MDHHS
Michigan Department of Health & Human Services

# BULLETIN

Michigan Medicaid Policy (MMP) | Health Services

**Bulletin Number:** MMP 26-36

**Distribution:** All Providers

**Issued:** September 1, 2026

**Subject:** Updates to the MDHHS Medicaid Provider Manual

**Effective:** October 1, 2026

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

The Michigan Department of Health and Human Services (MDHHS) has completed the October 2026 update of the online version of the MDHHS Medicaid Provider Manual. The manual will be available October 1, 2026, at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms >> Medicaid Provider Manual.

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

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

## 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 +0submit 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

Michigan Department of Health and Human Services

# Medicaid Provider Manual
# October 2026 Updates

## TECHNICAL CHANGES*

| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Throughout the Manual | | References to the "Medicaid Code and Rate Reference tool" were reviewed for consistency in terminology and edited as needed. | |
| Beneficiary Eligibility | 3.3 Eligibility Verification for Dates of Service Over 12 Months Old | The following paragraph was added:<br><br>For additional information related to exceptions to timely filing billing limitations, refer to the Timely Filing Billing Limitation subsection of the General Information for Providers chapter. | Update. |
| Billing & Reimbursement for Institutional Providers | 7.1 OPPS/Ambulatory Payment Classification | The subsection title was revised to read:<br><br>Outpatient Prospective Payment System (OPPS)/Ambulatory Payment Classification (APC) | Adding acronym description. |
| Billing & Reimbursement for Institutional Providers | 7.23 Pediatric Immunization Services<br><br>(new subsection; the following subsections were re-numbered) | New subsection text reads:<br><br>Some pediatric immunization services are reimbursed at different rates based on the age of the beneficiary. In certain instances, MDHHS requires outpatient hospital providers to report modifier SL with the appropriate procedure code for these services when rendered to beneficiaries under 19 years of age to ensure appropriate payment is made.<br><br>Procedure codes with an SL modifier requirement will be denied if modifier SL is not reported for beneficiaries under 19 years of age. Procedure codes with an SL modifier requirement will be denied if modifier SL is reported for beneficiaries over 19 years of age.<br><br>Refer to the MDHHS Outpatient Prospective Payment System Rates Code List or CHAMPS Medicaid Code Rate and Reference tool for more information about codes with an SL modifier requirement. | Additional information regarding modifier SL requirement. |

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## TECHNICAL CHANGES*

| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Billing & Reimbursement for Institutional Providers | 7.23 Preadmission Diagnostic Services<br><br>(reflects new numbering) | Text was revised to read:<br><br>~~MDHHS policy/billing guidelines align with billing guidance referenced in the Medicare Claims Processing Manual and the applicable section (i.e., date specific) for "Outpatient Services Treated as Inpatient Services."~~<br><br>~~MDHHS does not differentiate any specialty hospitals or facilities referenced in the CMS policy (i.e., critical access hospital [CAH], cancer, etc.). (NOTE: This policy does not apply to ambulance providers, freestanding dialysis centers or inpatient rehabilitation hospitals.) MDHHS will use a hospital's tax identification number to align with the CMS definition of "any hospital entity that is wholly owned or wholly operated by" the hospital. Otherwise, MDHHS will align as closely as possible with Medicare policy and guidelines for all beneficiaries.~~<br><br>MDHHS aligns as closely as possible with Medicare's guidelines for the Three-Day Payment Window policy, including claim types and Medicare recognized exempted entities (as determined by the hospital's tax identification number). In accordance with 42 CFR § 412.2(c)(5), a hospital (or entity that is wholly owned or wholly operated by the hospital) must include on the claim for a beneficiary's inpatient stay the diagnoses, procedures, and charges for all outpatient diagnostic services and admission-related outpatient nondiagnostic services that are furnished to the beneficiary during the three-day (or one-day) payment window. | Clarification. |

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# Medicaid Provider Manual
# October 2026 Updates

## TECHNICAL CHANGES*

| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Billing & Reimbursement for Professionals | 6.4 Ambulatory Surgical Centers<br><br>(new subsection; the following subsections were re-numbered) | New subsection text reads:<br><br>Some pediatric immunization services are reimbursed at different rates based on the age of the beneficiary. In certain instances, MDHHS requires ambulatory surgical center providers to report modifier SL with the appropriate procedure code for these services when rendered to beneficiaries under 19 years of age to ensure appropriate payment is made.<br><br>Procedure codes with an SL modifier requirement will be denied if modifier SL is not reported for beneficiaries under 19 years of age. Procedure codes with an SL modifier requirement will be denied if modifier SL is reported for beneficiaries over 19 years of age.<br><br>Refer to the MDHHS Ambulatory Surgical Centers Payment Rate List or CHAMPS Medicaid Code Rate and Reference tool for more information about codes with an SL modifier requirement. | Additional information regarding modifier SL requirement. |

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## TECHNICAL CHANGES*

| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 1.7 Definition of Terms | The definition for "Qualified Mental Health Professional (QMHP)" was revised to read:<br><br>~~An individual who has specialized training or one year of experience in treating or working with a person who has mental illness; and is a psychologist, physician, educator with a degree in education from an accredited program, licensed or limited licensed master's or bachelor's social worker, physical therapist, occupational therapist, speech pathologist or audiologist, registered nurse, therapeutic recreation specialist, rehabilitation counselor, licensed or limited licensed professional counselor or individual with a human services degree hired and performing in the role of QMHP prior to January 1, 2008. (Refer to Staff Provider Qualifications in the Program Requirements Section of this chapter for specific requirements of the professionals.)~~<br><br>~~NOTE: If an individual was hired and performed the role of a QMHP prior to January 1, 2008 and later transfers to a new agency, their QMHP status will be grandfathered into the new agency.~~<br><br>Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with persons receiving mental health services as part of that experience) or one year of experience in treating or working with a person who has mental illness; **AND** is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, therapeutic recreation specialist, licensed/limited licensed professional counselor, licensed or limited licensed marriage and family therapist, a licensed physician's assistant, or a human services professional with at least a bachelor's degree in a human services field. | Update. |

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| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 1.7 Definition of Terms | The definition for "Qualified Intellectual Disability Professional (QIDP)" was revised to read:<br><br>~~An individual who meets the qualifications under 42 CFR 483.430. A QIDP is a person who has specialized training or one year of experience in treating or working with a person who has an intellectual disability; and is a psychologist, physician, educator with a degree in education from an accredited program, licensed or limited licensed master's or bachelor's social worker, physical therapist, occupational therapist, speech pathologist or audiologist, registered nurse, therapeutic recreation specialist, rehabilitation counselor, licensed or limited licensed professional counselor or individual with a human services degree hired and performing in the role of QIDP prior to January 1, 2008. (Refer to Staff Provider Qualifications in the Program Requirements Section of this chapter for specific requirements of the professionals.)~~<br><br>~~NOTE: If an individual was hired and performed the role of a QIDP prior to January 1, 2008 and later transfers to a new agency, their QIDP status will be grandfathered into the new agency.~~<br><br>Individual with specialized training (including fieldwork and/or internships associated with the academic curriculum where the student works directly with persons with intellectual or developmental disabilities as part of that experience) or one year of experience in treating or working with a person who has intellectual disability (prior to or post-degree acquisition); **AND** is a psychologist, physician, educator with a degree in education from an accredited program, social worker, physical therapist, occupational therapist, speech-language pathologist, audiologist, behavior analyst, registered nurse, dietician, therapeutic recreation specialist, a licensed/limited licensed professional counselor, or a human services professional with at least a bachelor's degree in a human services field. | Update. |

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## TECHNICAL CHANGES*

| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 2.5.D. PIHP Decisions | The 2nd paragraph was revised to read:<br><br>A PIHP may not deny services based solely on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis. Assessment or screening tools cannot be utilized by a PIHP as a means for identifying the amount, scope or duration of services that a beneficiary will receive. While such assessments can certainly help inform the person-centered planning process, it is the person-centered planning process and medical necessity criteria that determine the amount, scope and duration of services. | Adding clarifying language. |
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 3.5 Child Therapy | The 2nd paragraph was revised to read:<br><br>Telemedicine is approved for Individual Therapy or Family Therapy using approved children's evidence-based practices (i.e., Trauma Focused Cognitive Behavioral Therapy, Parent Management Training-Oregon, Parenting Through Change) ~~and utilizes the GT modifier when reporting the service~~. Qualified providers of children's evidence-based practices have completed their training in the model, its implementation via telehealth, and are able to provide the practice with fidelity. | Removal of obsolete information. |
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | Section 15 – Habilitation Supports Waiver for Persons with Developmental Disabilities | The following text was added after the 1st paragraph:<br><br>The HSW is a Long-Term Services and Supports (LTSS) program. | |
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 15.1.N. Respite Care<br><br>(re-numbered as 15.2.M.) | The last paragraph was revised to read:<br><br>Cost of room and board must not be included as part of the respite care unless provided as part of the respite care in a facility that is not a private residence. Respite provided in an institution (i.e., ICF/IID, nursing facility, or hospital), ~~or~~ MDHHS-approved day program site, or respite worker's personal residence (unless it is the home of a friend, relative, or beneficiary) is not covered by the HSW. The beneficiary's record must clearly differentiate respite hours from CLS services. | Adding clarifying language. |

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| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 17.4.A. Community Living Supports (CLS) | The 2nd paragraph was revised to read:<br><br>Community Living Supports (CLS) are used to increase or maintain personal self-sufficiency, facilitating a beneficiary's achievement of their goals of community inclusion and participation, independence or productivity. The supports may be provided in the beneficiary's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.). The CLS staff's home, if not the beneficiary's residence, is not an approved setting to provide CLS services. | Adding clarifying language. |
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 17.4.G. Respite Care Services | The 4th paragraph was revised to read:<br><br>Respite care may not be provided in:<br>• day program settings<br>• Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)<br>• nursing homes<br>• hospitals<br>• respite worker's personal residence (unless it is the home of a friend, relative, or beneficiary) | Adding clarifying language. |
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 21.3.A. Eligibility Criteria Ages Birth Through 5 | Text was revised to read:<br><br>~~The following~~ MichiCANS Screener Decision Support Model criteria will be used to ~~determine eligibility~~ indicate potential need for Specialty Behavioral Health Services for children ages birth through 5 years (day prior to 6).~~:~~ MichiCANS Decision Support Models (DSMs) are available on the MDHHS website. (Refer to the Directory Appendix for website information.) | |
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 21.3.A.1. Level 1 – Mild/Moderate Level of Need (Referral to Appropriate Services) | Subsection was deleted.<br><br>The following subsections were re-numbered. | |

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## TECHNICAL CHANGES*

| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 21.3.A.2. Level 2 – Severe/Serious Level of Need (If Initial, Move to Initial Assessment) | The 1st paragraph was revised to read:<br>~~Note:~~ If a ~~youth~~ child is identified as having a Severe/Serious Level of Need, the ~~youth~~ child should be referred for an intake appointment through the PIHP.<br><br>The 2nd paragraph and table were deleted. | |
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 21.3.A.3. Level 3 – Crisis (Move to Crisis Continuum of Care Services) | The subsection title was revised to read:<br>Level 3 – Crisis ~~(Move to Crisis Continuum of Care Services)~~<br><br>The 1st paragraph was revised to read:<br>~~A youth will be classified as 'CRISIS' if they meet Criterion 3.1.~~ If the Screener indicates that a child meets Level 3, they should move to Crisis Continuum of Care Services.<br><br>The table was deleted. | |
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 21.3.B. Eligibility Criteria Ages 6 Through 20 | Text was revised to read:<br>~~The following~~ MichiCANS Screener Decision Support Model criteria will be used to ~~determine eligibility~~ indicate potential need for Specialty Behavioral Health Services for ~~children~~ youth and young adults ages 6 through 20 years (day prior to 21).~~:~~ MichiCANS Decision Support Models (DSMs) are available on the MDHHS website. (Refer to the Directory Appendix for website information.) | |
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 21.3.B.2. Level 2 – Severe/Serious Level of Need (If Initial, Move to Initial Assessment) | The 1st paragraph was revised to read:<br>~~Note:~~ If the Screener indicates that a youth is identified as having a Severe/Serious Level of Need, the youth should be referred for an intake appointment through the PIHP.<br><br>The 2nd paragraph and table were deleted. | |

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| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 21.3.B.3. Level 3 – Crisis (Move to Crisis Continuum of Care Services) | The subsection title was revised to read:<br>Level 3 – Crisis ~~(Move to Crisis Continuum of Care Services)~~<br><br>The 1st paragraph was revised to read:<br>~~A youth will be classified as 'CRISIS' if they meet Criterion 3.1 or Criterion 3.2.~~ If the Screener indicates that a youth meets Level 3 criteria, they should move to Crisis Continuum of Care Services.<br><br>The table was deleted. | |
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 21.4.A. Eligibility Criteria | The 1st sentence was revised to read:<br>The criteria for home-based services are described below for children ages birth through age 5 and ~~children~~ youth and young adults ~~aged~~ ages 6 through age 20. | |
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 21.4.A.1. Ages Prenatal/Birth Through 5 | The 1st paragraph was revised to read:<br>~~The following~~ MichiCANS Comprehensive Decision Support Model criteria will be used to ~~determine eligibility~~ indicate potential need for Home-Based Services for children ages birth through 5 years (day prior to 6). MichiCANS Decision Support Models (DSMs) are available on the MDHHS website. (Refer to the Directory Appendix for website information.)<br><br>The 2nd paragraph and table were deleted. | |

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|---|---|---|---|
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 21.4.A.2. Ages 6 Through 20 | The 1st paragraph was revised to read:<br>~~The following~~ MichiCANS Comprehensive Decision Support Model criteria will be used to ~~determine eligibility~~ indicate potential need for Home-Based Services for ~~children,~~ youth~~,~~ and young adults ages 6 through 20 years (day prior to 21). MichiCANS Decision Support Models (DSMs) are available on the MDHHS website. (Refer to the Directory Appendix for website information.)<br><br>The 2nd paragraph and table were deleted. | |
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 21.5.A.1. Ages Birth Through 5 | The 1st paragraph was revised to read:<br>~~The following~~ MichiCANS Comprehensive Decision Support Model criteria will be used to ~~determine eligibility~~ indicate potential need for Respite Care for ~~beneficiaries~~ children ages birth through 5 years (day prior to 6). MichiCANS Decision Support Models (DSMs) are available on the MDHHS website. (Refer to the Directory Appendix for website information.)<br><br>The 2nd paragraph and table were deleted. | |
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 21.5.A.2. Ages 6 Through 20 | The 1st paragraph was revised to read:<br>~~The following~~ MichiCANS Comprehensive Decision Support Model criteria will be used to ~~determine eligibility~~ indicate potential need for Respite Care for ~~beneficiaries~~ youth and young adults ages 6 through 20 years (day before 21). MichiCANS Decision Support Models (DSMs) are available on the MDHHS website. (Refer to the Directory Appendix for website information.)<br><br>The 2nd paragraph and table were deleted. | |

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| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 21.6.A.1. Ages Birth Through 5 | The 1st paragraph was revised to read:<br><br>~~The following~~ MichiCANS Comprehensive Decision Support Model criteria will be used to ~~determine eligibility~~ indicate potential need for ICCW for ~~beneficiaries~~ children ages birth through 5 years (day prior to 6). MichiCANS Decision Support Models (DSMs) are available on the MDHHS website. (Refer to the Directory Appendix for website information.)<br><br>The 2nd paragraph and table were deleted. | |
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 21.6.A.2. Ages 6 Through 20 | The 1st paragraph was revised to read:<br><br>~~The following~~ MichiCANS Comprehensive Decision Support Model criteria will be used to ~~determine eligibility~~ indicate potential need for ICCW for ~~beneficiaries~~ youth and young adults ages 6 through 20 years (day prior to 21). MichiCANS Decision Support Models (DSMs) are available on the MDHHS website. (Refer to the Directory Appendix for website information.)<br><br>The 2nd paragraph and table were deleted. | |
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 21.7.A.1. Ages Birth Through 5 | The 1st paragraph was revised to read:<br><br>~~The following~~ MichiCANS Comprehensive Decision Support Model criteria will be used to ~~determine eligibility~~ indicate potential need for ICSS for ~~beneficiaries~~ children ages birth through 5 years (day prior to 6). MichiCANS Decision Support Models (DSMs) are available on the MDHHS website. (Refer to the Directory Appendix for website information.)<br><br>The 2nd paragraph and table were deleted. | |

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|---|---|---|---|
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 21.7.A.2. Ages 6 Through 20 | The 1st paragraph was revised to read:<br><br>~~The following~~ MichiCANS Comprehensive Decision Support Model criteria will be used to ~~determine eligibility~~ indicate potential need for ICSS for ~~beneficiaries~~ youth and young adults ages 6 through 20 years (day prior to 21). MichiCANS Decision Support Models (DSMs) are available on the MDHHS website. (Refer to the Directory Appendix for website information.)<br><br>The 2nd paragraph and table were deleted. | |
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 21.8.A.1. Ages 11 Through 20 | The 1st paragraph was revised to read:<br><br>~~The following~~ MichiCANS Comprehensive Decision Support Model criteria will be used to ~~determine eligibility~~ indicate potential eligibility for Youth Peer Support for ~~beneficiaries~~ youth and young adults ages 11 through 20 years. MichiCANS Decision Support Models (DSMs) are available on the MDHHS website. (Refer to the Directory Appendix for website information.)<br><br>The 2nd paragraph and table were deleted. | |
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 21.9.A.1. Ages Birth Through 5 | The 1st paragraph was revised to read:<br><br>~~The following~~ MichiCANS Comprehensive Decision Support Model criteria will be used to ~~determine eligibility~~ indicate potential need for Parent Support Partners for ~~beneficiaries~~ children ages birth through 5 years (day prior to 6). MichiCANS Decision Support Models (DSMs) are available on the MDHHS website. (Refer to the Directory Appendix for website information.)<br><br>The 2nd paragraph and table were deleted. | |

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| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 21.9.A.2. Ages 6 Through 20 | The 1st paragraph was revised to read:<br><br>~~The following~~ MichiCANS Comprehensive Decision Support Model criteria will be used to ~~determine eligibility~~ indicate potential need for Parent Support Partners for ~~beneficiaries~~ youth and young adults ages 6 through 20 years (day prior to 21). MichiCANS Decision Support Models (DSMs) are available on the MDHHS website. (Refer to the Directory Appendix for website information.)<br><br>The 2nd paragraph and table were deleted. | |
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 21.10.A. Eligibility Criteria | Text was revised to read:<br><br>The Children with Serious Emotional Disturbances Home and Community-Based Services Waiver (SEDW) provides services that are enhancements or additions to Medicaid State Plan coverage for ~~beneficiaries~~ children, youth, and young adults up to age 21 with serious emotional disturbance (SED) who are enrolled in the SEDW. | |
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 21.10.A.1. Ages Birth Through 5 | The 1st paragraph was revised to read:<br><br>~~The following~~ MichiCANS Comprehensive Decision Support Model criteria will be used to ~~determine eligibility~~ indicate potential need for the SEDW for children ages birth through 5 years (day prior to 6). MichiCANS Decision Support Models (DSMs) are available on the MDHHS website. (Refer to the Directory Appendix for website information.)<br><br>The 2nd paragraph and table were deleted. | |

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|---|---|---|---|
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 21.10.A.2. Ages 6 Through 20 | The 1st paragraph was revised to read:<br><br>~~The following~~ MichiCANS Comprehensive Decision Support Model criteria is used to ~~determine eligibility~~ indicate potential need for the SEDW for youth and young adults ages 6 years through 20 years (day prior to 21). MichiCANS Decision Support Models (DSMs) are available on the MDHHS website. (Refer to the Directory Appendix for website information.)<br><br>The 2nd paragraph and table were deleted. | |
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 21.11.A.1. Ages Birth Through 5 | The 1st paragraph was revised to read:<br><br>~~The following~~ MichiCANS Comprehensive Decision Support Model criteria will be used to ~~determine eligibility~~ indicate potential need for CWP for ~~beneficiaries~~ children ages birth through 5 years (day prior to 6). MichiCANS Decision Support Models (DSMs) are available on the MDHHS website. (Refer to the Directory Appendix for website information.)<br><br>The 2nd paragraph and table were deleted. | |
| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 21.11.A.2. Ages 6-18 | The 1st paragraph was revised to read:<br><br>~~The following~~ MichiCANS Comprehensive Decision Support Model criteria will be used to ~~determine eligibility~~ indicate potential need for CWP for ~~beneficiaries~~ youth and young adults ages six through 17 years (day prior to 18). MichiCANS Decision Support Models (DSMs) are available on the MDHHS website. (Refer to the Directory Appendix for website information.)<br><br>The 2nd paragraph and table were deleted. | |

