duplication of Services 12.3.G.1. Medicaid Health Plan (MHP) Coordination 12.4 Core Elements of CMC TCM Services 12.4.A. Comprehensive Assessment 12.4.B. Comprehensive, Individualized Plan of Care Development 12.4.C. Referrals and Care Coordination Services 12.4.D. Monitoring and Follow-Up Activities 12.4.D.1. Frequency of Monitoring and Follow-Up Activities 12.4.E. Service Availability and Accessibility 12.4.F. Types of Encounters 12.4.G. Excluded Services 12.5 CMC TCM Case Management Qualifications 12.5.A. CMC TCM Core Team 12.5.B. Telemedicine 12.6 Reporting Requirements 12.6.A. CMC TCM Case Management Entity Reporting 12.7 Claims Submission 12.7.A. Allowable Procedure Codes 12.7.B. Date of Service (DOS) 12.7.C. Place of Service (POS) 12.7.D. Third Party Liability

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MMP 24-62	11/27/2024	Pharmacy	14.15 Physician-Administered Injectable Drugs	The 1st paragraph was revised to read: Pharmacy claims for the following physician-administered injectable drugs are reimbursable under Michigan Medicaid, ~~and the~~ Healthy Michigan Plan, and Children's Special Health Care Services: The following bullet point was added to the 1st paragraph: • Injectable drug products covered under the medical benefit and carved-out of Medicaid Health Plan coverage. Refer to the PBM's Pharmacy Claims Processing Manual for billing procedures. (Refer to the Directory Appendix for website information.)
MMP 25-01	1/13/2025	Pharmacy	2.2 Prescriber Identification	The 1st paragraph was revised to read: Pharmacy providers must provide the individual prescriber's National Provider Identifier (NPI) on the submitted claim. MDHHS will deny pharmacy claims where the prescriber is not enrolled in CHAMPS. Exceptions to this in compliance with MDHHS policy include: • Prescriber enrollment in another state Medicaid program has been validated. • Prescription is being provided during a declared natural disaster or emergency services.

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