MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 13-09

Distribution: Practitioners, Local Health Departments, Federally Qualified Health Centers, Rural Health Clinics, Medicaid Health Plans, MIChild Health Plans, Tribal Health Centers, Pre-Paid Inpatient Health Plans

Issued: March 1, 2013

Subject: Coverage of Autism Services

Effective: April 1, 2013

Programs Affected: Medicaid and MIChild

NOTE: Implementation of this policy is contingent upon State Plan and Waiver approval from the Centers for Medicare & Medicaid Services (CMS).

BACKGROUND

The purpose of this policy is to clarify developmental screening policy for children who may be affected by Autism Spectrum Disorder (ASD), and to describe coverage and processes for the treatment of ASD for Medicaid and MIChild children from age 18 months through 5 years.

According to the U.S. Department of Health & Human Services, autism is characterized by impaired social interactions, problems with verbal and nonverbal communication, repetitive behaviors, and/or severely limited activities and interests. Early detection and treatment can have a significant impact on the child's development. Autism can be viewed as a continuum or spectrum, known as ASD, and includes Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS). The disorders on the spectrum vary in severity and presentation, but have certain common core symptoms. The goals of treatment for ASD focus on improving core deficits in communication, social interactions, and restricted behaviors. Changing these fundamental deficits may benefit children by developing greater functional skills and independence.

MEDICAID BENEFIT FOR AUTISM

I. Screening

The American Academy of Pediatrics (AAP) endorses early identification of developmental disorders as being essential to the well-being of children and their families. Early identification of developmental disorders through screening by health care professionals should lead to further evaluation, diagnosis, and treatment. Early identification of a developmental disorder and its underlying etiology may affect the medical treatment of the child and family intervention planning for his/her parents.

Screening for ASD typically occurs during a well-child visit with the pediatrician or family physician. The screening tool may be completed by the parent and reviewed/verified by the practitioner. The Modified Checklist for Autism in Toddlers (M-CHAT) is validated for toddlers 16 through 30 months of age. For children older than 4 years of age (mental age greater than 2 years of age), the Social Communication Questionnaire (SCQ) may be utilized. For children 30 months through 4 years of age, the most applicable of the two tools should be administered (M-CHAT if mental age is less than 2 years of age; SCQ if mental age is greater than 2 years of age).

A validated screening tool must be administered as part of the well-child visit by the pediatrician or family physician as recommended by the AAP. Proper assessment of autism is accomplished by administering a validated standardized screening tool, such as the M-CHAT, at 18 and 24 months of age as indicated by the AAP Periodicity Schedule. Surveillance for ASD must be completed at other well-child visits beginning at 12 months of age by listening for parent concerns and by watching for red flag abnormalities, such as no babbling by 12 months of age. Children older than 24 months of age who have not been screened may be screened at preventive care visits using a validated standardized screening tool such as the M-CHAT or the SCQ. Providers may bill for the administration of an autism screen by using CPT code 96110 with a U5 modifier.

II. Referral

The primary care physician (PCP) who screened the child for ASD and determined a referral for further evaluation was necessary will contact the Pre-paid Inpatient Health Plan (PIHP) directly to arrange for a follow-up evaluation. After a beneficiary is screened and the PCP determines a referral is necessary for a follow-up visit, the PIHP is responsible for the Autism Benefit additional screenings, evaluation, assessment, diagnosis and services for Applied Behavior Analysis (ABA) for eligible Medicaid and MIChild beneficiaries and for the related medically necessary services under the Mental Health Specialty Services. The PCP must refer the child to the PIHP in the geographic service area for Medicaid and MIChild beneficiaries. The PIHP will contact the child's parent(s) to arrange a follow-up appointment for a diagnostic evaluation. Each PIHP will identify a specific point of access for children who have been screened and are being referred for a diagnostic evaluation of ASD. PIHP contact information can be found at: http://www.michigan.gov/documents/PIHPDIRECTOR_97962_7.pdf.

III. Diagnosis/Determination of Eligibility for Target Population

Accurate and early diagnosis of ASD is critical in ensuring appropriate intervention and positive outcomes. The following is the process for determining eligibility for ABA for a child referred to the PIHP with a suspected diagnosis of autism or one of the related ASDs including Autistic Disorder, Asperger's Disorder, and PDD-NOS. The Medicaid agency will make the final eligibility determination for ABA services.