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| Behavioral Health and Intellectual and Developmental Disability Supports and Services | 22.3 Individual Plan of Service | The 12th bullet point was revised to read:<br>• Be finalized, indicating the beneficiary's continued desire to receive services and remain in the community, and agreed to with the informed consent of the beneficiary. This is reflected by the beneficiary's signature and their guardian (if applicable). The beneficiary's signature has no impact on the beneficiary's due process rights. The beneficiary must be allowed to sign the IPOS, noting any problems/issues with the IPOS in the document itself or as a supplemental document. | Adding clarifying language. |
| Federally Qualified Health Centers | 2.2 Transportation/ Outreach | The 2nd paragraph was revised to read:<br>The FQHC provides non-emergency transportation to and from the FQHC for Medicaid covered services provided to Medicaid Fee-for-Service beneficiaries. For Medicaid managed care enrollees, ~~the FQHC may provide transportation in certain circumstances.~~ refer to the Managed Care Programs section of the Non-Emergency Medical Transportation chapter for additional information. | Clarification. |
| Home Help | 8.4.B.1. Agency Caregiver and Agency Employee Enrollment | In the 1st paragraph, the 2nd bullet point was revised to read:<br>• All agency employees are listed in the agency provider's CHAMPS enrollment in ~~"Step 9:~~ the "Provider Controlling Interest/Ownership Details" step prior to accessing client information. | Removal of the reference to a specific step number in the Community Health Automated Medicaid Processing System (CHAMPS). |
| Home Help | 8.6.A. Home Help Services Agreement (MSA-4676) | The 4th paragraph was revised to read:<br>An agency provider only needs to sign one MSA-4676 per client. A new MSA-4676 is not required when a new agency caregiver begins working with the client. The agency owner(s) may either sign the MSA-4676 or designate an authorized signer(s). Any individual who signs the MSA-4676 on the agency provider's behalf binds the agency provider to the terms outlined in the form. The agency owner(s) is responsible for ensuring the form is signed by an authorized signer. The authorized signer must be associated to the agency provider in CHAMPS or listed in ~~"Step 9:~~ the "Provider Controlling Interest/Ownership Details" step of its CHAMPS enrollment. | Removal of the reference to a specific step number in the Community Health Automated Medicaid Processing System (CHAMPS). |

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| Hospital Reimbursement Appendix | 7.6.H. Mergers<br>(new subsection) | New subsection text reads:<br>In the event of a merger between two or more hospitals, Medicaid Access to Care Initiative (MACI) distribution to the surviving hospital is calculated using the combined paid claims files of the merged hospitals. The surviving hospital must notify MDHHS within 30 calendar days after the merger is completed. | Adding new section as clarification in alignment with other sections addressing mergers in this chapter. |
| Independent Diagnostic Testing Facilities and Portable X-ray Suppliers | Section 4 - Portable X-ray Suppliers (PXRS) | The 4th paragraph was revised to read:<br>Portable x-rays furnished in a place of residence used as the patient's home, including a nursing facility, require the corresponding POS code. PXRS claims must include the NPI of the Medicaid enrolled billing provider and the Medicaid enrolled ordering provider in the applicable claim loops or fields. Reporting of a rendering provider on the CMS 1500/ASC X12N 837 5010 professional format may cause the PXRS claim to deny. | Incorporate language from provider alert. |
| Medical Supplier | 1.6.C. Documentation | Text was revised to read:<br>The Coverage Conditions and Requirements Section of this chapter specifies the documentation requirements for individual service areas. Additional information other than what is required on the prescription may be required. To provide this information, Medicaid ~~accepts~~ requires a certificate of medical necessity (CMNs ~~will be mandatory for electronic PA~~ may be a CMN form or a letter)~~, a letter or~~ and a copy of applicable medical record. The prescribing physician must sign all documentation and the documentation (if a letter or applicable medical records) must state the beneficiary's name, DOB and ID number (if known) or SSN (if known). | Removal of obsolete information and providing clarification of required documentation. |
| MI Coordinated Health | 3.2 Deemed Enrollment | Addition of the following paragraph:<br>Additional guidance on deemed enrollment is included in the MICH Deeming Resource Document. (Refer to the Directory Appendix for document location information.) | Adding reference to resource document. |
| MI Coordinated Health | Section 14 – Encounters | The last paragraph was removed:<br>~~Additional guidance on encounter requirements is included in the MICH Encounter Requirements Resource Document. (Refer to the Directory Appendix for document location information.)~~ | This document is no longer being maintained and has been removed from the website. |

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## TECHNICAL CHANGES*

| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Nursing Facility Coverages | 5.1.B. Correct/Timely Preadmission Screening/Annual Resident Review (PASARR) | The last paragraph was revised to read:<br>MDHHS ~~is required~~ has the authority to recover any payments made to nursing facilities for the period that a participant may have been admitted to a nursing facility when the PASARR screening process was not completed. | Changing to reflect current practices. |
| Nursing Facility Coverages | 8.9 Out of State Admissions<br>(new subsection) | New subsection text reads:<br>For those admitting from locations outside of the state of Michigan, the PASARR process must be completed prior to admission. | Updating to clarify Federal Regulations regarding OBRA PASARR process from out of state. |
| Nursing Facility Coverages | 10.36 Therapies | The 3rd and 4th paragraphs were revised to read:<br>Non-routine therapies do not require prior authorization (PA) for Medicaid beneficiaries residing in a skilled nursing facility within 60 days of their admission to the facility. Providers must obtain PA for any non-routine therapy services that are provided after the initial 60-day post-admission period. This change only applies to new admissions to a nursing facility. Subsequent emergency or planned hospitalizations do not impact the requirements for PA. A copy of the physician prescription or documented clearance to resume therapy must be retained in the beneficiary's medical record. Refer to the Prior Authorization Requests section within the Therapy Services chapter of this Manual for additional information.<br>Refer to the Therapy Services Chapter of this manual for additional ~~information~~ therapy service requirements. | Clarification. |
| Directory Appendix | Beneficiary Assistance | Under "MI Enrolls", the phone number was revised as follows:<br>~~888-367-6557~~<br>800-975-7630 | Update. |

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## TECHNICAL CHANGES*

| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Directory Appendix | Eligibility Verification | Under "CHAMPS Eligibility Inquiry", the website address was revised to read:<br>~~www.michigan.gov/mdhhs >> Resources >> Beneficiary Eligibility Verification >> Benefit Plans >> Benefit Plan ID table~~<br>www.michigan.gov/medicaidproviders >> (under 'Resources') Beneficiary Eligibility Verification | Update. |
| Directory Appendix | Health Plan Information | Addition of:<br>**CONTACT/TOPIC:** Hospital Reimbursement<br>**WEB ADDRESS:**<br>https://www.michigan.gov/mdhhs/doing-business/providers/providers/billingreimbursement/hospital-access-initiative<br>https://www.michigan.gov/mdhhs/doing-business/providers/providers/billingreimbursement/medicaid-inpatient-hospital-providers<br>**INFORMATION AVAILABLE/PURPOSE:** Hospital Access Agreement, Rapid Dispute Resolution Process, Health Plan Obligations, HIDE SNP Obligations | |

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| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Directory Appendix | Provider Resources | Information for "Recovery Audit Contractor (RAC)" was revised as follows:<br><br>**PHONE # FAX #:** ~~614-801-0495~~ Phone: 844-364-6108<br><br>**MAILING/EMAIL/WEB ADDRESS:**<br><br>~~CoventBridge~~<br>~~2118 Southwest Blvd.~~<br>~~Grove City, OH 43123~~<br>~~https://www.michigan.gov/mdhhs/inside-mdhhs/office-of-inspector-general~~<br><br>Health Management Systems, Inc. (HMS)<br>225 East John Carpenter Fwy.<br>Suite 500<br>Mail Stop 200-MI<br>Irving, TX 75062<br><br>https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Assistance-Programs/Medicaid-BPHASA/Other-Prov-Specific-Page-Docs/RAC-Provider-Outreach-Document-final.pdf?rev=7cb66e2e87b24f869e8f6010bf26b62a | Update. |

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## TECHNICAL CHANGES*

| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Directory Appendix | Provider Resources | Addition of the following:<br><br>**CONTACT/TOPIC:** Unified Program Integrity Contractor (UPIC)<br><br>**PHONE # FAX #:** Phone: 614-801-0495<br><br>**MAILING/EMAIL/WEB ADDRESS:**<br>CoventBridge<br>2118 Southwest Blvd.<br>Grove City, OH 43123<br><br>https://www.michigan.gov/mdhhs/-/media/Project/Websites/mdhhs/Folder3/Folder76/Folder2/Folder176/Folder1/Folder276/Audit_Process_and_FAQ-final.pdf?rev=d89bf71088c84b1b858951d97ecd5474<br><br>**INFORMATION AVAILABLE/PURPOSE:** Audit resources for providers. | Update. |
| Directory Appendix | Behavioral Health/SUD Resources | Addition of new information:<br><br>**CONTACT/TOPIC:** MichiCANS<br><br>**MAILING/EMAIL/WEB ADDRESS:**<br><br>Website: Decision Support Models<br><br>Email address: MDHHS-MichiCANS@michigan.gov<br><br>**INFORMATION AVAILABLE/PURPOSE:** Decision Support Models (DSMs) | |

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|---|---|---|---|
| Directory Appendix | MI Coordinated Health | Under "MI Coordinated Health (MICH) Program Information", text was revised as follows:<br><br>**INFORMATION AVAILABLE/PURPOSE:** Documents and resources, including State Medicaid Agency Contract (SMAC); HCBS CHAMPS User Guide; Setting Survey templates; Acknowledgement of Exclusions Resource Document; Acknowledgement Form and Acknowledgement Form Resource Guide; Assessment Tools Overview; Critical Incidents Resource Document; ~~Encounter Requirements Resource Document;~~ Home Delivered Meals Service Guidelines Resource Document; Hospice Resource Document; ICP Signature Requirements Resource Document; Personal Care Services Resource Document; Person Centered Planning Resource Document; QAS Resource Document; Self Determination Implementation Technical Advisory; HCBS Waiver Services Requirements Resource Document; LOCD Resource Document; LARA and MDHHS Joint Guidance Document; Marketing Resource Document, MICH Deeming Resource Document | This document is no longer being maintained and has been removed from the website.<br><br>Adding reference to resource document. |
| Directory Appendix | Other Health Care Resources/Programs | Under "Habilitation Supports Waiver for Persons with Developmental Disabilities":<br><br>Removal of phone number: ~~517-256-7522~~<br><br>Addition of email address: MDHHS-BHFederalCompliance@michigan.gov | General update. |
| Forms Appendix | HASA-2104; Home Help Agency Provider Employment Requirements | On page 2, under Section 2, the 3rd bullet point was revised to read:<br><br>• Agency employees who have access to client information for the purposes of billing, answering phone calls, or assisting with setting up services for the client must be listed in the agency provider's CHAMPS enrollment in ~~"Step 9:~~ the "Provider Controlling Interest/Ownership Details" step prior to accessing the information. | Removal of the reference to a specific step number in the Community Health Automated Medicaid Processing System (CHAMPS). |

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| CHAPTER | SECTION | CHANGE | COMMENT |
|---|---|---|---|
| Forms Appendix | MSA-1653-B; Special Services Prior Authorization Request | On page 2 of the Instructions, instructions for boxes 15-20 were revised to read:<br>Indicate if an Expedited Review is being requested (due to medical necessity for provision of services within 10 calendar days). Standard reviews will be determined within 7 calendar days.<br>If YES, questions 16-~~18~~ 20 must be answered. If NO, skip to box #21. If the request does not meet expedited criteria, it will be processed as a standard review and the requesting provider will be notified via the Provider Communication section for this request in CHAMPS. | Correction. |
| Forms Appendix | MSA-1680-B; Dental Prior Authorization Request | On page 4, text after section 21 was revised to read:<br>If request is for Periodontal Services, complete boxes # ~~20-23~~ 20, 22, 23. Completion of boxes # 20-23 satisfies requirement for inclusion of clinical record. | Correction. |
| Forms Appendix | MSA-2081; Genetic and Molecular Laboratory Test Authorization Request | On page 2 of the Instructions, instructions for boxes 16-21 were revised to read:<br>Indicate if an Expedited Review is being requested (due to medical necessity for provision of services within 10 calendar days). Standard reviews will be determined within 7 calendar days.<br>If YES, questions ~~16~~ 17-21 must be answered. If NO, skip to box #22. If the request does not meet expedited criteria, it will be processed as a standard review and the requesting provider will be notified via the Provider Communication section for this request in CHAMPS. | Correction. |

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# Medicaid Provider Manual
# October 2026 Updates

## BULLETINS INCORPORATED*

| BULLETIN NUMBER | DATE ISSUED | CHAPTER | SECTION | CHANGE |
|---|---|---|---|---|
| MMP 25-49 | 10/1/2025 | Behavioral Health and Intellectual and Developmental Disability Supports and Services | 19.5.C. Provider Requirements | The 1st and 2nd paragraphs were revised to read:<br><br>PIHPs and providers must adhere to the requirements of the State Plan Amendment, all Medicaid statutes, policies, procedures, rules, and regulations, and the SUDHH Handbook.<br><br>**Regional PIHP (per 100 patients)**<br>• Health Home Director (0.5 FTE)<br><br>**Health Home Partners (per 100 patients)**<br>• Behavioral Health Specialist (0.25 FTE)<br>• Nurse Care Manager (1.00 FTE)<br>• Peer Recovery Coach, Community Health Worker (~~2.00~~ 3.00-4.00 FTE)<br>• Medical Consultant (0.10 FTE)<br>• Psychiatric Consultant (0.05 FTE)<br>• Addictionologist Medical Physician Consultant (0.10 FTE) |

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

<table>
<tr><th>BULLETIN NUMBER</th><th>DATE ISSUED</th><th>CHAPTER</th><th>SECTION</th><th>CHANGE</th></tr>
<tr><td></td><td></td><td></td><td></td><td>Contingent upon MDHHS exceptions, all providers referenced above must meet the following criteria:
<table>
<tr><td>Health Home Director</td><td>• Must be an administrative staff person employed by the PIHP.</td></tr>
<tr><td>Behavioral Health Specialist</td><td>• an individual who has a minimum of a Bachelor’s Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR<br>• who has a bachelor’s degree from an accredited four-year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience; OR<br>• who has a master’s degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school)</td></tr>
<tr><td>Nurse Care Manager</td><td>• licensed registered nurse, licensed practical nurse</td></tr>
<tr><td>Peer Recovery Coach, Community Health Worker, Medical Assistant</td><td>• Appropriate certification/training.<br>• Must be at least 18 years of age.<br>• Must possess high school diploma or equivalent.</td></tr>
<tr><td>Medical Consultant</td><td>• primary care physician, physician’s assistant, or nurse practitioner</td></tr>
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| | | | | **Psychiatric Consultant** • licensed mental health service professional (i.e., psychologist, psychiatrist, psychiatric nurse practitioner)<br>**Addictionologist Medical Physician Consultant** • Licensed provider in compliance with the Administrative Rules for Opioid Treatment Program |
| MMP 26-02 | 1/23/2026 | | | **NOTE: This is additional incorporation from the July 2026 update.** |
| | | Hearing Services and Devices | 3.1 Prior Authorization Form and Completion Instructions | Subsection text was revised to read:<br>~~Requests for PA must be submitted on~~ Providers are encouraged to submit PA requests electronically through direct data entry (DDE) in CHAMPS via the CHAMPS Provider Portal (refer to the Directory Appendix for website information) whenever possible. Refer to the General Information for Providers chapter of this manual for PA submission instructions and additional information. Providers unable to submit authorization requests electronically may send requests to the MDHHS Program Review Division using the Special Services Prior Authorization Request (MSA-1653-B). (Refer to the Forms Appendix or the MDHHS website for a copy of the form.) This form may be faxed or mailed to the MDHHS Program Review Division. (Refer to the Directory Appendix for contact information.)<br>Medical documentation (e.g., medical clearance, audiogram, and hearing aid recommendation from an audiologist) must accompany the electronic DDE PA submission or the MSA-1653-B. |

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| | | | | Providers requesting PA for items without an established fee screen must also include a copy of the manufacturer's invoice that lists the acquisition cost for the item. Manufacturer quotes or dealer list prices are not accepted as documentation of the cost. Modified manufacturer invoices will not be accepted. If the manufacturer's invoice is not included with the initial PA request, the MDHHS determination letter will indicate an approved fee of $0.01 for PA purposes; the reimbursement fee will be updated once the actual invoice is submitted to MDHHS for pricing.<br><br>~~The information on the MSA-1653-B must be:~~<br>• ~~Typed – All information must be clearly typed in the designated boxes of the form;~~<br>• ~~Thorough – Complete information, including manufacturer, model, and style of the hearing device requested (if applicable), and the appropriate HCPCS procedure codes with applicable modifiers must be provided on the form. The MSA-1653-B and all documentation must include the beneficiary's name and mihealth card identification (ID) number, provider name, address, and National Provider Identification (NPI) number.~~<br><br>~~A sample of the MSA-1653-B with additional instructions is available in the Forms Appendix of this manual.~~<br><br>~~For all Medicaid Fee-for-Service (FFS) beneficiaries, the MSA-1653-B must be mailed or faxed to the MDHHS Program Review Division. Providers can check the status of a PA request in CHAMPS or by contacting the MDHHS Program Review Division via telephone. (Refer to the Directory Appendix for website and contact information.)~~<br><br>~~PA requests may also be submitted electronically via FFS Direct Data Entry (DDE) in CHAMPS. (Refer to the General Information for Providers chapter of this manual for additional information.) A copy of the MSA-1653-B must be attached to each electronic PA request.~~<br><br>~~A copy of the PA determination letter must be retained in the beneficiary's medical record.~~ |

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## BULLETINS INCORPORATED*

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| | | Laboratory | 5.2 Authorization Requirements | The subsection title was revised to read:<br>Authorization Requirements and Submission Instructions<br><br>Subsection text was revised to read:<br>Authorization is required for most genetic and molecular laboratory tests. (Refer to the Community Health Automated Medicaid Processing System (CHAMPS) Code Rate and Reference tool for authorization necessity.) Authorization requests must be submitted to MDHHS within 30 days of the DOS. Whenever possible, specimen processing should not be completed until after the authorization request has been approved. Approval is not guaranteed as PA submission requirements and testing standards of coverage guidelines must be met.<br>~~Authorization requests require supporting medical documentation relevant to the requested test or a~~ Providers are encouraged to submit PA requests electronically through direct data entry (DDE) in CHAMPS via the CHAMPS Provider Portal (refer to the Directory Appendix for website information) whenever possible. Refer to the General Information for Providers chapter of this manual for PA submission instructions and additional information. Providers unable to submit authorization requests electronically may send requests to the MDHHS Program Review Division using the Genetic and Molecular Laboratory Test Authorization Request form (MSA-2081) completed by the beneficiary's Medicaid enrolled treating/ordering provider (i.e., MD, DO, PA, NP). (Refer to the Forms Appendix for a copy of the form, including form completion instructions.) This form may be faxed or mailed to the MDHHS Program Review Division. (Refer to the Directory Appendix for contact information.) If faxed, providers must include only one authorization request per fax. |

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| | | | | Supporting medical documentation relevant to the requested test must accompany the electronic DDE PA submission (or MSA-2081) if the submission is incomplete or contains insufficient clinical justification associated with the authorization request. Instructions for uploading documentation to a PA request are available on the Prior Authorization website. (Refer to Prior Authorization in the Directory Appendix for website information.)<br><br>Medical necessity letters submitted as clinical documentation must be beneficiary specific and created and signed by the treating/ordering provider. Generic statements, letters, or order/requisition forms created by the performing laboratory will not be accepted as a substitute for clinical documentation from the medical record or completion of the PA request (electronic DDE PA or MSA-2081).<br><br>The completed electronic DDE PA submission (or MSA-2081) and/or supporting clinical documentation must document the following:<br>• Indication for the test. Indications should be beneficiary specific and clinical in nature.<br>• The beneficiary's related signs and symptoms.<br>• Family history relevant to the beneficiary's condition and test being requested. A family pedigree analysis must be made available upon request.<br>• Other related testing or clinical findings of the beneficiary or family member.<br>• How the test results will be used to significantly alter the management or treatment of the disease. This definitive treatment or action plan should be specific to the beneficiary and completed by the provider who will manage the beneficiary using the test results. |

