
**DEPARTMENT
POLICY****Medicaid (MA)**

General lists of MA covered services are located at the end of this item; see EXHIBIT I.

In this item MA includes MAGI-related and SSI-related beneficiaries.

**CHOICE OF
PROVIDERS**

The beneficiary is usually free to select a provider or health care plan. However, there are some situations when the recipient may be restricted to certain providers (such as primary care provider, pharmacy, specialist provider). Reimbursement for services rendered is limited to enrolled providers except for emergencies.

HEALTH PLANS

Health plans provide Medicaid-covered health care services for an enrolled group of beneficiaries in a defined service area.

Enrollment

Beneficiaries are given an opportunity to select a health plan. If no selection is made, the beneficiary is automatically enrolled by the state's contracted enrollment broker, Michigan ENROLLS, with a health plan in the beneficiary's county of residence.

Health plan enrollees are identified by program enrollment type (PET) codes which start with MHP-XXXX. Health plan enrollees will also receive an identification card from their health plan.

There are beneficiaries who:

- Must enroll in a health plan.
- May voluntarily enroll in a health plan.
- Are excluded from enrollment in a health plan.

Persons Who Must Enroll In a Health Plan

The following must enroll in a health plan, unless they are **Persons Who May Voluntarily Enroll in a Health Plan** or **Persons Excluded from Enrollment in a Health Plan**.

- Family Independence Program (FIP) recipients.
- Children under 19 (U19) beneficiaries.
- Pregnant women (PW) beneficiaries.
- Group 2 Under 21(G2U) beneficiaries.
- Parent/Caretaker (PCR) and LIF beneficiaries.
- Healthy Michigan Plan (HMP) beneficiaries.
- Supplemental Security Income (SSI) recipients who do not receive Medicare.
- Blind, disabled, and aged MA beneficiaries who do not receive Medicare.
- Persons with full Medicaid coverage and Children Special Health Care Services (CSHCS).

Persons Who May Voluntarily Enroll In a Health Plan

The following may voluntarily enroll in a health plan:

- Migrants.
- Native Americans.
- Persons in the traumatic brain injury program.
- Persons with both Medicare and Medicaid eligibility.
- Persons eligible for QMB; see BEM 165.

Persons Excluded From Enrollment in a Health Plan

- PlusCare recipients.
- Persons limited to emergency MA coverage (ESO).

- Persons enrolled in the Children's Special Health Care Services (CSHCS) program only.
- Persons residing in an ICF/ID (intermediate care facility for individuals with intellectual disability) or a state psychiatric hospital.
- Persons receiving long-term care (custodial care) in a licensed nursing facility.
- Persons receiving MI Choice waiver services for the elderly and disabled; see BEM 106.
- Persons receiving private duty nursing services.
- Persons with commercial HMO coverage, including Medicare HMO coverage.

Note: Letters are mailed out each month to Medicaid recipients who have private HMO coverage. This letter informs recipients that they are being disenrolled from their Health Plan; see EXHIBIT II for further information.

- PACE (Program for All-inclusive Care for the Elderly) recipients.
- Deductible beneficiaries.
- Children in child caring institutions.
- Refugee Assistance Program Medical Aid-only recipients.
- Repatriate Assistance Program Medical-only recipients.

Note: When a person(s) is excluded from health plan enrollment, other members of that person's family may enroll in a health plan.

If a beneficiary enrolled in a health plan enters a long-term care facility for custodial purposes, the health plan may initiate a request for disenrollment from the health plan; see BAM 120. The health plan may request disenrollment by calling:

Michigan Department of Health and Human Services
Managed Care Plan Division
Quality Improvement and Program
517-241-8179

Additional Information about Health Plans

For additional information about health plans, contact:

Michigan Department of Health and Human Services
Comprehensive Health Plan Division
CCC Bldg.
PO Box 30479
Lansing, MI 48909-7979

Michigan Enrolls: 1-888-367-6557

A list of the health plans available in each county is on the Michigan Department of Health and Human Services (MDHHS) website (Medicaid Link). This list is updated monthly. The MDHHS website address is: www.michigan.gov/mdch.

