MDHHS
Michigan Department of Health & Human Services

BULLETIN

Michigan Medicaid Policy (MMP) | Health Services

Bulletin Number: MMP 25-56

Distribution: All Providers

Issued: November 26, 2025

Subject: Updates to the Medicaid Provider Manual; OT/ST/PT for Beneficiaries with Autism Spectrum Disorder Clarification; Electronic Health Record (EHR) Incentive Program for Hospitals

Effective: January 1, 2026

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

Updates to the Medicaid Provider Manual

The Michigan Department of Health and Human Services (MDHHS) has completed the January 2026 quarterly update of the MDHHS Medicaid Provider Manual. The Manual is maintained on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Medicaid Provider Manual. A compact disc (CD) version of the manual is available to enrolled providers upon request.

The January 2026 version of the manual does not highlight changes made in 2025. Refer to the online version of this bulletin at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms to view the attachments that describe the changes made, the location of the changes within the manual and, when appropriate, the reason for the change. Subsequent changes made for the April, July, and October 2026 versions of the manual will be highlighted within the text of the on-line manual.

OT/ST/PT for Beneficiaries with Autism Spectrum Disorder Clarification

Medically necessary Occupational Therapy (OT), Physical Therapy (PT), and Speech Therapy (ST) is covered in accordance with the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for Medicaid beneficiaries who have been diagnosed with an autism spectrum disorder (ASD). Beneficiaries should be referred to their Prepaid Inpatient Health Plan (PIHP) for an ASD comprehensive assessment when further evaluation and treatment is determined necessary. Beneficiaries who have been assessed and determined eligible by the PIHP for specialty Behavioral Health Treatment (BHT) services may have related OT, PT, and ST services covered through the PIHP. If the beneficiary was determined ineligible by the PIHP, ASD related OT, PT, and ST may be covered by the Medicaid Health Plan (MHP) or Medicaid Fee-for-Service (FFS) program. Therapy covered by the MHP or FFS

program must meet the standards of coverage outlined within the Therapy Services chapter of the MDHHS Medicaid Provider Manual.

Beneficiaries receiving ASD therapy services through the PIHP may also receive concurrent therapy services through the MHP/FFS program for co-morbid physical health impairments or diagnosis. If therapy is provided under both the physical and behavioral health benefit, the goals and purpose for each must be distinct and collaboration between therapy providers is required to coordinate therapy and prevent direct duplication of services.

Providers should refer to the MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter and the Therapy Services chapter for complete coverage details.

Electronic Health Record (EHR) Incentive Program for Hospitals

The Electronic Health Record (EHR) Incentive Program for Hospitals section of the Hospital Reimbursement Appendix will be removed from the Medicaid Provider Manual due to the completion of the program. The last eligible payment for the EHR Incentive Program for Hospitals was made in 2019. Medicaid policy bulletins pertaining to the EHR Incentive Program for Hospitals will be maintained at http://www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Manual Maintenance

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

Questions

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

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

Approved

Meghan E. Groen, Chief Deputy Director
Health Services

Medicaid Provider Manual
January 2026 Updates

TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
General Information for Providers	10.2.A. Beneficiaries Excluded from Medicaid Copayment Requirements	In the 1st paragraph, the 10th bullet point was revised to read: • ~~Native~~ American Indians/Alaska Natives consistent with federal regulations at 42 CFR §447.56(a)(1)(x)	Updated language to reflect current terminology used by the IHS.
General Information for Providers	Section 18 – Electronic Health Record (EHR) Incentive Program	Section was removed in its entirety.	This program is no longer active in accordance with promulgated policy and Manual language. The last payments for this program were completed in 2019.
Beneficiary Eligibility	2.1 Benefit Plans	**Benefit Plan ID:** CCBHC Addition of the following text: **NOTE: This benefit plan is obsolete as of 09/30/2025 with the implementation of CCBHC-FFS.**	Update.

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

Medicaid Provider Manual
January 2026 Updates

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CHAPTER	SECTION	CHANGE	COMMENT
Beneficiary Eligibility	2.1 Benefit Plans	Addition of: **Benefit Plan ID:** CCBHC-FFS **Benefit Plan Name:** Certified Community Behavioral Health Clinic - Fee For Service **Benefit Plan Description:** The CCBHC Demonstration benefit plan will reimburse state certified CCBHC demonstration sites for providing a comprehensive array of high-quality outpatient behavioral health services. CCBHCs will receive a fixed daily clinic-specific rate (known as a PPS-1 rate) for all CCBHC services provided on a given day. Medicaid beneficiaries are eligible for the benefit plan if they have a mental health or substance use disorder diagnosis. CCBHCs are federally required to provide nine core behavioral health services and must meet stringent standards for care coordination, quality and financial reporting, staffing, and governance. **Type:** Fee for Service **Funding Source:** XIX-XXI **Covered Services:** AI, MH	Update.
Beneficiary Eligibility	9.1 Enrollment	In the table, under "Voluntary Enrollment", the 2nd bullet point was revised to read: • ~~Native~~ American Indians/Alaska Natives of Federally recognized tribes	Updated language to reflect current terminology used by the IHS.

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CHAPTER	SECTION	CHANGE	COMMENT
Billing & Reimbursement for Institutional Providers	6.2.H Medicare	In the table at the end of the subsection, under "Medicare Part A Becomes Effective During Stay", the last bullet point was revised to read: • Report amount applied to coinsurance, copay or deductible [OI and Medicare (Inpatient, Outpatient, LTC, Home Health, Hospice)]. ➢ ~~For DOS prior to July 1, 2007 – electronic/paper claims: Value Code A1, B1, C1, A2, B2, C2, A7, B7, C7 and amount~~ ➢ ~~For DOS on/after July 1, 2007:~~ ○ Electronic claims: use CAS segments only ○ Paper claims: use only Value Codes (A1, B1, C1, A2, B2, C2, A7, B7, C7 and amount)	Removal of obsolete text.
Billing & Reimbursement for Institutional Providers	11.1 Billing Instructions for Hospice Claim Completion	The 5th bullet point was revised to read: • ~~Effective for dates of service on or after January 1, 2016,~~ Hospice routine home care is reimbursed as a two-tiered reimbursement rate: The 14th bullet point was revised to read: • Billing for Service Intensity Add-on (SIA): ~~Effective for dates of service on and after January 1, 2016,~~ The SIA rate will be reimbursed for a minimum of 15 minutes but not more than four hours daily during the last seven days of a beneficiary's life for in-person visits made by a Registered Nurse (RN) and/or Social Worker when the beneficiary is receiving routine home care. However, the total of combined time rendered by an RN and Social Worker will not be reimbursed more than four hours per day. For example, if an RN provides three hours of care and a Social Worker provides two hours during a given day, four hours will be reimbursed. The following items must be documented on the claim in order for the SIA to be paid:	Removal of obsolete text.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	1.2.A. Network Adequacy Standards for the Specialty Behavioral Health System	Correction to the following sentence: (Refer to the Directory Appendix; ~~Mental Health/Substance Abuse~~ Behavioral Health/SUD Resources section, for website information.)	Update.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	1.5 Programs Requiring Special Approval	In the 2nd paragraph, the 6th and 7th bullet points were revised to read: • Intensive ~~Crisis Stabilization for Adults and Children~~ Care Coordination with Wraparound • ~~Wraparound and~~ Children's Therapeutic ~~Foster~~ Family Care	Revised for consistency in chapter/manual terminology.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	18.2 Referral	The 1st paragraph was revised to read: The PCP who screened the child for ASD and determined a referral for further evaluation was necessary will contact the Pre-paid Inpatient Health Plan (PIHP) directly to arrange for a follow-up evaluation. The PCP must refer the child to the PIHP in the geographic service area for Medicaid beneficiaries. The PIHP will contact the child's parent(s)/guardian(s) to arrange a follow-up appointment for a comprehensive diagnostic evaluation and behavioral assessment. Each PIHP will identify a specific point of access for children who have been screened and are being referred for a diagnostic evaluation and behavioral assessment of ASD. ~~If the PCP determines the child who screened positive for ASD is in need of occupational, physical, or speech therapy, the PCP will refer the child directly for the service(s) needed.~~	Correction.
Behavioral Health and Intellectual and Developmental Disability Supports and Services	19.4 Covered Services	In the last paragraph, last bullet point (**Referral to Community and Social Support Services)**, the 2nd sub-bullet point was revised to read: ➢ Collaborating/coordinating with community-based organizations, ~~and~~ key community stakeholders, and partners;	Updated language to include "partners" in addition to "stakeholders" (referring to tribal partners).

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CHAPTER	SECTION	CHANGE	COMMENT
Behavioral Health and Intellectual and Developmental Disability Supports and Services	20.4 Covered Services	In the last paragraph, last bullet point (**Referral to Community and Social Support Services)**, the 2nd sub-bullet point was revised to read: ➢ Collaborating/coordinating with community-based organizations, ~~and~~ key community stakeholders, and partners;	Updated language to include "partners" in addition to "stakeholders" (referring to tribal partners).

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Children's Special Health Care Services	Section 1 – General Information	Text was revised to read: CSHCS is mandated by the Michigan Public Health Code, Public Act 368 of 1978, Part 58, children and youth with special health care needs (MCL 333.5801 – 333.5879), in cooperation with the federal government under Title V of the Social Security Act, Sec. 501. [42 U.S.C. 701] (a) 1 (D) and the annual Michigan Department of Health and Human Services (MDHHS) Appropriations Act. ~~CSHCS is a separate program from Medicaid.~~ ~~However, CSHCS partners closely with the Medicaid program regarding the use of the Medicaid system. This allows for greater efficiency in administering the two programs and allows both programs to collaborate on the care of a beneficiary to avert duplication of services. CSHCS does not pay for Medicaid-covered services that have been denied by Medicaid.~~ Medicaid beneficiaries with CSHCS coverage are assigned to a CSHCS benefit plan. (Refer to the Benefit Plan table in the Beneficiary Eligibility Chapter of this manual.) As a Medicaid benefit plan, the CSHCS program is fully integrated into Medicaid. CSHCS is a part of the Medicaid benefit package for clients enrolled in both Medicaid and CSHCS. Most Medicaid beneficiaries with CSHCS coverage are required to enroll in a Medicaid Health Plan. CSHCS strives to enroll CSHCS beneficiaries into Medicaid when they are eligible in order to access the broader range of medical services that are covered by Medicaid. CSHCS, as a grantee under Title V of the Social Security Act, is an exception to Medicaid's payer of last resort rule. (Refer to the Exceptions to Medicaid Payer of Last Resort subsection in the Coordination of Benefits Chapter in this manual for more information.) CSHCS does not pay for Medicaid-covered services for Medicaid enrollees, including services that have been denied by Medicaid.	Clarification of CSHCS relationship with Medicaid. Clarification of program eligibility to include eligible adult populations.

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		CSHCS is charged by the Social Security Act, Title V, Maternal and Child Health Office with promoting the development of systems of care that are family-centered, community-based, and coordinated~~, and culturally competent with a focus on health equity~~. CSHCS strives ~~for having~~ to have the most appropriate pediatric subspecialists and services that are identified by combining the family's expertise regarding their child and the condition, the medical services provider, MDHHS medical expertise, and CSHCS policy and program intent. CSHCS increases access to resources and supports for ~~the families and~~ beneficiaries and their families. Services occur in partnership, recognizing the family as the constant in the child's life. The goal is to reduce or eliminate barriers that are inherent to the condition. This, in turn, is intended to increase the quality of life for the beneficiary and the family. This family-centered approach impacts the level of independence most beneficiaries are able to achieve. CSHCS identifies children and some adults with special health care needs when the ~~child~~ individual appears to have a condition that CSHCS may cover. CSHCS does not cover behavioral, developmental or mental health conditions. The ~~child's pediatric~~ individual's physician subspecialist submits medical reports to CSHCS for determination of medical eligibility. When the ~~child~~ individual does not have a ~~pediatric~~ physician subspecialist and there is no other option to obtain a medical report (i.e., private insurance, Medicaid, etc.), CSHCS pays for a diagnostic evaluation of medical conditions that are likely to be covered by CSHCS. The ~~beneficiary~~ individual may be diagnosed with a CSHCS covered condition, which is the first step toward CSHCS eligibility but is not the only criterion. The condition must also meet chronicity, medical severity criteria, and the need for treatment by a ~~pediatric~~ physician subspecialist before the ~~beneficiary~~ individual can be determined medically eligible for CSHCS. Unlike other programs, there are no financial criteria that would limit eligibility for CSHCS. Eligibility is determined based upon medical circumstances and not on financial circumstances. Medical eligibility ~~(~~and allowable citizenship/permanent residency status~~)~~ must be established by ~~MDHHS~~ the Department before the ~~beneficiary~~ individual can enroll in CSHCS.	