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| | | | | • The name and NPI number of the laboratory performing the test.<br>• The name, specialty, and NPI number of the provider ordering the test.<br>• Treating/ordering provider signature. ~~Alternatively,~~ A signed MSA-2081, laboratory order or requisition, or signed medical documentation supporting the clinician's intent to order the test will satisfy the ~~MSA-2081~~ signature requirement. |
| | | Laboratory | 5.2.A. Authorization Submission<br><br>(the subsection was deleted and the following subsections were renumbered) | The subsection was removed. |
| | | Laboratory | 5.5 Multi-Gene Panels | The 3rd paragraph was revised to read:<br><br>If a procedure code is available for the multi-gene panel test, this procedure code should be utilized. If no procedure code accurately describes the panel performed, an unlisted molecular pathology or unlisted molecular multi-analyte assay with algorithmic analysis procedure code (as applicable) may be used. When an unlisted procedure code is reported, providers should include the name of the panel test in ~~box 21 of~~ the Provider Comments field in the electronic DDE PA submission or the Test Name field on form MSA-2081. ~~The test name should also be reported in the Procedure Code Comment field in the MDHHS CHAMPS authorization form.~~ |

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| | | Medical Supplier | 1.8.A. Prior Authorization Form | Text was revised to read:<br><br>Requests for PA must be submitted on the Special Services Prior Authorization Request (MSA-1653-B) or, for mobility and custom seating items, submit the Complex Seating and Mobility Device Prior Authorization Request (MSA-1653-D). (Refer to the Forms Appendix for a copy of the PA form and completion instructions.) PA requests submitted in the CHAMPS PA direct data entry (DDE) system replace the need to complete the MSA-1653-B or the MSA-1653-D forms. In addition, the medical documentation specific to each type of device requested must accompany the form or upload with the PA request submitted via CHAMPS PA DDE. The information on the PA request form must be:<br><br>• Typed – All information must be clearly typed in the designated boxes of the form.<br><br>• Complete – The provider must use the specific HCPCS code and the code description. A NOC code may not be used unless the use of a NOC code for the item has been approved by the PDAC. The brand, model, product or part number must be stated on MSA-1653-B or MSA-1653-D (or entered in CHAMPS PA DDE) with the appropriate HCPCS code and description. The prescription and medical documentation must be submitted with the request. (Refer to the Coverage Conditions and Requirements section of this chapter for additional information regarding standards of coverage and payment rule requirements.)<br><br>PA request forms and attached documentation may be mailed or faxed to the MDHHS Program Review Division. (Refer to Directory Appendix for contact information.) PA requests submitted into the CHAMPS PA DDE system replace the need to complete forms MSA-1653-B and MSA-1653-D. Only complete these forms if submitting PA requests to the MDHHS Program Review Division via mail or fax. (Refer to the General Information for Providers chapter for PA processes.) |

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| | | | | Instructions for the electronic submission of PA requests and the HIPAA 278 transaction code set are available on the MDHHS website. (Refer to the Directory Appendix for website information.) |
| | | | 1.8.B. Evaluation and Medical Justification for Complex Seating Systems and Mobility Devices Form | The 6th paragraph was revised to read:<br><br>The initial MSA-1656 is retained on file by MDHHS. A new MSA-1656 is not required for additions or revisions to a seating system or mobility item unless there is a change in the beneficiary's functional status.<br><br>• Addendum A: Mobility/Seating – This form must be completed and submitted with MSA 1656 and MSA-1653-D (or upload with PA request entered in CHAMPS PA DDE) when requesting complex seating, a manual wheelchair with accessory add-ons, power wheelchairs, scooters, and power accessories. The evaluator must complete only the sections that apply to the requested equipment and accessories.<br><br>• Addendum B: Strollers, Gait Trainers, Standers, Car Seats, and Children's Positioning Chairs – This form must be completed and submitted with MSA-1656 and MSA-1653-D (or upload with PA request entered in CHAMPS PA DDE) when requesting these items. The evaluator must complete only the sections that apply to the requested equipment and accessories. |
| | | | 1.8.C. Emergency Prior Authorization | The subsection title was revised to read:<br><br>~~Emergency~~ Verbal Prior Authorization<br><br>In the 5th paragraph, the 2nd bullet point was revised to read:<br><br>• A completed PA request (MSA-1653-B, MSA-1653-B, or submitted in the CHAMPS PA DDE) is not received within 30 days of the verbal authorization. |

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| | | | | Addition of the following text:<br><br>Refer to the General Information for Providers chapter for standard, expedited, and verbal prior authorization processes. |
| | | | 1.8.E. Beneficiary Eligibility | The 1st paragraph was revised to read:<br><br>Approval of a service ~~on MSA-1653-B or MSA-1653-D~~ confirms that the service is authorized for the beneficiary. The approval does not guarantee that the beneficiary is eligible for Medicaid. If the beneficiary is not eligible on the DOS or is enrolled in a Medicaid Health Plan (MHP) and the provider orders or delivers the service, MDHHS will not reimburse the provider. To assure payment, the provider must verify eligibility prior to ordering or delivering the service. (Refer to the Beneficiary Eligibility Chapter of this manual for additional information.) |

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|---|---|---|---|---|
| | | | 1.8.G. Reimbursement Amounts | The 1st paragraph was revised to read:<br><br>Most items have established fee screens that are published in the MDHHS Medical Supplier/DME/Prosthetics and Orthotics Fee Schedule. The approved reimbursement amount of the fees for NOC codes and all codes without established fee screens will be indicated on the authorized PA request. For items that do not have established fee screens or are custom fabricated, refer to the Medicaid Code and Rate Reference tool for payment rules. (Refer to the Directory Appendix for website information.) The provider must provide a manufacturer's invoice that states the acquisition cost for the service on the PA request form (or upload invoice into CHAMPS PA DDE). Manufacturer quotes or dealer list prices are not accepted as documentation of cost. Modified manufacturer invoices will not be accepted. If the manufacturer's actual invoice is not included, medical review will assign a penny screen to the code until the actual invoice is received. If the provider is requesting reimbursement for labor, the specific time must be stated on the request form. MDHHS reserves the right to set a dollar limit on how much MDHHS will reimburse for a NOC code or any manually priced procedure code for a specific range of products. |
| | | | 1.9.C. Repairs and Replacement Parts | The 7th paragraph was revised to read:<br><br>For a repair in which no specific HCPCS code is appropriate, report HCPCS code K0739 (for the labor charge) and HCPCS code E1399 (for the replacement part). For wheelchairs, HCPCS code K0108 is to be used in place of HCPCS code E1399. The RB modifier is reported for the replacement part of the DME furnished as part of the repair. PA is required. The provider must provide a manufacturer's invoice that states the acquisition cost for the service with the PA request ~~form~~. If the provider is requesting reimbursement for labor, the specific time must be stated on the request ~~form~~. |

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| | | | | The 10th paragraph was revised to read:<br><br>MDHHS will not replace an item due to damage to the item ~~as a result~~ because of misuse or abuse by the beneficiary or the caregiver. If damage to an item is the result of theft or car accident, attempts should be made to collect the full or partial payment from the third party's insurance company, if applicable. A copy of the police or fire report must be submitted with the PA request ~~form~~. |
| | | | 2.14.A. Enteral Nutrition (Administered Orally) | Under "PA Requirements", the last paragraph was revised to read:<br><br>For ~~emergency~~ verbal prior authorization of initial orders for beneficiaries discharging from the inpatient hospital setting, the medical supplier may call the Program Review Division ~~to request a verbal authorization~~. (Refer to the Directory Appendix for contact information.) |
| | | | 2.14.B. Enteral Nutrition (Administered by Tube) | Under "PA Requirements", the last paragraph was revised to read:<br><br>For ~~emergency~~ verbal prior authorization of initial orders for beneficiaries discharging from the inpatient hospital setting, the medical supplier may call the Program Review Division ~~to request a verbal authorization~~. (Refer to the Directory Appendix for contact information.) |
| | | | 2.29 Osteogenesis Stimulators | Under "PA Requirements", the 2nd paragraph was revised to read:<br><br>For consideration of rental beyond the initial three months, a new ~~MSA-1653-B~~ PA request must be submitted, along with physician documentation establishing medical reason(s) for continued need. |

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| | | | 2.39 Speech Generating Devices | Under "PA Requirements", the 2nd paragraph was revised to read:<br><br>PA is required for all SGDs, eye control mechanisms, upgrades, modifications, accessories, repairs, replacements and device trials. Required documentation must accompany the MSA-1653-B or upload documentation with the PA request in the CHAMPS PA DDE system when requesting authorization for all original and replacement/upgrade SGD requests. |
| | | Nursing Facility Coverages | 11.5 Complex Care | The 5th paragraph was revised to read:<br><br>~~It may take up to 15 business days for the~~ A determination for form MSA-1576 ~~to be processed~~ will be made no later than seven calendar days after MDHHS receives the form. If it appears that a beneficiary, upon discharge, will require intensive nursing care, the hospital's discharge planning coordinator should initiate the MSA-1576 as early in the beneficiary's hospital stay as possible to ensure a smooth transition to the nursing facility. |

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| | | Therapy Services | 3.1 Form and Completion Instructions | The subsection title was revised to read:<br>~~Form and Completion~~ Submission Instructions<br><br>Subsection text was revised to read:<br><br>~~Prior authorization requests must be submitted on~~ Providers are encouraged to submit PA requests electronically through direct data entry (DDE) in CHAMPS via the CHAMPS Provider Portal (refer to the Directory Appendix for website information) whenever possible. Refer to the General Information for Providers chapter of this manual for PA submission instructions and additional information. Providers unable to submit authorization requests electronically may send requests to the MDHHS Program Review Division using the Occupational Therapy-Physical Therapy-Speech Therapy Prior Authorization Request (MSA-115). (Refer to the Forms Appendix or the MDHHS website for a copy of the form and completion instructions.) Requests for extension of a previously approved authorization period must be submitted within 15 days prior to the end of the authorization period.<br><br>Required medical documentation must accompany the electronic DDE PA submission or MSA-115 form. This includes a copy of the initial evaluation and treatment plan for initial PA requests. All documents must contain the beneficiary's name and mihealth card number.<br><br>~~The information on the MSA-115 must be:~~<br>• ~~Typed – All information must be clearly typed in the designated boxes of the form.~~<br>• ~~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, the provider's billing NPI number, and must support the procedure codes, quantity, and frequency being requested.~~ |

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| | | | | Whenever a beneficiary is admitted to a nursing facility directly from a general hospital or from another nursing facility where the beneficiary was receiving reimbursable therapy services, the name of that facility and the date of discharge from that facility should be included on the prior authorization request.<br><br>Prior authorization requests must be submitted with the appropriate therapy modifier to distinguish the discipline under which the service is being requested. When the therapy is habilitative, a modifier that represents the nature of the therapy being requested must also be reported. Requests for maintenance therapy services should also contain the appropriate maintenance modifier. Refer to the Billing & Reimbursement Chapters for additional modifier information.<br><br>~~For all Medicaid Fee-for-Service (FFS) beneficiaries, prior authorization requests should be submitted electronically via FFS Direct Data Entry (DDE) in CHAMPS. (Refer to the General Information for Providers chapter of this manual for additional information.) A copy of the MSA-115 must be attached to each electronic PA request. Prior authorization requests (MSA-115) may also be faxed or mailed to the MDHHS Program Review Division.~~<br><br>~~Providers can check the status of a PA request in CHAMPS or by contacting the MDHHS Program Review Division via telephone. (Refer to the Directory Appendix for website and contact information.)~~<br><br>A copy of the prior authorization determination letter must be retained in the beneficiary's medical record. |

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| | | Therapy Services | 3.2 Emergency/Verbal Prior Authorization | The subsection title was revised to read:<br>~~Emergency/~~ Expedited and Verbal Prior Authorization<br><br>Subsection text was revised to read:<br><br>Providers may request an expedited PA review if therapy will be rendered within 10 calendar days following the date of submission of the PA request and meet specified criteria. Refer to the General Information for Providers chapter of this manual for more information.<br><br>A provider may also contact MDHHS to obtain a verbal emergency prior authorization when the prescribing practitioner ~~(practicing within their scope of practice as defined by state law)~~ has indicated that it is medically necessary to provide therapy services without delay. To obtain verbal prior authorization, providers may call the Program Review Division. (Refer to the Directory Appendix for contact information.) If the initiation of a therapy service is required during MDHHS nonworking hours, providers may perform the service and call the Program Review Division by the end of the next working day.<br><br>The provider must also submit a PA request via DDE or MSA-115 (with supporting documentation) to MDHHS within 30 days. MDHHS will issue an authorization number and approval, contingent upon the supporting documentation matching the information relayed for verbal authorization.<br><br>~~To obtain verbal prior authorization, providers may call the Program Review Division. (Refer to the Directory Appendix for contact information. Refer to the Forms Appendix for a copy of form MSA-115 and completion instructions.)~~ |

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| | | | | ~~The following steps must be completed before a prior authorization number is issued for billing purposes:~~<br>• ~~The verbal authorization date must be entered on the MSA-115 or electronically in CHAMPS via FFS DDE.~~<br>• ~~The MSA-115 or FFS DDE prior authorization request must be submitted to the Program Review Division within 30 days of the verbal authorization.~~<br>• ~~Supporting documentation must be submitted with the prior authorization request.~~<br>The verbal authorization does not guarantee reimbursement for the services if:<br>• The beneficiary was not eligible for Medicaid when the therapy service was provided.<br>• The Program Review Division does not receive the electronic DDE PA submission or completed MSA-115 and required documentation within 30 days of the verbal authorization.<br>• The prescription is dated after the date the verbal authorization was requested. |
| MMP 26-12 | 5/1/2026 | Behavioral Health and Intellectual and Developmental Disability Supports and Services | Section 17 – Behavioral Health 1915(i) Home and Community-Based Services (HCBS) State Plan Amendment | The 2nd paragraph was deleted.<br>~~NOTE: Certain services found in this section are State Plan Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services when delivered to children birth-21 years.~~ |

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| | | | 17.1.B. Independent Evaluations and Re-Evaluations | The 1st paragraph was revised to read:<br><br>For an independent evaluation/re-evaluation, MDHHS Health Services staff will apply the needs-based criteria to determine whether the individual in the targeted group is eligible for §1915(i) benefit services. The PIHP's provider network, which must adhere to conflict free requirements, will utilize standardized instruments to assist in identifying level of need ~~(i.e., Level of Care Utilization System [LOCUS], Supports Intensity Scale [SIS], American Society of Addiction Medicine [ASAM], Global Appraisal of Individual Needs Initial [GAIN-I])~~, administer other face-to-face assessments related to the individual's functional abilities ~~(i.e., Essential for Living [EFL], Assessment of Functional Living Skills [AFLS], administer other adaptive behavior/global functioning scales, etc.)~~, and identify services and supports required to reach the expected outcomes of community inclusion and participation. The PIHP's provider network will provide evidence to MDHHS Health Services for making the needs-based eligibility determination through a Waiver Support Application (WSA) portal.<br><br>• ~~For children and adolescents with Serious Emotional Disturbance (SED), standardized tools (i.e., the Preschool and Early Childhood Functional Assessment Scale [PECFAS], the Child Adolescent Functional Assessment Scale [CAFAS], etc.) are utilized.~~ For children and adolescents with Serious Emotional Disturbance (SED), to meet Maintenance of Effort (MOE) requirements, from effective date of the amendment through the state spending and CMS notification of close-out of American Rescue Plan (ARP) section 9817 funding, Michigan will use both the Child and Adolescent Functional Assessment Scale (CAFAS) or Preschool and Early Childhood Functional Assessment Scale (PECFAS) **and** the Michigan Child and Adolescent Needs and Strengths (MichiCANS). If the results are different between the two instruments, the state will apply the results of the instrument that establishes eligibility for the individual. |

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| | | | | For beneficiaries receiving a reevaluation of eligibility, the state will use MichiCANS and, if the results indicate that a beneficiary is no longer eligible, the state will use and apply the results of the CAFAS/PECFAS.<br>• For children and adolescents with intellectual or developmental disability, ~~standardized tools to identify functional abilities, adaptive behavior/global functioning, and level of support needs (i.e., Developmental Disabilities Children's Global Assessment Scale [DD-CGAS], Vineland, Supports Intensity Scale – Children's Version [SIS-C], etc.) are~~ the MichiCANS is utilized.<br>• For adults with mental health and co-occurring mental health and substance use disorder related needs, the Level of Care Utilization System (LOCUS) is applied. For adults with intellectual or developmental disability-related needs, the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0), the Supports Intensity Scale – Adult Version [SIS-A], if still current, or other assessment tool as approved by MDHHS is used. ~~For~~ Adults presenting with needs only involving substance use disorders~~, the GAIN-I core assessment is utilized as it directly supports the ASAM level of care criteria that this service system is based on~~ should be assessed using the American Society of Addiction Medicine (ASAM) Continuum. |

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| | | | 17.4.A. Community Living Supports (CLS) | The beginning note was removed.<br>~~NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.~~<br><br>In the 3rd paragraph, 1st bullet point, the 2nd paragraph was revised to read: CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or State Plan services, e.g., Personal Care (assistance with activities of daily living in a certified specialized residential setting) and Home Help (assistance in the beneficiary's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, the beneficiary must request Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help. If the beneficiary requests it, the PIHP case manager, ICCW or supports coordinator entity must assist them in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the MDHHS assessment.<br><br>For the 2nd bullet point, the 2nd sub-bullet point was revised to read:<br>➢ non-medical care (not requiring nurse or physician intervention), which includes observing and/or monitoring while preserving the health and safety of the beneficiary as they are waiting for medical care or hospitalization |

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| | | | | The 8th sub-bullet point was revised to read:<br>➢ Reminding, observing and/or monitoring of medication administration. For beneficiaries who are unable to self-administer medications, CLS may support the beneficiary with administration. CLS is not intended to replace or supplant what would be the responsibility of a parent or guardian of a minor to provide.<br><br>The last paragraph was revised to read:<br>CLS provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the beneficiary's independence and integration into the community. This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the beneficiary. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For beneficiaries up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings or to be provided during the times when a child or adult would typically be in school but for the parent's choice to home school. |

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| | | | | Addition of the following text:<br><br>The case manager will assist the beneficiary in securing CLS services by providing a list of CLS providers and other hiring resources, including education and information on utilizing a self-directed arrangement and opportunities to direct hire staff through this method. This will include referrals to CLS providers as appropriate, along with monitoring progress to ensure access and delivery of the CLS service is implemented as identified in the IPOS.<br><br>Costs associated with room and board are excluded from CLS coverage. |
| | | | 17.4.C. Environmental Modifications | The 1st paragraph was revised to read:<br><br>Physical adaptations to the beneficiary's own home or apartment ~~and/or workplace~~. There must be documented evidence that the modification is the most cost-effective alternative to meet the beneficiary's need/goal based on the results of a review of all options, including a change in the use of rooms within the home or alternative housing~~, or in the case of vehicle modification, alternative transportation~~. All modifications must be prescribed by a physician. Prior to the environmental modification being authorized, PIHP may require that the beneficiary apply to all applicable funding sources (e.g., housing commission grants, Michigan State Housing Development Authority (MSHDA), and community development block grants), for assistance. It is expected that the PIHP case manager/ICCW/supports coordinator entity will assist the beneficiary in the pursuit of these resources. Acceptances or denials by these funding sources must be documented in the beneficiary's records. Medicaid is a funding source of last resort.<br><br>In the 2nd paragraph ("Coverage includes:"), the last bullet point was removed:<br><br>• ~~Adaptations to the work environment limited to those necessary to accommodate the beneficiary's individualized needs.~~ |

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| | | | | In the 3rd paragraph ("Coverage excludes:"), the following bullet point was added:<br>• Environmental modifications may not be furnished to adapt living arrangements that are owned or leased by providers of 1915(i) SPA services. |
| | | | 17.4.D. Family Support and Training | The beginning note was removed.<br>~~NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.~~<br><br>The 3rd paragraph was revised to read:<br>The training and counseling goals, content, frequency and duration of the training must be identified in the beneficiary's individual plan of service, along with the beneficiary's goal(s) that are being facilitated by this service. The training that is provided must be directly related to the family's role in supporting the beneficiary in areas specified in the service plan.<br><br>In the last paragraph ("Coverage includes:"), the last bullet point was removed:<br>• ~~Parent-to-Parent Support is designed to support parents/family of children with serious emotional disturbance or developmental disabilities as part of the treatment process to be empowered, confident and have skills that will enable them to assist their child to improve in functioning. The trained parent support partner who has or had a child with special mental health needs provides education, training, and support, and augments the assessment and mental health treatment process. The parent support partner provides these services to the parents/family. These activities are provided in the home and in the community. The parent support partner is to be provided regular supervision and team consultation by the treating professionals.~~ |

