

Michigan Department of Community Health
Medical Services Administration

Durable Medical Equipment & Supplies
Medicaid Provider Liaison Meeting
Capitol Commons Center
Monday, April 9, 2012
1:00 p.m. – 3:00 p.m.

Welcome and Introductions

Lisa Trumbell opened the meeting; introductions were made.

Purpose of Meeting

Cindy Linn indicated the purpose of the meeting was for the Michigan Department of Community Health (MDCH) to provide Medicaid updates and to provide an opportunity for providers to voice concerns they have regarding durable medical equipment (DME) and supplies. It was stressed to not wait until meetings to voice concerns. If providers have a problem please contact MDCH so that research can be completed in an attempt to provide a resolution before the meeting.

Budget/Other Medicaid Updates

Dick Miles explained that we are in the second year of the Snyder administration and the budget is doing well and is sustained. There are a couple minor reductions for fiscal year (FY) 2013 but nothing that creates major issues. There is an expected 2.4% increase of Medicaid beneficiaries for FY13, though over the course of the last few months there has been stabilization in Medicaid caseloads. There are new components to the budget. There is \$34 million built into the budget for autism coverage for Medicaid beneficiaries. Healthy Kids Dental program currently covers 65 counties and the plan is to expand statewide over the next 4 years. As part of the Affordable Care Act (ACA), program enhancements include increasing primary care physician (PCP) rates to equal Medicare rates, in which MDCH will get 100% federal match. Only services provided by an internal medicine physician, family practice physician, or pediatrician are eligible for the 100% match. MDCH is currently awaiting federal guidance as to how states are to implement this change.

MDCH estimates a savings of \$30 million dollars for the implementation of the Integrated Care Project. This plan applies to dual eligible beneficiaries (persons with Medicare and Medicaid coverage).

CSHCS Transition into health plans

Jackie Prokop added that there is movement to enroll beneficiaries who have both Children's Special Health Care Services (CSHCS) and Medicaid coverage into the Medicaid health plans. Currently, if a beneficiary is CSHCS only or CSHCS/Medicaid they are excluded from enrollment into a Medicaid health plan. Enrollment into Medicaid health plans will be mandatory for beneficiaries with CSHCS and Medicaid coverage. Beneficiaries with CSHCS only continue to be exempt from the health plan enrollment. MDCH is currently working with the health plans with a target date of October 1, 2012. This may not be a solid date. Jackie asked for input regarding this change and offered to send comments to the planning committee.

Mobility, Positioning and Seating Evaluation (MSA-1656) Update

Lisa Trumbell explained that the new MSA-1656 form will have changes to it. The providers that fill this form out will notice that it is a lot easier to complete than the older version. Policy will change regarding some items that require evaluation and prior authorizations. The goal is to make the form closer to Medicare as well as other State Medicaid Programs. The plan is to develop educational material to assist providers in completing the form. Lisa says the main comments that people shared regarding the last 1656 form was that physicians believed it was their responsibility to fill the form out. Lisa reiterated that physicians do not complete the form; it is for physiatrists, physical therapists, occupational therapists, or RNs with at least 2 years of rehabilitative experience to complete.

A question was asked by an attendee wanting to know a rough estimate of when the new form will be available for use.

Lisa explained that MDCH wanted physical and occupational therapists to have enough time to test the form when it was posted online and no one completed it. Many attendees expressed they had no idea the form was available for testing

purposes. Lisa said that she hopes to get it out in the next couple of weeks barring any other issues from providers. Jackie Prokop added that the policy promulgation process has started; it is in the final stages of internal review and MDCH will send it out for public comment shortly.

At attendee stated he didn't fill out the form because he thought there was a pilot group that was to test out the form and would report back to MDCH.

Lisa says that no one from the group responded to the list serv email or filled out the form. Lisa asked that every attendee makes sure their email is correct before they left the meeting so they receive future correspondence.

A provider asked, with the new form coming out, would it be possible for policy to state that once a provider submits for prior authorization (PA) an approval or denial is granted, rather than a request for information (RFI). It is a costly loop that providers encounter. Also, if the person who works on the prior authorization signs their name to it, the provider will know who to contact with any inquiries.

Lisa responded by stating those issues are related to operations rather than policy. MDCH will bring those concerns to the operations staff to be addressed.

Re-Pricing Of Penny Screen Items

Lisa explained that if providers do not submit an invoice, PAs will be priced at a penny screen until an invoice is received. This topic is being brought up because of delays in getting those penny screens re-priced. The Program Review Division (PRD) could not attend the meeting so Lisa spoke with the Director. There were examples sent to PRD and the Director will get back to those individuals. The goal for completing re-pricing requests is 10 days. Over the last few months the turnaround time has improved to within 6 business days. They do acknowledge that there were delays in re-pricing but there should be improvements now due to process changes.

A provider asked if the invoice is sent with the PA request, would the pricing appear on the approved authorization? She is finding that the invoice information is being requested again after they sent it already.

Lisa says that if this is happening providers should contact PRDs manager, Lori Hinkle. Lisa stated only contact Lori if a PA was received and it came back at a penny screen. Please allow at least 3 business days to respond to inquiries.

Another attendee asked if operations staff attended these meetings because she has an issue to discuss.

Lisa explained they were at our last meeting and typically do attend DME meetings.

Is there anyone providers can call to assure that faxed PAs are being received? A few different providers mentioned having major issues with getting faxes to go through.

Lisa says this is an operations issue. She suggested getting examples together and contacting Lori Hinkle in PRD.

Lisa spoke in regards to getting a group together to talk with Sue Moran about processes in regards to the 1656 and prior authorization.

A provider mentioned the HME and CRT committees had compiled a summary of the reports of how much money the DME providers are making. MDCH has had these in the past but have lost them along the way, so a copy of recent reports was provided to Lisa.

BiPAP/CPAP Policy Concerns

Lisa discussed the BiPAP/CPAP policy because there was confusion as to who does the ordering and signing of prescriptions. Lisa further clarified that a physician's assistant can order but they are not enrolled with Medicaid as providers so when it comes time to submit the claim, the supervising physician's NPI would be noted on the claim form as the ordering provider. Lisa noted that the ACA might change this. Also, for CSHCS beneficiaries, the subspecialist must be the ordering provider, not the general practitioner.

Lisa explained that after the initial period, the standards of coverage for BiPAP say that physicians must address patient compliance and indicate whether the equipment is stabilizing the patient. For CPAP, physicians must address patient compliance, and may also submit use logs (if available) as supporting documentation.

A provider asked what to do with a patient who fails the standard of coverage but the physician or patient wants to continue.

Lisa replied that physician documentation must support the request.

A provider asked if a patient fails standards of coverage and refuses to give the equipment back, can providers rightfully bill the patient for the equipment.

Yes, a patient can be held responsible for payment. Lisa added that it is the physician's job to tell beneficiaries they have the responsibility to return the equipment if it is no longer medically necessary. MDCH suggests that this is written up front.

PA Denial Letter Explanations

Lisa explained that when a PA is denied, the denial letter should have the specific policy information stated on it. However, if the denial letter is received and the denial doesn't make sense, contact the PRD.

ICD-10 Update

The Center for Medicaid and Medicare Services (CMS) delayed the October 2013 start date to October 2014. MDCH does not know how long the delay is but is moving forward as if there was no delay. MDCH will align with CMS ICD-10 implementation date.

Next Steps

The next DME meeting is October 8, 2012.

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.