Other Insurance

Health plan enrollees with other insurance should advise their health plan of their insurance coverage.

Covered Services

The health plan is responsible for providing and arranging for all medically necessary services covered by Medicaid with the **exception** of:

- Dental care (Services rendered by an oral surgeon are included in the health plan capitation rate).
- Mental health services including inpatient psychiatric services (the health plan is responsible for up to 20 outpatient visits).
- Substance abuse treatment.
- Medical transportation for the three services listed above; see BAM 825.
- Personal care services.
- School-based services.

The health plan is responsible for providing up to 45 days of restorative health care which is intermittent or short-term, restorative or rehabilitative nursing care.

The health plan may also provide services that are not covered by MA.

MICHIGAN PHARMACEUTICAL BEST PRACTICES

MA

MDHHS has contracted with Magellan Medicaid Administration, Inc. to be the pharmacy benefits manager for its fee-for-service health programs and pregnancy-related pharmacy services for Maternity Outpatient Medical Services (MOMS) beneficiaries. The pharmacy benefits manager is responsible for all of the following:

- Prior authorizing certain drugs.
- Processing pharmacy claims.
- Approving payment to pharmacies.
- Other administrative functions to ensure that appropriate payments are being made.

Magellan Medicaid Administration, Inc. does not prior authorize or pay claims for Medicaid contracted health plans.

Prior Authorization

Drugs that require prior authorization appear on the Michigan Pharmaceutical Products List (MPPL). Physicians or other prescribers may request prior authorization by contacting First Health Services.

Magellan Medicaid Administration, Inc.
MAP Department
4300 Cox Road
Glenn Allen, VA 23060
Telephone: 1-877-864-9014
Fax: 1-888-603-7696 or 1-800-250-6950

Hearing Rights

A beneficiary is notified in writing within 10 calendar days of a prior authorization denial. The notice tells the beneficiary how to apply for a MDHHS administrative hearing. The MDHHS hearings application form and a stamped envelope are included with the notice.

HEALTHY KIDS DENTAL

MA

MDHHS has contracted with two Dental Health Plans (DHPs) to administer the healthy Kids Dental benefit statewide. The DHPs administer the Medicaid dental benefit to **all** Medicaid beneficiaries under age 21.

The dental services provided through the DHPs include at a minimum, the same dental services provided through fee-for-service (FFS) Medicaid. DHPs, at their discretion may cover additional dental services not covered through FFS Medicaid.

Healthy Kids Dental is not limited to persons receiving MA under Children Under 19 (U19). It is for **all** MA beneficiaries under age 21.

Beneficiaries must see a dentist that participates with the beneficiary's chosen DHP dental network. Beneficiaries may contact their DHP's customer service with questions.

Enrollment

All HKD beneficiaries will initially be automatically enrolled on an alternate basis in one of two DHPs.

MDHHS will mail confirmation letters to all beneficiaries who have been automatically enrolled in a DHP. The letter will include the beneficiary's assigned DHP and information on their right to choose a different DHP.

Beneficiaries will be able to contact the Michigan enrollment broker, Michigan Enrolls, for help with their DHP selection. Michigan Enrolls is independent from the DHPs and will provide beneficiaries with choice counseling information, including dental provider participation in each DHP's network. Beneficiaries will be able to call or send a form to Michigan Enrolls to change their DHP.

Any change of DHP made by a beneficiary will be made on a prospective basis. If the beneficiary contacts Michigan Enrolls prior to the last business day of the month, the new DHP enrollment should be effective on the first day of the following month. For example, a beneficiary who calls Michigan Enrolls on October 5, 2018, and selects a different DHP will be changed to the new DHP effective November 1, 2018.

The beneficiary may change DHPs within 90 days of the DHP enrollment effective date. MDHHS gives beneficiaries the opportunity to change DHPs without cause during each beneficiary's annual open enrollment period.