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| | | | 17.4.E. Fiscal Intermediary Services | The subsection title was revised to read:<br><br>~~Fiscal Intermediary~~ Financial Management Services<br><br>The 1st paragraph was revised to read:<br><br>~~Fiscal Intermediary~~ Financial Management Services is defined as services that assist the beneficiary, or a representative identified in the beneficiary's individual plan of services, to meet the beneficiary's goals of community participation and integration, independence or productivity while controlling their individual budget and choosing staff who will provide the services and supports identified in the IPOS and authorized by the PIHP. The ~~fiscal intermediary~~ financial management services provider helps the beneficiary manage and distribute funds contained in the individual budget. ~~Fiscal intermediary~~ Financial Management services include, but are not limited to: ..<br><br>The 2nd, 3rd and 4th paragraphs were revised to read:<br><br>The ~~fiscal intermediary~~ financial management services provider may also perform other supportive functions that enable the beneficiary to self-direct needed services and supports. These functions may include selecting, contracting with or employing and directing providers of services, verification of provider qualifications (including reference and background checks), and assisting the beneficiary to understand billing and documentation requirements. |

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| | | | | ~~Fiscal intermediary~~ Financial Management services may not be authorized for use by a beneficiary's representative where that representative is not conducting tasks in ways that fit the beneficiary's preferences, and/or do not promote achievement of the goals contained in the beneficiary's plan of service so as to promote independence and inclusive community living for the beneficiary, or when they are acting in a manner that is in conflict with the interests of the beneficiary.<br><br>~~Fiscal intermediary~~ Financial Management services must be performed by entities with demonstrated competence in managing budgets and performing other functions and responsibilities of a ~~fiscal intermediary~~ financial management services provider. Neither providers of other covered services to the beneficiary, family members, or guardians of the beneficiary may provide ~~fiscal intermediary~~ financial management services to the beneficiary. |
| | | | 17.4.H. Skill Building Assistance | The beginning note was removed.<br><br>~~NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.~~ |

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| | | | | The 2nd paragraph and following text was revised to read:<br><br>Skill-building assistance consists of activities identified in the individual plan of services that assist a beneficiary to increase their economic self-sufficiency with an emphasis on developing and teaching skills that lead to individual competitive integrated employment (ICIE) and~~/or~~ to develop skills to successfully engage in meaningful activities such as school, work, and/or volunteering. The services occur in community-based integrated settings and provide knowledge and specialized skill development and/or supports to achieve specific outcomes consistent with the beneficiary's identified goals, as written in the IPOS, with the purpose of furthering habilitation goals that will lead to greater opportunities of community independence, inclusion, participation, and productivity. ~~Refer to the Home and Community Based Services chapter for further detail.~~ Skill building assistance is a time-limited service, with primary focus on skill development, acquisition, retention, or improvement in self-help socialization and adaptive skills.<br><br>Services include two pathways to skill development:<br><br>• ~~Assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills.~~<br>• ~~Activities that support a beneficiary to attain and retain Individual Competitive Integrated Employment (ICIE) are time-limited and include work pathway services in the community in which a beneficiary is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.~~<br>• Skill building as a pathway to develop skills to successfully engage in meaningful activities such as school work and/or volunteering includes the following: |

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| | | | | ➢ Developing and teaching skills that lead to ~~ICIE including, but not limited to,~~ successful engagement in meaningful community based activities, ability to communicate effectively with ~~supervisors, co-workers and customers~~ individuals in the community; generally accepted community ~~workplace~~ conduct and dress; ability to follow directions; ability to attend to tasks; ~~workplace~~ problem-solving skills and strategies; general ~~workplace~~ community safety; and mobility training. May also provide learning ~~and work~~ experiences~~, including volunteering,~~ through community participation where the beneficiary can develop general~~, non-job-task-specific~~ strengths and skills ~~that contribute to employability in ICIE. Such employment related services are expected to occur over a defined period of time, with specific employment-related goals and outcomes to be achieved as determined by the beneficiary's individual plan of service~~ to engage in meaningful activities.<br>➢ Are expected to occur over a defined period of time and provided in sufficient amount and scope to achieve the outcome and encourage fading to promote community inclusion, as determined by the beneficiary and their care planning team in the ongoing person-centered planning process.<br>• Skill Building as a pathway on developing and teaching skills that lead to ICIE:<br>➢ Participation in skill-building is not a required prerequisite for ICIE or receiving supported employment services.<br>➢ Work preparatory (time-limited work pathway) services to attain ICIE in the community in which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. |

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| | | | | ➢ Services are intended for the beneficiary to develop, acquire or improve skills that lead to ICIE. Examples of such skills include, but are not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety; and mobility training.<br>➢ Provide learning and work experiences, including volunteering, where the individual can develop general, non-job-tasks-specific strengths and skills that may contribute to employability in competitive integrated employment.<br>➢ Enable an individual to attain ICIE and, with the job matched to the beneficiary's interests, strengths, priorities, abilities and capabilities.<br>➢ Are expected to occur over a defined period of time and provided in sufficient amount and scope to achieve the outcome and encourage fading to promote ICIE as determined by the beneficiary and their care planning team in the ongoing person-centered planning process.<br>Skill-building service components needed for each beneficiary are documented, coordinated, and non-duplicative of other services ~~otherwise available under a program funded under the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1401 et seq.)~~.<br>Skill building is not funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.) which will be documented in each beneficiary's file receiving the service. |

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| | | | | Beneficiaries who are still attending school may receive skill building and other work-related transition services through the school system while also participating in skill building services designed to complement and reinforce the skills being learned in the school program during portions of their day that are not the educational system's responsibility, e.g. after school or on weekends and school vacations.<br><br>If a beneficiary has a need for transportation to participate, maintain, or access the skill-building services, the same provider may be reimbursed for providing this transportation only after it is determined that it is not otherwise available (e.g., volunteer, family member) and is the least expensive available means suitable to the beneficiary's need, in accordance with the Medicaid non-emergency medical transportation policy outlined in the Non-Emergency Medical Transportation chapter of the MDHHS Medicaid Provider Manual. |

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| | | | 17.4.J. Supported/Integrated Employment Services | The subsection title was revised to read:<br>17.4.J. Supported~~/Integrated~~ Employment ~~Services~~ – Individual Supported Employment<br><br>The beginning note was removed.<br>~~NOTE: This service is a State Plan EPSDT service when delivered to children birth-21 years.~~<br><br>Text was revised to read: (NOTE: The following reflects changes to formatting/layout of current text.)<br><br>Supported~~/integrated~~ employment services are services that are provided in a variety of community settings for the purposes of supporting beneficiaries in obtaining and sustaining ICIE. ICIE ~~refers to~~ is individual employment that is found in the typical labor market in the community that anyone can apply for and is the optimal outcome of supported employment services. Supported employment services support achieving full- or part-time work at minimum wage or higher, with wages and benefits similar to workers without disabilities performing the same work, and fully integrated with co-workers without disabilities. Supported employment services promote self-direction, are often customized, and are aimed to meet a beneficiary's personal and career goals and outcomes identified in the IPOS. Services may be provided continuously, intermittently, or on behalf of, ~~a beneficiary. Services may be delivered~~ and encourage fading to promote community inclusion and competitive integrated employment. |

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| | | | | ~~Coverage includes~~ Supported Employment Services include the following categories:<br>• Individual Supported Employment Services are individualized. Services include:<br>➢ Job-related discovery,<br>➢ person-centered employment/career planning,<br>➢ job placement, job development, negotiation with prospective employers,<br>➢ job analysis,<br>➢ customized employment discovery and job carving, training and systematic instruction,<br>➢ job coaching and systematic instruction,<br>➢ benefits ~~and work incentives planning and~~ management, financial literacy, asset development~~,~~ and career advancement services, career planning that supports the beneficiary to make informed choices about ICIE or self-employment. The outcome of this service is sustained ICIE at or above the minimum wage in an integrated setting in the general workforce and in a job that meets personal and career goals as outlined in the beneficiary's IPOS,<br>➢ training and planning<br>➢ transportation<br>➢ other workplace support services including services not specifically related to job skill training that enable the person to attain a job in a competitive integrated community setting of their choice. |

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| | | | | ~~Supported employment services include the following categories:~~<br>• ~~Individual supported employment supports to attain or sustain paid employment at or above the minimum wage, and career development in an integrated, competitive setting in the general workforce in a job that meets personal and career goals.~~<br>• Self-employment refers to an individual-run, IRS recognized self-employment business ~~that~~ and nets the equivalent of a competitive wage, after reasonable period for start-up, and is either home-based or takes place in regular integrated business, industry or community-based settings. Services include:<br>➢ Vocational/job related discovery or assessment,<br>➢ Person-centered employment planning,<br>➢ Benefits management, financial literacy, assess development and career advancement services,<br>➢ Relative business planning services<br>• ~~Small group supported employment support are services and training activities, provided in typical business, industry and community settings for groups of two to six workers with disabilities, paying at least minimum wage that leads to ICIE. The purpose of funding for this service is to support sustained paid employment and work experience that leads to ICIE. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities. Small group supported employment must promote integration into the workplace and interaction between workers with disabilities and people who do not have disabilities. Participation in small group supported employment is not a required prerequisite for ICIE or receiving supported employment services.~~ |

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| | | | | Supported~~/integrated~~ employment service components needed for each beneficiary are documented, coordinated, and are non-duplicative of ~~other~~ those services otherwise available ~~under a program~~ to an eligible person through a vocational rehabilitation program funded under the Workforce Innovation and Opportunity Act (WIOA) or the IDEA (20 U.S.C. 1401 et seq.).<br><br>If a beneficiary has a need for transportation to participate, maintain, or access the supported~~/integrated~~ employment services, the same service provider may be reimbursed for providing this transportation only after it is determined that it is not otherwise available (e.g., volunteer, family member) and is the least expensive available means suitable to the beneficiary's need, in accordance with Medicaid non-emergency medical transportation policy outlined in the Non-Emergency Medical Transportation chapter. |
| | | | 17.4.K. Supported Employment – Small Group<br><br>(new subsection) | New subsection text reads:<br><br>Small group supported employment is not competitive integrated employment. Services instead provide supports and training activities provided in typical business, industry and community settings for groups of two to six workers with disabilities paying at least minimum wage. The purpose of funding for this service is to support sustained paid employment and work experience that leads to ICIE. Examples include mobile crews, enclaves, and other business-based workgroups employing small groups of workers with disabilities. Supported employment services for small groups employment support must promote integration into the workplace and interaction between workers with disabilities and people without disabilities in those workplaces. |

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| | | | | Services include:<br>• job analysis<br>• training and systemic instruction<br>• training and planning<br>• transportation<br>• other workplace support services may include services not specifically related to job skill training that enable the waiver beneficiary to be successful in integrating into the workplace.<br>Supported Employment service component(s) needed for each beneficiary are documented, coordinated, and non-duplicative of those services otherwise available to an eligible person through a vocational rehabilitation program funded under WIOA or IDEA (20 U.S.C. 1401 et seq.).<br>If a beneficiary has a need for transportation to participate, maintain, or access the supported employment services, the same provider may be reimbursed for providing this transportation only after it is determined that it is not otherwise available (e.g., volunteer, family member) and is the least expensive available means suitable to the beneficiary's need, in accordance with MDHHS Medicaid Provider Manual non-emergency medical transportation policy. |
| | | | 17.4.L. Vehicle Modifications<br><br>(reflects new numbering) | Addition of the following text:<br>The vehicle that is adapted may be owned by the beneficiary, a family member with whom the beneficiary lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the beneficiary and is not a paid provider of such services. |

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| | | Healthy Michigan Plan | 5.3.B.3. Covered Supports and Services | In the 3rd paragraph, the following bullet point was revised:<br>• ~~Supported/Integrated Employment Services *~~<br>• Supported Employment – Individual Supported Employment*<br>• Supported Employment - Small Group Employment* |
| | | Acronym Appendix | | Addition of:<br>ARP – American Rescue Plan<br>WHODAS 2.0 - World Health Organization Disability Assessment Schedule 2.0<br>WIOA - Workforce Innovation and Opportunity Act |

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| MMP 26-14 | 5/1/2026 | Behavioral Health and Intellectual and Developmental Disability Supports and Services | Section 15 – Habilitation Supports Waiver for Persons with Developmental Disabilities | The 4th paragraph was revised to read:<br><br>The PIHP's enrollment process responsibilities also include confirmation of changes in the beneficiary's enrollment status, including termination from the waiver, changes of residence requiring transfer of the waiver to another PIHP, and death. The PIHPs will report monthly any beneficiaries waiting for HSW enrollment due to lack of capacity of slots available. MDHHS will reallocate slots for individuals who are in need of HSW enrollment but there are no slots available within the PIHP.<br><br>The following text was added after the 4th paragraph:<br><br>Highest priority of entrants into the HSW is based upon the following hierarchy:<br>• Children's Waiver Program (CWP) beneficiaries who are disenrolling from the CWP at the end of their 18th birthday month.<br>• Beneficiaries applying to the HSW who are age 21 and older, who require Private Duty Nursing services, and who meet all other eligibility requirements for HSW enrollment.<br>• Beneficiaries who are at imminent risk of being placed in the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). |

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| | | | | Annual reallocation of slots follows the methodology in which PIHPs self-report to MDHHS their monthly slot usage as well as input on unused capacity or greater need. MDHHS monitors slot utilization by the PIHP on a monthly basis and works with any PIHPs that are less than 95 percent filled for three consecutive months by providing technical assistance to assist staff in identifying and applying for HSW enrollment on behalf of beneficiaries who are eligible.<br><br>The selection of beneficiaries is made at the state level. The procedure for enrollment begins at the PIHP. A clinical screening tool appropriate for beneficiaries with intellectual/developmental disabilities (I/DD) can be used to identify potential enrollees to HSW. PIHPs will begin utilizing a MDHHS-approved screening tool for all beneficiaries with I/DD to identify those who may meet ICF level of care (LOC) criteria to assist the PIHP/CMHSP/other subcontractor to identify potential enrollees on the HSW.<br><br>The HSW Eligibility Certification form (DCH-3894) is maintained in the beneficiary's clinical record at the PIHP. The PIHP ensures the beneficiary and/or guardian is provided a copy of the completed HSW eligibility certification upon enrollment and subsequent re-evaluations.<br><br>Addition of the following text:<br><br>For active HSW beneficiaries not receiving HSW services in three consecutive months, MDHHS will provide technical guidance with the PIHP and may recommend disenrollment from the HSW.<br><br>The last paragraph was removed.<br><br>~~Habilitation services under the HSW are not otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973.~~ |

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| | | | 15.1 Waiver Implementation Requirements<br><br>(new subsection; the following subsections were re-numbered) | Addition of new text; refer to the chapter for full content. |
| | | | 15.2 Waiver Supports and Services<br><br>(re-numbered, previously 15.1) | The following text was added:<br><br>The beneficiary must be informed of services available under the HSW initially through an intake process, again through the pre-planning and PCP process, and through other discussions with the Supports Coordinator. The beneficiary is also informed through the customer services handbook and other print materials available from the PIHP.<br><br>A list of service providers will be made available to the beneficiary by the case management entity in order to assist the beneficiary in connecting with potential service providers and to ensure implementation of the needed service. PIHPs are required to have a comprehensive list of services within their provider network which identifies service providers at the local level. |

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| | | | 15.2.A. Community Living Supports (CLS)<br><br>(re-numbered, previously 15.1.A.) | The 2nd, 3rd, 4th and 5th paragraphs were revised to read:<br><br>~~Community Living Supports (CLS) facilitate an individual's independence, productivity, and promote inclusion and participation.~~ Community Living Supports (CLS) are used to increase or maintain personal self-sufficiency, facilitating a beneficiary's achievement of their goals of community inclusion and participation, independence or productivity. The supports can be provided in the beneficiary's residence (licensed facility, family home, own home or apartment) and in community settings (including, but not limited to, libraries, city pools, camps, etc.). ~~, and may not supplant other waiver or Medicaid State Plan covered services (e.g., out-of-home non-vocational habilitation, Home Help Program, personal care in specialized residential setting, respite). The supports are:~~ The CLS staff's home, if not the beneficiary's residence, is not an approved setting to provide CLS services.<br><br>CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973, or the waiver or State Plan covered services (e.g., out-of-home non-vocational habilitation, Home Help Program, personal care in specialized residential setting, respite). |

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| | | | | ~~Assisting (that exceeds the Medicaid State Plan for adults), prompting, reminding, cueing, observing, guiding and/or training the beneficiary with~~ Coverage for CLS includes assisting (that exceeds state plan for adults), prompting, reminding, cueing, observing, guiding and/or training in the following activities:<br>• Meal preparation;<br>• Laundry;<br>• Routine, seasonal, and heavy household care and maintenance (where no other party, such as a landlord or licensee, has responsibility for provision of these services);<br>• Activities of daily living (ADL), such as bathing, eating, dressing, personal hygiene; and<br>• Shopping for food and other necessities of daily living.<br>• ~~Assisting, supporting and/or training the beneficiary with:~~<br>In addition, CLS staff provide assistance, support and/or training with activities such as:<br>• Money management;<br>• Non-medical care (not requiring nurse or physician intervention) which includes observing and/or monitoring while preserving the health and safety of the beneficiary as they are waiting for medical care or hospitalization;<br>• Socialization and relationship building;<br>• ~~Transportation (excluding to and from medical appointments that are the responsibility of Medicaid through Medicaid Fee for Service [FFS] or the Medicaid Health Plan [MHP]) from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence);~~ |

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| | | | | • Transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded);<br>• ~~Leisure choice and participation in regular community activities;~~<br>• Participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting);<br>• Attendance at medical appointments; ~~and~~<br>• Acquiring ~~goods and/or services~~ or procuring products, resources and accommodations other than those listed under shopping and non-medical services.<br>• Reminding, observing, and/or monitoring of medication administration. For beneficiaries who are unable to self-administer medications, CLS may support the beneficiary with administration. CLS is not intended to replace or supplant what would be the responsibility of a parent or legal guardian of a minor to provide.<br>• Observing and/or monitoring with preserving the health and safety of the beneficiary in order that they may reside or be supported in the most integrated, independent community setting. |

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| | | | | Revision of the following paragraph:<br>For beneficiaries living in unlicensed homes, CLS assistance with meal preparation, laundry, routine household care and maintenance, ADL, and/or shopping may be used to complement Home Help services when the beneficiary's needs for this assistance have been officially determined to exceed MDHHS allowable parameters. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help. CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, Medicaid State Plan coverage of Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through MDHHS or the Medicaid Health Plan (MHP).<br><br>Addition of the following text:<br>The case manager will assist the beneficiary in securing CLS services by providing a list of CLS providers and other hiring resources, including education and information on utilizing a self-directed arrangement and opportunities to direct hire staff through this method. This will include referrals to CLS providers as appropriate, along with monitoring progress to ensure access and delivery of the CLS service is implemented as identified in the IPOS. |

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| | | | 15.2.B. Enhanced Medical Equipment and Supplies<br><br>(re-numbered, previously 15.1.B.) | The 1st paragraph was revised to read:<br><br>Enhanced medical equipment and supplies include devices, supplies, controls, or appliances that are not available under regular ~~Medicaid~~ State Plan coverage or through other insurances. (Refer to the Medical Supplier Chapter of this manual for more information about Medicaid-covered equipment and supplies.) All enhanced medical equipment and supplies must be specified in the IPOS and must enable the beneficiary to increase their abilities to perform ADL; or to perceive, control, or communicate with the environment.<br><br>In the 3rd paragraph, the 1st bullet point was removed:<br><br>This coverage includes:<br><br>• ~~Adaptations to vehicles;~~<br><br>The 7th paragraph was revised to read:<br><br>Items that are considered family recreational choices are not covered (e.g., outdoor play equipment, swimming pools, pool decks and hot tubs). ~~The purchase or lease of a vehicle, as well as any repairs or routine maintenance to the vehicle, is not covered.~~ Educational equipment and supplies expected to be provided by the school are not covered. Eyeglasses, hearing aids, and dentures are not covered.<br><br>Addition of the following text:<br><br>Medical equipment and supplies that can be covered under the State Plan should be furnished as services required under Early and Periodic Screening, Diagnosis and Treatment (EPSDT) to waiver participants under age 21. |