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		Once enrolled, CSHCS covers pediatric and adult specialty medical treatment ~~(adult specialty for the few enrolled adults)~~ related to the qualifying condition. ~~Care~~ Coverage is limited to the qualifying diagnosis(es) and related conditions. ~~The limitation occurs by authorizing particular~~ CSHCS authorizes specialty providers for each ~~child~~ beneficiary and ~~having the~~ those authorized provider(s) order additional services, such as therapies, lab tests, etc., as needed as related to their specialty. Providers who are not CSHCS-authorized, and services not ordered by a CSHCS authorized provider, are not eligible for reimbursement. CSHCS does not cover primary care or condition-related care delivered by a primary care provider. **NOTE:** ~~CSHCS and Medicaid interface –~~ CSHCS follows Medicaid policy except where specified in this chapter. To maximize efficiency, many ~~of the~~ CSHCS processes (e.g., prior authorizations, medical determinations, claims, etc.) are ~~integrated into the Medicaid system and processes for CSHCS beneficiaries~~ administered by Medicaid. ~~CSHCS strives to enroll CSHCS beneficiaries into Medicaid when they are eligible in order to access the broader range of medical services that are covered by Medicaid.~~ ~~CSHCS also partners with Medicaid when beneficiaries have both CSHCS and Medicaid. Most beneficiaries who also have Medicaid are required to enroll with a Medicaid Health Plan. Under this situation, medical coverage is subject to the Medicaid rules. CSHCS can, at times, provide additional services beyond what is available through the Medicaid benefit package. These services include care coordination, the development of a plan of care in which the family participates, referral to appropriate medical providers, and assistance with locating, accessing, and navigating community support services, etc.~~	
Children's Special Health Care Services	11.2 NEMT Reimbursement Process	In the table after the last paragraph, under "Lodging", the last bullet point was revised to read: • MDHHS reimburses lodging up to the allowable amount established by MDHHS, regardless of cost. Itemized receipts are required.	Clarification.

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Dental	9.2.A.3. Comprehensive Orthodontic Treatment	Text was revised to read: Comprehensive orthodontic treatment procedure codes are used when multiple phases of treatment are provided at different stages of orofacial development. Comprehensive orthodontic treatment services are covered for a lifetime maximum of six years, with each phase of treatment covered for up to two years. There is an initial reimbursement for each stage, with a maximum allowable amount within the two-year period. The submission of the first MSA-1680-B for comprehensive orthodontic treatment must include the appropriate procedure code and the expected banding/start date of treatment.	Clarification for the provider to include the expected banding/ start date of treatment on the prior authorization request.
Early and Periodic Screening, Diagnosis and Treatment	9.15 Diabetes (Type 2)	In the 2nd paragraph, the 2nd bullet point was revised to read: • Belongs to a certain race/ethnic group (e.g., ~~Native~~ American Indian/Alaska Native, African-American, Hispanic, Asian/Pacific Islander); or	Updated language to reflect current terminology used by the IHS.
Federally Qualified Health Centers and Tribal Health Centers	7.4 Covered Services	In the 5th bullet point (**Referral to Community and Social Support Services)**, the 2nd sub-bullet point was revised to read: ➢ Collaborating/coordinating with community-based organizations, ~~and~~ key community stakeholders, and partners;	Updated language to include "partners" in addition to "stakeholders" (referring to tribal partners).
Healthy Michigan Plan	1.2 Benefit Administration	Text was revised to read: All Healthy Michigan Plan beneficiaries, with the exception of some beneficiaries (e.g., ~~Native Americans~~ American Indian/Alaska Native), are required to enroll in a health plan. Enrollees will select their health plan with assistance from MI Enrolls. In addition, behavioral health and substance use disorders will be administered in accordance with the current service delivery model.	Updated language to reflect current terminology used by the IHS.

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Hospital Reimbursement Appendix	Section 13 - Electronic Health Record (EHR) Incentive Program for Hospitals	Removal of entire section which includes the following subsections: • 13.1 Registration and Interfaces with the National Level Repository • 13.2 Requirements for Participation • 13.3 Eligible Hospitals Defined • 13.4 Eligibility Verification • 13.4.A. Average Length of Stay (LOS) • 13.4.B. Medicaid Eligible Patient Volume • 13.5 Incentive Payment Calculation • 13.5.A. Timing • 13.5.B. Payment Formula • 13.6 Payment Notification and Gross Adjustments • 13.7 Adopt, Implement, and/or Upgrade or Meaningful Use	This program is no longer active in accordance with promulgated policy and Manual language. The last payments for this program were completed in 2019.
MI Choice Waiver	Section10 – Program Quality	The last paragraph was revised to read: Through the course of doing business, MDHHS may identify potential areas of concern with administration of the MI Choice program as specified in the contract between MDHHS and the waiver agency. This includes but is not limited to Clinical and Administrative Quality Assurance Reviews, receipt of complaints from participants or other stakeholders and partners and review of State Fair Hearing Decisions and Orders. MDHHS will investigate all issues to determine their scope. When the scope of an issue is widespread (meaning not isolated to a single participant, supports coordinator, or scenario) or has the potential to impinge upon the rights of participants or applicants, MDHHS will initiate a formal corrective action process. This process begins with identifying the scope of the issue identified and discussing the issue in person with the waiver agency. MDHHS or its designee may require corrective action from the waiver agency. Failure to implement a corrective action plan that addresses the issue identified may lead to implementation of sanctions as identified in the contract between MDHHS and the waiver agencies.	Updated language to include "partners" in addition to "stakeholders" (referring to tribal partners).

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Nursing Facility Coverages	10.30 Private Room	The 3rd paragraph was revised to read: In cases where a current Medicaid resident needs to be in a private room because they require isolation due to an infection or illness, but no Medicaid-certified private rooms are available, the MDHHS Long-Term Care Operations section may provide a written exception to this policy. This exception is provided to allow the residents to reside in a non-Medicaid-certified bed within their facility on a short-term, temporary basis. Form MSA-0823 (Nursing Facility Isolation Bed Request) may be completed by the NF in need of isolating a Medicaid resident in a private room using a non-Medicaid-certified bed. Only forms approved by MDHHS may result in Medicaid reimbursement for Medicaid beneficiaries residing in a non-Medicaid-certified bed on a temporary basis. (Refer to the Forms Appendix for a sample form.)	Clarification.
Pharmacy	1.9 Medicare Part D Benefit	The following bullet point was added to the 3rd paragraph: • Any other products identified on the MDHHS Medicare Dual Eligible Covered NDC List available on the Pharmacy website. (Refer to the Directory Appendix for website information.)	Pharmacy maintains a list of covered products for dual eligible beneficiaries that are excluded from Part D coverage. Adding the bullet and pointing to this list ensures the language in the manual is consistent with current policy and operations. Pointing to this list will also allow for addition of new drugs or types of drugs to be covered in a timely manner once they are determined to be excluded from Medicare Part D, and without additional policy promulgation or manual updates.
Pharmacy	13.6.A. Medicaid Copayments	In the table, under "Other Exclusions", the 2nd bullet point was revised to read: • ~~Native~~ American Indians/Alaska Natives consistent with federal regulations at 42 CFR §447.56(a)(1)(x).	Updated language to reflect current terminology used by the IHS.

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School Services Program	Section 1 – General Information	The following terms were added to the last paragraph: **Family Training** Term used in the IFSP to describe an early intervention service that equips families with the skills and knowledge to support their infant or toddler with a developmental delay or disability. The goal is to enhance the family's ability to help their child learn and grow through everyday routines and activities. **Specialized Instruction** Term used in the IFSP to describe the specific, early intervention services for children from birth to age three who have developmental delays or disabilities. These services, which can include physical, cognitive, communication, and social-emotional support, are designed to help the child's development and are delivered in a way that addresses the needs of the family as a whole.	Terms have specific meaning when included in the IFSP.
School Services Program	1.7 Plan of Care (POC)	Under "Requirements", text was revised to read: If an evaluation indicates that Medicaid-covered services are required, qualified staff must develop and maintain a POC for the student. The student's IEP/IFSP/NPSP or individual POC form may suffice as the POC if the IEP/IFSP/NPSP or individualized POC contains the required components described below. When the IFSP is used as the POC, the terms 'family training' and 'specialized instruction' may indicate an allowable direct service when associated with an approved service or allowable provider type. Only qualified staff may initiate, develop, or change the student's POC. The POC must be signed, titled, and dated by a qualified medical provider prior to billing Medicaid for services and must be retained in the student's school clinical record. By signing the POC, the qualified medical provider is indicating that they have reviewed the POC and it is appropriate for the student's needs. The qualified medical provider is not taking individual responsibility for the provision or supervision of services, coordination of services, or taking personal liability for the services performed. Services may be billed in the absence of a POC for up to 30 calendar days when determined to be medically necessary. (Refer to the Covered Services section of this chapter for definitions of qualified staff.)	

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Special Programs	13.4.F. Organization Authority, Governance, and Accreditation	In the 1st paragraph, the 3rd bullet point was revised to read: • an organization operated under the authority of the Indian Health Service, an ~~Indian~~ American Indian/Alaska Native tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 United States Code [USC] 450 et seq.); or	Updated language to reflect current terminology used by the IHS.
Telemedicine	1.13 Audio-Only Telemedicine	The last paragraph was revised to read: To effectuate this in perpetuity, MDHHS will publish audio-only databases that will include all codes MDHHS is permitting via audio-only. These databases will be created for both FFS/MHP providers and for those providers within the PIHP/CMHSP system and will be maintained on the MDHHS website. (Refer to the Directory Appendix for website information.) MDHHS will, on a regular and ongoing basis, assess the audio-only databases and will add/remove codes as needed. Some of the criteria used to determine addition/removal from the audio-only database include provider/stakeholder/partner feedback, new coding guidelines, utilization data and quality reports.	Updated language to include "partners" in addition to "stakeholders" (referring to tribal partners).
Therapy Services	1.3 Documentation in Beneficiary Medical Record	The last sentence was revised to read: For example, if a therapist performed ~~10~~ 28 minutes of a service represented by a ~~28~~ 15-minute timed procedure code and 17 minutes of another service represented by an untimed procedure code, documentation should indicate that the total treatment minutes of all timed procedure codes was 28 minutes, and the total active treatment time was 45 minutes.	Correction.
Therapy Services	3.1 Form and Completion Instructions	In the 2nd paragraph, the 2nd bullet point was revised to read: • Thorough – Complete information, including the required signatures and appropriate procedure codes, must be provided on the form. The form and all documentation must include the beneficiary's name and mihealth card ID number, provider name and facility address, ~~and~~ the provider's billing NPI number, and must support the procedure codes, quantity, and frequency being requested.	Clarification.

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Therapy Services	4.5 Therapy for Beneficiaries with Autism Spectrum Disorder	Subsection text was revised to read: Medically necessary OT, PT, and ST is covered in accordance with the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for Medicaid beneficiaries who have been diagnosed with autism spectrum disorder (ASD). The ASD diagnosis must be made by a qualified licensed practitioner as specified within the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter. Beneficiaries should be referred to the Prepaid Inpatient Health Plan (PIHP) for a comprehensive ASD assessment when further evaluation and treatment has been determined necessary. Beneficiaries ~~diagnosed with autism spectrum disorder (ASD)~~ who have been assessed and determined eligible by the ~~Prepaid Inpatient Health Plan (~~PIHP~~)~~ for specialty Behavioral Health Treatment (BHT) services may ~~also~~ have ~~any~~ ASD related OT, PT, and ST services covered through the PIHP. ~~when the therapy will result in a functional improvement that is significant to the beneficiary's ability to perform daily living tasks appropriate to their chronological, developmental or functional status. These functional improvements should be able to be achieved in a reasonable amount of time and should be durable (i.e., maintainable).~~ Therapy services covered by the PIHP must meet the criteria outlined within the Program Requirements section (Medical Necessity Criteria subsection) of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter. Providers should also refer to the Covered Services section in the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter for additional information. Therapy may be covered by the Medicaid Health Plan (MHP) or Medicaid Fee-for-Service (FFS) program if the beneficiary was assessed by the PIHP but determined ineligible for specialty BHT OT, PT, ST services. Therapy covered by the MHP/FFS must meet the standards of coverage outlined within this chapter.	Clarification.