ID Cards

In addition to the MI health card, Healthy Kids Dental beneficiaries will receive a benefit ID card from their assigned DHP. If the card is lost the beneficiary must call their DHP customer service to request a replacement card. The beneficiary's SSN is on the card, not the MA beneficiary ID number.

Retroactive Enrollment

The effective date of enrollment in the DHP will be the first day of the month that CHAMPS receives information that the beneficiary has been determined eligible for Medicaid. For example, if CHAMPS is notified that a beneficiary has been determined eligible on October 24, 2018, the beneficiary will have a DHP enrollment effective date of October 1, 2018.

Covered Dental Services

Healthy Kids Dental provides services that are applicable to persons under age 21. These services include:

- Emergency services
- Diagnostic services
- Preventive services
- Restorative services
- Limited adjunctive services
- Endodontic services
- Limited crown coverage
- Prosthodontics
- Removable prosthodontics
- Oral surgery services
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services
- All medically necessary services

At a minimum, the DHP's coverage of these services is the same as for fee-for-service MA. DHPs at their discretion may cover additional services.

**HEALTH PLAN
BENEFICIARY
INFORMATION****MA**

The health plan may notify the local office specialist of a beneficiary's pregnancy. The health plan will fax a MDCH-2010, Health Plan Beneficiary Information, to 517-346-9888 with the pregnancy information they have for the beneficiary.

Review the information from the health plan and update Bridges as appropriate.

**BENEFIT
MONITORING
PROGRAM
(FEE-FOR- SERVICE)****MA**

State and federal regulations require the Medicaid program to conduct benefit utilization reviews to ensure the medically necessary services are being provided to program beneficiaries. The Benefit Monitoring Program (BMP) is in place to monitor program usage and to identify beneficiaries who may be over-utilizing and/or misusing their Medicaid services and benefits.

While in the BMP beneficiaries may be assigned to one or more provider through which they can obtain medical services.

For further information or to make a referral contact:

Michigan Department of Health and Human Services
Benefit Monitoring Program
PO Box 30170
Lansing, MI 48909
Phone: 855-808-0312

**EPSDT/WELL CHILD
PROGRAM****MA**

The Early Periodic Screening Diagnosis Treatment Program (EPSDT) Well Child Program consists of well-child visits, immunizations and early detection and treatment of diseases for beneficiaries under age 21. The objective of this preventive health

care is early intervention to detect and treat mental or physical disease.

The same components of a well-child visit and the same interval schedule are used regardless of whether the child is in a health plan or is fee-for-service.

MDCH Publication (795), Michigan Free Health Check-ups for *persons 21 and younger*, explains the well-child visits.
<http://www.michigan.gov/mdch>

ENROLLED PROVIDER BILLING PROCEDURES (FEE-FOR-SERVICE)

MA

Enrolled providers are aware of the covered and excluded services available to MA beneficiaries. Providers must use MA billing procedures to obtain payment for services performed. Billings should be submitted within 12 months from the date of service.

Twelve Month Billing Exceptions

Exceptions to the 12 month billing policy can be made if the delay is caused by agency error or as a result of a court or administrative hearing decision. Agency errors are limited to:

- Delayed Bridges coding, including PET code changes.
- Disability Determination Service (DDS) review.
- Administrative review.
- Delayed eligibility determination.

Exceptions cannot be granted due to provider delays in billing or failure of a recipient or provider to obtain prior authorization.

Form MSA-1038, Request for Exception to the Twelve Month Billing Limitation for Medical Services, is an internal document and must be completed by local office staff to begin the exception process. The completed MSA-1038 should be sent to: 1038@michigan.gov.

A family independence manager, district manager, or other office designee must be copied on the email. A copy of the hearing decision is no longer required; however, the hearing registration number must be indicated on the MSA-1038.

MDHHS will notify the specialist within 30 days of the decision. If approved MSA will notify providers to bill Medicaid as usual but to enter in the comments section of the claim, "MSA 1038 approval on file".

