

Durable Medical Equipment & Supplies Medicaid Provider Liaison Meeting

Capitol Commons Center
Monday, September 14, 2015
1:00 p.m. – 3:00 p.m.

Minutes

Welcome and Introductions

Cindy Linn opened the meeting and introductions were made.

New Bulletins

MSA 15-25 was released on July 1, 2015, and discusses revisions to blood glucose testing supplies policy. The revised policy allows for high quantities for insulin-treated and non-insulin treated adults.

MSA 15-28 was also released on July 1, 2015, and discusses the development of used rates for specified Durable Medical Equipment (DME). Several areas of concern with MSA 15-28 were discussed, including the documentation process for used DME that was not manufactured with a serial number. In response, Lisa Trumbell indicated that a detailed description of the item, including the brand name and model, would be sufficient to document DME that does not have a serial number. Providers will still have the option to provide either new or used equipment.

MSA-1656 Documentation Issues

Meeting attendees were provided with a handout outlining several examples of documentation issues with the submission of the MSA-1656 form. While it is the responsibility of the therapist performing the evaluation to complete the MSA-1656 form, meeting participants were reminded that it is important for DME providers to be able to identify common documentation errors.

A meeting attendee requested clarification on how to bill Medicaid for a specialty wheelchair head rest when standard equipment will not meet a beneficiary's needs, since there is only single billing code for all head rests. In response, Lisa agreed to look into the issue and share some additional information with the provider when the meeting minutes are posted.

Update: Following the meeting, Lisa reviewed the website of the manufacturer of the sample headrest provided at the meeting and researched other manufacturers, the long descriptions of Healthcare Common Procedure Coding System (HCPCS) codes E0955 and E1028, and the Pricing, Data Analysis and Coding (PDAC) contractor's website. Although the sample Planar headrest is different than the sample i2i headrest, these items fall within the same HCPCS code. Until the manufacturer provides a PDAC letter indicating the i2i has a different code assigned to it or has the American Medical Association (AMA) coding board develop a new HCPCS code, Medicaid must code the i2i under the E0955 for the headrest and the E1028 for the swing-away hardware.

Reporting Waste, Fraud and Abuse

In 2012, an audit by the federal government revealed many instances of Medicaid waste, fraud and abuse among DME providers. In response, MDHHS is encouraging providers to report fraudulent or abusive behavior by other providers to the Office of Inspector General (OIG). Some common forms of waste, fraud and abuse among DME providers include billing Medicaid for items that are not delivered to the beneficiary, billing for items that are not medically necessary and misleading beneficiaries into paying for a Medicaid-covered item out-of-pocket. Meeting attendees were provided with contact information for OIG.

Liaison Meeting Schedule

MDHHS staff and meeting attendees discussed the current DME liaison meeting schedule in order to determine if any changes need to be made in the future to better accommodate providers and MDHHS staff. The group agreed to continue with quarterly meetings on Mondays from 1:00 pm-3:00 pm.

National Correct Coding Initiative (NCCI) Procedure-to-Procedure Medically Unlikely Edits (PTP-MUE)

The Centers for Medicare and Medicaid Services (CMS) developed the NCCI to promote national correct coding methodologies and reduce improper coding that may result in inappropriate payments in Medicare Part B claims and Medicaid claims. Two types of edits were developed: NCCI PTP edits, which define pairs of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes that should not be billed together, while MUEs define for each HCPCS/CPT code the maximum units or services provided for a single beneficiary on a single day of service. However, MDHHS may bypass NCCI edits if prior authorization has been obtained, and may request deactivation of an edit for medical reasons, state laws, etc. NCCI edits are updated quarterly, and may be viewed on the CMS website at www.medicaid.gov >> Medicaid >> By Topic >> Program Integrity >> National Correct Coding Initiative in Medicaid.

Other Issues

Bulletin MSA 14-60

Bulletin MSA 14-60 became effective on January 1, 2015, and expands coverage beyond hospital-grade electric breast pumps. In response to beneficiary feedback on the implementation of the policy, meeting attendees were reminded to ensure that appropriate equipment is provided to meet each beneficiary's individual needs.

IDC-10

Effective October 1, 2015, providers will be required to use ICD-10 diagnosis codes when billing for services. In order to allow providers time to prepare for billing changes, a meeting attendee inquired about whether a list of ICD-10 codes will be available in the Medicaid Code and Rate Reference tool in the Community Health Automated Medicaid Processing System (CHAMPS) prior to October 1 for providers to review. In response, MDHHS staff indicated that a preview of ICD-10 codes in CHAMPS is not anticipated prior to October 1, but that they would look into the issue further and provide additional information. A participant also requested additional information regarding the process for submitting Medicaid claims using ICD-9 diagnosis codes if it is possible a determination on the claim may not be made until after October 1. Providers are encouraged to visit the ICD-10 website www.michigan.gov/medicaidproviders >> HIPAA ICD-10. The website offers various tools to assist providers through the transition.

Transportation

Due to provider expense involved in servicing a Medicaid beneficiary's equipment in their home and other labor costs, a meeting attendee requested that Medicaid allow providers to require a Medicaid beneficiary to travel to an appointment when Non-Emergency Medical Transportation (NEMT) is available. In response, MDHHS staff noted that MDHHS cannot require beneficiaries to travel to the DME provider. A workgroup has been meeting to discuss this issue, and the need for future policy changes is being examined, as well.

Reimbursement for MI Health Link Beneficiaries

A participant reported that services to beneficiaries of the new integrated care demonstration, MI Health Link, are currently being reimbursed at no more than 80% of the Medicare reimbursement rate. MDHHS staff responded that while Medicaid cannot pay more than the Medicare reimbursement rate or adjust its fee schedule based on changes in the reimbursement rates established by other payers, possible solutions to this problem will be explored. Reimbursement rules under MI Health Link may be different than Fee-for-Service (FFS) Medicaid. Providers may email questions to integratedcare@michigan.gov.

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Complex Rehab Benefit

A participant reported that a provider workgroup has been meeting to discuss recommendations to MDHHS for changes to complex rehab benefit policy in Medicaid, and the workgroup expects to submit their recommendations by the end of September 2015.

Next meeting: Monday, December 14, 2015 1:00 – 3:00PM CCC Lower Level Conf. E

Please be sure to sign-in upon arrival and provide your email address for electronic notification of future meetings, including minutes from this meeting. – Thanks.