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| | | | | Although all beneficiaries are afforded the opportunity to direct their waiver services, not all waiver services can be directed by the beneficiary or their representative. While beneficiaries have the right to choose among service providers who are on contract with, or employed by, the PIHP or hired through self-directed services, this waiver service is considered a provider-managed service only. |
| | | | 15.2.D. Environmental Modifications (re-numbered, previously 15.1.D.) | The 1st paragraph was revised to read:<br><br>Environmental Modifications are physical adaptations to the home ~~and/or workplace~~ required by the beneficiary's assessed need and identified in the IPOS that are necessary to ensure the health, safety, and welfare of the beneficiary, or enable them to function with greater independence within the environment(s) and without which the beneficiary would require institutionalization.<br><br>The 4th paragraph was revised to read:<br><br>"Direct medical or remedial" benefit is a prescribed specialized treatment and its associated equipment or environmental accessibility adaptation that are essential to the implementation of the IPOS. The plan must document that, as a result of the treatment and its associated equipment or adaptation, institutionalization of the beneficiary will be prevented. There must be documented evidence that the item is the most cost-effective alternative to meet the beneficiary's need. An example of a reasonable alternative, based on the results of a review of all options, may include changing the purpose, use, or function of a room within the home ~~or finding alternative housing~~. Assessments and specialized training needed in conjunction with the use of such environmental modifications are included as a part of the cost of the service. All items must be ordered on a physician's prescription as defined in the General Information section of this chapter. An order is valid for one year from the date it was signed. |

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| | | | | The 8th paragraph was removed:<br>~~Environmental modifications for licensed settings includes only the remaining balance of previous environmental modification costs that accommodate the specific needs of current waiver beneficiaries, and will be limited to the documented portion being amortized in the mortgage, or the lease cost per bed. Environmental modifications exclude the cost of modifications required for basic foster care licensure or to meet local building codes.~~<br><br>The 12th paragraph was removed:<br>~~Adaptations to the work environment are limited to those necessary to accommodate the beneficiary's individualized needs and cannot be used to supplant the requirements of Section 504 of the Rehabilitation Act, the Americans with Disabilities Act (ADA), or covered by the Michigan Department of Labor and Economic Opportunity (LEO) Michigan Rehabilitation Services (MRS) or the LEO Bureau of Services for Blind Persons (BSBP).~~<br><br>Addition of the following text:<br>Environmental modifications may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services. A private residence is considered provider-controlled when a beneficiary lives in a private residence owned by an unrelated caregiver who is paid for providing HCBS services to the beneficiary.<br>Beneficiaries living in their own home, family home or the home of another (who is not a paid provider of HCBS services) are eligible for this benefit as medical necessity is met. |

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| | | | | While beneficiaries have the right to choose among service providers who are on contract with or employed by the PIHP or hired through self-directed services, this waiver service is considered a provider-managed service only. |
| | | | 15.2.E. Family Training (re-numbered, previously 15.1.E.) | The 1st paragraph was revised to read:<br><br>Family Training includes training and counseling services for the families of beneficiaries served by the waiver. For purposes of this service, "family" is defined as ~~family members who live with or provide care to the beneficiary on the HSW, and may include parent, spouse, children, relatives, foster family, unpaid caregivers, or in-laws~~ the persons who live with and provide uncompensated care and support to the beneficiary directly related to their role in supporting the beneficiary in areas specified in the IPOS.<br><br>Addition of text:<br><br>Federal Financial Participation (FFP) is available for the cost of registration and training fees associated with formal instruction in areas relevant to beneficiary needs identified in the IPOS.<br><br>FFP is not available for the cost of travel, meals, and overnight lodging to attend a training event or conference. |

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| | | | 15.2.F. Fiscal Intermediary<br><br>(re-numbered, previously 15.1.F.) | The subsection title was revised to read:<br><br>~~Fiscal Intermediary~~ Financial Management Services<br><br>Throughout the subsection, use of 'fiscal intermediary' was revised to read 'financial management' and/or 'FMS'.<br><br>Addition of:<br><br>Although all beneficiaries are afforded the opportunity to direct their waiver services, not all waiver services can be directed by the beneficiary or their representative. While beneficiaries have the right to choose among service providers who are on contract with or employed by the PIHP or hired through self-directed services, this waiver service is considered a provider-managed service only. |
| | | | 15.2.G. Goods and Services<br><br>(re-numbered, previously 15.1.G.) | Text was revised to read:<br><br>The purpose of Goods and Services is to promote individual control over, and flexible use of, the individual budget by the beneficiary using self-directed services and facilitate creative use of funds to accomplish the goals identified in the IPOS through achieving better value or an improved outcome. ~~Goods and Services must increase independence, facilitate productivity, or promote community inclusion and substitute for human assistance (such as personal care in the Medicaid State Plan and CLS and other one-to-one support as described in the HSW or covered Medicaid State Plan definitions) to the extent that individual budget expenditures would otherwise be made for the human assistance.~~<br><br>~~A Goods and Services item must be identified using a person-centered planning process, meet medical necessity criteria, and be documented in the IPOS. Purchase of a warranty may be included when it is available for the item and is financially reasonable.~~ |

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| | | | | ~~Goods and Services are available only to beneficiaries who self-direct their services whose individual budget is lodged with a fiscal intermediary.~~<br><br>~~This coverage may not be used to acquire goods or services that are prohibited by federal or state laws or regulations, e.g., purchase or lease or routine maintenance of a vehicle.~~<br><br>Goods and Services can be services, equipment or supplies not otherwise provided through either the HSW, the State Plan or 1915(i) SPA that address an identified need through the PCP process. Each item or service specified in the IPOS must identify the beneficiary has a need and does not have the funds to purchase the good or service and the good or service is not available through another source.<br><br>Goods and Services must:<br>• Increase independence, facilitate productivity, or promote, improve or maintain community inclusion; and/or<br>• Decrease the need for other Medicaid services and meet all of the following:<br>➢ Be provided to, or directed exclusively toward, the benefit of the beneficiary;<br>➢ Be identified through the PCP process, documented in the IPOS, and meet the Goods and Services medical necessity criteria which identifies the need and demonstrates how the good or service will increase independence, productivity and community inclusion; and<br>➢ Be provided through a self-directed arrangement purchased through an individual budget. |

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| | | | | A Goods and Services item can include the purchase of a warranty and may be included when it is available for the item and is financially reasonable. A Good may also include the purchase of adaptive clothing. Adaptive clothing is specifically designed to accommodate the needs of beneficiaries who require specialized garments. These specialized garments aim to enhance comfort, dignity, promote independence, and ease the burden of dressing.<br><br>Coverage of this service is limited to waivers that incorporate the budget authority participant direction opportunity.<br><br>Goods and Services has a limit of $2,000 per IPOS year.<br><br>Goods and Services may not be used for the following:<br>• To acquire goods or services that are prohibited by federal or state laws or regulations (e.g., purchase or lease or routine maintenance of a vehicle).<br>• Services covered by third parties or services that are the responsibility of a non-Medicaid program/service.<br>• Services already covered through Medicaid, EPSDT and/or 1915(i) SPA.<br>• Health-related services, equipment and supplies.<br>• Room and board (including rent and mortgage payments).<br>• Vacation expenses (travel, lodging costs, etc.) for the beneficiary and any paid staff who accompany the beneficiary on vacation.<br>• Academic tutoring or other services covered under the Rehabilitation Act or IDEA.<br>• Internet, cell phones, utilities and telephone purchase or costs.<br>• Any purchase that does not meet HCBS settings requirements.<br>• Service animals or cost of pet care.<br>• Expenses and/or costs of meals incurred. |

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| | | | | • If the purchase of items or services, as determined by the PIHP,:<br>➢ Leads to significant monetary gain for a beneficiary's support person(s);<br>➢ Provides the support person(s) with significant influence over the beneficiary; and/or<br>➢ Constitutes a conflict of interest. As used herein, the term "support person" includes a beneficiary's spouse, children, parents, guardians, any person engaging in sexual activity with the beneficiary, partners residing with the beneficiary, and/or any person who provides paid services. |
| | | | 15.2.I. Out-of-Home Nonvocational Habilitation<br><br>(re-numbered, previously 15.1.I.) | Text was revised to read:<br><br>NOTE: This is a habilitative service.<br><br>This service provides assistance with acquisition, retention, or improvement in self-help, socialization, and adaptive skills; and the supports services, including transportation to and from, incidental to the provision of that assistance that takes place in a non-residential setting, separate from the home or facility in which the beneficiary resides. This service is provided in a community setting.<br><br>This service is intended to enhance social development and develop skills in performing ADL and community living as specified and furnished consistent with the beneficiary's IPOS.<br><br>These supports focus on enabling the beneficiary to attain or maintain their maximum functioning level and should be coordinated with any needed therapies in the beneficiary's IPOS, such as physical, occupational, or speech therapy. Services may serve to reinforce skills or lessons taught in school, therapy, or other settings. |

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| | | | | Personal care/assistance may be a component part of out-of-home non-vocational habilitation services as necessary to meet the needs of a beneficiary but may not comprise the entirety of the service.<br><br>Examples of incidental support include:<br>• Aides helping the beneficiary with their mobility, transferring, and personal hygiene functions at the various sites where habilitation is provided in the community.<br>• When necessary, helping the person to engage in the habilitation activities (e.g., interpreting).<br><br>Services must be furnished on a regularly scheduled basis for one or more days per week unless provided as an adjunct to other day activities included in the beneficiary's IPOS.<br><br>~~These supports focus on enabling the beneficiary to attain or maintain their maximum functioning level, and should be coordinated with any physical, occupational, or speech therapies listed in the IPOS. Services may serve to reinforce skills or lessons taught in school, therapy, or other settings.~~<br><br>Different types of non-residential habilitation services may not be billed during the same period of the day.<br><br>Out-of-Home Non-Vocational Habilitation services may not provide for the payment of services which are vocational in nature.<br><br>Meals are not provided as a part of Out-of-Home Non-Vocational services. |

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| | | | 15.2.J. Overnight Health and Safety Supports (OHHS)<br><br>(re-numbered, previously 15.1.J.) | The 1st paragraph was revised to read:<br><br>NOTE: Overnight Health and Safety Supports (OHSS) is not available for beneficiaries residing in licensed or non-community facilities or settings.<br><br>The 7th and last paragraphs were revised to read:<br><br>OHSS may be appropriate when:<br>• Service is necessary to safeguard against injury, hazard, or accident, including monitoring for non-life threatening self-harm behaviors that require redirection.<br>• Service will allow the beneficiary to remain at home safely after all other available preventive interventions have been undertaken, and the risk of injury, hazard or accident remains.<br>• Assistance is needed with instrumental activities of daily living (IADL) that cannot be pre-planned or scheduled.<br>• The need is caused by a medical condition or the form of supervision required is medical in nature (i.e., wound care, sleep apnea, end-stage hospice care, etc.) or in anticipation of a medical emergency (i.e., uncontrolled seizures, serious impairment to bodily functions, etc.).<br>• 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. |

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| | | | | • 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.<br>• 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, has a cognitive impairment, 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.).<br>• 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.<br>• A beneficiary requires overnight supervision in order to maintain living arrangements in the most integrated community setting appropriate for their needs.<br><br>The following exceptions apply for OHSS:<br>• OHSS does not include friendly visiting or other social activities.<br>• ~~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.~~<br>• ~~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.~~<br>• OHHS is not available for medical needs beyond provider qualification requirements (aide level staff) for this service. |

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| | | | | • OHSS is not available to prevent, address, treat, or control significantly challenging anti-social or severely aggressive individualized behavior.<br>• 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.<br>• 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.<br>• 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.<br>• 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 life-threatening self-harm behaviors. |
| | | | 15.1.L. Prevocational Services<br><br>(subsection was removed; the following subsections were re-numbered) | The subsection was removed. |

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| | | | 15.2.L. Private Duty Nursing (PDN)<br>(re-numbered, previously 15.1.M.) | In the 1st paragraph, the bullet list was revised to read:<br>The beneficiary receiving PDN must also require at least one of the following habilitative services:<br>• CLS<br>• Out-of-home non-vocational habilitation<br>• ~~Prevocational or supported employment~~ Supported Employment – Individual<br>• Supported Employment – Small Group |
| | | | 15.2.M. Respite Care<br><br>(re-numbered, previously 15.1.N.) | In the 4th paragraph, the 2nd bullet point was revised to read:<br>• Licensed foster care home.<br>➢ Licensed foster family home or licensed foster family group home<br>➢ Licensed Children's Therapeutic group home<br><br>Addition of:<br>FFP is not to 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.<br>Respite care may not be furnished for the purpose of compensating relief or substitute for a waiver residential service. |

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| | | | 15.2.N. Supported Employment<br><br>(re-numbered, previously 15.1.O.) | The subsection title was revised to read:<br><br>Supported Employment – Individual Supported Employment<br><br>Text was revised to read: (NOTE: The following reflects changes to formatting/layout of current text.)<br><br>NOTE: This is a habilitative service.<br><br>~~Competitive integrated employment (CIE)~~ Individual Supported Employment services are services provided in a variety of community settings for the purpose of supporting beneficiaries in obtaining and sustaining individual competitive integrated employment (CIE). CIE is individual employment that is found in the typical labor market in the community that anyone can apply for and is the optimal outcome of supported employment services. Supported employment services ~~seek to align with the Work Innovation and Opportunity Act (WIOA) to achieve desired outcomes for beneficiaries~~ support achieving full- or part-time work at minimum or higher, with wages and benefits similar to workers without disabilities performing the same work and fully integrate with co-workers without disabilities. Supported Employment services promote self-direction, are customized, and are aimed at meeting a beneficiary's personal and career goals and outcomes identified in the IPOS. Services may be provided continuously or intermittently or on behalf of and encourage fading to promote community inclusion and CIE.<br><br>~~Supported employment services support CIE in the general workforce where the beneficiary is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Supported employment services can be provided through many different service models.~~ |

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| | | | | ~~Specific~~ Supported employment services include the ~~two~~ following categories:<br>• Individual Supported Employment Services are individualized. Services include:<br>~~Supported Individual Employment Services for Job Development/Career Planning support CIE that is found in the typical labor market in the community that anyone can apply for and is the optimal outcome of supported employment services. Such services may provide ongoing supports to beneficiaries who, because of their disabilities, need some fading level of supports to be successful. Additionally, this service array may include intensive on-going support to obtain or maintain an individual job in competitive or customized employment, or self-employment in CIE in the general workforce for which the beneficiary is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Self-employment refers to an individual-run business that nets the equivalent of a competitive wage, after a reasonable period for start-up, and is either home-based or takes place in regular integrated business, industry, or community-based settings. This service supports sustained paid employment at or above the minimum wage in CIE in the general workforce in a job that meets personal and career goals.~~<br>~~Individual supported employment services are individualized and may include any combination of the following services:~~<br>➢ Vocational/job-related discovery or assessment<br>➢ Person-centered employment/career planning<br>➢ Job placement/job development, negotiation with prospective employers<br>➢ Job analysis<br>➢ Customized employment discovery and job carving<br>➢ Job coaching |

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| | | | | ➢ Training and systematic instruction<br>➢ Benefits management, financial literacy, asset development and career advancement services/career planning that supports a beneficiary to make informed choices about individual competitive employment or self-employment. The outcome of this service is sustained individual CIE at or above the minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals as outlined in the beneficiary's IPOS.<br>➢ Training and planning<br>➢ Transportation<br>➢ Other workplace support services, including services not specifically related to job skill training that enable the beneficiary to attain a job in a CIE competitive integrated community setting of their choice.<br>~~• Group Employment Services for two to six individuals:~~<br>➢ ~~Supported Group Employment Services and training activities provided in regular business, industry, and community settings for groups of two (2) to six (6) workers with disabilities, paying at least minimum wage in an integrated setting. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Group Employment Services must be provided in a manner that promotes integration into the workplace and interaction between beneficiaries and individuals without disabilities in those workplaces. Funding for~~ |

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| | | | | ~~this service is to support sustained paid employment and work experience leading to further career development in individual CIE-based employment for which the beneficiary is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Supported Group Employment Services does not include volunteer work or vocational services provided in facility-based work settings.~~<br>➢ ~~Supported Group Employment Services may include any combination of the following services:~~<br>• ~~job analysis~~<br>• ~~training and systematic instruction~~<br>• ~~job coaching~~<br>• ~~benefits management support and financial literacy~~<br>• ~~training and planning~~<br>• ~~transportation~~<br>• ~~career advancement services~~<br>• ~~other workplace support services that may include services not specifically related to job skill training that enable the beneficiary to be successful in integrating into the workplace.~~<br>Self-employment refers to a beneficiary-run, Internal Revenue Service (IRS) recognized self-employment business and nets the equivalent of a competitive wage, after a reasonable period for start-up, and is either home-based or takes place in regular integrated business, industry or community-based settings. Services include: |

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| | | | | • Vocational/job-related discovery or assessment<br>• Person-centered employment planning<br>• Benefits management, financial literacy, asset development and career advancement service<br>• Relative business planning services<br><br>~~Federal Financial Participation (~~FFP~~)~~ may not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as:<br>• Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;<br>• Payments that are passed through to users of supported employment programs; or<br>• Payments for vocational training that is not directly related to a beneficiary supported employment program.<br><br>Supported employment service component(s) needed for each beneficiary are documented, coordinated, and nonduplicative of other services otherwise available ~~under a program funded under Section 110 of the Rehabilitation Act of 1973, or under IDEA, MRS or BSBP. Documentation must be maintained by the PIHP that the beneficiary is not currently eligible for work activity or supported employment services provided by MRS. Information must be updated when MRS eligibility conditions change~~ to an eligible person through a Vocational Rehabilitation program funded under the Workforce Innovation and Opportunity Act (WIOA) or the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. 1401 et seq.). Documentation to assure compliance will be maintained in the file of each beneficiary receiving this service.<br><br>Skill Building assistance is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or IDEA. Documentation to ensure compliance will be maintained in the file of each beneficiary receiving this service. |

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| | | | | If a beneficiary has a need for transportation to participate, maintain, or access supported employment services, the same provider may be reimbursed for providing this transportation only after it is determined that it is not otherwise available (e.g., volunteer, family member) and is the least expensive available means suitable to the beneficiary's need in accordance with MDHHS Medicaid Provider Manual non-emergency medical transportation policy. |
| | | | 15.2.O. Supported Employment – Small Group<br><br>(new subsection) | Addition of new text; refer to the chapter for full content. |
| | | | 15.2.P. Vehicle Modification<br><br>(new subsection) | Addition of new text; refer to the chapter for full content. |
| | | Acronym Appendix | | Addition of:<br>FMS – Financial Management Services |
| MMP 26-16 | 6/1/2026 | Medical Supplier | 2.14.D. Enteral Nutrition Non-Covered Items<br><br>(new subsection) | Addition of new text; refer to the chapter for full content. |
| | | Directory Appendix | Provider Resources | Addition of:<br>**CONTACT/TOPIC:** U.S. Food & Drug Administration<br>**WEB ADDRESS:** U.S. Food and Drug Administration<br>**INFORMATION AVAILABLE/PURPOSE:** Regulations and guidance |

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| MMP 26-17 | 6/1/2026 | Behavioral Health and Intellectual and Developmental Disability Supports and Services | 2.3 Location of Service | Text was revised to read:<br><br>Services may be provided at or through PIHP service sites or contractual provider locations. Unless otherwise noted in this manual, PIHPs are encouraged to provide mental health and developmental disabilities services in integrated locations in the community, including the beneficiary's home, according to individual need and clinical appropriateness. ~~For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's residence.~~ For children and youth, services are to be provided in the least restrictive setting appropriate for the needs of the child or youth (e.g. home or community setting such as schools, clinics, etc.).<br><br>Services must meet MDHHS Network Adequacy Standards.<br><br>Medicaid does not cover services delivered to beneficiaries with a Serious Mental Illness (SMI) in Institutions for Mental Diseases (IMD) for individuals between ages 21 and 64, as specified in §1905(a)(B) of the Social Security Act when the length of stay in the IMD is more than 15 days during the month. However, per Michigan's 1115 Behavioral Health Demonstration, Medicaid does cover services delivered to beneficiaries with a Substance Use Disorder (SUD) in IMDs for individuals between ages 21 and 64 when the stay in the IMD is more than 15 days during the month.<br><br>Refer to the Amount and Scope of Service subsection for additional information regarding Wraparound program expectations. |

