General Information for Providers

Table of Contents

SECTION 1 – INTRODUCTION

This chapter applies to all providers.

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

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

1.1 BULLETINS

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

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

1.2 NUMBERED LETTERS

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

1.3 FILE TRANSFER

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

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

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

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

1.4 ListServ Communications

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

1.5 MDHHS Website

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

1.5.A. Additional Code/Coverage Resource Materials

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

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

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

(Refer to the Directory Appendix for website information.)

1.5.B. Forms & Publications

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

1.5.C. Disclaimer

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

1.6 Inquiries

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

1.6.A. Provider Inquiry Line

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

1.6.B. Written Inquiries

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

1.7 Beneficiary Medical Assistance Line

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

1.8 Reporting Fraud and Abuse

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

1.9 Provider Liaison Meetings

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

1.10 Claims Processing System

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

SECTION 2 - PROVIDER ENROLLMENT

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

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

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

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

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

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

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

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

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

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

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

2.1 Provider Ownership and Control Disclosures

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

2.1.A. Required Disclosure Information

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

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

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

2.1.B. Criminal Offense Notification

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

2.1.C. Nursing Facility Change of Ownership (CHOW) [Subsection Added 7/1/23]

When a nursing facility changes ownership, the successive owner can either retain the preceding owner's National Provider Identifier (NPI) or obtain a new NPI. If the successive owner chooses to obtain a new NPI, then they must complete the enrollment process in the Community Health Automated Medicaid Processing System (CHAMPS) and submit the required disclosure information within 35 days of the Centers for Medicare & Medicaid Services (CMS) established effective date of the change in ownership. If the successive owner decides to retain the preceding owner's NPI, then the successive owner cannot do a new enrollment. The successive owner's decision to either retain the NPI or to obtain a new NPI does not impact the automatic assignment of the provider agreement. **(text added per bulletin MMP 23-12)**

2.2 Enrollment Application Fees

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

2.3 Enrollment Screening

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

2.3.A. Provider Categorical Risk Enrollment Screening

2.3.A.1. Categorization of Providers Based on Level of Risk

Provider types must be categorized based on the potential risk of fraud, waste, and abuse to the Medicaid Program. MDHHS has adopted the risk categorization established by the Centers for Medicare & Medicaid Services (CMS) for provider types. For all other provider types, MDHHS establishes the risk level. A provider's categorical risk level may

be adjusted to "high" due to payment suspension, overpayment status, or Office of Inspector General (OIG)/Medicaid Program exclusion status and after listing of a temporary moratorium.

2.3.A.2. Screening Activities Based on Risk Category and Provider Type

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

Category	Type of Provider	Screening Activities
High	▪ Prospective (newly enrolling) home health agencies ▪ Prospective (newly enrolling) DMEPOS suppliers	▪ Fingerprint based criminal background checks ▪ Unannounced pre- and post-enrollment site visits ▪ Verifications, including licensure, Social Security Number, Taxpayer Identification Number, National Provider Identifier (NPI), OIG exclusion status, and information regarding disclosed individuals
Moderate	▪ Ambulance services ▪ Community Mental Health centers ▪ Comprehensive Outpatient Rehabilitation Facilities (CORFs) ▪ Hospice organizations ▪ Independent clinical laboratories ▪ Physical therapists enrolling as individuals or as group practices ▪ Revalidating home health agencies ▪ Revalidating DMEPOS suppliers	▪ Unannounced pre- and post-enrollment site visits ▪ Verifications, including licensure, Social Security Number, Taxpayer Identification Number, NPI, OIG exclusion status, and information regarding disclosed individuals ▪ Criminal background check
Limited	▪ All other provider types	▪ Verifications, including licensure, Social Security Number, Taxpayer Identification Number, NPI, OIG exclusion status, and information regarding disclosed individuals ▪ Criminal background check

2.3.B. Site Inspections

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

2.3.C. Criminal Background Checks

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

2.3.D. Verification of Provider Information

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

2.4 Temporary Moratoria

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

2.5 Medicare Cost Share Enrollment Type [Subsection Added 4/1/23]

Billing, rendering, attending, ordering, and referring Medicare providers who only intend to submit claims to Medicaid for reimbursement of Medicare cost-sharing for dual eligible beneficiaries may choose the restricted cost-sharing option, Medicare Cost Share, during CHAMPS enrollment. Medicare provider types not recognized by Medicaid must choose the Medicare Cost Share option. These providers must contact Provider Enrollment for enrollment assistance. (Refer to the Directory Appendix for contact information.) This special enrollment type is only available to providers participating in original Medicare. Providers participating in Medicare Part C, also known as a Medicare Advantage Plan, must complete a full Medicaid enrollment. **(text added per bulletin MMP 22-52)**

SECTION 3 - MAINTENANCE OF PROVIDER INFORMATION

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

Examples of such changes include:

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

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

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

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

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

SECTION 4 – ESTABLISHING PROVIDER ACCESS IN CHAMPS

4.1 PROVIDER DOMAINS

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

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

4.2 PROVIDER PROFILES

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

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

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

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

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

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

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

SECTION 5 – NONDISCRIMINATION

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

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

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

SECTION 6 – DENIAL OF ENROLLMENT, TERMINATION AND SUSPENSION

6.1 TERMINATION OR DENIAL OF ENROLLMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NOTE: Individual Home Help providers denied enrollment due to certain program exclusions may still provide services through the Personal Choice and Acknowledgement of Provider Selection process. (Refer to the Providers [Prohibited Providers] Section of the Home Help chapter for more information.)