Determination of diagnosis of ASD shall be performed by a child mental health professional (CMHP), which includes physicians, fully licensed psychologists, limited licensed psychologists, licensed or limited licensed master's social workers, licensed or limited licensed professional counselors, or registered nurses, with a minimum education of a master's degree in a mental health-related field from an accredited school. The CMHP, as defined above, who has at least one year of experience in the examination and treatment of children with ASD, and who is able to diagnose within their scope of practice and professional license. The determination of diagnosis will be performed using the Autism Diagnostic Observation Schedule-Second Edition (ADOS-2). A developmental family history interview such as the Autism Diagnostic Interview Revised (ADI-R) shall be administered with validation of diagnosis by a physician (preferably a child psychiatrist) and/or a fully licensed psychologist, unless the diagnosis is made by either of those professionals.

The CMHP, as defined above, will use the appropriate ADOS-2 Module that includes the Toddler Module, or Module 1, 2, or 3. The ADOS-2 Modules are appropriate to use from 12 months of age through adulthood. The ADOS-2 is to be administered at intake and discharge.

An ASD developmental family history interview, such as the ADI-R, shall be administered by the clinicians who are required to obtain advanced training in conducting the ADI-R. Interviews should thoroughly address all domains relevant to ASD (social affective/communications skills, restricted repertoire).

The target group that will be covered for the Applied Behavior Analysis Home and Community Based Services benefit and the MIChild benefit are children, ages 18 months through five years, with a diagnosis of ASD based upon a medical diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-R) of Autistic Disorder, Asperger's Disorder or PDD-NOS and who have the developmental capacity to clinically participate in the available interventions covered by the benefit. When the DSM V goes into effect, with expected new diagnostic criteria, a medical diagnosis of ASD will include the child in the target group as operationalized below.

The target group criteria for ASD is operationalized using the criteria below as modified from the current DSM IV-R and has been operationalized in consideration of the upcoming diagnostic changes in the DSM V:

To be diagnosed with AUTISTIC DISORDER, the child must exhibit:

A. A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):

(1) Qualitative impairment in social interaction, as manifested by at least two of the following:

(a) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
(b) failure to develop peer relationships appropriate to developmental level
(c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
(d) lack of social or emotional reciprocity

(2) Qualitative impairment in communication as manifested by at least one of the following:

(a) delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
(b) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
(c) stereotyped and repetitive use of language or idiosyncratic language
(d) lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

(3) Restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

(a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
(b) apparently inflexible adherence to specific, nonfunctional routines or rituals
(c) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole body movements)
(d) persistent preoccupation with parts of objects

To be diagnosed with ASPERGER'S DISORDER, the child must exhibit:

A. Qualitative impairment in social interaction, as manifested by at least two of the following:

(1) marked impairment in the use of multiple nonverbal behaviors, such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
(2) failure to develop peer relationships appropriate to developmental level
(3) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
(4) lack of social or emotional reciprocity

B. Restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

(1) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
(2) apparently inflexible adherence to specific, nonfunctional routines or rituals
(3) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole body movements)
(4) persistent preoccupation with parts of objects

C. A clinically significant impairment caused by the disturbance.

D. No clinically significant general delay in language.

E. No clinically significant delay in cognitive development [Developmental Quotients (DQ) or Intelligence Quotient (IQ) > 75] or in the development of age-appropriate self-help skills, adaptive behavior (other than in social interaction), and curiosity about the environment.

To be diagnosed with PERVASIVE DEVELOPMENTAL DISORDER-NOT OTHERWISE SPECIFIED, the child must exhibit:

A. Substantial and prominent impairment in:

(1) social interaction
(2) language as used in social communication, and
(3) symbolic or imaginative play

B. Impairment which is indicated by satisfaction of at least four diagnostic criteria from (1), (2), and (3), including at least one criterion from (1) and one criterion from (2):

(1) Qualitative impairment in social interaction, as manifested by at least two of the following:

(a) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
(b) failure to develop peer relationships appropriate to developmental level
(c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
(d) lack of social or emotional reciprocity

(2) Qualitative impairment in communication, as manifested by at least one of the following:

(a) delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
(b) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
(c) stereotyped and repetitive use of language or idiosyncratic language
(d) lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

(3) Restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

(a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
(b) apparently inflexible adherence to specific, nonfunctional routines or rituals
(c) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole body movements)
(d) persistent preoccupation with parts of objects

To be eligible for this benefit, a diagnosis of ASD must not be attributable to a disorder of sensory impairment (e.g., deafness), to a primary language disorder, to schizophrenia, or to social phobia. The ASD is not associated with a progressive neurodegenerative condition that would preclude anticipated benefits of treatment, as determined by a physician. The ASD is not associated with motor or sensory deficits so severe as to preclude benefit from treatment.