MEDICAL SERVICES PROVIDER POLICIES

MA

Local office staff is not expected to be the beneficiary's primary source of information for covered services. The providers of medical services are best equipped to determine medical needs and whether those services are covered by MA as specified in the MA provider manuals.

Some basic guidelines:

- The provider is required to bill all other insurances prior to billing MA.
- Providers must be appropriately licensed and/or certified before entering into an agreement with MDHHS to participate in the MA program.
- Enrolled providers receive direct payment for services rendered but must agree to provide services according to the policies published in the MA provider manuals.
- Certain medical/dental services require the provider to obtain prior approval from MDHHS; see the [Medicaid Provider Manual](#) for co-pay information.
- The provider is required to accept payments received from MA as payment in full, **except** for patient-pay amounts authorized by MDHHS and co-payments.
- The provider may seek payment from a beneficiary for services not covered if the beneficiary elects to receive the services with the prior knowledge that such services are not covered.
- Institutional and nursing home providers holding a beneficiary's funds in trust are accountable to the beneficiary and may not require the deposit of such funds with the facility. The management of such funds is subject to review by MDHHS.

Local offices may obtain more information on medical/dental care coverage by consulting the MA provider manuals or contacting MDHHS at:

Michigan Department of Health and Human Services
Provider Inquiry
CCC Bldg.
PO Box 30479
Lansing, MI 48909-7979
Phone: 1-800-292-2550

MEDICAL/DENTAL SERVICES IN ANOTHER STATE

MA

A Michigan MA beneficiary may receive medical/dental care outside of Michigan. The areas beyond the Michigan borders are classified as either borderland or beyond borderland. Borderland and beyond borderland providers must comply with applicable Michigan MA policies and procedures, including prior authorization, to be reimbursed for services.

Borderland Areas

The borderland areas are the out-of-Michigan counties which are adjacent to the Michigan border and certain cities beyond these adjacent counties. The specific counties and cities which are borderland areas are:

States, Counties, Cities	
Ohio	Wisconsin
<ul style="list-style-type: none"> • Fulton County • Lucas County • Williams County 	<ul style="list-style-type: none"> • Ashland • Green Bay • Rhinelander
Indiana	Indiana
<ul style="list-style-type: none"> • Elkhart County • Lagrange County • LaPorte County 	<ul style="list-style-type: none"> • St. Joseph County • Steuben County • Fort Wayne
Wisconsin	Minnesota
<ul style="list-style-type: none"> • Florence County • Iron County • Marinette County • Forest County • Vilas County 	<ul style="list-style-type: none"> • Duluth

A beneficiary is covered for medical/dental services rendered in a borderland area to the same extent that such services are covered in Michigan.

Borderland providers are considered to be Michigan providers. They must be enrolled in Michigan Medicaid and adhere to the same policies as Michigan providers.

**Beyond
Borderland Areas**

The beyond borderland areas are all areas of the U.S. outside of Michigan which are not borderland areas.

Beyond borderland medical/dental services received by a Michigan MA beneficiary will be covered only when:

- The beneficiary is temporarily out-of-state and the services are necessary because the individual's health would be endangered if travel to Michigan was required.

- The beneficiary is temporarily out-of-state and the services are necessary because of a medical/dental emergency (as defined by the program).
- The service is prior authorized by MDHHS as more readily available in another state.

Prior Authorization

Certain services provided by **borderland** providers require prior authorization the same as services requiring prior authorization by Michigan providers.

Except in emergencies, the services of a **beyond borderland** provider must be prior authorized. The beneficiary's local physician should submit the following to MDHHS:

- Documentation of the need for beyond borderland services.
- Beneficiary identification.
- Eligibility data.

The address to submit the above information is:

Michigan Department of Health and Human Services
Review and Evaluation Division
400 S. Pine Street
PO Box 30170
Lansing, MI 48909-7979

The beneficiary's physician and the local office may also make telephone inquiries regarding beyond borderland services when it appears that time is of the essence.