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| | | | | The remaining text was relocated to new subsections:<br>2.3.A. Coverage of Substance Use Disorder Treatment Services<br>2.3.B. Coverage of Services in Nursing Facilities<br>2.3.C. Coverage of Services in Child Caring Institutions<br>2.3.D. Coverage of Services for Children with I/DD in Child Caring Institutions<br>2.3.E. Coverage in a Children's Therapeutic Group Home<br>2.3.F. Coverage of Medicaid Services in Correctional and Detention Facilities |
| | | | 2.3.A. Coverage of Substance Use Disorder Treatment Services<br><br>(new subsection) | Text (consisting of relocated text, edited text, and new text) reads as follows:<br>Substance abuse covered services must generally be provided at state licensed sites. Licensed providers may provide some activities, including outreach, in community (off-site) settings. Mental health case management may be provided off-site, as necessary, to meet individual needs when case management is purchased as a component of a licensed service. ~~For office or site-based services, the location of primary service providers must be within 60-minutes/60-miles in rural areas, and 30-minutes/30-miles in urban areas, from the beneficiary's home.~~ Services must meet MDHHS Network Adequacy standards. |

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| | | | 2.3.B. Coverage of Services in Nursing Facilities<br><br>(new subsection) | Text (consisting of relocated text, edited text, and new text) reads as follows:<br><br>For beneficiaries residing in nursing facilities, only the following clinic services may be provided:<br>• Nursing facility mental health monitoring;<br>• Psychiatric evaluation;<br>• Psychological testing, and other assessments;<br>• Treatment planning;<br>• Individual therapy, including behavioral services; and<br>• Crisis intervention.~~; and~~<br>• ~~Services provided at enrolled day program sites.~~<br><br>Refer to the Nursing Facility Chapter of this manual for PASARR ~~information~~ policy as well as information on mental health services provided by nursing facilities. |
| | | | 2.3.C. Coverage of Services in Child Caring Institutions<br><br>(new subsection) | Text (consisting of relocated text, edited text, and new text) reads as follows:<br><br>A Child Caring Institution (CCI) is defined in Public Act 116 of 1973, as amended, as "…a childcare facility that is organized for the purpose of receiving minor children for care, maintenance, and supervision, usually on a 24-hour basis, in buildings maintained by the institution for that purpose, and operates throughout the year." |

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| | | | | For children admitted to a CCI who are eligible for PIHP services, the PIHP must also coordinate with the family and/or legal guardian, CCI, and the family's primary care provider to ensure that any Early and Periodic Screening, Diagnosis and Treatment (EPSDT) well child visits are performed in accordance with the American Academy of Pediatrics (AAP) periodicity schedule, its components and medical guidelines, and with the MDHHS Medicaid Provider Manual. The MDHHS Medicaid Provider Manual describes the coverage responsibilities for screening, diagnostic, and treatment services that are required per EPSDT federal regulations.<br><br>Medicaid does not cover services provided to children with serious emotional disturbance in Child Caring Institutions (CCI) unless it is licensed as a "children's therapeutic group home" as defined in Section 722.111 Sec. 1(f) under Act No. 116 of the Public Acts of 1973, as amended, or it is for the purpose of transitioning a child out of an institutional setting (CCI). Medicaid may also be used for the purpose of transitioning a child out of a State Hospital. For both the CCI and State Hospital, the following mental health services initiated by the PIHP (the child needs to be open to the PIHP/CMHSP) may be provided within the designated timeframes:<br>• The assessment of a child's eligibility and needs for the purpose of determining the community based services necessary to transition the child out of a CCI or State Hospital. This should occur up to 180 days prior to the anticipated discharge from a CCI or State Hospital.<br>• Intensive Care Coordination with Wraparound (ICCW) planning, Targeted Case Management, ~~or~~ and supports coordination. This should occur up to 180 days prior to discharge from a CCI or State Hospital.<br><br>Community Living Supports (CLS) under 1915(i) and waiver programs cannot be delivered in a CCI or children's therapeutic group home.<br><br>PIHPs cannot use Medicaid funding to reimburse provision of room and board but may use other funding sources as permissible under state and federal law. |

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| | | | | Admission to a CCI will impact a child's enrollment in the Habilitation Supports Waiver, Children's Waiver Program, Waiver for Children with Serious Emotional Disturbances, or 1915(i). PIHPs cannot reimburse Medicaid services available exclusively through 1915(i) or waiver services except for respite services in a children's therapeutic group home.<br><br>The provider must collect any payments available from other health insurers, including Medicare and private health insurance, for services provided to its members in accordance with Section 1902(a)(25) of the Social Security Act and 42 CFR 443 Subpart D and the Michigan Mental Health Code and Public Health Code as applicable. If a child has been placed by MDHHS into a contracted CCI, the CCI is responsible for providing services as required in the MDHHS contract and is paid through the contracted rate. |
| | | | 2.3.D. Coverage of Services for Children with I/DD in Child Caring Institutions<br><br>(new subsection) | Text (consisting of relocated text, edited text, and new text) reads as follows:<br><br>Medicaid-funded behavioral health services may be provided to support children with intellectual and developmental disabilities (I/DD) in a CCI that exclusively serves children with I/DD when authorized by the respective PIHP/CMHSP. The CCI cannot have more than 16 beds as licensed by the State of Michigan and must comply with applicable state licensing laws. Authorization by the PIHP/CMHSP ~~includes special considerations, services and/or funding arrangements~~ must include identification of the funding source(s) for services rendered to the child in the CCI. Enrollment of the CCI provider is the responsibility of the PIHP/CMHSP to ensure providers rendering services adhere to all state and federal regulations on the use of seclusion and restraint and are appropriately credentialed to perform I/DD services. |

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| | | | | The purpose of the child admission to a CCI must be for treatment purposes and requires medical necessity. The setting must also exclusively serve children with I/DD. PIHPs may reimburse treatment or rehabilitative services that are specifically authorized for the child with I/DD if the services are accessed through EPSDT services or Medicaid State Plan services. Services for children with I/DD that can be delivered within a CCI through EPSDT or Medicaid State Plan services include the following:<br>• Assessments<br>• Behavioral Health Treatment Services/Applied Behavior Analysis<br>• Child Therapy<br>• Family Therapy<br>• Group Therapy<br>• Individual Therapy<br>• Intensive Care Coordination with Wraparound<br>• Medication Administration<br>• Medication Review<br>• Occupational Therapy<br>• Physical Therapy<br>• Psychological Testing<br>• Speech Therapy<br>• Supports Coordination<br>• Targeted Case Management<br><br>CLS under 1915(i) and waiver programs cannot be delivered in a CCI or children's therapeutic group home. |

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| | | | | PIHPs cannot use Medicaid funding to reimburse the provision of room and board but may use other funding sources as permissible under state and federal law.<br><br>Personal care services may be rendered to a Medicaid-eligible individual in a CCI setting licensed and certified by the State under the 1987 Administrative Rule R330.1801-09 (as amended in 1995). For children birth to 21, personal care may be rendered to a child with Medicaid in a CCI setting with a specialized residential program facility licensed by the State for individuals with I/DD under Act No. 116 of the Public Acts of 1973, as amended, and Act No. 258 of the Public Acts of 1974, as amended.<br><br>Admission to a CCI will impact a child's enrollment in the Habilitation Supports Waiver, Children's Waiver Program, Waiver for Children with Serious Emotional Disturbances, or 1915(i). PIHPs cannot reimburse Medicaid services available exclusively through 1915(i) or waiver services except for respite services in a children's therapeutic group home.<br><br>The provider must collect any payments available from other health insurers, including Medicare and private health insurance, for services provided to its members in accordance with Section 1902(a)(25) of the Social Security Act and 42 CFR 443 Subpart D and the Michigan Mental Health Code and Public Health Code as applicable. If a child has been placed by MDHHS into a contracted CCI, the CCI is responsible for providing services as required in the MDHHS contract and is paid through the contracted rate. |
| | | | 2.3.E. Coverage in a Children's Therapeutic Group Home<br><br>(new subsection) | Text (consisting of new text) reads as follows:<br><br>"Children's Therapeutic Group Home" means a CCI receiving children who are diagnosed with a developmental disability as defined in section 100a of the Mental Health Code, 1974 PA 258, MCL 330.1100a, or a SED as defined in section 100d of the Mental Health Code, 1974 PA 258, MCL 300.1100d, and that meets all of the following requirements: |

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| | | | | • Provides care, maintenance, and supervision, usually on a 24-hour basis.<br>• Has a capacity of not more than six (6) children.<br>• Complies with rules for CCIs. Emergency safety intervention in the form of physical management is allowed but must comply with the Mental Health Code, 1974 PA 258, MCL 330.1001 to 330.2106, and associated administrative rules.<br>• Is not a private home.<br>• Is not located on a campus with other licensed facilities.<br><br>In addition to the services that are reimbursable through all CCIs, PIHPs can also reimburse the following services that are specifically delivered in a children's therapeutic group home for children with SED and/or children with I/DD:<br><br>• Children's Crisis Residential (when certified by MDHHS)<br>• Respite (when specifically authorized through a 1915(c) waiver program or the 1915(i) State Plan Amendment on a short-term basis)<br><br>The provider must collect any payments from other health insurers, including Medicare and private health insurance, for services provided to its members in accordance with Section 1902(a)(25) of the Social Security Act and 42 CFR 433 Subpart D and the Michigan Mental Health Code and Public Health Code as applicable. If a child has been placed by MDHHS into a contracted CCI, the CCI is responsible for providing services as required in the MDHHS contract and is paid through the contracted rate. |

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| | | | 2.3.F. Coverage of Medicaid Services in Correctional and Detention Facilities<br><br>(new subsection) | Text (consisting of new text) reads as follows:<br><br>Federal law prohibits the use of Medicaid funds to cover services for incarcerated individuals, with the exception of inpatient hospitalization (including inpatient psychiatric hospitalization). Medicaid does not cover services provided to children or adults involuntarily residing in public institutions (such as jails, prisons or juvenile detention facilities). For information regarding coverage of Targeted Case Management for recently incarcerated beneficiaries, refer to the Special Programs chapter of this Manual. |
| MMP 26-19 | 7/1/2026 | Medical Supplier | 2.15 High Frequency Chest Wall Oscillation Device | Under "Standards of Coverage", the following text was added:<br><br>The initial HFCWO device supplied must include an equipment usage meter. The meter type may be one that measures daily usage or cumulative hour usage.<br><br>Under "Documentation", the following bullet point was added:<br><br>• Upon initial delivery (first four months of coverage), the DME provider must document the following:<br>➢ The device's serial number.<br>➢ The date of delivery.<br>➢ The start date meter reading*<br>➢ The end date meter reading (record at the end of the initial four months)*<br><br>*Pictures taken of the start and end date meter readings are acceptable forms of documentation. |

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| | | | | The last bullet point was revised to read:<br>• For continuation beyond the initial four months, the following information must be provided:<br>➢ Documentation of any change in the prescribed treatment plan;<br>➢ The device's serial number;<br>➢ Documentation from equipment ~~use logs (includes a meter that measures daily use; a cumulative hours meter does not meet this requirement) demonstrating ongoing utilization in accordance with the current, prescribed treatment plan~~ usage meter (start/end date readings) demonstrating ongoing use in accordance with the current, prescribed treatment plan. (If the meter has daily usage downloadable capabilities, the provider must submit the download data. If the meter is a cumulative hour meter, submit the start/end date meter readings. Pictures are an acceptable form of documentation.); and<br>➢ For CSHCS beneficiaries, the CSHCS program requires a medical statement from the authorized physician subspecialist substantiating the continued effectiveness of the vest.<br><br>Addition of the following text:<br>All documentation must be kept in the beneficiary file and be available upon request. If PA is required, the documentation must be submitted with the PA request. |

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| MMP 26-20 | 6/1/2026 | General Information for Providers | Section 3 - Maintenance of Provider Information | In the 2nd paragraph, the following bullet point was revised:<br>Examples of such changes include:<br>• Addition/change of a specialty or subspecialty<br>and the following bullet point was added:<br>• Addition/change of training or educational requirements |
| | | Laboratory | 1.2 Ordering Practitioner | In the 1st paragraph, the following bullet point was added:<br>Laboratory services provided to Medicaid beneficiaries can be ordered by the following Medicaid enrolled practitioners:<br>• Pharmacist<br>The following text was added:<br>Prior to ordering Medicaid-covered laboratory tests, a pharmacist must have completed a laboratory training program as specified within licensure rules. Pharmacists must attest to this completion as part of the provider enrollment process and should select the laboratory subspeciality. Pharmacists who fail to attest and designate the appropriate subspeciality may not order laboratory tests for Medicaid beneficiaries. |
| | | Pharmacy | 2.1 Scope of Practice | Text was revised to read:<br>MDHHS only reimburses for products prescribed by a licensed prescriber that are within the prescriber's scope of currently accepted medical practice and MDHHS limitations. Pharmacists are included as prescribers for certain services such as vaccine ordering, self-administered hormonal contraceptives, and antiviral treatments when acting within their scope of practice and applicable program requirements under MDHHS Administrative Rule R338.581. |

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| | | | 4.3 Self-Administered Hormonal Contraceptive Counseling<br><br>(new subsection) | New subsection text reads:<br><br>Pharmacists authorized to prescribe self-administered hormonal contraceptives must provide face-to-face counseling to the beneficiary as one of the required conditions of prescribing.<br><br>This counseling is allowable and separately billable as a professional claim encounter in CHAMPS, whether or not a prescription is ultimately written, provided the pharmacist is authorized to prescribe hormonal contraceptives and bills in accordance with the Medicaid fee schedule and all applicable rules and policy requirements. Counseling under this section is repeatable, with no frequency limits. |
| | | | 14.4 Antivirals<br><br>(new subsection; the following subsections were re-numbered) | New subsection text reads:<br><br>Qualified enrolled pharmacists may test beneficiaries for upper respiratory infections via nasal or throat swab, or finger-prick point of care testing. Based on the test result, the pharmacist's professional clinical judgment, and a review of the beneficiary's available medical history and prescribing documentation, pharmacists may prescribe antivirals to treat COVID-19 and influenza.<br><br>Coverage and ordering of antivirals prescribed under this section are subject to the same requirements as other prescription drugs, including the Single Preferred Drug List (PDL) and the Michigan Pharmaceutical Product List (MPPL). |

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| | | | 14.12 Oral Contraceptives | The subsection title was revised to read:<br><br>~~Oral~~ Self-Administered Hormonal Contraceptives<br><br>Text was revised to read:<br><br>Prescriptions for ~~oral~~ self-administered hormonal contraceptives may be dispensed for a 12-month supply when the prescriber writes the prescription accordingly. |
| | | | 14.16 Vaccines | The 1st through 3rd paragraphs were revised to read:<br><br>The program covers the cost of medically necessary vaccines and their administration when ordered and administered by qualified pharmacists acting within their scope of practice as defined by state and federal laws, rules, and regulations and in accordance with currently accepted standards of medical or professional practice for adults aged 19 years and older for Fee-For-Service Medicaid, Healthy Michigan Plan, and MOMS program beneficiaries ~~19 years of age and older~~. This includes, but is not limited to, all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) or those endorsed or developed by medical professional societies such as the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Physicians, and the American College of Obstetricians and Gynecologists. Additionally, pharmacies approved to participate in the Vaccines for Children (VFC) program may order and administer ACIP recommended vaccines to Medicaid, Healthy Michigan |

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| | | | | Plan, and MOMS beneficiaries ages 3 through 18 years. The cost of the VFC vaccine is at no cost to participating pharmacies. VFC enrolled pharmacies can bill administration fees for VFC vaccines as a Medicaid Fee-For-Service pharmacy benefit, including for beneficiaries ages 3 through 18 years of age who are enrolled in a Medicaid Health Plan. (Refer to the Directory Appendix for information on the Vaccines For Children program.)<br><br>Pharmacies may submit a claim for COVID-19 and seasonal influenza vaccines and their administration for CSHCS beneficiaries. For beneficiaries 19 years and older who are enrolled in a Medicaid Health Plan, the pharmacy provider must confirm coverage of pharmacist-ordered and -administered vaccines with the plan.<br><br>Pharmacists must be in compliance with State of Michigan laws, rules and regulations and must have ~~received~~ successfully completed the appropriate training for vaccine administration ~~in order~~ to be eligible to order and administer vaccines. ~~Standing orders are required from a Michigan-licensed physician who is responsible for the clinical practice of the vaccine operations. This documentation~~ Pharmacists who are qualified to order immunizations may do so by their own authority and are not required to obtain a standing order from a licensed physician for those immunizations. Documentation of the pharmacist's prescriptive authority, including completed training and enrollment requirements, must be readily available onsite in the event of an audit. |

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| MMP 26-21 | 6/15/2026 | Home Help | 8.5.B. New Agency Provider Compliance Review | Text was revised to read:<br><br>Once a new agency provider begins billing for Home Help services, it must undergo a compliance review. The MDHHS Home Help Policy Section will request the following documents three months after the first payment for Home Help services:<br><br>• A completed form HS-2602, Home Help Audit Submission Checklist.<br>• A letter listing the agency owner(s) and managing employee(s), along with their email addresses and phone numbers, and the agency's correspondence address.<br>• ~~A list of all agency caregivers currently providing Home Help services. The list must include each agency caregiver's name, individual CHAMPS provider ID, and the name(s) of the client(s) they serve~~. A completed form HS-2601, Home Help Audit Caregiver List.<br>• Three months of payroll records that must, at a minimum, include ~~agency caregiver names, pay period dates, payment amounts, Federal Insurance Contributions Act (FICA) withholdings, and proof of compliance with state unemployment insurance filings and payments.~~ all the information in Section 2 of the Home Help Agency Provider Audit Payroll Template (HS-2603). NOTE: An agency that does not use a payroll company may use form HS-2603 to meet this requirement. The agency may choose to submit its own payroll documents if those documents include all the information in Section 2 of HS-2603.<br>• If payroll records do not verify tax payments, the agency provider ~~may need to~~ must submit State of Michigan Employer's Quarterly Wage/Tax Reports and IRS Form 941.<br>• A current and complete IRS Form W-9, Request for Taxpayer Identification Number and Certification. |

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| | | | | MDHHS will include the forms with the initial audit letter sent to the agency. Refer to the Forms Appendix for copies of forms HS-2601 and HS-2603. The forms are also available on the MDHHS website. Refer to the Directory Appendix for website information.<br><br>Additional documents may be needed to clarify information received in the documents above. The MDHHS Home Help Policy Section will email the agency provider a letter listing the required documents. The agency provider is encouraged to scan and email documents to the MDHHS Home Help Policy Section with the subject line of "New Agency Compliance Review". Fax and mail are acceptable; however, confirmation that documents have been received is not available with these options. (Refer to the Directory Appendix for contact information.) |
| | | Forms Appendix | | Addition of:<br><br>HS-2601 – Home Help Agency Provider Audit Caregiver List<br><br>HS-2603 – Home Help Audit Payroll Template |
| MMP 26-25 | 7/1/2026 | Home Help | 5.3.D. Case Transfer to a New County | Text was revised to read:<br><br>A client who moves to a new county must participate in ~~an in-person comprehensive assessment with the ASW in the client's home before payment for Home Help services in the new county can be authorized~~ a phone interview with the ASW in the new county when at least one of the following changes occurs:<br><br>• The client changes providers.<br>• The composition of the client's household changes in a way that impacts the proration of IADL.<br><br>If at least one of these changes occurs, the client's phone interview with the ASW must be completed before Home Help payments can be authorized. |

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| MMP 26-26 | 7/1/2026 | MI Coordinated Health | 1.1 Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs) Eligibility and Service Areas | The 1st paragraph was revised to read:<br><br>The HIDE SNP must operate in one or more of ~~12~~ the eligible regions throughout the State for the provision of covered services. The HIDE SNP must provide services in accordance with the SMAC to enrollees residing in all counties within the region(s) it is approved to cover. Regions are defined and numbered as follows:<br><br>• Region 1: Alger, Baraga, Delta, Dickinson, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Ontonagon, Schoolcraft<br>• ~~Region 2: Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Wexford~~<br>• ~~Region 3: Alcona, Alpena, Cheboygan, Crawford, Iosco, Montmorency, Ogemaw, Oscoda, Otsego, Presque Isle, Roscommon~~<br>• ~~Region 4: Allegan, Ionia, Kent, Lake, Mason, Mecosta, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Ottawa~~<br>• ~~Region 5: Arenac, Bay, Clare, Gladwin, Gratiot, Isabella, Midland, Saginaw~~<br>• ~~Region 6: Genesee, Huron, Lapeer, Sanilac, Shiawassee, St. Clair, Tuscola~~<br>• ~~Region 7: Clinton, Eaton, Ingham~~<br>• Region 8: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren<br>• ~~Region 9: Hillsdale, Jackson, Lenawee, Livingston, Monroe, Washtenaw~~<br>• Region 10: Macomb<br>• ~~Region 11: Oakland~~<br>• Region 12: Wayne |