6.2 Enrollment and Reinstatement After Termination or Denial

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

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

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

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

6.3 Suspension

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

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

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

6.4 Loss of Licensure/Limited Licenses

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

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

Suspension or revocation of a provider's license by the appropriate standard setting authority results in termination of Medicaid participation effective on the date the provider is no longer licensed. In the case of a provider not located in Michigan, suspension or revocation would be administered by the appropriate state licensing board.

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

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

6.5 Payment Suspension

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

6.6 Appeals

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

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

7.1 SANCTIONED PROVIDERS

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

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

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

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

7.2 BORDERLAND PROVIDERS

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

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

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

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

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

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

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

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

7.3 Out of State/Beyond Borderland Providers [Change Made 7/1/23]

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

- Emergency services as defined by the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and the federal Balanced Budget Act of 1997 and its regulations; or
- Medicare and/or private insurance has paid a portion of the service and the provider is billing MDHHS for the coinsurance and/or deductible amounts; or
- The service is prior authorized by MDHHS. MDHHS will only prior authorize non-emergency services to out of state/beyond borderland providers if the service is not available within the state of Michigan and borderland areas.
- Genetic or Molecular laboratory services. Services are subject to clinical PA requirements that would apply if the laboratory provider were located in-state. (Refer to the Laboratory chapter for more information.) **(text added per bulletin MMP 23-19)**

Managed Care Plans follow their own Prior Authorization criteria for out of network/out of state services. Providers participating in Medicaid Health Plan and Dental Health Plan networks should refer to the

Dental chapter (Healthy Kids Dental section) and the Medicaid Health Plans chapter of this manual for additional prior authorization information.

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

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

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

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

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

All non-emergency services rendered by providers, except genetic or molecular laboratory services, require the referring provider to obtain written PA from MDHHS as indicated in the Prior Authorization Section of this chapter. (revised per bulletin MMP 23-19)

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

SECTION 8 - DELIVERY OF SERVICES

8.1 FREE CHOICE

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

8.2 RENDERING SERVICES

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

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

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

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

8.3 NONCOVERED SERVICES

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

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

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

8.4 Nondiscrimination in Delivery of Service

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

8.5 Service Acceptability

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

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

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

8.6 Ordering, Prescribing and Referring Services/Items

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

SECTION 9 - PRIOR AUTHORIZATION

9.1 GENERAL INFORMATION

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

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

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

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

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

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

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

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

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

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

9.2 Processing Requests

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

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

9.2.A. Verbal Prior Authorization

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

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

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

9.2.B. Approval

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

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

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

9.2.C. Denial

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

9.2.D. Reimbursement

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

Documentation that may be accepted for PA requests includes:

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

Medicaid does not provide reimbursement if:

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

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

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

9.3 Prior Authorization (Medicaid Health Plans Only)

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

9.4 Clinical Trials [Change Made 4/1/23]

PA requirements that apply to services provided outside of a clinical trial apply to routine services within a clinical trial. PA requests, when required, must contain the clinical trial number, be complete, and include a completed and signed Attestation to the Appropriateness of the Qualified Clinical Trial form (BPHASA-2210). (Refer to the Forms Appendix to review the form and to the Directory Appendix for form access on the MDHHS website.) Submit requests electronically via FFS Direct Data Entry (DDE) in CHAMPS to allow for expedited review. Refer to the Practitioner Chapter for additional information for coverage of routine patient costs for services associated with participation in a qualified clinical trial. **(text revised per bulletin MMP 22-42)**

9.5 Custom-Fabricated Medical Equipment, Devices and Medical Supplies

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

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

If a custom-fabricated item, medical device, or equipment (e.g., prosthetic limb, custom-fabricated medical equipment such as a brace, custom motorized wheelchair, orthotics) is ordered for a beneficiary

during a hospital stay but is not delivered until after discharge and enrollment status changes, payment must be made by the party responsible for the hospital stay.

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

SECTION 10 - BILLING BENEFICIARIES

10.1 GENERAL INFORMATION

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

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

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

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

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

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

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

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

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

10.2 Beneficiary Copayment Requirements

Beneficiary copayments may be required for the following Medicaid services:

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

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

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

10.2.A. Beneficiaries Excluded from Medicaid Copayment Requirements

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

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

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

10.2.B. Refusal of Service Due to Non-Payment of Copayment

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

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

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

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

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

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

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

  The notice must include:

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

- The fact that the beneficiary cannot be denied future care, items, or services if he makes the required full or partial payment on his newly-created copayment debt in the above-designated period.