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TECHNICAL CHANGES*

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		Beneficiaries receiving ASD therapy services through the PIHP may also receive concurrent therapy services through the MHP/FFS program for co-morbid physical health impairments or diagnosis. If therapy is provided under both the physical and behavioral health benefit, the goals and purpose for each must be distinct. Collaboration between therapy providers is required to coordinate therapy and prevent direct duplication of services. Documentation of the collaboration must be retained in the beneficiary's medical record for audit purposes. Medicaid does not require beneficiaries to be referred to or access therapy services through the Medicaid Health Plan (MHP) or Medicaid Fee-for-Service (FFS) program prior to, or in lieu of, accessing therapy through the PIHP when the therapy is related to the beneficiary's ASD diagnosis.	
Therapy Services	5.1 Standards of Coverage and Service Limitations	In the table in the last paragraph, under "Occupational therapy is not covered for the following:", the following bullet point was added: • If a therapy service requires prior authorization and the service rendered was not approved in the prior authorization request.	Clarification.
Therapy Services	6.1 Standards of Coverage and Service Limitations	In the table in the last paragraph, under "Physical therapy is not covered for the following:", the following bullet point was added: • If a therapy service requires prior authorization and the service rendered was not approved in the prior authorization request.	Clarification.
Therapy Services	7.1 Standards of Coverage and Service Limitations	In the table in the last paragraph, under "Speech-Language therapy is not covered for the following:", the following bullet point was added: • If a therapy service requires prior authorization and the service rendered was not approved in the prior authorization request.	Clarification.

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Acronym Appendix		Removal of the following: ~~**EH** - eligible hospital (NOTE: Term applies to EHR Incentive Program only.)~~ ~~**EP** - eligible professional (NOTE: Term applies to EHR Incentive Program only.)~~	Removal of obsolete information.
Directory Appendix	Prior Authorization (Authorization of Services)	Addition of: **Contact/Topic:** Distinct Part Rehab Unit and Freestanding Rehabilitation Hospital **Phone #:** 844-PACERMI (844-722-3764) **Mailing Address:** MDHHS Program Review Division PO Box 30170 Lansing, MI 48909 **Information Available/Purpose:** Telephone prior authorization for Medicaid and CSHCS admissions and continued stays	Clarification in response to L 23-55.
Directory Appendix	Pharmacy Resources	Under "List of Participating Entities in 340B Program", web address information was revised as follows: ~~https://340bopais.hrsa.gov/coveredentitysearch~~ https://340bopais.hrsa.gov/SearchCe	Update.
Directory Appendix	Pharmacy Resources	Under "Pharmacy Liaison Meeting Calendar", the website path was revised to read: https://mi.primetherapeutics.com >> Provider Portal >> Pharmacy Liaison	Update.

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TECHNICAL CHANGES*

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Pharmacy Resources	Under "Centers for Medicare & Medicaid Services", the following changes were made: **Contact/Topic:** Centers for Medicare & Medicaid Services Tamper Resistant Prescription Fact Sheet **Web Address:** ~~https://www.cms.gov/medicaremedicaid-coordination/fraudprevention/fraudabuseforprofs/trp.html~~ https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-program/education/resource-library/medicaid-tamper-resistant-prescription-law-fact-sheet	Update.
Directory Appendix	Pharmacy Resources	Addition of: **Contact/Topic:** Medicare Dual Eligible Covered NDC List **Web Address:** https://mi.primetherapeutics.com >> Provider Portal >> Documents >> Fee for Service Drug Coverage **Information/Purpose:** Medicare Part D excluded products covered for dual eligible members.	Added to align with Pharmacy chapter; Medicare Part D Benefit subsection.
Directory Appendix	Therapy Services (new section)	Addition of: **Contact/Topic:** MDHHS Therapy Services Fee Schedules **Web Address:** www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Therapies **Information Available/Purpose:** Fee schedules include current service codes that are allowed to be rendered by outpatient and nursing facility physical therapists, occupational therapists, and speech-language pathologists.	

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

CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Therapy Services (new section)	Addition of: **Contact/Topic:** Therapy Provider Liaison Meetings **Web Address:** www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Therapies **Information Available/Purpose:** Meeting minutes and other materials from scheduled Provider Liaison meetings.	
Directory Appendix	Therapy Services (new section)	Addition of: **Contact/Topic:** Occupational Therapy - Physical Therapy - Speech Therapy Prior Approval Request/Authorization Form (MSA-115) **Web Address:** www.michigan.gov/medicaidproviders >> Policy, Letters & Forms **Information Available/Purpose:** Form used by outpatient hospitals, outpatient therapy providers, nursing facilities and home health agencies to request prior authorization (PA) for therapy services.	
Directory Appendix	Other Health Care Resources/Programs	Under "Children in Foster Care", the following websites were updated: **From:** 1. ~~www.michigan.gov/mdhhs >> Adult & Children's Services >> Foster Care >> Forms and Publications~~ **To:** 1. www.michigan.gov/mdhhs >> Child Welfare Medical and Behavioral Health Resources >> Foster Care Psychotropic Medication Oversight Unit >> Psychotropic Medication Informed Consent (DHS-1643) **From:** 3. ~~http://www.massgeneral.org/psychiatry/services/psc_forms.aspx~~ **To:** 3. https://www.massgeneral.org/psychiatry/treatments-and-services/pediatric-symptom-checklist	Update.

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CHAPTER	SECTION	CHANGE	COMMENT
Directory Appendix	Miscellaneous Contact Information	Removal of the entry for "Electronic Health Record (EHR) Incentive Program".	Removal of obsolete information.
Forms Appendix	MSA-1550; Beneficiary Verification of Coverage	Form footer was revised to remove "Previous edition obsolete" language and replaced with "Previous editions may be used."	Clarification.
Forms Appendix	MSA-4240; Certification for Induced Abortion	Form footer was revised to remove "Previous edition obsolete" language and replaced with "Previous editions may be used."	Clarification.

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<table>
<tr><th>BULLETIN NUMBER</th><th>DATE ISSUED</th><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th></tr>
<tr><td>MMP 25-27</td><td>8/1/2025</td><td>Billing & Reimbursement for Professionals</td><td>7.14 School Services Program</td><td>Text was revised to read:
<table>
<tr><th>Modifier</th><th>Description</th><th>Special Instructions</th></tr>
<tr><td>HA</td><td>C4S</td><td>The HA modifier is used with an appropriate procedure code to identify services delivered outside of an IEP/IFSP/NPSP.</td></tr>
<tr><td>HT</td><td>Multi-disciplinary team</td><td>~~Use this modifier with the appropriate evaluation procedure codes to identify participation by each qualified profession in the Individuals with Disabilities Education Act (IDEA) assessment.~~
The HT modifier is used when billing for an assessment, evaluation or test performed for the IDEA assessment. Each qualified staff bills using the appropriate procedure code followed by the HT modifier (multi-disciplinary team).</td></tr>
<tr><td>~~TL~~ TJ</td><td>Re-evaluation of Existing Data (REED)</td><td>~~Use this~~ The TJ modifier is used with the appropriate procedure codes to identify when a re-evaluation of existing data (REED) was used in the determination of the ~~child's~~ student's eligibility for special education services.</td></tr>
</table></td></tr>
</table>

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Modifier	Description	Special Instructions
TL	Individualized Family Service Plan (IFSP)	The TL modifier is used with the appropriate procedure codes to identify services provided under the provisions of an IFSP.
TM	Individualized Education Program (IEP)	~~Use this modifier with the appropriate procedure codes to identify participation by each qualified staff in the development, review and revision of the IEP.~~ The TM modifier is used when billing for the multi-disciplinary evaluation team assessment for the development, review and revision of an IEP/IFSP/NPSP POC. Each qualified staff bills for this assessment using the appropriate procedure codes with the modifier. The TM modifier is also used to identify all services provided through an IEP.

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		School Services Program	Section 1 – General Information	In the last paragraph, the following terms were added: **Program Components** Indicates if the service was provided through an IEP/IFSP (DSC) or outside of an IEP/IFSP (C4S). **Program Component Modifiers** CPT/HCPCS code modifier used to indicate if the service provided was provided under provisions of an IEP (TM Modifier), an IFSP (TL Modifier), or a plan of care outside of an IEP/IFSP (HA Modifier). **TL Modifier (Individualized Family Service Plan [IFSP])** The TL modifier is used with the appropriate procedure codes to identify services provided under the provisions of an IFSP. In the last paragraph, the following terms were modified: **HA Modifier (C4S)** The HA modifier is used with ~~the~~ an appropriate procedure code~~s~~ to identify services delivered outside of an IEP/IFSP/NPSP. **~~TL~~ TJ Modifier (Re-evaluation of Existing Data [REED])** The ~~TL~~ TJ modifier is used with the appropriate procedure codes to identify when a re-evaluation of existing data (REED) was used in the determination of the student's eligibility for special education services.

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				TM Modifier (Individualized Education Program [IEP]) The TM modifier is used when billing for the multi-disciplinary evaluation team assessment for the development, review and revision of an IEP/IFSP/NPSP POC. Each qualified staff bills for this assessment using the appropriate procedure codes with the modifier. The TM modifier is also used to identify all services provided through an IEP.
			1.4 Under the Direction of and Under the Supervision of	The subsection title was revised to read: ~~Under the Direction of and Under the Supervision of~~ Supervision Requirements Text was revised to read: Certain specified services may be provided under the ~~direction~~ supervision of or under the direct supervision of another clinician. Clinicians within SSP can be divided into three general categories regarding supervision. ~~For the supervising clinician, "under the direction of" means that the clinician is supervising the student's care which, at a minimum, includes seeing the individual initially, prescribing the type of care to be provided, reviewing the need for continued services throughout treatment, ensuring professional responsibility for services provided, and ensuring that all services are medically necessary. "Under the direction of" requires face-to-face contact by the clinician at least at the beginning of treatment and periodically thereafter.~~

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				~~"Supervision of" limited licensed mental health professionals consists of the practitioner meeting regularly with another professional, at an interval described within the professional administrative rules, to discuss casework and other professional issues in a structured way. This is often known as clinical or counseling supervision or consultation. The purpose is to assist the practitioner to learn from the supervisor's experience and expertise, as well as to ensure good service to the student.~~ • Fully licensed clinicians not requiring supervision. • Limited licensed clinicians required to be under the supervision of a fully licensed clinician of the same profession. Limited licensed clinicians are required to meet regularly with the supervising clinician, at an interval described within the professional administrative rules, to discuss casework and other professional issues in a structured way. This is often known as clinical or counseling supervision or consultation. Additionally, any clinician designated as an assistant (board certified assistant behavior analyst (BCaBA), occupational therapy assistant (OTA), or physical therapy assistant (PTA), must be supervised by a fully qualified clinician from the same discipline. The purpose of supervision is to assist the supervised clinician to learn from the supervisor's experience and expertise, as well as to ensure good service to the student. • A student completing their clinical affiliation under the direct supervision of (i.e., in the presence of) a fully licensed therapist. All documentation must be reviewed and co-signed by the supervising therapist.
			1.5 Covered Services	The following bullet point was added: • Community Health Worker Services

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			1.7 Plan of Care (POC)	Under "Individuals Authorized to Review/Sign the POC", the following bullet point was added: • A limited licensed SLP (under the supervision of a licensed SLP)
			2.1 Assessment and POC Development, Review and Revision	Under "Provider Qualifications", the following bullet point was revised: ▪ A limited-licensed speech-language pathologist (under the ~~direction~~ supervision of a licensed speech-language pathologist) Under "Procedure Codes", in the 1st paragraph: Addition of the following bullet point: • The TL modifier is used with the procedure code when billing for services provided through an IFSP.

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				Revisions to the following bullet points: • The ~~TL~~ TJ modifier is used with the appropriate procedure codes to identify when a REED was used in the determination of the student's eligibility for special education services. • The TM modifier is used with the procedure code when billing for the multi-disciplinary team assessment to develop, review and revise an IEP/IFSP POC. Each qualified staff bills using the appropriate procedure code below with the modifier TM (Individualized Education Program [IEP]). The date of service is the date of the multi-disciplinary team assessment. The TM modifier is also used as a program component modifier to identify services provided through an IEP. The 2nd paragraph was revised to read: No modifier is used, other than the program component modifier, for assessments/evaluations/tests unless one of the following is true:
			2.2.A. Occupational Therapy Services	Under "Provider Qualifications", revision of the following bullet point: • A licensed occupational therapy assistant (OTA) under the ~~direction~~ supervision of a licensed OT; or
			2.3.A. Physical Therapy Services	Under "Provider Qualifications", revision of the following bullet point: • A licensed physical therapy assistant (PTA) under the ~~direction~~ supervision of a licensed PT (i.e., the PT supervises and monitors the PTA's performance with continuous assessment of the student's progress). All documentation must be reviewed and signed by the supervising PT.