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| | | | 1.2.A.5. Personal Care Services and the MICH HCBS Waiver | The 2nd paragraph was revised to read:<br>~~ECLS may be provided in addition to State Plan PCS if the enrollee requires hands-on assistance with some ADL, as covered under PCS, but requires prompting, cueing, guiding, teaching, observing, reminding, or other support (not hands-on) to complete other ADL and IADL independently to ensure safety, health, and welfare of the enrollee. PCS and ECLS may also be provided for the same ADL or IADL but at different times during the day.~~<br>MICH HCBS waiver ECLS may be provided in addition to PCS if the enrollee requires hands-on assistance with some ADL and IADL as covered under State Plan PCS, and requires prompting, cueing, guiding, teaching, observing, reminding, or other support (not hands-on) to complete ADL and IADL independently to ensure safety, health, and welfare of the enrollee.<br>ECLS and State Plan PCS can be provided for the same ADL or IADL during the same day but at different times.<br>• Example: Mrs. Jane just needs prompting/cueing/supervision in the morning but needs additional hands-on assistance in the evening due to being more tired at the end of the day. This is an acceptable use of the services as long as they are assessed, billed, and paid for according to the appropriate service code.<br>ECLS can be provided in addition to State Plan PCS for different time periods under the same ADL or IADL. The distinction must be apparent by unique minutes in the approved ICP.<br>• Example: Mr. Brown takes 20 minutes to take a shower. He needs hands-on assistance for 8 minutes during the shower while he washes his hair. The remaining 12 minutes of his shower requires only supervision. Eight minutes can be provided through PCS, while the remaining 12 minutes of supervision can be provided through ECLS. |

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| | | | | Additional information on ADL and IADL can be found in the MICH HCBS Waiver Requirements Resource Document. Refer to the Directory Appendix for document location information. |
| | | | 1.2.A.6. Reasonable Time and Task | The subsection title was revised to read:<br>~~Reasonable~~ Time and Task<br><br>Text was revised to read:<br>~~When a task (activity) is assigned to a specific provider, the rank of the activity is used against a Reasonable Time Schedule (RTS) table to determine the recommended time that activity should be assigned. Providers should use the RTS table provided by MDHHS to record and report minutes spent delivering services. The maximum amount is across all assigned providers for an enrollee so these are case maximums. When an enrollee's needs exceed the hours recommended by the RTS, a rationale must be provided and maintained in the enrollee's health record.~~<br>The HIDE SNP must ensure that adequate minutes of services are provided to meet the enrollee's needs based on the observation of the enrollee's abilities during the in-person assessment. Additional guidance on ~~Reasonable~~ Time and Task is available in the MICH Personal Care Services Resource document. Refer to the Directory Appendix for document location information. |

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| | | | 1.2.A.7. Complex Care Needs | The 2nd and last paragraphs were revised to read:<br><br>The HIDE SNP care coordinator will allocate time for each task assessed a rank of 3 or greater based on the PCA, interviews with the enrollee and provider, and observation of the enrollee's abilities. ~~, and use of the RTS as a guide. When hours exceed the RTS,~~ A rationale for time allocations must be provided and maintained in the enrollee's record.<br><br>~~An assessment of need at a ranking of 3 or greater does not automatically guarantee the maximum allotted time allowed by the RTS.~~ The HIDE SNP care coordinator must assess each task according to the actual time required for its completion. |
| | | | 1.2.A.8. Reimbursement and Rates | The 4th paragraph was deleted:<br><br>~~A request for higher or lower hours than shown on the RTS is permissible. A textual rationale is required if the amount of services needed is different than the RTS. Possible reasons for using higher hours include incontinence, severely impaired speech, paralysis and obesity. Possible reasons for lower hours include shared living arrangements (specifically for IADL, except for administering medications) and responsible relatives able and available to assist.~~ |
| | | | 1.2.A.13. Mandatory and Permissive Exclusions | The subsection was deleted in its entirety. (Information is covered elsewhere in the chapter.)<br><br>The following subsection was re-numbered. |
| | | | 1.2.B. Home and Community Based Services (HCBS) Waiver Services | The 1st paragraph was revised to read:<br><br>The HIDE SNP must provide HCBS waiver services in accordance with ~~Medicaid State Plan and HIDE SNP~~ CMS approved 1915(c) waiver application requirements. |

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| | | | 1.2.B.1. Adaptive Medical Equipment and Supplies | The 6th paragraph was revised to read:<br>Adaptive Medical Equipment and Supplies include enteral formula administered orally once the State Plan coverage amount is exceeded (900 units). (Refer to the Medical Supplier chapter of this Manual for additional information.) Liquid nutritional supplement orders must be renewed every six months by a physician, physician's assistant, or nurse practitioner (in accordance with scope of practice). |
| | | | 2.7.B.3. Behavioral Health State Plan Concurrent Enrollment<br><br>(new subsection) | New subsection text reads:<br>MICH enrollees may also qualify for benefits under the Behavioral Health State Plan or the Behavioral Health 1915(i) State Plan Amendment (SPA) and the Habilitations Support Waiver (HSW). Concurrent enrollment is permitted under the following guidelines:<br>• HSW: MICH enrollees may also participate in the Habilitation Supports Waiver (HSW). Concurrent enrollment in the HSW and MICH HCBS waiver is not permitted.<br>• BH 1915(i) SPA: MICH enrollees may also participate in the BH 1915(i) SPA. Those enrolled in both MICH and the BH 1915(i) SPA may concurrently enroll in the MICH HCBS waiver (given eligibility requirements are met).<br>• Behavioral Health Home (BHH)/Substance Use Disorder Health Home (SUDHH): MICH enrollees may be enrolled in a BHH or SUDHH. Those enrolled in both MICH and a BHH or SUDHH may concurrently enroll in the MICH HCBS waiver (given eligibility requirements are met).<br>The HIDE SNP must collaborate with the Prepaid Inpatient Health Plan (PIHP) to support coordination of services and alignment of care management activities in a timely and non-duplicative manner. The HIDE SNP should refer to the SMAC for additional requirements on coordination with PIHPs. |

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| | | | Section 4 – Program Enrollment Types | The section title was revised to read:<br>Program Enrollment ~~Types~~ Type (PET) Codes<br><br>Text added as 1st paragraph:<br>Program Enrollment Type (PET) codes identify an enrollee's type of admission or managed care enrollment along with their living arrangement.<br><br>Text added as last paragraph:<br>When an enrollee qualifies for and elects MICH HCBS waiver enrollment, the HDE-HCBS PET code will be assigned when MICH HCBS waiver enrollment is entered in CHAMPS. When an enrollee is disenrolled from the MICH HCBS waiver, the HIDE SNP must enter the disenrollment in CHAMPS, which will remove the HDE-HCBS PET code. |

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| | | | 10.6 Nursing Facility Level of Care Determination (LOCD) | The 2nd paragraph was revised to read:<br><br>In order to determine eligibility for HCBS Waiver or Medicaid NF services, the HIDE SNP will ensure that the LOCD tool is conducted as necessary for enrollees demonstrating NF level of care needs identified in the HRA, for those enrollees residing in a NF at the time of enrollment, and for those enrollees enrolled in the HIDE SNP HCBS Waiver.<br><br>• The entity completing the tool will record the findings in CHAMPS for MDHHS to make final eligibility determinations and authorize appropriate tier assignment and the HIDE SNP Capitation Payment. For MICH HCBS waiver enrollees in CHAMPS with no LOCD or LOCD Door 0, the HIDE SNP will receive the Tier 3 capitation payment. In the case where a MICH HCBS waiver enrollee has filed a timely LOCD appeal, the Tier 2 capitation payment will be manually entered by MDHHS.<br>• Final eligibility determinations for LOCD will be completed by MDHHS or by an independent contracted entity, as directed by MDHHS. |

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| | | | 13.1.A. Out of State HCBS Waiver Enrollees<br><br>(new subsection) | New subsection text reads:<br><br>If a MICH HCBS waiver enrollee moves out of state permanently, the HIDE SNP may discontinue waiver services once the enrollee no longer resides in the service area. The HIDE SNP is not required to cover waiver services through the date of disenrollment (the last day of the month) when the enrollee moves out of state.<br><br>The HIDE SNP, at its own discretion, may help the waiver enrollee access resources in other states to aid in the transition to the new service area. The HIDE SNP does remain responsible for all other non-HCBS waiver-covered MICH services until an enrollee's date of disenrollment after a move out of state. The HIDE SNP may utilize a single case agreement, as defined by the SMAC, to ensure the enrollee's access to non-HCBS waiver services when the enrollee has moved permanently out of state or out of the HIDE SNP's service area until the enrollee's date of disenrollment. |

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| | | | 13.2 Person-Centered Planning | Text was added after the 1st paragraph:<br>For provider-owned or -controlled settings, any modification of the additional conditions under 42 CFR § 441.301(c)(4)(vi)(A) through (D) must be supported by a specific assessed need and justified in the ICP and the following will be documented in the ICP:<br>• A specific and individualized assessed need for the modification<br>• Positive interventions and supports used prior to any modifications to the person-centered service plan<br>• Less intrusive methods of meeting the need that have been tried but did not work<br>• A clear description of the condition that is directly proportionate to the specific assessed need<br>• Regular collection and review of data to measure the ongoing effectiveness of the modification<br>• Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated<br>• Informed consent of the enrollee<br>• An assurance that interventions and supports will cause no harm to the enrollee |

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| | | | | The 2nd paragraph was revised to read:<br><br>The ICP clearly identifies the types of services needed from both paid and non-paid providers of supports and services. The ICP must reflect the services and supports (paid and unpaid) that will assist the enrollee to achieve identified goals and the providers of those services and supports, including natural supports. Natural supports are unpaid supports who choose to volunteer their time to assist enrollees in lieu of MICH services and supports. The amount (units), frequency, and duration of each waiver service to be provided are included in the ICP. The enrollee chooses the supports and services that best meet their needs and whether to use the option to self-direct applicable services or rely on a HIDE SNP care coordinator and/or other supports coordinator to ensure the services are implemented and provided according to the ICP. When an enrollee chooses to participate in arrangements that support self-determination, information, support and training are provided by the HIDE SNP care coordinator and/or other supports coordinator and others identified in the ICP and according to the MICH Self-Determination Implementation Technical Advisory document. (Refer to the Directory Appendix for document location information.) When an enrollee chooses not to participate in self-determination, the HIDE SNP care coordinator or other supports coordinator ensures that supports and services are implemented as planned. The HIDE SNP care coordinator and/or other supports coordinator, as applicable, oversee the coordination of State Plan and waiver services included in the ICP. This oversight ensures that waiver services in the ICP are not duplicative of similar State Plan services available to or received by the enrollee. |

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| | | | Section 15 – Criminal History Reviews | Section text was revised to read:<br><br>~~Each HIDE SNP and direct provider of home-based services must conduct a criminal history review, at a minimum, for any paid or volunteer individuals who will be entering the enrollee's residence. The HIDE SNP and direct provider must have completed reference and criminal history reviews before authorizing the person providing services in an enrollee's residence. At a minimum, the scope of the reference and criminal history investigation is statewide.~~<br><br>All typical and atypical providers who will be entering the residence of an enrollee, and any person with a five percent or more direct or indirect ownership interest in the provider, must consent to a criminal history review as a condition of participation.<br><br>The HIDE SNP must have completed the criminal history review and a reference check before authorizing the provider to provide services in an enrollee's residence. At a minimum, the scope of the criminal history review is statewide.<br><br>HIDE SNPs and MDHHS will conduct annual reviews to ensure mandatory criminal history reviews have been conducted in compliance with direction given by MDHHS or otherwise required by federal and state law, policy or operating standards.<br><br>Refer to the General Information for Providers chapter of this Manual for additional information. In the MICH program, the requirements and criteria outlined in the General Information for Providers chapter apply to both typical and atypical MICH providers who will be entering the residence of an enrollee and any person with a five percent or more direct or indirect ownership interest in the provider. |

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| | | | 15.1. Criminal History Reviews for Caregivers Who are Providing PCS to Enrollees Who are Transitioning to MICH From the Home Help Program<br><br>(new subsection) | New subsection text reads:<br><br>When an enrollee who was receiving PCS through the Home Help program transitions their enrollment to MICH, the HIDE SNP is responsible for continued coverage of their PCS starting on day one of the enrollment with MICH.<br><br>MDHHS provides the HIDE SNP with a monthly Home Help Report that identifies caregivers who are serving an enrollee who is transitioning their enrollment to MICH from the Home Help program. The HIDE SNP must utilize the Home Help Report to expedite the provider onboarding process for the transitioning enrollee's caregiver.<br><br>The onboarding process includes completion of the criminal history review. The HIDE SNP must ensure that the criminal history review is completed as soon as possible, but no later than within 30 calendar days of enrollment with MICH. The HIDE SNP must have completed the criminal history review before authorizing the provider to provide services in an enrollee's residence. To avoid a disruption in services during the 30 calendar day period after enrollment with MICH, confirmation that the caregiver has an active CHAMPS enrollment can serve as proof of a current criminal history review. The HIDE SNP must consistently check 5938 files as they become available on a weekly basis to confirm that CHAMPS enrollment is active.<br><br>The flexibility to rely on active CHAMPS enrollment as proof of a current criminal history review applies only during the 30 calendar-day period after enrollment in MICH (to allow time for the HIDE SNP to complete the criminal history review and onboard the provider) for those enrollees who have transitioned to MICH from the Home Help program. |

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| | | | Section 17 – Provider Participation | The following text was added:<br>The HIDE SNP is prohibited from making payments to all typical network and out-of-network providers who appear on a claim and are not enrolled in CHAMPS. This also applies to the following atypical providers who are eligible to enroll in CHAMPS under MICH:<br>• Adaptive Medical Equipment and Supplies/Assistive Technology providers (must enroll in Medicare and/or Medicaid as a Durable Medical Equipment provider, pharmacy, etc., as appropriate).<br>• Fis and agencies providing services that require EVV (including State Plan PCS, ECLS and Respite agency providers).<br>• NEMT providers.<br>The HIDE SNP should reference the MICH Acknowledgment of Exclusions Resource document for additional information on the requirements for notification of mandatory and permissive exclusions and the process for the termination and summary suspension of current providers. (Refer to the Directory Appendix for document location information.) |
| | | Acronym Appendix | | Addition of:<br>BHH – Behavioral Health Home |
| MMP 26-27 | 7/31/2026 | General Information for Providers | 1.6.B. Written Inquiries | Text was revised to read:<br>Complex problems may require research and analysis. The problem should be clearly explained, in writing, with complete documentation (e.g., RA) attached and sent to Provider Inquiry.<br>All Fee-for-Service (FFS) providers must include a service request number as part of the relevant documentation required with a written claim inquiry. Written claim inquiries submitted without a service request number will not be reviewed. A service request number can be obtained by contacting Provider Support. |

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| MMP 26-30 | 7/31/2026 | Behavioral Health and Intellectual and Developmental Disability Supports and Services –<br><br>Non-Physician Behavioral Health Appendix | Section 1 - General Information | Text was revised to read:<br><br>This appendix applies to Licensed, Limited Licensed, Educational Limited Licensed, and Temporary Limited Licensed non-physician behavioral health providers, including psychologists, social workers, counselors, and marriage and family therapists, providing outpatient behavioral health services not included under the PIHP specialty services and supports benefit. Information is included to assist the practitioner in determining how the Michigan Department of Health and Human Services (MDHHS) covers specific services. This information should be used in conjunction with the Billing & Reimbursement Chapters of this manual, as well as the Medicaid Code and Rate Reference tool, MDHHS Practitioner and Medical Clinic Fee Schedule, and other related procedure databases/fee schedules located on the MDHHS website. (Refer to the Directory Appendix for website information.) |
| | | | Section 2 – Provider Qualifications | Text was revised to read:<br><br>Medicaid covers non-physician behavioral health services when performed by any of the following provider types:<br><br>• Licensed, Limited Licensed, Educational Limited Licensed, and Temporary Limited Licensed Psychologist (Master's or Doctoral Level)<br>• Licensed and Limited Licensed Social Worker (Master's level)<br>• Licensed and Educational Limited Licensed Marriage and Family Therapist (Master's or Doctoral level)<br>• Licensed and Limited Licensed Professional Counselor (Master's or Doctoral level),<br>• ~~Limited Licensed Psychologist (Master's or Doctoral Educational level) (LLPs) under the supervision of an enrolled, fully licensed psychologist (except as noted in Section 333.18223 of the Public Health Code).~~ |

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| | | | | These practitioners are required to be currently licensed by the Department of Licensing and Regulatory Affairs (LARA), enroll as Medicaid providers, and be uniquely identified on all claims. (Refer to the Billing & Reimbursement for Professionals Chapter for billing information.) Limited, Educational Limited, and Temporary Limited Licensees must perform services under the supervision of a Medicaid-enrolled, fully licensed provider of the same profession. Supervision is defined by Section 333.16109 of the Public Health Code (Act 368 of 1978) when required. Master's Level Limited Licensed Psychologists are exempt from supervision requirements in certain settings as noted in Section 333.18223 of the Public Health Code.<br><br>Limited, Educational Limited, or Temporary Limited licensed behavioral health providers are required to enroll as "Rendering Only" providers within CHAMPS and associate themselves to an organizational billing provider who is either a clinic, group practice, facility, or other organization type the individual is employed by or contracted with to perform services. These providers are not eligible to be directly reimbursed by Medicaid as a sole proprietor.<br><br>With the exception of master's level Limited Licensed Psychologists, all Limited, Educational Limited, or Temporary Limited Licensed behavioral health providers must also report their supervising fully licensed provider on their CHAMPS provider enrollment checklist. Additionally, the limited licensee must associate themselves to their supervisor within the CHAMPS provider enrollment Billing Provider/Other Association field.<br><br>~~LLPs are not eligible to be directly reimbursed by Medicaid. LLPs must enroll as Rendering/Servicing Only providers and associate themselves to at least one Billing Provider within CHAMPS. Associated Billing Providers may be either employers or organizations the LLP is contracted with to perform services (i.e., Community Mental Health Services Programs [CMHSPs], Prepaid Inpatient Health Plans [PIHPs]).~~ |

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| | | | | Non-physician behavioral health services may also be performed by any of the following provider types under the supervision of an enrolled, fully licensed provider of the same profession:<br>• ~~Temporary Limited License Psychologist (Master's or Doctoral Level)~~<br>• ~~Educational or Temporary Limited License Social Worker, Marriage and Family Therapist, or Professional Counselor~~<br>• Graduate of a board-approved health profession training program for psychology, social work, counseling, or marriage and family therapy (Master's or Doctoral Level) who has completed all requirements but has not obtained a limited or temporary educational license. Medicaid will cover services for a period of no longer than one year from the date the individual successfully completed their graduate coursework. The graduate's supervising provider must monitor and ensure compliance of this requirement.<br>• Student Intern. A student intern is an individual who is currently enrolled in a health profession training program for psychology, social work, counseling, or marriage and family therapy that has been approved by the appropriate board, is performing the duties assigned in the course of training, and is appropriately supervised according to the standards set by the appropriate board and the training program. Social work student interns must be pursuing a Master's degree in social work and be supervised by a Licensed Master's Social Worker in a manner that meets the requirements of a Council on Social Work Education (CSWE) accredited education program curriculum that prepares an individual for licensure.<br>Student interns~~,~~ and graduates ~~and temporary or educational limited licensed providers~~ are not eligible to enroll or be directly reimbursed by Medicaid. Services should be billed to Medicaid under the National Provider Identifier (NPI) of the supervising behavioral health provider. |

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| | | | | ~~Supervision is defined by Section 333.16109 of the Public Health Code (Act 368 of 1978) when required.~~<br><br>To comply with 42 CFR 431.110, licensed health professionals employed by a Tribal Health Program must be licensed in good standing in at least one state, but do not need to be licensed in the state where they are practicing. This Federal regulation supersedes any licensing requirements of individual states. |
| | | | Section 3 – Covered Services | The 1st paragraph was revised to read:<br><br>Medicaid beneficiaries whose needs do not render them eligible for specialty services and supports through the PIHP/CMHSP may receive outpatient behavioral health services directly through the Fee-for-Service (FFS) Medicaid program or Medicaid Health Plan. Non-physician behavioral health services performed by Licensed, Limited, Educational Limited, or Temporary Limited psychologists, social workers, counselors, and marriage and family therapists or graduates and interns in these fields are covered when performed in a non-facility setting or outpatient hospital clinic and provided within their specific profession's scope of practice guidelines as defined by State law. Providers should refer to the Medicaid Code and Rate Reference tool and the Non-Physician Behavioral Health Provider fee schedule on the MDHHS website for the current list of covered procedure codes. The list of allowable services is reviewed annually and updated as applicable. |

