

Michigan Department of Community Health
Medical Services Administration

Prosthetics & Orthotics
Medicaid Provider Liaison Meeting

Capitol Commons Center
Monday, May 14, 2012
1:00 p.m. – 3:00 p.m.

Meeting Minutes

Welcome and Introductions

Cindy Linn opened the meeting, welcomed the participants and had all parties introduce themselves.

Purpose of Meeting

Lisa Trumbell 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 Prosthetics & Orthotics.

Budget/Medicaid Updates

Dick Miles, Deputy Director, updated the group on MDCH budget. The Integrated Care Project for FY13 budget savings is estimated at \$30 million. This plan applies to dual eligible beneficiaries (persons with Medicare and Medicaid coverage). There was a little less than \$1 million dollars given to develop a plan for implementation for this project.

The executive budget was introduced at the end of January 2012. The revenue estimating conference is this week. This conference is when they figure out what happens with tax revenues in the state, which in turn helps them decide what the final decisions are relative to the budget.

Over the last few months there has been stabilization in Medicaid caseloads. There are currently around 1.9 million people on Medicaid in the State. There are a couple minor reductions for FY13 but nothing that creates major issues. Graduate Medical Education (GME) and the Home Help Program are programs included in the cuts. There are new components to the budget. There is \$34 million built into the budget for autism coverage for Medicaid and Children's Special Health Care Service (CSHCS) beneficiaries. Healthy Kids Dental program currently cover 65 counties and the plan is over the next 4 years a phase in approach to expand statewide.

Program Enhancements include increasing primary care physician (PCP) rates to equal Medicare rates, as part of the Affordable Care Act (ACA). MDCH will get 100% federal match. To get the 100% match it must be an internal medicine physician, family practice physician, or pediatrician. If the law holds, the plan will add 500,000-600,000 more Medicaid beneficiaries in January 2014.

Chiropractic Services were added back into covered benefits starting June 2012.

MDCH is doing well as far as funding for the Medicaid Program.

CSHCS Transition into Health Plans

Jackie Prokop stated that plans are in progress to enroll beneficiaries who have both Children's Special Health Care Services (CSHCS) and Medicaid coverage into Medicaid Health Plans. Enrollment will be mandatory for this population. MDCH is currently working with the health plans and has set a target date of October 1, 2012 to begin enrollment. CSHCS ONLY beneficiaries will remain in fee-for-service and will continue to be exempt from managed care enrollment.

O & P Workgroup Updates

Lisa addressed concerns that were brought to the workgroup. Lisa reminded attendees that the O&P May workgroup meeting is cancelled because she and the Program Review department are reviewing all O&P codes. This will give time to complete research and review the codes. Lisa will email the O&P workgroup about a possible June date for the meeting.

Lisa handed out an action item list to attendees from Michigan Orthotics & Prosthetics Association (MOPA), and put together a list that shows progress that has been made addressing original concerns that were brought to MDCH last year. The group has worked very hard on the concerns.

There was a request from MOPA to have a standardized letter of medical necessity (LMN) form because providers were struggling with not knowing what information was needed to fill it out correctly and thoroughly. The LMN is owned by MOPA not MDCH. Lisa reminded attendees that if the form is not filled out correctly or is missing information that MDCH requires, it can be sent back to the provider. If anyone is interested in obtaining the form please contact MOPA.

Another struggle among providers concerns beneficiaries who have spend down, now called the deductible program. Issues that were brought to the attention of MDCH include beneficiaries that were not submitting medical expenses to their DHS worker. Also, when the items are turned into the worker, there is a delay in the determination. When a deductible beneficiary needs service and they are not yet Medicaid eligible, the beneficiary is responsible for payment. If the beneficiary agrees to pay the provider for the service, the beneficiary can turn the expense receipt in to DHS. The other alternative is that if the beneficiary does not actually pay for the service but makes an agreement to pay the provider, documentation of the incurred expenses (unpaid bills) can be turned in to DHS. It is important that providers inform the beneficiary that it is their responsibility to get the expense information to their DHS worker. Some providers will submit receipts directly to the caseworker on behalf of the beneficiary to speed up the process. If the caseworker is taking an extremely long amount of time calculating the deductible, Lisa suggested speaking with the County Manager or Director.

Is there any way as a provider to look up what the beneficiary deductible is on Community Health Automated Medicaid Processing System (CHAMPS)?

Yes, there is a database through MPHI that shows deductible amounts. It can be found on the MDCH website under provider tips. If providers need the information they can email Provider Support.

Coding for Benik-Custom or Prefab

It was noted on the action form that the BD88 mod was being down coded to an A4466 according to Pricing, Data Analysis and Coding (PDAC). The A4466 is still manually priced. If there are any issues or concerns with coding please contact Benik and have them reevaluate with PDAC.

Coverage for Carbon AFO's

Lisa stated that if there is proof that medical needs exist beyond what is covered by the standard HCPCS code then to please share it with her and more research will be done regarding coverage. The least costly item will be covered to meet the person's needs.

Dynamic Movement Orthoses (DMO)-DME

A4466/L1300

Jessica explained that there were problems with understanding which code to bill for. In the letter it says that the finished DMO would be coded as an L1300 and that PBGC9 would be coded to A4466, which does not have the panels in it. Jessica contacted PDAC and asked how providers should bill. PDAC confirmed that billing should be for one code or the other, not both. If it is a finished DMO is coded as L1300. If it is the other code without the finished part, use A4466.

Other Issues

An attendee asked about frequency limits for P&O's for new amputees. This is a follow up question from last meeting.

Lisa still has the information that was provided to her but she needs to meet with the Office of Medical Affairs. It will be addressed.

The fee for suspension sleeves code L5685 is 58% below Medicare rates, which is way off. Can MDCH make this one code a priority?

Lisa has already submitted recommendations for this code, just waiting to hear back on it.

Next Steps

June meeting with the O&P workgroup will be held. The next O&P liaison meeting will be held on Monday August 13, 2012 Conference room E&F.

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.