- Gives verbal notice in lieu of written notice when the provider:
  - Publicly and prominently posts their policy regarding denial of service based on copayment debt in a public area such as the provider's reception area; and
  - At the time that verbal notice is given, either provides a copy of the posted policy or verbally informs the beneficiary of the existence and location of the posted notice and the beneficiary's right to a copy of the notice upon request; and
  - Makes a copy of the written policy available to the beneficiary and to MDHHS immediately upon request.

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

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

10.2.C. Cost-Sharing Limits

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

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

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

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

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

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

SECTION 11 - BILLING REQUIREMENTS

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

11.1 BILLING PROVIDER

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

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

11.2 CHARGES

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

11.3 TIMELY FILING BILLING LIMITATION

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

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

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

*Initial pharmacy claim must be received within 180 days.

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

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

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

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

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

- Department administrative error occurred, including:
  - The provider received erroneous written instructions from MDHHS staff;
  - MDHHS staff failed to enter (or entered erroneous) authorization or restriction in the system;
  - The MDHHS contractor issued an erroneous PA; and
  - Other administrative errors by MDHHS or its contractors that can be documented.

  Retroactive provider enrollment is not considered an exception to the timely filing billing limitation.
- Medicaid beneficiary eligibility/authorization was established retroactively more than 12 months after the DOS.
- Medicaid beneficiary eligibility/authorization was established retroactively less than 12 months after the DOS. Claims will be accepted up to six months after the retroactive eligibility determination date. Providers with claims that meet this retroactive eligibility exception must indicate 'timely filing' in the comment section of the claim.
- Judicial Action/Mandate: A court or MOAHR administrative law judge ordered payment of the claim. A copy of the judicial action or court order may be required to support this exception.

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

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

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

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

11.4 Provider Returning Overpayments

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

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

11.5 Professional Corporation

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

11.6 Invoice Completion Fee

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

11.7 Claim Documentation

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

A claim without the requested information may be reviewed:

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

11.8 Claim Certification

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

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

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

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

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

11.9 Billing Agents

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

11.9.A. Authorization of Billing Agent

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

11.9.B. Provider Association with a Billing Agent

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

11.9.C. Communication with Billing Agents

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

SECTION 12 - THIRD PARTY LIABILITY

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

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

12.1 ESTATE RECOVERY PROGRAM

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

Estate recovery applies only to Medicaid beneficiaries who:

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

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

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

SECTION 13 – REIMBURSEMENT

13.1 PAYMENT IN FULL

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

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

13.2 PRE- AND POST-PAYMENT REVIEW/AUDIT

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

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

13.3 EMERGENCY SERVICES (MHPS ONLY)

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

13.4 NON-PAYMENT AND REPORTING REQUIREMENTS FOR PROVIDER PREVENTABLE CONDITIONS (PPCS)

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

13.4.A. CATEGORIES OF PROVIDER PREVENTABLE CONDITIONS

Health Care Acquired Conditions (HCAC)	Applies to inpatient hospital settings and includes, at a minimum, the full list of conditions/secondary diagnosis codes identified by CMS as HCACs when not present on hospital admission.

Other Provider Preventable Conditions (OPPC)	Applies to conditions occurring in any health care setting that could have reasonably been prevented through the application of evidence based guidelines. Conditions currently identified by CMS include: ▪ wrong surgical or other invasive procedure performed on a patient; ▪ surgical or other invasive surgery performed on the wrong body part; and ▪ surgical or other invasive procedure performed on the wrong patient.

13.4.B. Payment Adjustment and Reporting Requirements for PPCs

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

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

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

13.5 Factoring

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

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

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

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

SECTION 14 – RECORD KEEPING

14.1 RECORD RETENTION

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

14.2 ORDERS, PRESCRIPTIONS AND REFERRALS

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

14.3 BENEFICIARY IDENTIFICATION INFORMATION

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

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

14.4 AVAILABILITY OF RECORDS

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

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

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

14.5 Confidentiality

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

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

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

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

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

14.5.A. Standard Consent Form

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

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

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

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

14.6 Fiscal Records

The following fiscal records must be maintained:

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

14.7 Clinical Records

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

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

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

Examples:

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

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

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

Clinical Documentation Requirements

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

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

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

SECTION 15 – POST-PAYMENT REVIEW AND FRAUD/ABUSE

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

15.1 MDHHS OFFICE OF INSPECTOR GENERAL

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

15.2 STATE LAW

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

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

  Examples of Medicaid fraud are:

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

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

- Social Welfare Act (MCLA 400.111d): A conviction may result in a denial, suspension, or termination of the provider's license or similar action from Medicaid.
- Public Health Code (MCLA 333.16226): A conviction may result in a fine or probation from Medicaid or the denial, suspension, or revocation of a provider's license.

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

15.3 Federal Law

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

The following federal laws are primarily used:

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

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

15.4 Patient Abuse

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

Examples of patient abuse are:

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

The above examples are not all inclusive.

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

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

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

15.5 Beneficiary Fraud/Abuse

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

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

SECTION 16 - PROVIDER APPEAL PROCESS

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

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

SECTION 17 - REVIEW OF PROPOSED CHANGES

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

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

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

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

Your request to receive draft policies must include:

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

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

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

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

SECTION 18 - ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAM

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

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

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

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

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

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

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

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

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