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			2.4.A. Speech, Language and Hearing Therapy	Under "Provider Qualifications", revision of the following bullet points: • A speech-language pathologist (SLP) and/or audiology candidate (i.e., in their clinical fellowship year or having completed all requirements but has not obtained a license), under the ~~direction~~ direct supervision of a qualified SLP or audiologist. All documentation must be reviewed and signed by the appropriately licensed SLP or licensed audiologist; or • A limited licensed SLP, under the ~~direction~~ supervision of a fully licensed SLP or audiologist. All documentation must be reviewed and signed by the appropriately licensed supervising SLP or licensed audiologist.
			2.9 Community Health Workers (new subsection; the following subsections were re-numbered)	Addition of new subsection/text. Refer to the chapter for full content.

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			2.10 Personal Care Services (previously numbered as 2.9)	Under "Personal Care Paraprofessional Provider Qualifications", text was revised to read: Personal care paraprofessional personnel are employed by the ISD/LEA and shall be qualified under the requirements established by their respective POC. Providers must be trained in the skills needed to perform covered services and must be under the ~~direction~~ direct supervision of a qualified professional as designated in the POC. Paraprofessional personnel may include, but are not limited to: Under "Documentation", text was revised to read: PCS must be medically necessary and the need for the service must be documented in the student's POC. ~~Each student's school clinical record must contain a completed, signed and dated monthly activity log. Any days where the student is absent must be documented on the monthly activity log. Days where the student was present and services were not provided must also be documented on the monthly activity log. The monthly activity log may be in an electronic format; however, all services provided to the student must be listed.~~ Service documentation must be retained for all dates of service for which Medicaid was billed. The required documentation may be in electronic or paper format as long as the personal care service provided is clearly documented. Service categories (i.e., toileting, feeding, transferring, etc.), times, and frequencies must be documented either in the POC, in an attached document, or in the student's treatment authorization.
			11.2 Student Claims Audit Activities to be Performed by MDHHS Audit Division	The 5th bullet point was revised to read:: • Verification that the providers requiring supervision, both "under the ~~direction~~ supervision of" and "under the direct supervision of", have the necessary support documentation on file.

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				The 7th bullet point was revised to read: • ~~Confirmation that support documentation for PCS includes a completed, signed and dated monthly activity log.~~ • Service documentation must be retained for all dates of service for which Medicaid was billed. The required documentation may be in electronic or paper format as long as the personal care service provided is clearly documented.
		School Services Program Random Moment Time Study Appendix	3.3.B. AOP & Direct Medical Services Staff Pool	Revisions to the following bullet points: • Limited-Licensed Speech-Language Pathologists under the ~~direction~~ supervision of a Fully-Licensed Speech-Language Pathologist • Limited-Licensed Speech-Language Pathologists in their Clinical Fellowship Year under the ~~direction~~ direct supervision of a Fully-Licensed Speech-Language Pathologist
MMP 25-28	8/1/2025	Behavioral Health and Intellectual and Developmental Disability Supports and Services	14.2 Eligibility	Removal of the following bullet points: • ~~The child must have a score on the Global Assessment of Functioning (GAF) Scale of 50 or below.~~ • ~~The child must reside with their birth or legally adoptive parent(s) or with a relative who has been named the legal guardian for that child under the laws of the State of Michigan, provided that the relative is not paid to provide foster care for that child.~~

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
			14.2.A. Enrollment and Disenrollment (new subsection)	New subsection text reads: Eligibility for CWP includes the requirement for the child or youth to reside in a home or community-based setting at the time of enrollment into the waiver. It is also the requirement that the family agree to receive intensive home and community-based waiver services. MDHHS does not make an adverse determination on waiver enrollment based on the family's intent to pursue institutionalization or hospitalization. MDHHS will not deny enrollment or hold enrollment for the CWP if the family is seeking residential services. If a youth who is enrolled in one of the waiver programs is admitted to a residential program or hospital for a full calendar month, the PIHP should switch the beneficiary's waiver status to inactive using the Waiver Support Application (WSA). For inactive CWP beneficiaries who have not received waiver services in three months, the PIHP should proceed with disenrollment.
			14.3.A. Community Living Supports	Refer to the chapter for full content.

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			14.3.B. Enhanced Transportation	Text was revised to read: ~~Transportation costs may be reimbursed when separately specified in the individual plan of services and provided by people other than staff performing CLS, in order to enable a child served by the CWP to gain access to waiver and other community services, activities and resources. Transportation is limited to local distances, where local is defined as within the child's county or a bordering county. This service is an enhancement of transportation services covered under Medicaid. Family, neighbors, friends, or community agencies that can provide this service without charge must be utilized before seeking funding through the CWP. The availability and use of natural supports should be documented in the record.~~ ~~Parents of children served by the waiver are not entitled to enhanced transportation reimbursement.~~ Refer to policy outlined in the Non-Emergency Medical Transportation chapter of this manual.
			14.3.C. Environmental Accessibility Adaptations (EAAs)	The 1st paragraph was revised to read: Environmental Accessibility Adaptations (EAAs) include those physical adaptations to the home, specified in the individual plan of services, which are necessary to ensure the health, welfare and safety of the child, or enable them to function with greater independence in the home and without which the child would require institutionalization. Home adaptations may include the installation of ramps, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems that are essential to support the child's medical equipment. Requests for EAAs must be prior authorized by the ~~CWP Clinical Review Team following denial by all applicable insurance sources, e.g., private insurance, Children's Special Health Care Services (CSHCS), Medicaid~~ overseeing PIHP. All services shall be provided in accordance with applicable state or local building codes. A prescription is required and is valid for one year from the date of signature.

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			14.3.H.1. Coverage	The 4th and last paragraphs were revised to read: OHSS may be appropriate when: • ~~Service is necessary to safeguard against injury, hazard, or accident.~~ • ~~A beneficiary has an evaluation that includes medical necessity that determines the need for OHSS and will allow an individual to remain at home safely after all other available preventive interventions/appropriate assistive technology, environmental modifications and specialty supplies and equipment (i.e., Lifeline, Personal Emergency Response System [PERS], electronic devices, etc.) have been undertaken to ensure the least intrusive and cost-effective intervention is implemented.~~ • A beneficiary requires supervision to prevent or mitigate mental health or disability related behaviors that may impact the beneficiary's overall health and welfare during the night. • A beneficiary is non-self-directing (i.e., struggles to initiate and problem solve issues that may intermittently come up during the night or when they are typically asleep), confused or whose physical functioning overnight is such that they are unable to respond appropriately in a non-medical emergency (i.e., fire, weather-related events, utility failure, etc.). • A beneficiary has a documented history of a behavior or action that supports the need to have an awake provider on-site for supported assistance with incidental care activities that may be needed during the night that cannot be pre-planned or scheduled. • A beneficiary requires overnight supervision in order to maintain living arrangements in the most integrated community setting appropriate for their needs.

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				• Service is necessary to safeguard against injury, hazard, or accident, including monitoring for non-life-threatening self-harm behaviors that require redirection. • OHSS will allow an individual to remain at home safely after other available preventive interventions (e.g. appropriate assistive technology, environmental modifications and specialty supplies and equipment (i.e., Lifeline, Personal Emergency Response System [PERS], electronic devices, etc.) have been undertaken to ensure the least intrusive and cost-effective intervention is implemented. The following exceptions apply for OHSS: • ~~OHSS does not include friendly visiting or other social activities.~~ • ~~OHSS is not available when the need is caused by a medical condition and the form of supervision required is medical in nature (i.e., nursing facility level of care, wound care, sleep apnea, overnight suctioning, end-stage hospice care, etc.) or in anticipation of a medical emergency (i.e., uncontrolled seizures, serious impairment to bodily functions, etc.) that could be more appropriately covered under PERS or medical specialty supplies.~~ • ~~OHSS is not intended to supplant other medical or crisis emergency services to address acute injury or illness that poses an immediate risk to a person's life.~~ • ~~OHSS is not available to prevent, address, treat, or control significantly challenging anti-social or severely aggressive individualized behavior.~~ • ~~OHSS is not available for an individual who is anxious about being alone at night without a history of a mental health or disability related behavior(s) that indicates a medical need for overnight supports.~~

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				• OHSS is not intended to supplant services, such as respite, for the relief of the primary caregiver or legal guardian living in the same home. • OHSS is not intended to replace a parent's or legal guardian of a minor's obligations and parental rights of minor children living in a family home. • ~~OHSS is not an alternative to inpatient psychiatric treatment or other appropriate levels of care to meet the beneficiary's needs and is not available to prevent potential suicide or other self-harm behaviors.~~ • Payments for OHSS may not be made, directly or indirectly, to responsible relatives (i.e., spouses, parents of minor children or the legal guardian). • OHSS cannot be provided in a licensed residential setting. • If the child/youth receiving OHSS demonstrates the need for CLS or Respite, the individual plan of service (IPOS) must document coordination of services to assure no duplication of services provision with OHSS. • It does not include friendly visiting or other social activities. • It is not available for medical needs beyond provider qualification requirements (aide level staff) for the service. • It is not available in anticipation of a medical emergency. • It is not available for a child/youth without a physical, cognitive, or memory impairment who has anxiety about being alone at night. • It is not an alternative to inpatient psychiatric treatment.
			14.3.I. Respite Care	Subsection text was replaced in its entirety. Refer to the chapter for full content.

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			14.3.J. Specialized Medical Equipment and Supplies	Revision to the following sentence in the 1st paragraph: This service also includes vehicle modifications, ~~van~~ lifts and wheelchair tie-downs. Specialized medical equipment and supplies includes items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not covered by Medicaid or through other insurance. The table at the end of the subsection was removed. Text was revised and reformatted to new subsection, 14.3.J.1. Authorization of Specialized Medical Equipment and Supplies.
			14.3.J.1. Authorization of Specialized Medical Equipment and Supplies (new subsection)	New subsection contains text previously located in 14.3.J. Specialized Medical Equipment and Supplies and reflects edits. **~~Local~~ Authorization of Specialized Medical Equipment and Supplies** ~~As defined below under the various Healthcare Common Procedure Coding System (HCPCS) codes, the CMHSP may locally authorize selected medical equipment and supplies covered under this service category. Medicaid payment will not be made for items that exceed quantity/frequency limits or established Medicaid fee screens as published in the MDHHS CMHSP Children's Waiver Database in effect at the time the equipment or supply is authorized.~~ Requests for specialized medical equipment and supplies are sent to the PIHP for the PRAR process following denial by all applicable insurance sources, e.g., private insurance, CSHCS, Medicaid.

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				• **Miscellaneous therapeutic items and supplies, retail purchases, not otherwise classified; identify product in "Remarks" (HCPCS T1999)** This code is used to bill Medicaid for age-appropriate adaptive toys identified in the child's individual plan of services to address the adaptive or therapeutic need for the item and the specific habilitative outcome. Items that are typically available in a home and ordinarily provided by families, schools, etc. (e.g., crayons, coloring books, regular board games, educational or non-adaptive toys/software, CD/DVD players, camera, film, computers) are not covered. • **Personal care item, not otherwise specified, each; identify product in "Remarks" (HCPCS S5199)** This code is used to bill Medicaid for ADL aids that enable the child to be as independent as possible in areas of self-care. The child's individual plan of services must describe the purpose and use of the ADL aid and any training that the child requires for its use. ADL aids must not be similar in function to items previously billed to Medicaid. • **Specialized supply, not otherwise specified, waiver; identify product in "Remarks" (HCPCS T2028)** This code is used to bill Medicaid for allergy control supplies used for the on-going management of a diagnosed severe reaction to airborne irritants and must be specified in the child's individual plan of services. Household items routinely found in a home are not covered (e.g., bed linens, mattress, pillow, vacuum cleaner).

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				~~**State-Level Prior Authorization of Specialized Medical Equipment and Supplies**~~ ~~All other items and services covered under this category must be prior authorized by the MDHHS CWP Clinical Review Team following denial by all applicable insurance sources, e.g., private insurance, CSHCS, Medicaid. (Refer to the Children's Waiver Program [CWP] Prior Authorization subsection for details regarding the prior authorization process.) Prior authorization will not be given for items and services that exceed quantity/frequency limits as published in the MDHHS CMHSP Children's Waiver Database in effect at the time the service is authorized. Pursuant to prior authorization by the MDHHS CWP Clinical Review Team and provision of the items or service, Medicaid payment will be at the rate prior authorized.~~ • **Specialized medical equipment, not otherwise specified, waiver (HCPCS T2029)** This code is used to bill Medicaid for environmental safety and control devices that enable the child to be as independent as possible. These devices may assist in controlling the environment or assuring safety in conjunction with programs designed to teach safety awareness or skills. The child's individual plan of services must address the use of the device and include any training that the child requires for its use. Environmental safety and control devices do not include items of general utility such as standard smoke detectors, fire extinguishers, home security systems, and storage cabinets. This service is limited to five environmental safety and control devices or sets of devices per quarter. A set is considered a group of like items that must be purchased in a quantity to meet the child's needs, e.g., outlet plug covers.