IV. Independent Evaluation

The CMHP, as defined in Section III of this document, applies needs-based criteria for ABA services to determine whether the child is eligible for ABA services.

Needs Based Criteria:

The child demonstrates substantial functional impairment in social interaction (as evidenced by needing ABA to address two or more items from A below) and significant functional impairment in age-appropriate activities due to the interference by restricted repetitive and stereotyped patterns of behavior, interests and activities (as evidenced by needing ABA to address one or more items from B below).

A. Qualitative impairment in social interaction, as manifested by at least two of the following:

(1) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
(2) failure to develop peer relationships appropriate to developmental level
(3) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
(4) lack of social or emotional reciprocity

B. Restricted, repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

(1) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
(2) apparently inflexible adherence to specific, nonfunctional routines or rituals
(3) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole body movements)
(4) persistent preoccupation with parts of objects

The child may possess age-appropriate expressive and receptive language skills, learning [defined as cognitive development (DQ or IQ > 75)], self-care skills, mobility, adaptive behavior (other than in social interaction), and curiosity about the environment.

V. Independent Assessment

The independent assessment is performed by a psychologist who is fully-licensed, limited-licensed or temporary limited licensed by the State of Michigan (MCL 333.182 *et seq.*) and who has one year of experience working with children with ASD.

The independent assessment by the psychologist will determine recommendations for the intensity of the ABA service and should include cognitive testing. If cognitive testing is not completed at the initial assessment, it is required to be completed within the first quarter of intervention using one of the following cognitive assessment tools:

Cognitive Assessment Tools

Cognitive Assessment Tool	Age Range	Purpose of Tool
Mullen Scales of Early Learning	Children from birth to 5 years 8 months of age	Assesses motor, language, spatial processing skills, and global cognitive ability
Wechsler Preschool and Primary Scale of Intelligence-III (WPPSI-III) or Wechsler Preschool and Primary Scale of Intelligence-IV (WPPSI-IV)	Children 2 years 6 months of age through 7 years 6 months of age	Assess processing skills and the child's global IQ
Differential Ability Scales-II (DAS-II)	Children 2 years 6 months of age through 17 years 11 months of age	Assesses a child's global cognitive ability

An adaptive behavior assessment, the Vineland Adaptive Behavior Scales- Second Edition (VABS-2) Interview must be administered at the time of the cognitive testing. The VABS-2 is an adaptive behavior assessment that is used from birth to 90 years of age and is administered at intake, annually and whenever there is a level of change.

It is required that one of the behavioral outcome measurement tools be used and administered by a Board Certified Behavior Analyst (BCBA), licensed or limited licensed psychologist (LP, LLP), or CMHP (that meet the provider qualifications outlined under VII Provider Qualifications and within their scope of practice) every 6 months for every child that is receiving Early Intensive Behavior Intervention (EIBI).

Behavior Outcome Measurement Tools

Behavior Outcome Measurement Tool	Age Range	Purpose of Tool
Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP)	Children from birth to 4 years of age	Assesses verbal behavior, play based behaviors
Assessment of Basic Language and Learning Skills Revised (ABBLLS-R)	Children from birth to 8 years of age	Assesses expressive and verbal language

Other medically necessary assessments will be performed by appropriately qualified professionals of other functional domains to determine service needs leading up to the individual plan of service (IPOS) development. Results from the independent assessment and any other medically-necessary assessments by qualified providers, including but not limited to behavioral, psychosocial, communication/speech, occupational and/or physical therapy assessments, as well as health/medical concerns and psychosocial/family support needs are information used in the person-centered planning process. Assessment and planning functions are completed by a team of individuals with a case manager or supports coordinator, or other qualified staff overseeing the development of the IPOS. The strengths, needs, preferences, abilities, interests, goals and health status of the child are determined through pre-planning and the person-centered planning process using the results of the independent assessment, other medically necessary assessments by qualified providers, and the family. For children, the concepts of person-centered planning are incorporated into a family-driven, youth-guided approach that encompasses the belief that the family is at the center of the service planning process and the service providers are collaborators.