## BULLETINS INCORPORATED*

| BULLETIN NUMBER | DATE ISSUED | CHAPTER | SECTION | CHANGE |
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| | | | Section 5 – Claims Processing and Reimbursement Amounts | The section title was revised to read:<br>~~Claims Processing~~ Billing and Reimbursement ~~Amounts~~<br><br>The 3rd and 4th paragraphs were revised to read:<br>~~Limited License Psychologists (LLPs) (Master's and Doctoral Educational level)~~ Limited, Educational Limited, or Temporary Limited non-physician behavioral health providers are not eligible to be directly reimbursed by Medicaid and must associate themselves to at least one organizational billing provider within CHAMPS.<br>Limited Licensed Psychologist (LLP) services requiring supervision and billed on a professional claim form must include the NPI of the LLP in the Rendering Provider field and the NPI of the Medicaid enrolled supervising Licensed Psychologist in the Supervising Provider field.<br>~~All temporary limited licensees, educational limited licensees other than Doctoral Educational Limited License Psychologists,~~ Non-licensed graduates and student interns are not eligible to be directly reimbursed by Medicaid. Services should be billed to Medicaid under the NPI of the supervising provider. The supervising provider must be listed as the Rendering Provider on the claim. |

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## BULLETINS INCORPORATED*

| BULLETIN NUMBER | DATE ISSUED | CHAPTER | SECTION | CHANGE |
|---|---|---|---|---|
| | | Early and Periodic Screening, Diagnosis and Treatment | 7.1 Referrals for Behavioral Health Services/Therapy | The 3rd paragraph was revised to read:<br><br>In general, MHPs are responsible for outpatient mental health treatment when the child is experiencing or demonstrating mild or moderate psychiatric symptoms or signs of sufficient intensity to cause subjective distress or mildly disordered behavior. For children not enrolled in a MHP, behavioral health services are covered through FFS Medicaid. Under FFS, behavioral health services may be provided by a physician (MD or DO), physician assistant, nurse practitioner, ~~psychologist, social worker, professional counselor, or marriage and family therapist~~ or behavioral health provider as defined in the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, Non-Physician Behavioral Health Appendix working within their scope of practice under State law. |

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## BULLETINS INCORPORATED*

| BULLETIN NUMBER | DATE ISSUED | CHAPTER | SECTION | CHANGE |
|---|---|---|---|---|
| | | Federally Qualified Health Centers and Tribal Health Centers | 1.1.A. Non-Physician Behavioral Health Services | The 1st paragraph was revised to read:<br><br>Licensed, Limited Licensed, Educational Limited Licensed, or Temporary Limited Licensed non-physician behavioral health providers, including psychologists ~~(Master's Limited or Doctoral level)~~, Master's Level social workers ~~(Master's level)~~, professional counselors ~~(Master's or Doctoral levels)~~, and marriage and family therapists who serve Medicaid beneficiaries are required to enroll as Medicaid providers to provide behavioral health services. The NPI of the ~~psychologist, social worker, professional counselor, or marriage and family therapist~~ non-physician behavioral health provider is reimbursed under the FQHC PPS or MOU. Services provided by Limited, Educational Limited, and Temporary Limited Licensed providers must be performed under the supervision of an enrolled, fully licensed provider of the same profession.<br><br>Behavioral health services performed by a Limited, Temporary Limited, or Educational Limited Licensed provider must include the individual NPI of the supervising fully licensed provider in the "Attending Provider" field of the intuitional claim. The Limited, Educational Limited, or Temporary Limited Licensed provider's NPI should be reported in the "Rendering Provider" field.<br><br>~~These~~ Behavioral Health services must be billed using the appropriate ~~evaluation and management (E/M)~~ procedure codes listed in the American Medical Association's Current Procedural Terminology (CPT) Book or Healthcare Common Procedure Coding System (HCPCS) codes. Providers should refer to the Non-Physician Behavioral Health provider database on the MDHHS website for covered procedure codes. The list of allowable services is reviewed annually and updated as applicable. Refer to the Additional Code/Coverage Resource Materials Section of the General Information for Providers Chapter for additional information regarding coverage parameters. |

## BULLETINS INCORPORATED*

| BULLETIN NUMBER | DATE ISSUED | CHAPTER | SECTION | CHANGE |
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| | | | 1.4 Nonenrolled Provider Services | The 1st paragraph was revised to read:<br><br>Professional services performed by ~~limited licensed psychologists (except as noted in Section 333.18223 of the Public Health Code), social workers, professional counselors, marriage and family therapists,~~ non-licensed behavioral health graduates or student interns must be performed under the supervision of an enrolled, fully-licensed provider of the same profession. These services are reimbursed under the FQHC PPS or MOU. Since MDHHS does not directly enroll these non-licensed providers, claims for their services must ~~be billed using the NPI of the supervising provider responsible for ensuring the medical necessity and appropriateness of the services~~ include the individual NPI of the supervising fully licensed provider who is responsible for ensuring the medical necessity and appropriateness of the services in the "Attending Provider" field of the institutional claim. Claims submitted with ~~the~~ a non-enrolled provider~~'s~~ NPI in the attending or rendering provider field will reject. ~~The clinical psychologist and clinical social worker~~ Services must be billed with the appropriate procedure codes that reflect the services provided. |

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## BULLETINS INCORPORATED*

| BULLETIN NUMBER | DATE ISSUED | CHAPTER | SECTION | CHANGE |
|---|---|---|---|---|
| | | Practitioner | 14.2.C. Primary Care Office-Based Substance Use Treatment (OBSUT) | The 1st paragraph was revised to read:<br><br>OBSUT services may be reimbursed directly by MDHHS or through the Medicaid Health Plans (MHP) when provided to MHP enrollees and Fee for Service (FFS) beneficiaries based upon their enrollment. Primary healthcare providers (which encompasses the following healthcare providers: Physicians [MD/DO], Nurse Practitioners, Physician Assistants, Clinical Nurse Specialists, Certified Nurse Midwives, Obstetricians/Gynecologists, and Pediatricians) in an office-based setting who are licensed or otherwise trained to provide SUD services and behavioral health providers ~~(Licensed Psychologist [doctoral level], Licensed Social Worker [master's level], Licensed Marriage and Family Therapist [master's or doctoral level], Licensed Professional Counselor [master's or doctoral level], Limited Licensed Psychologist [master's or doctoral educational level] under the supervision of an enrolled, fully licensed psychologist [except as noted in Section 333.18223 of the Public Health Code]~~ as defined in the Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, Non-Physician Behavioral Health Appendix who are associated with them, and who do not have a specialty SUD benefit services contract with a PIHP) may be reimbursed through the Medicaid FFS program or through the MHPs. OBSUT services provided by qualified providers, as identified above, will be considered for reimbursement through the FFS program or through the MHPs when the beneficiary meets the American Society of Addiction Medicine (ASAM) criteria for outpatient treatment. |

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| | | Rural Health Clinics | 2.1.A. Non-Physician Behavioral Health Service | The 1st paragraph was revised to read:<br><br>Licensed, Limited Licensed, Educational Limited Licensed, or Temporary Limited Licensed non-physician behavioral health providers, including psychologists ~~(Master's Limited or Doctoral level)~~, Master's Level social workers ~~(Master's level)~~, professional counselors ~~(Master's or Doctoral level)~~, and marriage and family therapists who serve Medicaid beneficiaries are required to enroll as Medicaid providers. The NPI of the ~~psychologist, social worker, professional counselor, or marriage and family therapist~~ non-physician behavioral health provider is reimbursed under the RHC PPS. Services provided by Limited, Educational Limited, and Temporary Limited Licensed providers must be performed under the supervision of an enrolled, fully licensed provider of the same profession.<br><br>Behavioral health services performed by a Limited, Temporary Limited, or Educational Limited Licensed provider must include the supervising fully licensed provider's individual NPI in the "Attending Provider" field of the institutional claim. The Limited, Educational Limited, or Temporary Limited Licensed provider's NPI should be reported in the "Rendering Provider" field.<br><br>~~These~~ Behavioral Health services must be billed using the appropriate ~~evaluation and management (E/M)~~ procedure codes listed in the American Medical Association's Current Procedural Terminology (CPT) Book or Healthcare Common Procedure Coding System (HCPCS) codes. Providers should refer to the Non-Physician Behavioral Health provider database on the MDHHS website for the current list of covered procedure codes. The list of allowable services is reviewed annually and updated as applicable. Refer to the Additional Code/Coverage Resource Materials Section of the General Information for Providers Chapter for additional information regarding coverage parameters. |

| BULLETIN NUMBER | DATE ISSUED | CHAPTER | SECTION | CHANGE |
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| | | | 2.2 Nonenrolled Providers | Text was revised to read:<br><br>Professional services performed by ~~limited licensed psychologists (except as noted in Section 333.18223 of the Public Health Code), social workers, professional counselors, marriage and family therapists,~~ non-licensed behavioral health graduates or student interns must be performed under the supervision of an enrolled, fully-licensed provider of the same profession. These services are reimbursed under the RHC PPS. Since MDHHS does not directly enroll these non-licensed providers, claims for their services must ~~be billed using the NPI of the supervising provider responsible for ensuring the medical necessity and appropriateness of the services~~ include the individual NPI of the supervising fully licensed provider who is responsible for ensuring the medical necessity and appropriateness of the services in the "Attending Provider" field of the institutional claim. Claims submitted with ~~the~~ a non-enrolled provider~~'s~~ NPI in the attending or rendering provider field will reject. |
| | | Telemedicine | 2.2.B. Outpatient Mental Health Services Providers | Text was revised to read:<br><br>Medicaid beneficiaries whose needs do not render them eligible for specialty services and supports through the PIHPs/CMHSPs may receive outpatient mental health services through Medicaid FFS or MHPs as applicable. These FFS/MHP enrolled non-physician behavioral health services may be provided via telemedicine when performed by Medicaid-enrolled Licensed, Limited Licensed, Educational Limited Licensed, or Temporary Limited Licensed psychologists, social workers, counselors, and marriage and family therapists. Services are covered when performed in a non-facility setting or outpatient hospital clinic. All applicable services are listed in the telemedicine audio/visual and audio-only fee schedules. |

| BULLETIN NUMBER | DATE ISSUED | CHAPTER | SECTION | CHANGE |
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| | | Tribal Health Centers | 2.1.A. Non-Physician Behavioral Health Services | Text was revised to read:<br><br>Licensed, Limited Licensed, Educational Limited Licensed, or Temporary Limited Licensed non-physician behavioral health providers, including psychologists ~~(Master's Limited or Doctoral level)~~, Master's Level social workers ~~(Master's level)~~, professional counselors ~~(Master's or Doctoral level)~~, and marriage and family therapists who serve Medicaid beneficiaries are required to enroll as Medicaid providers. The NPI of the non-physician behavioral health provider is reimbursed under the THC AIR. Services provided by Limited, Educational Limited, and Temporary Limited Licensed providers must be performed under the supervision of an enrolled, fully licensed provider of the same profession.<br><br>Behavioral health services performed by a Limited, Temporary Limited, or Educational Limited Licensed provider must include the individual NPI of the supervising fully licensed provider in the "Attending Provider" field of the institutional claim. The limited, educational limited, or temporary limited licensed provider's NPI should be reported in the "Rendering Provider" field.<br><br>Behavioral Health services must be billed using the appropriate ~~evaluation and management (E/M)~~ procedure codes listed in the American Medical Association's Current Procedural Terminology (CPT) Book or Healthcare Common Procedure Coding System (HCPCS) codes. Providers should refer to the Non-Physician Behavioral Health provider database on the MDHHS website for the current list of covered procedure codes. The list of allowable services is reviewed annually and updated as applicable. Refer to the Additional Code/Coverage Resource Materials Section of the General Information for Providers Chapter for additional information regarding coverage parameters. |

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|---|---|---|---|---|
| | | | 2.2 Nonenrolled Providers | Text was revised to read:<br><br>Professional services performed ~~by limited licensed psychologists (except as noted in Section 333.18223 of the Public Health Code), social workers, professional counselors, marriage and family therapists~~ non-licensed behavioral health graduates or student interns must be performed under the supervision of an enrolled, fully-licensed provider of the same profession. These services are reimbursed under the THC AIR. Since MDHHS does not directly enroll these non-licensed providers, claims for their services must ~~be billed using the NPI of the supervising provider responsible for ensuring the medical necessity and appropriateness of the services~~ include the individual NPI of the supervising fully licensed provider who is responsible for ensuring the medical necessity and appropriateness of the services in the "Attending Provider" field of the institutional claim. Claims submitted with ~~the~~ a non-enrolled provider's NPI in the attending or rendering provider field will reject. |
| | | | Section 5 – Mental Health | Text was revised to read:<br><br>Outpatient mental health services provided by physicians~~, clinical social workers, and clinical psychologists~~ and behavioral health providers as defined in the Behavioral Health and Intellectual and Developmental Disability Supports and Services chapter, Non-Physician Behavioral Health Appendix are covered. These services may include: |
| | | | 5.1 Nonenrolled Providers | The subsection was deleted.<br><br>The following subsections were re-numbered. |
| MMP 26-31 | 7/31/2026 | Billing & Reimbursement for Institutional Providers | 7.1.B. Payment Status Indicators | The 1st paragraph was revised to read:<br><br>For categories covered differently than Medicare under the MDHHS OPPS, refer to the MDHHS ~~OPPS Wraparound~~ Outpatient Prospective Payment System Rates Code List posted on the MDHHS website. (Refer to the Directory Appendix for website information.) |

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| | | | 7.13 Dialysis (Hemodialysis and Peritoneal) | The last paragraph was revised to read:<br><br>Refer to the outpatient portion of the Hospital Chapter of this manual and to the MDHHS ~~OPPS Wraparound~~ Outpatient Prospective Payment System Rates Code List on the MDHHS website for additional information. (Refer to the Directory Appendix for MDHHS website information.) |
| | | | 7.21 Laboratory | Text was revised to read:<br><br>Differences in coverage of lab services between MDHHS and Medicare have been identified ~~and are included in~~ on the MDHHS ~~OPPS Wraparound~~ Outpatient Prospective Payment Systems Rates Code List available on the MDHHS website. (Refer to the Directory Appendix for website information.) |
| | | | 7.26 Self-Care Dialysis Training | The 1st paragraph was revised to read:<br><br>Bill self-care dialysis training using the appropriate revenue code and HCPCS/CPT codes. Refer to the MDHHS ~~OPPS Wraparound~~ Outpatient Prospective Payment System Rates Code List on the MDHHS website for ~~CPT HCPCS codes~~ additional information. (Refer to the Directory Appendix for MDHHS website information.) |
| | | Billing & Reimbursement for Professionals | 7.6 Dialysis Services | The 2nd paragraph was revised to read:<br><br>Dialysis codes (e.g., 90945, 90947) are reported for dialysis procedures other than hemodialysis (e.g., peritoneal dialysis, hemofiltration or continuous renal replacement therapies), and all E/M services related to the beneficiary's renal disease on the day of the procedure. Refer to the MDHHS Outpatient Prospective Payment System ~~(OPPS) Wrap Around~~ Rates Code List on the MDHHS website for additional information. (Refer to the Directory Appendix for website information.) |

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| BULLETIN NUMBER | DATE ISSUED | CHAPTER | SECTION | CHANGE |
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| | | Ambulatory Surgical Centers | Section 2 – Covered Services | Text was revised to read:<br>MDHHS follows Medicare's ASC coverage policies, with Medicaid-specific exceptions outlined by code. MDHHS-specific exceptions are outlined as part of the MDHHS Ambulatory Surgical Centers ~~(ASC) Wraparound~~ Payment Rates Code List. Updates are published quarterly on the MDHHS website. (Refer to the Directory Appendix for website information.) |
| | | | 2.1 ASC Payment Status Indicators | The 2nd paragraph was revised to read:<br>For categories of codes that MDHHS covers differently than Medicare ~~(wraparound codes)~~, the following alpha/numeric MDHHS Status Indicators Key is ~~are~~ used: |

| Status Indicator | Description |
|---|---|
| AA1 | MDHHS Covered Services~~/~~ (Non-Medicare) ~~Non-Covered~~ |
| AA2 | ~~MDHHS~~ Medicaid Covered Vaccines |
| AA3 | Vaccines For Children (VFC) |
| AA4 | State Plan Reimbursement |
| RR1 | MDHHS Non-Covered Items |
| M | "M" in fee is manually priced |

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| BULLETIN NUMBER | DATE ISSUED | CHAPTER | SECTION | CHANGE |
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| | | | 3.1 Payment Calculation | The 1st paragraph was revised to read:<br><br>Payments for ASC facility services are calculated utilizing the following formula:<br><br>~~Medicare~~ CMS ASC Payment Rate **X** Current OPPS/ASC Reduction Factor **=** ~~Medicaid~~ MDHHS ASC Payment Rate |
| | | | 3.7 Ambulatory Surgical Centers Wraparound Code List Fee Schedule | The subsection title was revised to read:<br><br>MDHHS Ambulatory Surgical Centers ~~Wraparound~~ Payment Rates Code List ~~Fee Schedule~~<br><br>Text was revised to read:<br><br>Services listed in the MDHHS Ambulatory Surgical Centers ~~(ASC) Wraparound~~ Payment Rates Code List are paid based on a MDHHS-specific fee schedule. CMS updates are published quarterly on the MDHHS website (revisions are made to align with Medicare). The OPPS/ASC reduction factor is not applied to ~~MDHHS Ambulatory Surgical Centers Wraparound Code List services~~ HCPCS codes that have been assigned an MDHHS Status Indicator. (Refer to the Directory Appendix for website information.) |

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| | | Hospital | 3.19 Injections/Intravenous Infusions | The 1st paragraph was revised to read:<br><br>MDHHS covers intramuscular, subcutaneous or intravenous injections and intravenous (IV) infusions when medically necessary. In the inpatient hospital, reimbursement is included in the DRG payment. In the outpatient hospital (OPH) or Ambulatory Surgical Center (ASC), reimbursement generally follows CMS Outpatient Prospective Payment System (OPPS) guidelines. Injectables paid differently than CMS OPPS are listed on the MDHHS ~~OPPS Wraparound~~ Outpatient Prospective Payment System Rates Code List for OPH or ASC. (Refer to the Directory Appendix for website information.) |
| | | | 3.21 Laboratory | The 5th paragraph was revised to read:<br><br>Generally, MDHHS follows Medicare's current OPPS laboratory coverage policies as closely and appropriately as possible ~~and appropriate~~. In those instances where program differences require coverage disparity, the differences will be reflected through the application of the MDHHS specific status indicator. Procedure codes associated with the identified services will appear on the MDHHS ~~OPPS Wraparound~~ Outpatient Prospective Payment System Rates Code List and reimbursement rates will appear on the Carrier Priced Laboratory Codes List. Both lists are available on the MDHHS website. (Refer to the Directory Appendix for website information.) |
| | | Hospital Reimbursement Appendix | 1.3 Status Indicators | The 2nd paragraph was revised to read:<br><br>~~For categories of codes that MDHHS covers differently than Medicare under its OPPS (wraparound codes), the following alpha-numeric status indicators are used.~~<br><br>The following alpha-numeric status indicators are used when MDHHS covers category codes differently than Medicare under the MDHHS Outpatient Prospective Payment System Rates Code List: |

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| BULLETIN NUMBER | DATE ISSUED | CHAPTER | SECTION | CHANGE |
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| | | Laboratory | 3.2 Outpatient Hospital | The 2nd paragraph was revised to read:<br><br>Generally, Medicaid follows Medicare's OPPS laboratory coverage and reimbursement policies whenever possible and appropriate. In instances where there are program differences, the differences will be reflected through the application of the MDHHS specific status indicator. Procedure codes associated with the identified laboratory services will appear on the MDHHS ~~OPPS Wraparound~~ Outpatient Prospective Payment System Rates Code List and reimbursement rates will appear on the Carrier Priced Laboratory Codes List. Both lists are available on the MDHHS website. (Refer to the Directory Appendix for website information.) |
| | | Directory Appendix | Billing Resources | Under "**MDHHS Procedure Code Databases/Fee Screens, Documentation Requirements, Readmission Example, etc.**", text for "**Information Available/Purpose**" was revised to read:<br><br>MDHHS-covered procedure codes, parameters, fee screens, 15-day readmission example, ~~OPPS Wraparound~~ Outpatient Prospective Payment System Rates Code Lists for each provider type available on-line, Revenue Code Requirement Table. |

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