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				• **Repair or non-routine service for durable medical equipment other than oxygen requiring the skill of a technician, labor component, per 15 minutes (HCPCS K0739)** This code is used to bill Medicaid for repairs to specialized medical equipment that are not covered benefits through other insurances. There must be documentation in the child's individual plan of services that the specialized medical equipment continues to be of direct medical or remedial benefit to the child. All applicable warranty and insurance coverage must be sought and denied before requesting funding for repairs through the CWP. The CMHSP must document that the repair is the most cost-effective solution when compared with replacement or purchase of a new item. If the equipment requires repairs due to misuse or abuse, the CMHSP must provide evidence of training in the use of the equipment to prevent future incidents. • **Vehicle modifications, waiver; per service (HCPCS T2039)** This code is used to bill Medicaid for modifications to ~~full-size vans, van~~ vehicles, wheelchair lifts and wheelchair tie-down systems. Modifications to the family-owned ~~van~~ vehicle must be necessary to ensure the accessibility of the child with mobility impairments, and the vehicle must be the child's primary means of transportation. The individual plan of services must specify the child's accessibility needs that will be addressed by these modifications. Prior authorization for a ~~van~~ wheelchair lift will be considered no more frequently than once every five years, which is the minimum life expectancy of a lift.

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				When purchasing new vehicles, many automobile manufacturers offer a rebate of up to $1,000 to reimburse documented expenditures for modification of a vehicle for accessibility. The CMHSP must request that the family purchasing the vehicle obtain information regarding any rebate programs and apply the rebate toward the cost of the modifications. Coverage of vehicle modifications to newly purchased vehicles or purchasing vehicles with a pre-installed lift should be considered. The PRAR process should be followed for coverage of pre-installed lifts. Other modifications ~~to a full-size van~~, such as raised doors, which are necessary to meet the child's accessibility needs will be considered. It is expected that the CMHSP will use prudence in considering and processing beneficiary requests for modifications to newly purchased vehicles (e.g., providing evidence that the child's needs were considered in purchasing a ~~full-size van; purchasing a~~ vehicle that has a raised roof). ~~Conversions to mini-vans are limited to the same modification and would not include additional costs required to modify the frame (e.g., lower the floor) to accommodate a lift.~~ Excluded are items such as automatic door openers, remote car starters, custom interiors, etc. The purchase of a vehicle or maintenance to the vehicle is the family's responsibility.

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				If the vehicle is stolen or damaged beyond repair within five years of the purchase, replacement would only be considered with documentation that the existing lift cannot be transferred to a new van and that no other funding source (e.g., automobile insurance, homeowner's insurance, personal liability, judgment settlement, etc.) is available to cover the replacement. • **Durable medical equipment, miscellaneous (HCPCS E1399)** This code is used to bill Medicaid for durable medical equipment as described below: ➢ Window air-conditioning unit for the room where the child spends the majority of their time (e.g., sleeping area). The child must have a documented medical diagnosis of one of the following specific medical diagnoses or conditions: ▪ temperature regulation dysfunction due to brain injury or other medical diagnosis; ▪ severe respiratory distress secondary to asthma, permanent lung damage, or other medical conditions which are exacerbated by heat and humidity; ▪ severe dehydration resulting from a medical diagnosis (e.g., diabetes insipidus) which may result in hospitalization; or ▪ severe cardiac problems which may result in hospitalization unless the environmental temperature is carefully controlled.

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				➢ Generator for a child who is ventilator-dependent or requires daily use of oxygen via a concentrator. The size of a generator will be limited to the wattage required to provide power to essential life-sustaining equipment (typically 5,000 watts) and is not intended to provide power for the entire home. The request for prior approval of a generator must include a documented history of power outages, including frequency and duration. The local power company must be notified in writing of the need to restore power on a priority basis due to the child's needs. ➢ Therapeutic items, assistive technology, and other durable medical equipment for a child who has sensory, communication, or mobility needs when the item is reasonably expected to enable the child to perceive, control or communicate with the environment in which the child lives, to have a greater degree of independence than would be possible without the item or device, or to benefit maximally from a program designed to meet physical or behavioral needs.

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			14.3.K. Specialty Services	In the 1st paragraph, the following bullet point was added: ▪ Equine Therapy The following text was added: An equine therapist must hold a current license in the State of Michigan as an occupational therapist, physical therapist, speech pathologist, clinical social worker, psychologist, or professional counselor. The equine therapist must have appropriate specialized training and experience and must deliver services within their scope of practice. Specialized training includes (but is not limited to) the following credentials: • Certification by the American Hippotherapy Certification Board • Certification by other MDHHS-approved certification boards • Completion of documented coursework in an applicable training program that is administered by an accredited university and approved by MDHHS Equine services are limited to four sessions per therapy per month.
			14.4 Children's Waiver Program (CWP) Prior Authorization	Refer to the chapter for full content.

BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
		Behavioral Health and Intellectual and Developmental Disability Supports and Services – Children's Waiver Community Living Supports Services Appendix	3.4 Exception Process	The 2nd paragraph was revised to read: Contingent upon the availability of funds and upon receipt of a Prior Review and Approval Request (PRAR), limited authority to exceed the published hourly care amount defined in the Decision Guide subsection may be granted by ~~MDHHS~~ a PIHP to a CMHSP to better serve identified children with exceptional care needs. The PRAR must be developed pursuant to family request, person-centered planning~~/family-centered practice team~~ recommendation, and CMHSP administrative concurrence. The 5th and 6th paragraphs were revised to read: Exceptions approved by ~~MDHHS~~ a PIHP can occur in one of the following ways: • Temporary emergency basis only. Verbal approval can be given to the CMHSP, with written justification to be forwarded to ~~MDHHS~~ the PIHP within 10 days; or • In a non-emergency situation, the CMHSP provides ~~MDHHS~~ the PIHP with written documentation of the specific rationale to support the exception (i.e., physician's prescription). This would include a revised Plan of Care, highlighting the care needs to be provided with the additional staffing hours, and all current assessments. A response from ~~MDHHS~~ the PIHP will occur within 10 working days. When approval of an exception is not granted through either of the two processes listed above, the family, case manager, or ~~MDHHS~~ PIHP may request a meeting in order to clarify and reconsider the basis for the exception.

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				The last paragraph was removed. ~~MDHHS has the option to request a home visit to meet the child when it is necessary for an effective decision.~~
		Directory Appendix	Behavioral Health/SUD Resources	The entry for "Children's Waiver Program" was removed.
		Directory Appendix	Other Health Care Resources/Programs	Addition of: **Contact/Topic:** Children's Waiver Program **Mailing/Email/Web Address:** MDHHS - Home and Community-Based Services Policy and Implementation Section Division of Access Standards, Service Array, and Policy Bureau of Children's Coordinated Health Policy and Supports 333 S. Grand Ave. Lansing, MI 48933 Email: MDHHS-BCCHPS-Waivers@michigan.gov **Information Available/Purpose:** Information regarding the Children's Waiver program.

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MMP 25-29	9/30/2025	Nursing Facility Cost Reporting & Reimbursement Appendix	3.4.A. Receivership (new subsection)	New subsection text reads: In the case of receivership, MDHHS will adjust a nursing facility's standard rates if a receiver has been appointed under MCL 600.2926 or MCR 2.622(A) solely to reflect the reasonable costs associated with the court-approved closure or sale of the nursing facility or other appropriate situation. This rate adjustment will only apply to the current fiscal rate period of the request and the following fiscal rate period. After this adjustment time period, the facility will return to the standard reimbursement methodology. If, upon audit, the agency finds a discrepancy between certified information and actual costs, all excess funds paid by the State to the facility as a result of that certification will be recovered with a penalty factor (equal to the then-current Medicare rate on net invested equity) applied to the discrepancy. Requests for consideration must be made in writing to the Reimbursement and Rate Setting Section (RARRS) at least 90 days in advance of the sale.

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MMP 25-30	8/29/2025	Local Health Departments	6.4 Filing Cost Reports	Subsection text was revised in its entirety. New text reads: Each LHD, unless specifically exempt, is required to submit a Medicaid Cost Report to the Facility Settlement subsystem in the Community Health Automated Medicaid Processing System (CHAMPS) on or before the last day of the fifth month following the close of its cost reporting period. The MDHHS Hospital and Clinic Reimbursement Division (HCRD) grants extensions only when an LHD's operation is adversely affected due to circumstances beyond its control (e.g., staffing turnovers are considered within the control of the LHD, whereas fires and floods would be considered beyond its control). If an LHD fails to submit a completed Medicaid Cost Report via the MDHHS Facility Settlement system on time and has not been granted an extension of the time limit, a notice of delinquency is issued. If a complete and acceptable Medicaid Cost Report is not submitted within 30 calendar days from the date of the notice of delinquency, the LHD's fee-for-service (FFS) payments and gross adjustment payments are suspended until the Medicaid Cost Report is accepted by MDHHS HCRD in the Facility Settlement system. Payments withheld due to late submission are paid upon acceptance of the Medicaid Cost Report. Managed care encounters are not subject to payment suspension.

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MMP 25-31	8/29/2025	Behavioral Health and Intellectual and Developmental Disability Supports and Services	2.1 Mental Health and Developmental Disabilities Services	The following bullet points were added: • Discuss self-directed service arrangements, including how budgets are developed and can be flexibly used to implement services, summary of methods to implement self-directed service arrangements, and the allowable use of budget dollars to spend on all components of medically necessary service. • Discuss with the beneficiary during the person-centered planning process all components of services (i.e., for CLS, this includes components such as transportation, activities, staff wages, employer costs, training time) as well as the amount, scope, duration, and frequency of each such component that may be medically necessary for the participant. Components of services are defined in relevant service sections of the Medicaid Provider Manual and the Behavioral Health Code Charts and Provider Qualifications.
			2.5 Medical Necessity Criteria	Text was revised to read: The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services and must be specific to the beneficiary.

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			2.5.B. Determination Criteria	Text was revised to read: The determination of a medically necessary support, service or treatment must be: • Tailored to the beneficiary's unique goals and objectives, as documented in the individual plan of service; • Based on information provided by the beneficiary, beneficiary's family, and/or other individuals (e.g., friends, personal assistants/aides) who know the beneficiary; • Based on clinical information (e.g., assessments conducted with input from the beneficiary and their support system) from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary; • ~~For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;~~ • For beneficiaries with mental illness or developmental disabilities, made in and as part of the PCP process; • For beneficiaries with substance use disorders, made during individualized treatment planning; • Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience; • Made within federal and state standards for timeliness; • Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and • Documented in the individual plan of service.

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			2.5.D. PIHP Decisions	Addition of the following text: PIHP decisions, specifically including utilization management, will not replace the PCP process. For example, utilization management review may not remove or change the beneficiary's goals. It may provide for less costly alternatives that accomplish the same goals. Edits to the beneficiary's Individual Plan of Service (IPOS) require the PCP process be reopened.
			2.5.D.1. PIHP Decisions for SD Service Arrangements/ Choice Voucher and Associated Budgets (new subsection)	Addition of new subsection/text. Refer to the chapter for full content.
			2.5.D.2. PIHP Decisions for HSW SD Service Arrangements/Choice Voucher and Associated Budgets (new subsection)	Addition of new subsection/text. Refer to the chapter for full content.
			2.5.E. Administrative Law Judge (ALJ) (new subsection)	Addition of new subsection/text. Refer to the chapter for full content.

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			2.5.E.1. ALJ Authority in Termination of Self-Directed Service Arrangements and Choice Voucher Hearings (new subsection)	Addition of new subsection/text. Refer to the chapter for full content.
			2.5.E.2. ALJ Authority in HSW Self-Directed and Choice Voucher Budget Hearings (new subsection)	Addition of new subsection/text. Refer to the chapter for full content.
			15.1.A. Community Living Supports (CLS)	The 2nd paragraph was replaced with the following text: ~~CLS does not include costs associated with room and board. Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian.~~ Any support may be covered as CLS if it is described in the Community Living Supports section of this chapter and is determined through the PCP process to "facilitate an individual's independence, productivity, and promote community inclusion and participation" for the particular beneficiary. Basic coverage criteria are defined in the Medical Necessity Criteria subsection of the Provider Requirements section of this chapter.