Phone: 1-800-622-0276

The Prior Authorization and Review Section may request information from local offices when evaluating the need for beyond borderland services. Prompt assistance from the local offices is appreciated. A copy of the prior authorization decision will be sent to the appropriate local office.

Inquiries

Refer non-enrolled provider questions about borderland or beyond borderland coverage and billings to:

Michigan Department of Health and Human Services

Provider Inquiry
400 S. Pine Street
PO Box 30239
Lansing, MI 48909-7979

Providers may call:

1-800-292-2550

Claims

Medicaid will pay non-enrolled Michigan and borderland providers for:

- Emergency services, and
- Nonemergency services with prior approval.

The following occurs when non-emergency services claims are submitted by a non-enrolled provider:

- The miscellaneous transactions unit will process the claim and send a letter to the provider with a Medical Assistance Provider Enrollment/Trading Partner Agreement form.
- If the provider elects not to complete the Medical Assistance Provider Enrollment/Trading Partner Agreement form, the claim will not be paid.

Reimbursement for services not paid by Medicaid is between the beneficiary and the provider. The provider must notify the beneficiary prior to rendering the service that it is not covered by Medicaid.

Borderland providers who are not enrolled and all beyond borderland providers should submit claims to:

Michigan Department of Health and Human Services
Provider Enrollment
Medicaid Payments
PO Box 30238
Lansing, MI 48909

**PROVIDER
INQUIRIES****Eligibility
Verification
System (EVS)****MA**

Beneficiary information is available to medical/dental providers through an automated system called the Eligibility Verification System (EVS).

If the beneficiary is eligible, the following information is available:

- Beneficiary name, beneficiary ID number, gender, date of birth.
- Benefit plan ID(s) for the date of service (DOS).
- PET code information, source provider ID, National Provider Identifier(NPI), provider name, telephone number, address, and the patient pay amount, if applicable.
- Medicaid health plan, primary care physician, including the provider name and telephone number.
- Third party liability, including the payer name, payer ID, coverage type code, group number, policy number, and policyholder ID.
- Pending Medicaid eligibility.

Additional information is not available through EVS.

CHAMPS

Providers may verify beneficiary eligibility using:

- CHAMPS Eligibility Inquiry.
- HIPAA 270/271 (eligibility inquiry/response) transactions.

Refer to the Michigan Medicaid Provider Manual, Beneficiary Eligibility and Directory Appendix Sections for further information.

Providers may contact the MDHHS Provider Inquiry Helpline at 1-800-292-2550 for questions/issues related to the eligibility response.

The Helpline number can also be used by providers without internet access and out-of-state providers.

Providers may also email Provider Support at providersupport@michigan.gov

Health Plans

MA

Refer provider questions about Medicaid Health Plans (MHP) to:

Provider Inquiry: 1-800-292-2550

Covered Services

After consulting the MA provider manuals, providers may call the following number to verify covered services or to receive billing assistance:

Provider Inquiry: 1-800-292-2550.

BENEFICIARY INQUIRIES

Covered Services

MA

Fee-for-Service -Refer beneficiary questions about MA covered services or billing problems to:

Medicaid Beneficiary Helpline:
1-800-642-3195.

Health Plans

MA

Refer beneficiary questions about MA Health Plans, including available providers in their area and enrollment to:

Michigan Enrolls: 1-888-367-6557.

Refer beneficiary complaints and questions about MA providers to:

Medicaid Beneficiary Helpline:
1-800-642-3195.
Michigan Department of Health and Human Services
Enrollment Services Section
CCC Bldg.

**COMPLAINTS
ABOUT PROVIDERS**

PO Box 30470
Lansing, MI 48909-9753

MA

Refer complaints about enrolled providers to:

Michigan Department of Health and Human Services
Comprehensive Health Plan Division
400 S Pine
PO Box 30479
Lansing, MI 48909-7979

Michigan Department of Attorney General
Health Care Fraud Division
PO Box 30218
Lansing, MI 48909
24 hour hotline: 1-855-643-7283 (1-855-MI FRAUD)
Email: hcf@michigan.gov

EXHIBIT I - MA COVERED SERVICES

The following are general categories of MA covered services. This listing should be used for reference purposes only. Some of the services listed are available **only to certain age groups**, may be limited in their scope or may require prior approval.