The IPOS includes: the identification of outcomes based on the child's and family's stated goals; the establishment of meaningful and measurable goals to achieve identified outcomes; determination of the amount, scope, and duration of all medically-necessary services (including ABA) for those supports and services provided through the public mental health system; and identification of other services and supports the child and family or authorized representative(s) may require, to which the public mental health system will assist with linking the family or authorized representative(s). Each child and family must be offered the choice of working with a case manager, supports coordinator, other qualified staff, or an independent facilitator to assist them in being actively engaged in the IPOS development process. The case manager, supports coordinator, or other qualified staff will perform the core requirements of case management. This will include linking the child and family back to the medical home, and assure linkage of planning and information to the child's PCP. The IPOS is a dynamic document that is revised based on changing needs, newly-identified or developed strengths, and/or the result of periodic reviews and/or assessment. A formal review of the IPOS is to occur no less than annually with the child and family.

VI. ABA Intervention

ABA services are available for Medicaid beneficiaries diagnosed with ASD and are provided for all levels of severity of ASD. The behavioral intervention should be provided at an appropriate level of intensity in an appropriate setting(s) for an appropriate period of time, depending on the needs of the child and their family within their community. Clinical determinations of service intensity, setting(s), and duration are designed to facilitate the child's goal attainment. These supports may serve to reinforce skills or lessons taught in school, therapy or other settings, but are not intended to supplant services provided in school or other settings or to be provided when the child would typically be in school but for the parent's choice to home-school the child. Each child's plan must document that these services do not include special education and related services defined in the Individuals with

Disabilities Education Improvement Act of 2004 (IDEA) that are available to the individual beneficiary through a local education agency. The recommended service intensity, setting(s), and duration will be included in the child's IPOS, with the clinical team and the family reviewing the IPOS at regular intervals (minimally every three months) and, if indicated, adjusting service intensity and setting(s) to meet the child's changing needs. Intensity includes the number of hours of the intervention that is provided to the child. Service intensity determination will be based on research-based interventions integrated into an IPOS with input from the planning team.

Treatment methodology will use an ethical, positive approach to any serious behaviors (e.g., self-injury, aggression) based on a comprehensive bio-psychosocial assessment including, but not limited to, functional analysis/assessment performed by a BCBA. The use of punitive, restrictive, or intrusive interventions is prohibited during ABA. The use of restraints, seclusion, and aversive techniques are prohibited by the Michigan Department of Community Health (MDCH) in all community settings.

There are two levels of intensity within ABA services: Early Intensive Behavioral Intervention (EIBI) and Applied Behavioral Intervention (ABI). EIBI is for children with a diagnosis of Autistic Disorder and is provided an average of 10-20 hours a week (actual hours as determined by a behavior intervention plan and interventions required). EIBI is appropriate for children 18 months through age 5 as defined by the child's ability to actively engage in the therapeutic treatment process. ABI is for children with Autistic Disorder whose family does not choose EIBI, children with Asperger's Disorder or PDD-NOS, and is provided an average of 5-15 hours a week. This range may fluctuate considerably over the course of treatment and is closely determined by interventions specified in the behavioral intervention plan and the child's mastery of skills. ABI is appropriate for children with ASD between the ages of 18 months through 5 years who are not receiving EIBI services.

A. Early Intensive Behavioral Intervention (EIBI)

EIBI is a structured ABA program that relies upon discrete trial training (DTT) methods and incidental teaching opportunities that can be administered in a child's home or clinic setting. This intensive intervention is available for children who have a diagnosis of 299.0 Autistic Disorder. It is typically provided in the home or in a center, several hours per day, five to seven days per week for two to three years. EIBI is used for reducing intrusive, disruptive behaviors, and/or stereotypic autistic behaviors and for improving socially acceptable behaviors and communication skills. DTT and other strategies are utilized over the course of treatment to teach imitation, establish play behaviors, integrate the family into treatment, develop early expressive and abstract language, increase peer interactions, social skills, academic skills, and move toward integrating the family into the community and school system. The comprehensive individualized ABA behavioral intervention plan is part of the child's IPOS and identifies specific targeted behaviors for improvement and includes measurable, achievable, and realistic goals for improvement. Ongoing determination of this level of service (every six months) requires evidence of measurable and ongoing improvement in targeted behaviors as demonstrated with the use of reliable and valid assessment instruments, such as Assessment of Basic Language and Learning Skills-Revised (ABLLS-R) or Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP). The IPOS is updated as the child gains new skills and addresses maintenance of acquired skills in a clear progression over the course of the intervention. The IPOS will be reviewed at regular intervals (minimally every three months) and, if indicated, adjusted for service intensity and settings to meet the child's changing needs. This intensive treatment involves training the parents/caregivers to continue the behavioral interventions in the home environment. Coordination with the school and/or early intervention program is also critical.