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				CLS does not include: • Costs associated with room and board • Financial management services • Purchase or rental of a vehicle • In-home entertainment subscription Payments for CLS may not be made, directly or indirectly, to responsible relatives (i.e., spouses or parents of minor children) or the legal guardian. However, payments to a non-guardian parent of an adult, or to a spouse of a legal guardian, are permitted. The following text was added after the 3rd paragraph: Costs that may be covered for CLS (and thus are reimbursed through the CLS rate) include, but are not limited to, the following if they are (1) not already covered by another Medicaid service provided to the beneficiary, (2) medically necessary for a particular CLS beneficiary, and (3) related to the beneficiary's IPOS goals of facilitating independence and productivity or of promoting community inclusion and participation: • CLS staff compensation (wages, benefits [such as health insurance and retirement contributions], payroll taxes, and Human Resource requirements which include required trainings, supervision and planning meetings) for time spent on any activities covered by CLS, including CLS staff time spent on delivering CLS services in the beneficiary's residence, required training, planning meetings, supervision, travel with the beneficiary, and attendance at community activities with the beneficiary.

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				• Transportation costs for the beneficiary and the CLS staff (i.e., mileage) to go to and from community activities (not to and from medical appointments). • Fees and other charges for a community activity for a CLS beneficiary and for the CLS worker to accompany the beneficiary in the community activity, including, for example: gym fee, movie ticket, theme park admission, meal in the community, fee for bowling, fee for horseback riding. • Membership fees for organizations that support the identified CLS objectives. If a particular activity, put in the IPOS through the PCP process, meets the definition of medical necessity and the definition of CLS, then it is part of the "scope" of the CLS service.
			15.1.F. Fiscal Intermediary	The following text was added: Financial Management Services (FMS) does not make a final determination on the amount, scope, or duration of services. No aspect of creating the budget is delegated to FMS personnel. The role of the FMS is to support the beneficiary. For example, the FMS supports the beneficiary to help ensure the budget created is implemented as planned.
			17.4.E. Fiscal Intermediary Services	The following text was added: Financial Management Services (FMS) does not make a final determination on the amount, scope, or duration of services. No aspect of creating the budget is delegated to FMS personnel. The role of the FMS is to support the beneficiary. For example, the FMS supports the beneficiary to help ensure the budget created is implemented as planned.

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BULLETIN NUMBER	DATE ISSUED	CHAPTER	SECTION	CHANGE
MMP 25-32	8/29/2025	Laboratory	2.7 Billing for Services Performed by Reference Laboratories Under Arrangement with Enrolled Hospital Laboratories	The subsection title was revised to read: Billing for Services Performed by Reference Laboratories Under Arrangement with Enrolled ~~Hospital~~ Laboratories The subsection was reformatted to include additional subsections. Text in 2.7 was relocated to 2.7.A. Hospital Laboratories.
			2.7.A. Hospital Laboratories (new subsection)	Text in 2.7 was relocated to 2.7.A. Hospital Laboratories.
			2.7.B. Independent Clinical Laboratories (new subsection)	New subsection text reads: Medicaid-enrolled independent laboratories have the option to bill Medicaid for arranged services provided by a reference laboratory under the following conditions: • The reference laboratory holds the required CLIA certification and state licensure, if required, to perform the test; • The enrolled referring laboratory and the reference laboratory have a contractual agreement to provide such services, ensuring compliance with federal and state laws (i.e., Anti-Kickback Statute [AKS], Eliminating Kickbacks in Recovery Act [EKRA], Stark, and False Claims Act); and • The referring laboratory is responsible for reimbursing the reference laboratory for the services.

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			2.7.B.1. Billing and Reimbursement (new subsection)	New subsection text reads: An independent laboratory that elects to bill for a referred service must report the service with modifier 90 and include both the billing's and the performing reference laboratory's name, NPI number, and address along with the performing laboratory's CLIA number in the appropriate claim loop or field. If an electronic claim submission contains both referred and non-referred tests, the claim must include the reference laboratory's information in loop 2420C on the referred test lines. The referring laboratory should bill for referred and non-referred tests separately when utilizing a paper claim format. If the service requires prior authorization (PA), the referring laboratory must request and receive PA approval for the test to be performed by the reference laboratory. The PA number must be included on the claim. The referring laboratory may not charge Medicaid more than it has paid the reference lab for performing laboratory testing. Claim submission on a specimen referred to and processed by another laboratory constitutes acceptance of fiscal responsibility, including recoupment, for monies paid for the reference testing and adherence to Medicaid laboratory policy.
		Acronym Appendix		Addition of: AKS - Anti-Kickback Statute EKRA - Eliminating Kickbacks in Recovery Act
MMP 25-34	8/29/2025	Nursing Facility Certification, Survey & Enforcement Appendix	2.5 Medicaid Enrollment as a Ventilator Dependent Care Unit (VDCU) and Additional VDCU Beds	Subsection text was replaced in its entirety. Refer to the chapter for full content.

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MMP 25-36	8/29/2025	Behavioral Health and Intellectual and Developmental Disability Supports and Services	21.2 Provider Requirements (new subsection; the following subsections were re-numbered)	Addition of new subsection/text. Refer to the chapter for full content.
			21.2.A. MichiCANS Screener (new subsection)	Addition of new subsection/text. Refer to the chapter for full content.
			21.2.B. MichiCANS Comprehensive (new subsection)	Addition of new subsection/text. Refer to the chapter for full content.
			21.2.C. Involvement of Child Welfare Workers, Foster Parents, and Relative Caregivers (new subsection)	Addition of new subsection/text. Refer to the chapter for full content.
			21.10 Waiver for Children with Serious Emotional Disturbance (SEDW) (new subsection)	Addition of new subsection/text. Refer to the chapter for full content.
			21.10.A. Eligibility Criteria (new subsection)	Addition of new subsection/text. Refer to the chapter for full content.

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			21.10.A.1. Ages Birth Through 5 (new subsection)	Addition of new subsection/text. Refer to the chapter for full content.
			21.10.A.2. Ages 6 Through 20 (new subsection)	Addition of new subsection/text. Refer to the chapter for full content.
MMP 25-37	8/29/2025	Behavioral Health and Intellectual and Developmental Disability Supports and Services – Children With Serious Emotional Disturbances Home and Community-Based Services Waiver Appendix	1.1 Key Provisions	Text was revised to read: The SEDW enables Medicaid to fund necessary home and community-based services for beneficiaries up to age 21 (one day prior to 21st birthday) with SED who meet the criteria for admission to a state inpatient psychiatric hospital and/or who are at risk of hospitalization without waiver services. The PIHP is responsible for assessment of potential waiver candidates. Application for the SEDW is made through the PIHP. The PIHP is responsible for the coordination of the SEDW services. ~~The Wraparound Facilitator, the beneficiary and their family and friends, and other professional members of the planning team work cooperatively to identify the beneficiary's needs and to secure the necessary services.~~ All services and supports must be included in an IPOS. A SEDW beneficiary must receive at least one SED waiver service, in addition to Intensive Care Coordination with Wraparound (ICCW) or Targeted Case Management, per month in order to retain eligibility.

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			1.2 Eligibility	The following text was added: The Michigan Department of Health and Human Services (MDHHS) must use the Decision Support Model criteria from the Michigan Child and Adolescent Needs and Strengths (MichiCANS) Comprehensive Decision Support Model tool to measure functional limitations for the purposes of determining eligibility for SEDW. The Child and Adolescent Functional Assessment Scale (CAFAS), Preschool and Early Childhood Functional Assessment Scale (PECFAS), and Devereaux Early Childhood Assessment (DECA) are required tools through state spending and CMS notification of close-out of American Rescue Plan Act Section 9817 funding as listed below: • For new applicants, MDHHS must use either the CAFAS, PECFAS, or DECA and the MichiCANS. If the results are different and one tool indicates eligibility, MDHHS must apply the results that establish the applicant is eligible. • For children, youth, or young adults receiving a re-evaluation of eligibility, MDHHS must use the MichiCANS. If the results indicate that a participant is no longer eligible, MDHHS must verify ineligibility with either the CAFAS, PECFAS or DECA.
			1.4 Enrollment and Disenrollment (new subsection)	Addition of new subsection/text. Refer to the chapter for full content.

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			Section 2 – Covered Waiver Services	Text was revised to read: Each beneficiary must have a comprehensive ~~Wraparound Plan and~~ IPOS that ~~specify~~ specifies the services and supports that the beneficiary and family will receive. ~~The Wraparound Plan is to be developed through the Wraparound Planning Process.~~ Each beneficiary must have a ~~Wraparound Facilitator who is responsible to assist the beneficiary/family in identifying, planning and organizing the Child and Family Team, developing the Wraparound Plan, and coordinating services and supports~~ Care Coordinator or Case Manager who oversees and facilitates planning and coordination among the family, providers, and other team members. (Refer to the Intensive Care Coordination with Wraparound (ICCW) Services for Children and Adolescents section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of this Manual for additional information.) In addition to Medicaid state plan services, beneficiaries enrolled in the SEDW may receive any of the following Serious Emotional Disturbances Waiver (SEDW) services as identified in the ~~Wraparound Plan and~~ IPOS.
			2.1 Child Therapeutic Foster Care	The subsection title was revised to read: Child Therapeutic ~~Foster~~ Family Care Subsection text was revised in its entirety. Refer to the chapter for full content.
			2.2 Community Living Supports	Subsection text was revised in its entirety. Refer to the chapter for full content.

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			2.3 Family Home Care Training	The subsection title was revised to read: ~~Family~~ Home Care Training – Family Text was revised to read: ~~Family~~ Home Care Training - Family provides training and counseling services for the families of beneficiaries served by this waiver. For purposes of these services, "family" is defined as the person(s) who lives with or provides care to a beneficiary served by the waiver and may include a parent and/or siblings or the foster parent(s) for a beneficiary in Child Therapeutic ~~Foster~~ Family Care. This service is provided by a Master's level social worker, psychologist, or qualified mental health professional (QMHP), includes instruction about treatment interventions and support intervention plans specified in the IPOS, and includes updates as necessary to safely maintain the beneficiary at home. ~~Family~~ Home Care Training - Family is also a counseling service directed to the family and designed to improve and develop the family's skills in dealing with the life circumstances of parenting a beneficiary with special needs and to help the beneficiary remain at home. All family training must be included in the beneficiary's IPOS and must be provided on a face-to-face basis and with the family present.
			2.4 Family Support and Training	Text was revised to read: Family Support and Training is not a service in the SEDW service array. For Parent Support Partner Service, refer to the Family Support and Training subsection (Behavioral Health §1915(I) Home and Community-Based Services (HCBS) State Plan Amendment Supports and Services section) of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of this Manual.

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			2.5 Fiscal Intermediary Services	The subsection title was revised to read: ~~Fiscal Intermediary~~ Financial Management Services The 1st and 2nd paragraphs were revised to read: A ~~fiscal intermediary~~ Financial Management Service is an independent legal entity that acts as the fiscal agent of the PIHP for the purpose of ensuring financial accountability for the funds authorized to purchase the services and supports identified in the beneficiary's IPOS. The ~~fiscal intermediary~~ Financial Management Service receives the funds; makes payments authorized by the beneficiary's representative to providers of services and supports; and acts as an employer agent when the beneficiary's representative directly employs staff or other service providers. ~~Fiscal intermediary~~ Financial Management Services include, but are not limited to: The 3rd paragraph was revised to read: The ~~fiscal intermediary~~ Financial Management Service may also perform other supportive functions that enable the beneficiary and their representative to self-direct needed services and supports. These functions may include helping the beneficiary recruit staff (e.g., developing job descriptions, placing ads, assisting with interviewing) – as requested by the beneficiary's representative; contracting with or employing and directing providers of services; verification of provider qualifications (including reference and background checks); and assisting the beneficiary and their representative to understand billing and documentation requirements.

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			2.6 Home Care Training, Non-Family	The 1st and 2nd paragraphs were revised to read: This service is reimbursable for up to four sessions per day but no more than 12 sessions per 90 days (i.e., three calendar months). A session can be of varying lengths of time but should meet the needs of the individual plan of service (IPOS); a billable session must be at least 45 minutes. This service provides coaching, training, supervision and monitoring of CLS staff by clinicians (i.e., licensed psychologist, Master's level social worker, occupational therapist, physical therapist, speech therapist, or Child Mental Health Professional). Professional staff work with CLS staff to implement the beneficiary's IPOS, with focus on services designed to improve the beneficiary's social interactions and self-control by instilling positive behaviors instead of behaviors that are socially disruptive, injurious to the beneficiary or others, or that cause property damage. The activities of the professional staff ensure the appropriateness of services delivered by CLS staff and continuity of care. This service can be provided by more than one clinician in any given month, as the service provider is selected on the basis of their competency in the aspect of the IPOS on which training is conducted.