Local office staff is not expected to be the beneficiary's primary source of information for MA covered services. The beneficiary should be advised to contact the medical services provider directly whenever information is needed regarding MA covered services.

- Allergy Testing/Treatment
- Ambulance Services
- Chiropractic Services
- Dental Services
- Diabetic Patient Education Program
- EPSDT/Well Child Services
- Family Planning Services
- Hearing Aid Dealers
- Hearing & Speech Center Services
- Home and Community-Based Waiver Services
- Home Health Services
- Hospice Services
- Hospital Services (Inpatient/Outpatient)
- Laboratory and X-Ray Services
- Long-Term Care (LTC)
- Maternal Infant Health Program
- Medical Supplies and Equipment
- Mental Health Services
- Methadone Maintenance Treatment
- Nurse-Midwife and Nurse Practitioner Services
- Orthotics, Prosthetics and Special Shoes
- Personal Care Services
- Pharmacy Services
- Physician Services (MD/DO)
- Podiatric Services
- Psychiatric Care
- School-Based Services
- Substance Abuse Treatment Services
- Therapy (Occupational, Physical, Speech)
- Transportation (BAM 825)
- Vision Services

For questions regarding a specific service, contact Provider Inquiry at 1-800-292-2550.

EXHIBIT II - NOTICE TO MEDICAID BENEFICIARIES WHO HAVE PRIVATE HMO INSURANCE



For questions and/or problems, or help to translate, call the Beneficiary Help Line at 1-800-642-3195 or TTY 1-866-501-5656.

Spanish: Si necesita ayuda para traducir o entender este texto, por favor llame al telefono, 1-800-642-3195 or TTY 1-866-501-5656

Arabic: TTY 1-866-501-5656

إذا كان لديكم أي سؤال، يرجى الإتصال بخط المساعدة على الرقم المجاني ١-٨٠٠-٦٤٢-٣١٩٥

Notice to Beneficiaries Who Have Private HMO Insurance

Our records show that the beneficiaries listed above have private HMO insurance. When you have private HMO insurance, you cannot be in a health plan. You will still have regular Medicaid. Your private HMO insurance always pays for medical services first. Medicaid pays after your private HMO has paid their part.

Co-payments

When you have regular Medicaid, you may have more co-payments or higher co-payments than charged by your health plan. Your providers will tell you about any co-payments.

Transportation

If you do not have a way to get to a doctor visit, call your local office of Michigan Department of Health and Human Services (MDHHS). They can help you get a ride. Unless you have an emergency, you must call before you need a ride.

mihealth ID Card

Remember to take your "mihealth" card and your private HMO card to show your providers when you go for an appointment or service.

myHealthButton® and myHealthPortal

Need to report changes to your private HMO Insurance? MDHHS has apps that can help. myHealthButton® and myHealthPortal are free apps that give you access to your healthcare information:

- myHealthButton® is for your smart phone
- myHealthPortal is for your home computer or laptop

Through either app, you can:

- report changes to your private HMO insurance information
- have an electronic copy of your mihealth card
- and much more!

For more information about these apps and instructions on how to register, visit www.michigan.gov/myhealthportal.

Questions

If you have questions about these changes, call the Beneficiary Help Line at 1-800-642-3195. Enclosed is a handbook explaining your rights and responsibilities with regular Medicaid.

Department of Community Health*PO Box 30470*LANSING, MICHIGAN 48909
www.michigan.gov

LEGAL BASE

MA

42 CFR 431, Subpart B

42 CFR 431.107

42 CFR, Part 440

42 CFR 441, Subpart B

42 CFR 456.3

MCL 400.109, .110

Social Security Act, Section 1927