B. Applied Behavioral Intervention (ABI)

ABI includes a variety of ABA "established treatments" to increase functional communication, independent self-care tasks, receptive language, expressive language, play behaviors, social skills, imitation, and/or any additional behaviors that will enable the child to more readily integrate with typically developing peers. Services may include comprehensive behavioral intervention plans, incidental teaching, naturalistic teaching, pivotal response treatment, peer training, modeling, schedules, story-based intervention packages, and/or other ABA "established treatments" which focus on teaching specific adaptive skills. As part of the IPOS, there is a comprehensive individualized behavioral treatment plan that includes specific targeted behaviors for improvement, along with measurable, achievable, and realistic goals for improvement. Ongoing determination of this level of service (every six months) requires evidence of measurable and ongoing improvement in targeted behaviors as demonstrated with the use of reliable and valid assessment

instruments (i.e., ABLLS-R, VB-MAPP). If indicated, the plan may adjust service intensity and setting(s) to meet the child's changing needs. ABI includes training for parents/caregivers that continue the intervention outside of the ABI professional intervention to extend the treatment into the home.

VII. Provider Qualifications

ABA services are provided to increase developmentally-appropriate skills to facilitate a child's independence. These services must be provided directly to, or on behalf of, the child by training their parents/caregivers, ABA Aides, and/or a Board Certified Assistant Behavior Analyst (BCaBA) to deliver the ABA services. The ABA services must be provided under the supervision of a BCBA, other appropriately qualified licensed or limited licensed psychologist (LP,LLP), or master's prepared CMHP working within their scope of practice.

- LPs and LLPs must have extensive knowledge and training in ABA. Extensive knowledge is defined as having taken documented course-work at the graduate level at an accredited university in at least three of the following six content areas:

    1. Ethical considerations
    2. Definitions, characteristics, principles, processes, and concepts of behavior
    3. Behavioral assessment, selecting interventions outcomes, and strategies
    4. Experimental evaluation of interventions
    5. Measurement of behavior, and developing and interpreting behavioral data
    6. Behavioral change procedures and systems supports

- The CMHP must possess a minimum of a master's degree from an accredited institution in one of the degree categories approved by the Behavioral Analyst Certification Board (BACB).

- The LP, LLP, or CMHP supervising the ABA plan must have one year of experience in diagnosing and/or treating children with ASD based on the principles of ABA, must enroll in a BCBA-eligible course sequence within one year of the time they begin providing ABA services, must complete all coursework and experience requirements, and be certified as a BCBA no later than September 30, 2016.

- The LP and LLP must work in consultation with a BCBA and the CMHP must be supervised by a BCBA. If the LP or LLP does not have the documented course-work as defined above, they are considered to be a CMHP requiring supervision by the BCBA. The BCaBA must have certification as a BCaBA through the BACB and work under the supervision of a BCBA. The BCBA must provide one hour of supervision for every 10 hours of direct treatment. Other Bachelor-degreed professionals (supervised by a BCBA) may provide direct provision of ABA services.

- The ABA Aide must: be at least 18 years of age, be able to prevent transmission of communicable disease, be able to communicate expressively and receptively, be able to report on activities performed, be in good standing with the law, be able to perform basic first aid procedures, and be trained in the child's plan of service. The ABA Aide must receive training in the principles of behavior, behavioral measurement and data collection, function of behaviors, basic concepts of ABA, generalization and its importance in sustainability of learned/acquired skills and medical conditions/illness that impact behaviors. The ABA Aide must work under the supervision of a BCBA, LP, LLP or CMHP overseeing the ABA plan.

VIII. Billing, Reimbursement and Coding

Autism Screening

Autism screening services may be billed by the appropriate PCP/Pediatrician. Information regarding fee screens and coding configuration is located in the Practitioner database on the MDCH website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Physicians / Practitioners / Medical Clinics.

Autism Assessment and Intervention

Information contained in this policy is to be used in conjunction with chapters of the Medicaid Provider Manual including the Billing & Reimbursement Chapters and the Practitioner Chapter, as well as the related procedure code databases located on the Michigan Department of Community Health (MDCH) website. (Refer to the Directory Appendix for website information).

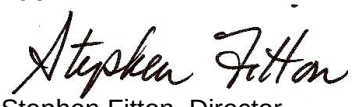
Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

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

Approved



Stephen Fitton, Director
Medical Services Administration