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			2.7.A. Coverage	The 4th and last paragraphs were revised to read: OHSS may be appropriate when: • ~~Service is necessary to safeguard against injury, hazard, or accident.~~ • ~~A beneficiary has an evaluation that includes medical necessity that determines the need for OHSS and will allow a beneficiary to remain at home safely after all other available preventive interventions/appropriate assistive technology, environmental modifications and specialty supplies and equipment (i.e., Lifeline, Personal Emergency Response System [PERS], electronic devices, etc.) have been undertaken to ensure the least intrusive and cost-effective intervention is implemented.~~ • A beneficiary requires supervision to prevent or mitigate mental health or disability related behaviors that may impact the beneficiary's overall health and welfare during the night. • A beneficiary is non-self-directing (i.e., struggles to initiate and problem solve issues that may intermittently come up during the night or when they are typically asleep), confused or whose physical functioning overnight is such that they are unable to respond appropriately in a non-medical emergency (i.e., fire, weather-related events, utility failure, etc.). • A beneficiary has a documented history of a behavior or action that supports the need to have an awake provider on-site for supported assistance with incidental care activities that may be needed during the night that cannot be pre-planned or scheduled. • A beneficiary requires overnight supervision in order to maintain living arrangements in the most integrated community setting appropriate for their needs. • Service is necessary to safeguard against injury, hazard, or accident, including monitoring for non-life-threatening self-harm behaviors that require redirection.

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				• OHSS will allow an individual to remain at home safely after other available preventive interventions (e.g. appropriate assistive technology, environmental modifications and specialty supplies and equipment (i.e., Lifeline, Personal Emergency Response System [PERS], electronic devices, etc.)) have been undertaken to ensure the least intrusive and cost-effective intervention is implemented. The following exceptions apply for OHSS: • ~~OHSS does not include friendly visiting or other social activities.~~ • ~~OHSS is not available when the need is caused by a medical condition and the form of supervision required is medical in nature (i.e., nursing facility level of care, wound care, sleep apnea, overnight suctioning, end-stage hospice care, etc.) or in anticipation of a medical emergency (i.e., uncontrolled seizures, serious impairment to bodily functions, etc.) that could be more appropriately covered under PERS or medical specialty supplies.~~ • ~~OHSS is not intended to supplant other medical or crisis emergency services to address acute injury or illness that poses an immediate risk to a person's life.~~ • ~~OHSS is not available to prevent, address, treat, or control significantly challenging anti-social or severely aggressive individualized behavior.~~ • ~~OHSS is not available for a beneficiary who is anxious about being alone at night without a history of a mental health or disability related behavior(s) that indicates a medical need for overnight supports.~~ • OHSS is not intended to supplant services, such as respite services, for the relief of the primary caregiver or legal guardian living in the same home.

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				• OHSS is not intended to replace a parent's or legal guardian of a minor's obligations and parental rights of minor children living in a family home. • ~~OHSS is not an alternative to inpatient psychiatric treatment or other appropriate levels of care to meet the beneficiary's needs and is not available to prevent potential suicide or other self-harm behaviors.~~ • Payments for OHSS may not be made, directly or indirectly, to responsible relatives (i.e., spouses, parents of minor children or the legal guardian). • OHSS cannot be provided in a licensed residential setting. • If the child/youth receiving OHSS demonstrates the need for CLS or Respite, the individual plan of service (IPOS) must document coordination of services to assure no duplication of services provision with OHSS. • It does not include friendly visiting or other social activities. • It is not available for medical needs beyond provider qualification requirements (aide level staff) for the service. • It is not available in anticipation of a medical emergency. • It is not available for a child/youth without a physical, cognitive, or memory impairment who has anxiety about being alone at night. • It is not an alternative to inpatient psychiatric treatment.

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			2.8 Respite Care	Text was revised to read: ~~Respite care is services provided to beneficiaries unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. This service can be provided by a qualified provider under contract with the PIHP/CMHSP. A parent or guardian may not be considered a provider, nor be reimbursed for this service.~~ Respite care services are provided to children/youth on a short-term basis due to the need for relief of those persons normally providing care. The purpose of respite care is to relieve the child's/youth's family from daily stress and care demands. "Short-term" means the respite service is provided during a limited period of time (e.g. a few hours, a few days, weekends, or for vacations). Decisions about the methods and amounts of respite are decided during the person-centered, family-driven youth-guided planning process and are specified in the IPOS. Paid respite care may not be provided by a parent or legal guardian of an SEDW child/youth. The maximum respite allocation is 1,248 units (312 hours) per month. Federal Financial Participation (FFP) may not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. Respite care can be provided in the following locations: • ~~Beneficiary's home or place of residence~~ • The child's/youth's home or place of residence or in a local community setting • Home of a relative or family friend's home in the community • Licensed Children's Camp • Licensed Foster Family Home ~~or Foster Family Group Home~~ • Licensed Foster Family Group Home • Children's Camp licensed by MDHHS • Licensed Children's Therapeutic Group Home

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			2.9 Therapeutic Activities	Text was revised to read: A therapeutic activity is an alternative service that can be used in lieu of, or in combination with, traditional professional services. The focus of therapeutic activities is to interact with the child to accomplish the goals identified in the IPOS. The IPOS ensures the child's health, safety and skill development and maintains the child in the community. Services must be directly related to an identified goal in the IPOS. Providers are identified through the ~~wraparound planning~~ person-centered, family-driven youth-guided planning process and participate in the development of a IPOS based on strengths, needs, and preferences of the child and family. Therapeutic activities may include the following: child and family training, coaching and supervision, monitoring of progress related to goals and objectives, and recommending changes to the IPOS. Services provided under Therapeutic Activities include music therapy, recreation therapy, ~~and~~ art therapy, and equine therapy. NOTE: The unit of service when billing G0176 for children/youth on the SEDW is per session, 45 minutes or more. Each therapeutic activity type is limited to four therapy sessions per month. The training, coaching, supervision and monitoring activities provided under this service are specific to music, art, ~~and~~ recreation, and equine therapy and must be provided by providers with the qualifications listed below.

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				<table><tr><td>Recreation Therapy</td><td>Must be provided by a Certified Therapeutic Recreation Specialist credentialed by the National Council for Therapeutic Recreation Certification (NCTRC).</td></tr><tr><td>Music Therapy</td><td>Must be provided by a Music Therapist - Board Certified (MT-BC) or by a music therapist listed on the National Music Therapy Registry (NMTR).</td></tr><tr><td>Art Therapy</td><td>Must be provided by a Registered Art Therapist - Board Certified (ATR BC).</td></tr><tr><td>Equine Therapy</td><td>Equine therapist must hold a current license in the state of Michigan as an occupational therapist, physical therapist, speech pathologist, clinical social worker, psychologist, or professional counselor. The equine therapist must have appropriate specialized training and experience and must deliver services within their scope of practice. Specialized training includes (but is not limited to) the following credentials: - Certification by the American Hippotherapy Certification Board - Certification by other MDHHS-approved certification boards - Completion of documented coursework in an applicable training program that is administered by an accredited university and approved by MDHHS </td></tr></table>

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				Recreation Therapist, Music Therapist, and Art Therapist are not required to be board certified to provide services in their field but must have completed all educational coursework requirements and be under the appropriate supervision working toward board certification in their respective fields.
			2.10 Therapeutic Overnight Camp	The 1st paragraph was revised to read: Therapeutic Overnight Camp is a group recreational and skill building service in a camp setting aimed at meeting the goal(s) detailed in the beneficiary's IPOS. A session can be one or more days and nights of camp. Room and Board costs are excluded from the SEDW payment for this service. ~~The maximum overnight camp allocation is $1,400 per session – three sessions per fiscal year.~~ Frequency is three sessions per year. Each session can encompass several days and nights.

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			2.11 Wraparound Services	The subsection title was revised to read: ~~Wraparound~~ Case Management Services Text was revised to read: (Refer to the Intensive Care Coordination with Wraparound (ICCW) Services for Children and Adolescents subsection of the Covered Services section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of this Manual.) ~~Wraparound services for beneficiaries is a highly individualized planning process facilitated by specialized Wraparound Facilitators. Due to the intense needs and level of risk of beneficiaries and their families served in the SEDW, all SEDW Wraparound providers must meet the following additional requirement:~~ • ~~Wraparound facilitators and those who provide supervision to facilitators will attend additional training (16 hours) related to provision of support to beneficiaries and their families served in the waiver annually as required by MDHHS. This training is in addition to identified requirements for all supervisors and Wraparound facilitators.~~
			2.11.A. Requirement for Participation in ICCW or TCM (new subsection)	Addition of new subsection/text. Refer to the chapter for full content.
			2.11.B. Requirements for Delivery of ICCW and TCM (new subsection)	Addition of new subsection/text. Refer to the chapter for full content.

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			2.11.C. Provider Qualifications (new subsection)	Addition of new subsection/text. Refer to the chapter for full content.
			Section 3 – Medicaid State Plan Services	The 3rd paragraph was removed. ~~PIHPs are responsible for transportation to and from the beneficiary's place of residence when provided so that a beneficiary may participate in a state plan, HSW, or additional/1915(i) State Plan Amendment (SPA) service at an approved day program site or in a clubhouse psychosocial rehabilitation program. Medicaid Health Plans (MHPs) are responsible for assuring enrollee transportation to Medicaid covered medical appointments. MDHHS is responsible for assuring transportation to medical appointments for Medicaid beneficiaries not enrolled in MHPs (except those noted above and in the HSW program – described in the Habilitation Supports Waiver for Persons with Developmental Disabilities Section of this chapter).~~
			Section 4 – Provider Qualifications	Addition of the following text: Refer to the Intensive Care Coordination with Wraparound (ICCW) Services for Children and Adolescents subsection or the Targeted Case Management subsection of the Covered Services section of the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter of this Manual.
			4.1 Respite and CLS	Revision of the following bullet point: • Trained on the IPOS and crisis safety plan, as applicable.

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			4.2 Wraparound Facilitator	The subsection title was revised to read: ~~Wraparound Facilitator~~ Case Managers
			4.4 Therapeutic Overnight Camp	Text was revised to read: Therapeutic Overnight Camps must be licensed and certified by MDHHS. Staff must be trained in working with children and youth with SED. Staff must be trained in the IPOS and crisis safety plan.
MMP 25-38	8/29/2025	Behavioral Health and Intellectual and Developmental Disability Supports and Services	3.32 Parent Support Partner (new subsection)	Addition of new subsection/text. Refer to the chapter for full content.
			3.32.A. Service Eligibility and Coverage (new subsection)	Addition of new subsection/text. Refer to the chapter for full content.
			3.32.B. Qualified Staff (new subsection)	Addition of new subsection/text. Refer to the chapter for full content.
			3.32.C. Training Requirements (new subsection)	Addition of new subsection/text. Refer to the chapter for full content.
			3.32.D. Supervision (new subsection)	Addition of new subsection/text. Refer to the chapter for full content.

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MMP 25-41	8/29/2025	Behavioral Health and Intellectual and Developmental Disability Supports and Services	15.3 HSW Self-Directed Service Arrangements for CLS (new subsection)	Addition of new subsection/text. Refer to the chapter for full content.
MMP 25-43	9/30/2025	Hearing Services and Devices	5.5.A. Standards of Coverage	The 1st and 2nd paragraphs were revised to read: Medicaid covers replacement of disposable hearing aid batteries, as appropriate, up to a quantity of ~~36~~ 72 batteries per hearing aid per DOS when dispensed by a hearing aid dealer, audiologist, hearing center, or medical supplier. A maximum of ~~72~~ 144 batteries per aid per year is covered. The dispensing of hearing aid batteries by a hearing aid provider is considered a service, and medical necessity must be documented in the beneficiary's chart along with the date of service and number of batteries dispensed. ~~Disposable hearing aid batteries must be ordered by a Medicaid enrolled physician or qualified non-physician medical practitioner (e.g., physician assistant, nurse practitioner, clinical nurse specialist). The dispensing~~ A medical supplier may require a ~~written~~ prescription ~~from the prescribing provider~~ in order to dispense the batteries. If required, the prescription must be written by a Medicaid enrolled physician or qualified non-physician medical practitioner (e.g., physician assistant, nurse practitioner, clinical nurse specialist) and contain all the following:

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MMP 25-45	9/30/2025	Private Duty Nursing	1.4 Prior Authorization	The 3rd paragraph was revised to read: The MSA-0732 must be submitted every time services are requested for the following situations: • for initial services when the beneficiary has never received PDN services under Medicaid, such as following a hospitalization or when there is an increase in severity of an acute or chronic condition; • for continuation of services beyond the end date of the current authorization period (renewal); • for a time-limited increase or decrease in services; • for an increase in services; or • for a decrease in services. The 7th paragraph was revised to read: If during an authorization period a beneficiary's condition changes ~~warranting~~ requiring an increase or decrease in the number of approved units or a discontinuation of services, the provider must report the change to the PRD. (Refer to the Directory Appendix for contact information.) It is important that the provider report all changes as soon as they occur, as well as properly updating the POC. The request to increase or decrease units must be ~~accompanied by~~ submitted through MSA-0732 with an updated and signed POC; and ~~documentation~~ updated order from the attending physician and documentation addressing the medical need if the request is for an increase in PDN units.

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				The last paragraph was revised to read: To determine the appropriate number of PDN hours for a beneficiary, PRD must be aware of any other services provided ~~in the home~~ by community-based programs ~~may affect the total care needs and the amount of PDN authorized~~. These other services must be disclosed on ~~the~~ MSA-0732 and documented in the POC. Although the amount of PDN authorized considers the beneficiary's medical needs and family circumstances, community-based services provided in the home are also part of this assessment. ~~Disclosure is necessary to prevent duplication of services to allow for an accurate calculation of authorized PDN hours.~~ Providers are advised that failure to ~~disclose all community resources in the home~~ complete MSA-0732 with all required information may result in a denial of authorization or may be cause for recoupment of funds.

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			1.7 Benefit Limitations	Text was revised to read: The purpose of the PDN benefit is to ~~assist the beneficiary with medical care~~ provide continuous skilled nursing care, enabling the beneficiary to remain in their home. ~~PDN is intended as a transitional benefit to support and teach family members to function as independently as possible.~~ Authorized hours ~~will~~ may be modified ~~as~~ if the beneficiary's condition ~~and~~ or living situation ~~stabilizes or~~ changes. ~~A decrease in hours will occur, for example, after a child has been weaned from a ventilator or after a long-term tracheostomy no longer requires frequent suctioning, etc.~~ The benefit is ~~not~~ intended to ~~supplant~~ support the caregiving responsibility of parents, guardians, or other responsible parties (e.g., foster parents). PDN services do not replace these caregiving responsibilities. There must be a primary caregiver (i.e., parent, guardian, significant other adult) who resides with a beneficiary under the age of 18.~~, and the caregiver must provide a monthly average of a minimum of eight hours of care during a typical 24-hour period. The calculation of the number of units authorized per month includes eight hours or more of care that will be provided by the caregiver during a 24-hour period, which are then averaged across the time authorized for the month.~~ The caregiver has the flexibility to use the monthly-authorized ~~units~~ PDN hours as needed during the month. Substantial alterations to the scheduled allotment of daily PDN hours due to family choice (i.e., vacations) unrelated to medical need or emergent circumstances require advance notice to the PRD. The remaining balance of authorized hours will not be increased to cover this type of utilization. Authorized time cannot be carried over from one authorization period to another.

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				~~The time a beneficiary is under the supervision of another entity or individual (e.g., in school, in day/child care, in work program) cannot be used to meet the eight hours of obligated care as discussed above, nor can the eight hours of care requirement for beneficiaries under age 18 be met by other public funded programs (e.g., MDHHS Home Help Program) or other resources for hourly care (e.g., private health insurance, trusts, bequests, private pay).~~ PDN providers are encouraged to work with families to assist in developing a backup plan for care of ~~their child~~ the beneficiary in the event that a PDN shift is delayed or cancelled, and the parent/guardian is unable to provide care. The parent/guardian is expected to arrange backup caregivers that they will notify, and the parent/guardian remains responsible for contacting these backup caregivers when necessary.
			1.10 PDN in Conjunction with Home Help or Personal Care Services	Text was revised to read: If the beneficiary receiving PDN demonstrates a need for personal care or Home Help services in addition to PDN, there must be coordination between the delivery of personal care or Home Help services and the PDN services, as well as documentation in the POC to verify there is no duplication of services. Respite is not a covered service for beneficiaries receiving PDN. PDN hours cannot be used during concurrent hours with other direct care services. All services must be included when submitting a prior authorization request, including the type of service provided and number of hours per day.
			2.1 Plan of Care	Addition of the following bullet point: • The plan includes other services the beneficiary is receiving, regardless of payor source, the type of service and number of hours provided.

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			2.4 Determining Intensity of Care and Maximum Amount of PDN	The subsection title was revised to read: Determining ~~Intensity of Care and Maximum~~ the Amount of Authorized PDN Hours The 1st paragraph was revised to read: ~~As part of determining the maximum amount of PDN a beneficiary is eligible for, their Intensity of Care category must be determined.~~ The determination of authorized hours will be based on an individual assessment of the beneficiary's medical condition and care needs. The number of authorized hours ~~This~~ is a clinical judgment based on several factors including the following ~~factors~~: • The beneficiary's medical condition; • The need for skilled nursing care versus unskilled support; • The type and frequency of needed nursing assessments, judgments and interventions; and • The impact of delayed nursing interventions.

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				The 3rd and 4th paragraphs were revised to read: ~~Medicaid uses the "Decision Guide for Establishing Maximum Amount of Private Duty Nursing to be Authorized on a Daily Basis" (below) to establish the amount of PDN that is approved. The Decision Guide is used to determine the appropriate range of nursing hours (prior authorized and billed in 15-minute increments) that can be authorized under the Medicaid PDN benefit and defines the "benefit limitation" for individual beneficiaries. The Decision Guide is used by the authorizing entity after it has determined the beneficiary meets both general eligibility requirements and medical criteria as stated above.~~ The amount of authorized PDN ~~(i.e., the time) that can be authorized~~ hours for a beneficiary is based on several factors, including the beneficiary's care needs which establish medical necessity for PDN, the need for continuous skilled nursing care, the beneficiary's and family's circumstances, and other resources for daily care (e.g., private health insurance, trusts, bequests, private pay). ~~To illustrate, the number of hours covered by private health insurance is subtracted from the hours approved under Medicaid PDN. These factors are incorporated into the Decision Guide. The higher number in the range is considered the maximum number of hours that can be authorized. Except in emergency circumstances, Medicaid does not approve more than the maximum hours indicated in the guide.~~ ~~Only those factors that influence the maximum number of hours that can be authorized are included on this decision matrix.~~ Other factors (e.g., additional dependent children, additional children with special needs, and required nighttime interventions, work or school) that impact the caregiver's availability to provide care should be identified during an assessment of service needs and included in MSA-0732 documentation. These factors have implications for service planning and ~~should~~ will be considered when determining the ~~actual~~ number of PDN hours ~~(within the range)~~ to authorize.

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				The following text was added prior to the last paragraph: PRD will take into consideration the beneficiary's family situation and resources. For example: • Availability of caregivers living in the home ➢ Two or more caregivers and both work or are in school full-time or part-time ➢ Two or more caregivers and one works or is in school full-time or part-time ➢ Two or more caregivers and neither work nor are in school full-time or part-time ➢ One caregiver who works or is in school full-time or part-time ➢ One caregiver who does not work or is not a student. • Health status of the caregiver(s) ➢ Significant health issues ➢ Some health issues • School ➢ Beneficiary attends school 25 or more hours per week on average. In the last paragraph, the 1st sentence was revised to read: ~~When using the Decision Guide,~~ The following definitions apply:

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				The last bullet point was revised to read: • "School" attendance: The average number of hours of school attendance per week is used to determine the maximum number of hours that can be authorized for the individual of school age. The average number of hours is determined by adding the number of hours in school plus transportation time. Authorization of PDN hours will not automatically be increased during breaks from school ~~(vacations) or adjusted beyond the limits of factors I and II~~. The Local School District (LSD) or Intermediate School District (ISD) is responsible for providing such "health and related services" as necessary for the student to participate in their education program. Unless medically contraindicated, individuals of school age should attend school. ~~Factor III applies when determining the maximum number of hours to be authorized for an individual of school age.~~ The Medicaid PDN benefit cannot be used to replace the LSD's or ISD's responsibility for services (either during transportation to/from school or during participation in the school program) or when the child would typically be in school but for the parent's choice to home-school the child. If the school district directs in-home schooling, due to clinical complexity, PDN services are to be provided by the school district for those hours. Authorized Medicaid PDN hours may be used outside of the hours provided by the school district. If a parent or legal guardian chooses to home school the beneficiary, PDN hours authorized will exclude the hours that the beneficiary would otherwise be in school or in transit. The hours may be used throughout the day but cannot exceed the authorized hours.
			2.5 Exception Process	Subsection was removed in its entirety. The following subsections were re-numbered.

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			2.6 Change in Beneficiary's Condition/PDN as a Transitional Benefit	The subsection title was revised to read: Change in Beneficiary's Condition~~/PDN as a Transitional Benefit~~ Text was revised to read: Medicaid policy requires that the ~~integrated~~ plan of care (POC) be updated as necessary based on the beneficiary's medical needs. Additionally, when a beneficiary's condition changes, warranting a ~~decrease~~ change in the number of approved hours or a discontinuation of services, the provider must report the change to the appropriate authorizing agent (i.e., the PRD, Children's Waiver, or Habilitation Supports Waiver) in writing. ~~Changes such as weaning from a ventilator or tracheostomy decannulation can occur after months or years of services, or a beneficiary's condition may stabilize to the point of requiring fewer PDN hours or the discontinuation of hours altogether.~~ Requests to change the amount of authorized PDN hours must be submitted through the prior authorization process. It is important that the provider report all changes in condition resulting in a ~~decrease~~ change in the number of hours to the authorizing agent as soon as they occur, as well as properly updating the POC.

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				If the change in the beneficiary's condition is time-limited, it must be documented as such in MSA-0732. PRD will also consider situations outside the beneficiary's or family's control that place the beneficiary in jeopardy of serious injury or significant deterioration of health status for a time-limited change in authorized hours. Some examples of when a change in PDN hours may be time-limited are: • temporary alteration in the beneficiary's care needs following a hospitalization, • acute illness or injury of the primary caregiver, • death of the primary caregiver, or • the home environment has been determined to be unstable, as evidenced by MDHHS protective or preventive services involvement. MDHHS will seek recovery of monies inappropriately paid to the provider if, during case review, the authorizing agent determines that a beneficiary required fewer PDN hours than was provided and MDHHS was not notified of the change in condition. ~~In some cases, the authorized PDN services may be considered a transitional benefit. In cases such as this, one of the primary reasons for providing services should be to assist the family or caregiver(s) to become independent in the care of the beneficiary. The provider, in collaboration with the family or caregiver(s), may decide that the authorized number of hours should be decreased gradually to accommodate increased independence on the part of the family, caregiver(s), and/or beneficiary. A detailed exit plan with instructions relating to the decrease in hours and possible discontinuation of care should be documented in the POC. The provider must notify the authorizing agent that hours are being decreased and/or when the care will be discontinued.~~

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		Forms Appendix	MSA-0732; Private Duty Nursing Prior Authorization – Request for Services	Form was revised; version date 10/2025.
MMP 25-48	10/31/2025	Medical Supplier	2.3 Blood Pressure Monitoring	Under **"Standards of Coverage"**, in the 1st paragraph, the 2nd bullet point was revised to read: • The beneficiary has any of the following conditions: ➢ History of heart disease, congenital heart defects, or stroke ➢ A neurological condition that affects blood pressure ➢ A medication regimen is present that affects blood pressure ➢ Blood pressure fluctuations due to renal disease ➢ Medications are titrated based on daily blood pressure readings ➢ ~~Hypertensive disorders in pregnancy, childbirth, or the puerperium period (e.g., pre-eclampsia)~~ ➢ Beneficiary who is pregnant or who is within the 12-month postpartum period. ➢ Hypertension, despite beneficiary compliance with the treatment plan (i.e., adherence to medication regimen, dietary changes, smoking cessation, etc.);

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				The following text was added after the 1st paragraph: **Note:** For beneficiaries who are pregnant or who are within the 12-month postpartum period, the ordering practitioner must report a pregnancy or postpartum-related diagnosis code on the order/prescription. Under **"PA Requirements"**, the 1st paragraph was revised to read: Prior authorization is not required for the following when Standards of Coverage are met, and the beneficiary has one of the following diagnoses/conditions: • renal disease; or • ~~hypertensive disorders in pregnancy, childbirth, or the puerperium period (e.g., pre-eclampsia).~~ • Beneficiaries who are pregnant or who are within the 12-month postpartum period.